

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2017
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242 SS=D	<p>483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interview, the facility failed to honor the choice of bath preference for 1 (Resident #5) of 2 sampled residents reviewed for choices in activities of daily living care needs. The findings included: Resident #5 was admitted to the facility on 6/5/17. The resident completed a resident shower/bath preference sheet upon admission which stated a preference for a daily bed bath. The resident care guide, used as an initial care plan, completed on admission stated the resident required limited or extensive assistance with baths. Resident #5 was identified on a resident listing provided by the facility administrator as alert and oriented. Resident #5 was interviewed on 6/9/17 at 2:50 PM. The resident stated, "I had a good bath today. This was the first bath I have had all</p>	F 242	<p>Piney Grove Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Piney Grove Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Further, Piney Grove Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute</p>	6/19/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/16/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2017
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	<p>Continued From page 1</p> <p>week. I would like to have a good bath every day.</p> <p>"</p> <p>Nurse aide documentation from 6/5/17 to 6/9/17 revealed Resident #5 was documented as either not receiving a bath or the record was left blank from 6/5/17 to 6/8/17. The nurse aide documentation documented a partial bed bath on the 7 AM to 3 PM shift on 6/9/17.</p> <p>Resident #5 was listed on the bath schedule to receive a bath on Wednesday and Saturday on the 3 PM to 11 PM shift. She was not on the bath schedule for any other days or times.</p> <p>NA #1, was interviewed on 6/9/17 at 4:50 PM. NA #1 revealed it was difficult to get all the baths or showers done on the 3 PM to 11 PM shift. NA #1 revealed the focus of the nurse aides was to provide incontinence care, eating assistance, and safety with baths or showers as the lesser priority. NA #1 did not recall if Resident #5 received a bed bath from 6/5-8/17 on the 3 PM to 11 PM shift.</p> <p>NA #2, was interviewed on 6/9/17 at 5:05 PM. NA #2 revealed if the bath or shower was not completed on the 3 PM to 11 PM shift another shift completed the task. NA #2 revealed, "We keep them dry, safe, and fed. If we don't have time to give a bath or a shower we tell the nurse so it can be done on another shift." NA #2 stated Resident #5 had baths on the 7 AM to 3 PM shift because the resident had switched rooms since admission. She said she would have to look at the shower schedule to be sure.</p> <p>NA #3, was interviewed on 6/10/17 at 3:15 PM. NA #3, was assigned to Resident #5 on the 7 AM to 3 PM shift on 6/8/17. She stated she thought</p>	F 242	<p>Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>F242 DON/Designee interviewed Resident #1, #3, #4, # 5 to ensure their choices in bathing are documented by 6/14/17. New interview form completed on each of these residents found to have been affected. All residents will be showered/bathed according to preference. Showers or refusals will be documented.</p> <p>An in-service has been initiated for all CNA staff on following the shower/bathing schedule. An in-service has also been initiated for all licensed nursing staff regarding documentation of shower refusal.</p> <p>An in-service on Bathing & Showers per Resident Choice for all CNA staff on how to follow the shower/bathing schedