STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. Building B. Wing	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Hills Center for Nursing and Rehab	109 S Holden Rd Greensboro, NC 27407

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on record review, observation, family and staff interviews, the facility, failed to protect a resident's right to be free from mistreatment by a staff member (Nursing Assistant #1) due to being rough while providing care, making disrespectful comments, and staff members (Nursing Assistants #2 and #4) were observed to continue to provide activities of daily living on Resident #3 while being resistive to care for 1 of 2 residents reviewed for mistreatment (Resident#3). The findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses of Dementia with behavioral disturbances and Alzheimer ' s disease. Resident #3 ' s admission Minimum Date Set (MDS) dated [DATE] indicated Resident #3 had cognitive impairment and required extensive assistance with 2-person physical assist with bed mobility, dependent with 2-person physical assist with transfer, toilet use, extensive assistance of one-person physical assist with eating. A review of care plan dated 5/3/22 and last revised on 7/15/22 revealed Resident #3 was resistive to care by exhibiting aggressive behaviors by biting, kicking, punching at staff, and screaming and yelling profanities. The goal was Resident would cooperate with care through next review. Interventions included staff were to give clear explanation of all care activities prior to an as they occur during each contact and make sure resident is safe, leave and reapproach resident once she is calm. During an interview on 8/15/22 at 4:36 pm with a family member it was indicated that she had reported to staff member an allegation of a staff member handling her family member rough during patient care. She indicated she reported to Resident #3 ' s Nurse (Nurse #2) around 5:00pm on Sunday [DATE], NA #1 was in Resident #3 ' s room providing care and yanked her leg very aggressive and told Resident you better stop. She indicated Resident had Dementia and could be resistive at times when staff provide care. A review of Nurses Progress Note dated 08/14/22 at 5:03 pm read in part Resident #3 ' s family member reported that the assigned NA rough-handled her mother and stated he was frustrated from the previous task he performed. She stated that she did not want him caring for her mother. Both parties were shouting at each other & threats were proposed by them both. Family member stated that he had better not touch her mother ever again! Reported situation to manager on-call. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Scheduler on 8/15/22 at 5:33 pm. She indicated she was the Manger on call on 8/14/22. She indicated she received a call from Nurse #2 on 8/14/22 and she was informed that a family member and staff member were arguing back and forth. She stated she told Nurse #2 to send the staff member home. She stated the staff member also had called her and informed her that the family member was cursing at him and making threats to him, and she told him to go home and come back the next day and talk with management. She stated she sent him home because she did not want it to escalate. She indicated she was not aware of an allegation of mistreatment with Resident #3. An interview was conducted on 8/15/22 at 5:49 pm with NA #1 and he indicated he was providing care for Resident #3 on 8/14/22 while the family member was present. He indicated during care he asked Resident #3 to stop being so aggressive so he could provide care for her. He indicated the family stated he looked a little frustrated, and the family member followed him down the hall. He stated he then called the manager on call because the family member was yelling and cussing at him, and he was told by the Manager on call to go home and return to work the next day. During this interview NA #1 indicated he was present in the dining room at the facility because he was told to come back to work at 2:00 pm on 8/15/22 and was working on the other side of the hallway and around 4:00 pm he was asked by the Director of Nursing to write a statement of what happened on Sunday. He stated he was not being aggressive with the resident and that the resident was aggressive at times and yells when care provided. He indicated it takes 2 people to help with Resident and he and another NA was providing care for Resident, and the other NA left the room briefly to get some soap. An interview was conducted with NA #5 on 8/15/22 at 6:08 pm and it was indicated she was asked by NA #1 to help provide care for Resident #3. NA #5 indicated she was not present during the entire time with NA #1 and the family. NA #5 stated NA #1 had already been in the room prior to asking her to help. During an interview with Nurse #2 on 8/17/22 at 10:01 am it was indicated she was the Nurse that was caring for Resident #3 on 8/14/2022 the evening the allegation was made. She indicated she reported the allegation to the Manager on-call at after dinner around 6:00 pm and NA was sent home by Manager on-call. She also indicated she attempted to contact the Director of Nursing (DON) and was unsuccessful. On 8/19/22 at 10:46 am an observation was made of NA #2 and NA #4 inform Resident prior to beginning care they were going to provide activities of daily living care. NA #2 attempted to wash Resident's face and Resident began to hit at staff cursing and moving about in bed. NA #4 was holding Resident ' s hands and attempting to take clothing off and Resident continued to hit and resist staff. Surveyor intervened and informed staff to go get Nurse. Surveyor went to desk with NA #2 and Nurse stated she had given Resident some Tylenol and they stated they would make the DON aware. During an interview on 8/19/22 at 10:54 am with NA#2 it was indicated Resident #3 is like that all the time, fighting and resisting to let us care for her. NA #2 indicated they sometime come back later, but we just try and get it done. On 8/19/22 at 11:41 am an interview with DON was made and she indicated she believed staff would initially stop providing care when Resident #3 became resistant to care and would re approach. DON indicated it was her expectation staff would stop and reapproach resident that were being resistant during care. She indicated she would continue to educate staff and provide dementia training for caring with residents with behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 8/19/2022 at 1:18 pm it was indicated it sounded like staff sometimes stop care when Resident #3 was resistant to care, and he expected staff to stop when residents were resistant to care and reapproach later.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28265 Based on record review, family and staff interview the facility failed to report the allegation of mistreatment within the specified timeframe of 2 hours. This was evident for 1 of 3 alleged abuse investigations completed by the facility (Resident #3). The findings included: The facility abuse policy 'Allegations of Abuse, Neglect, and Exploitation with the revised date of 11/01/2020 included in part: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e. g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury., or b. Not later 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury ., During an interview on 8/15/22 at 4:36 pm with a family member it was indicated that she had reported to staff member an allegation of a staff member handling her family member rough during patient care. She indicated she reported to Resident #3's Nurse (Nurse #2) around 5:00pm on Sunday [DATE], NA #1 was in Resident #3's room providing care and yanked her leg very aggressive and told Resident you better stop. She indicated Resident had Dementia and could be resistive at times when staff provide care. A review of Nurses Progress Note dated 08/14/22 at 5:03 pm read in part Resident #3's family member reported that the assigned NA rough-handled her mother and stated he was frustrated from the previous task he performed. She stated that she did not want him caring for her mother. Both parties were shouting at each other & threats were proposed by them both. Family member stated that he had better not touch her mother ever again! Reported situation to manager on-call. An interview was conducted with the Scheduler on 8/15/22 at 5:33 pm. She indicated she was the Manger on call on 8/14/22. She indicated she received a call from Nurse #2 on 8/14/22 and she was informed that a family member and staff member was arguing back and forth. She stated she told Nurse #2 to send the staff member home. She stated the staff member also had called her and informed her that the family member was cursing at him and making threats to him, and she told him to go home and come back the next day and talk with management. She stated she sent him home because she did not want it to escalate. She indicated she was not aware of an allegation of mistreatment with Resident #3. During an interview with Nurse #2 on 8/17/22 at 10:01 am it was indicated she was the Nurse that was caring for Resident #3 on 8/14/2022 the evening the allegation was made. She indicated she reported the allegation to the Manager on-call at after dinner around 6:00 pm and NA was sent home by Manager on-call. She also indicated she attempted to contact the Director of Nursing (DON) and was unsuccessful. A review of 24-hour initial report dated 8/15/22 was sent to NC Department of Health and Human Services, Division of Health Service Regulation via fax on 8/15/22 at 6:04 pm. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 08/19/2022 at 11:41 am, she indicated her expectation was for staff to notify the abuse compliance officer who is the Administrator and/or herself of any allegations of abuse, and the investigation would start within 2 hrs. During an interview with the Administrator on 8/19/2022 at 1:18 pm and it was indicated it appeared to a misunderstanding of the allegation. However, his expectation was any allegation of abuse had to be sent within 2 hours to the state, suspend the alleged perpetrator pending investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28265 Based on record reviews, staff and family interviews, the facility failed to provide protection to residents after an allegation of mistreatment for 1 of 3 residents reviewed for abuse (Resident #3) by allowing the alleged perpetrator to come back to work the next day. The findings included: Resident #3 was admitted to the facility on [DATE]. Resident #3's admission Minimum Date Set (MDS) dated [DATE] indicated Resident #3 had cognitive impairment and required extensive assistance with 2-person physical assist with bed mobility, dependent with 2-person physical assist with transfer, toilet use, extensive assistance of one-person physical assist with eating. During an interview on 8/15/22 at 4:36 pm with a family member it was indicated that she had reported to staff member an allegation of a staff member handling her family member rough during patient care. She indicated she reported to Resident #3's Nurse (Nurse #2) around 5:00pm on Sunday [DATE]. NA #1 was in Resident #3's room providing care and yanked her leg very aggressive and told Resident you better stop. She indicated Resident had Dementia and could be resistive at times when staff provide care. A review of Nurses Progress Note dated 08/14/22 at 5:03 pm read in part Resident #3's family member reported that the assigned NA rough-handled her mother and stated he was frustrated from the previous task he performed. She stated that she did not want him caring for her mother. Both parties were shouting at each other & threats were proposed by them both. Family member stated that he had better not touch her mother ever again! Reported situation to manager on-call. An interview was conducted with the Scheduler on 8/15/22 at 5:33 pm. She indicated she was the Manger on call on 8/14/22. She indicated she received a call from Nurse #2 on 8/14/22 and she was informed that a family member and staff member was arguing back and forth. She stated she told Nurse #2 to send the staff member home. She stated the staff member also had called her and informed her that the family member was cursing at him and making threats to him, and she told him to go home and come back the next day and talk with management. She stated she sent him home because she did not want it to escalate. She indicated she was not aware of an allegation of mistreatment with Resident #3. An interview was conducted on 8/15/22 at 5:49 pm with NA #1 and he indicated he was providing care for Resident #3 on 8/14/22 while the family member was present. He indicated during care he asked Resident #3 to stop being so aggressive so he could provide care for her. He indicated the family stated he looked a little frustrated and he to leave the room stated he left the room, and the family member followed him down the hall. He stated he then called the manager on call because the family member was yelling and cussing at him, and he was told by the Manager on call to go home and return to work the next day. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During this interview NA #1 indicated he was present in the dining room at the facility because he was told to come back to work at 2:00 pm on 8/15/22 and was working on the other side of the hallway and around 4:00 pm he was asked by the Director of Nursing to write a statement of what happened on Sunday. He stated he was not being aggressive with the resident and that the resident was aggressive at times and yells when care provided. He indicated it takes 2 people to help with Resident and he and another NA was providing care for Resident, and the other NA left the room briefly to get some soap. An interview was conduct with the NA#5 on 08/15/22 at 6:10pm, she was asked by NA #1 to help provide care for Resident #3. NA #5 indicated she was not present during the entire time with NA #1 and the family. NA #5 stated NA #1 had already been in the room prior to asking her to help. During an interview with Nurse #2 on 8/17/22 at 10:01 am it was indicated she was the Nurse that was caring for Resident #3 on 8/14/2022 the evening the allegation was made. She indicated she reported the allegation to the Manager on-call at after dinner around 6:00 pm and NA was sent home by Manager on-call. She also indicated she attempted to contact the Director of Nursing (DON) and was unsuccessful. Review of the alleged perpetrator's timecard revealed perpetrator had clocked in on 8/15/22 at 2:11 pm and clocked out at 6:01 pm. During an interview with the Director of Nursing on 08/19/2022 at 11:41 am, she indicated her expectation was for staff to notify the abuse compliance officer who is the Administrator and/or herself of any allegations of abuse, and the alleged perpetrator would be suspended until the investigation was completed to make sure all residents are protected. During an interview with the Administrator on 8/19/2022 at 1:18 pm and it was indicated it appeared to a misunderstanding of the allegation. However, his expectation was suspend the alleged perpetrator pending investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on record review and interviews with staff, Physician Assistant and the Medical Director, the facility failed to implement an order from the hospital discharge summary to test blood sugar twice daily for Resident #72. The facility administered injectable and oral diabetes medication to Resident #72 who was diagnosed with diabetes without monitoring the resident's blood sugar from admission to the facility until admission to the hospital. On 8/13/22, Resident #72's blood sugar registered HI on the glucometer. Resident #72 was sent to the emergency department (ED) due to being lethargic and staff were unable to obtain vital signs. At the hospital, Resident #72 ' s blood sugar was recorded as 764 milligrams per deciliter (mg/dl) and the Resident received insulin via intravenous method to lower blood sugar levels. Resident #72 was diagnosed with Diabetic Ketoacidosis (a buildup of acids in your blood that can lead to diabetic coma or even death) /Hyperosmolar hyperglycemia (an extremely high blood sugar level). This deficient practice occurred for 1 of 3 sampled residents reviewed for diabetes care (Resident #72). Immediate jeopardy began on 4/21/22 when the facility failed to monitor blood sugars for Resident #72 who had diabetes and received injectable and oral diabetes medications. The hospital discharge summary included orders to monitor the resident ' s blood sugars twice a day. The facility admission orders did not include blood sugar monitoring twice daily. The immediate jeopardy was removed on 8/18/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. The findings included: A review of Resident #72 ' s hospital discharge (d/c) summary dated 4/17/2022 revealed orders to test blood sugar twice daily. Resident #72 was admitted to the facility on [DATE] and had diagnoses including diabetes mellitus type 2, Parkinson ' s disease, and dementia. Physician orders dated 4/21/22 included Trulicity (an antihyperglycemic injectable medication used to control high blood sugar) 1.5 milligrams (mg)/0.5 milliliters (ml) subcutaneously in the morning every Monday and Metformin HCl (an oral diabetes medication) 1000 mg give 1 tablet by mouth one time a day. Nurse # 1 documented the admission orders. A review of Physician orders from 4/21/2022 through 8/13/2022 revealed no order documented for blood sugar monitoring. During an interview on 8/17/22 at 2:08 pm with Nurse #1 it was indicated she was not completely sure if she had put the orders in the computer from the hospital d/c summary on admission, however she indicated she was the nurse that day. She indicated if it was documented on the discharge summary for Resident #72 to have blood sugar checks done that then there should have been an order to do so. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Quarterly Minimum Data Set (MDS) dated [DATE] revealed resident had cognitive impairment received insulin during the assessment period. A review of Physician progress notes dated 4/27/22, 5/26/22, 6/23/22 read, in part, recent A1c (A blood test that measures your average blood sugar levels over the past three months.) was 6.6% (A level of 6.5% indicates diabetes.) and will check blood sugars before meals and at bedtime. A review of medical record revealed blood sugar was obtained after a fall on 4/29/22 and was 88 mg/dl. A review of the Basic Metabolic Panel dated 5/16/22 revealed the sugar result was high at 220 mg/dl, reference range is 70-99 mg/dl. A review of medical record revealed a blood sugar was obtained on 6/23/22 and was 155 mg/dl. A review of a Progress notes by Nurse #2 dated 8/13/22 read, in part, Resident #72 was found to be severely lethargic, skin cool to touch and staff were unable to obtain vital signs. Blood sugar registered HI, which per the glucometer manufacture information indicates a result of HI is over 600 mg/dl. Spouse was present & agreed with nurse to transfer Resident to hospital ED for evaluation and treatment. Call was placed to on-call Nurse Practitioner and was made aware. A call was placed to 911 to transfer Resident to hospital and emergency medical service arrived and transferred resident to hospital. An interview with Director of Nursing (DON) 8/17/22 at 3:05 pm was conducted and she indicated she was not aware Resident #72 had orders on admission for blood sugar checks. She stated the facility should have verified the orders for the blood sugar checks On 8/17/22 at 3:19 pm an interview with Physician Assistant who indicated an order for blood sugar checks was missed by her and the Physician. She indicated if blood sugar checking was on the orders from the hospital, then the blood sugar should have been checked as ordered. During an interview with the Medical Director (MD) on 8/18/22 at 4:49 pm it was indicated the facility had issues with orders that were not being transcribed as ordered. He indicated for Resident #72 the blood sugar checks were missed and the facility should have been doing the checks as they were ordered. He indicated if the facility had been doing the blood sugar checks, then staff could ' ve seen his blood sugar was rising ahead of time and modified his medications. A review of the EMS report dated 8/13/22 at 7:48 pm revealed upon arrival to facility Resident #72 was responsive to verbal stimuli by name only and blood sugar was obtained, and results read HI. According to the hospital ED documentation dated 8/13/22, Resident #72 had a blood sugar of 764 mg/dl in the ED and was diagnosed with Diabetic Ketoacidosis/Hyperosmolar hyperglycemia and remained in the hospital at the time of the survey. The Resident presented to the ED with altered mental status and was admitted for further management. He was started on an insulin drip for severe hyperglycemia. The Administrator was notified of immediate jeopardy on 8/17/22 at 5:06 pm. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/18/2022 the facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. The facility failed to complete an evaluation of residents #72 medication regimen that identified the need to monitor insulin administration and anti-diabetic medications. Resident #72 medication regimen review did not identify the inadequate monitoring of insulin administration and anti-diabetic medication. Resident #72 received weekly insulin and daily anti-diabetic medication without blood sugar testing as ordered and experienced critically high blood sugars identified at the hospital. A review of the pharmacy medication regimen reviews for the months of April, May, June, and July of 2022 revealed no identification of inadequate monitoring of insulin administration and anti-diabetic medication. On 8/17/2022 the Regional Director of Clinical Services (RDCS), reviewed residents with diabetic medication to ensure residents are receiving blood sugar checks. On 8/17/22 the RDCS notified the Nurse Managers of any opportunities identified during this audit and explained their responsibility to correct by 8/17/2022. On 8/17/2022 the Regional Director of Clinical Service (RDCS), reviewed 30 days of admissions to ensure accuracy of orders. Actions taken by the facility to alter to alter the process or system failure to prevent a serious adverse outcome from reoccurring and when the action will be completed. The Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers educated the Licensed Nurses regarding the process for verifying new admission orders for residents admitted to the facility. The nurse is to call the medical doctor and/or nurse practitioner to verify orders on the discharge summary prior to entering the orders into the residents ' electronic medical record. When the admission orders are entered into the electronic medical record, a second nurse is to verify orders for accuracy when confirming. The Director of Nursing will ensure no licensed nurse will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 8/17/2022 by the Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers. The Regional Director of Clinical Services educated the Director of Nursing and Nurse Managers regarding the validation of new admission orders during the morning clinical meeting for admissions from the prior day. This education was completed on 8/17/2022. Effective 8/17/2022 the Administrator will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance Alleged Date of Immediate Jeopardy Removal: 8/18/2022 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/19/22 the credible allegation of immediate jeopardy was validated by onsite verification. Record reviews and interviews were conducted which verified the audits were completed. Interview with the Regional Clinical Nurse Consultant revealed when a new admission was admitted to the facility, the nurse needed to call the Medical Director or Nurse Practitioner to verify discharge summary orders prior to entering the orders into the resident ' s medical record. She also indicated when admission orders were placed in the medical record, a second nurse was to verify orders when confirming for accuracy, and when the resident entered the facility, they were to take the discharge summary from the resident and verify the orders that were in the system for accuracy. A review of the audits revealed all residents ' orders were reviewed and any discrepancies were corrected. A review of the education training revealed education was provided to staff as stated in the credible allegation. Interview was conducted with staff on 8/19/2022 at 10:52 am who indicated knowledge of what to do for new admission residents and entering the new orders. Interview was conducted with staff on 8/19/2022 at 11:00 am who indicated knowledge of what to do for new admission residents and entering the new orders from the hospital. Interview was conducted with Unit Manager on 8/19/2022 at 11:45 am who indicated knowledge of the process implemented to verify orders from the d/c summary from the hospital for all new patients. Interview was conducted with Staff Development Coordinator on 8/19/2022 at 11:58 am and it was indicated she had the knowledge of how to complete the medication reconciliation for new admissions, and she also indicated a new checklist that was implemented for the completion of new admissions. Interview with the DON on 8/19/2022 at 12:00 pm revealed the new admission audit will help the nurses complete a full assessment of residents ' needs. All medications and treatments will be reviewed for the residents during the admission process. Interviews with staff revealed that education was provided. The immediate jeopardy removal date of 8/18/2022 was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. Building B. Wing	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Hills Center for Nursing and Rehab	109 S Holden Rd Greensboro, NC 27407

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 28265 Based on observation, record review, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following recertification and complaint survey conducted on 11/01/2019. This was for 1 deficiency that was cited in the areas of Resident Assessment/Accuracy of Assessment. And cited on again recertification and complaint survey on 12/16/21 and on the current recertification and complaint survey 08/19/22. The QAA committee additionally failed to maintain implemented procedures and monitor intervention the committee put in place following recertification and complaint survey conducted on 12/16/21. This was evident for 2 deficiencies that was cited in the areas of Quality of Care and Nursing Services and recited on the current recertification and complaint survey of 08/19/22. The QAA additionally failed to maintain implemented procedures and monitor intervention the committee put in place following complaint investigation on 02/05/21. This was evident of 1 deficiency in the area of Food and Nutrition Services: Food Procurement, Store/Prepare/Service- Sanitary and recited on the current recertification and complaint survey on 08/19/22. The duplicate citations during the four federal surveys of record shows a pattern of the facility's inability to sustain and effective QAA program Findings included: This tag is cross reference to: 1.F641: Based on record reviews and staff interviews, the facility failed to accurately code a discharge and a quarterly Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for facility discharge (Resident #98) and 1 of 1 resident reviewed for behaviors (Resident #30). During the recertification and complaint survey on-11/01/19, the facility failed to accurately code Section K-Swallowing/Nutritional Status of the Minimum Data Set (MDS) assessments for 1 of 6 sampled residents reviewed for Nutrition. During recertification and complaint survey on 12/16/21, the facility failed to accurately code the Minimum Data Set (MDS) for opiate medication for 1 of 24 residents reviewed for MDS. 2. F- 684: Based on record review and interviews with staff, Physician Assistant and the Medical Director, the facility failed to implement an order from the hospital discharge summary to test blood sugar twice daily for Resident #72. The facility administered injectable and oral diabetes medication to Resident #72 who was diagnosed with diabetes without monitoring the resident's blood sugar from admission to the facility until admission to the hospital. On 8/13/22, Resident #72's blood sugar registered HI on the glucometer. Resident #72 was sent to the emergency department (ED) due to being lethargic and staff were unable to obtain vital signs. At the hospital, Resident #72 ' s blood sugar was recorded as 764 milligrams per deciliter (mg/dl) and the Resident received insulin via intravenous method to lower blood sugar levels. Resident #72 was diagnosed with Diabetic Ketoacidosis (a buildup of acids in your blood that can lead to diabetic coma or even death) /Hyperosmolar hyperglycemia (an extremely high blood sugar level). This deficient practice occurred for 1 of 3 sampled residents reviewed for diabetes care (Resident #72). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. Building B. Wing	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Hills Center for Nursing and Rehab	109 S Holden Rd Greensboro, NC 27407

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the recertification and complaint survey on 12/16/21, the facility failed to consistently complete wound care as ordered for 2 of 2 sampled residents. 3.727: Based on record reviews and the staff interviews the facility failed to have a Registered Nurse scheduled for 8 consecutive hours a day for 1 (07/25/22) of 30 days reviewed. During the recertification and complaint survey on 12/16/21, the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 7 of 31 days. 4. F 812: Based on observations, record review and staff interviews, the facility failed to label and date food, so it was used by its use-by-date or discarded. Salad dressing, pickle relish and thickened liquids were not monitored in 2 of 2 refrigerated units. During a complaint investigation survey on 02/05/21, the facility failed to maintain the temperatures of hot foods being served from the kitchen's steam table at 135 degrees Fahrenheit (F.) or higher for five of five resident meals that were observed being prepared from the steam table. An interview with the Administrator was conducted on 08/19/22 at 2:35 pm, he revealed that his expectation was for the team to work together to sustain an effective QAPI Committee to ensure the facility does not recite a previous deficient practice. Administrator indicated that this was his goal that the facility does not received any more repeat tags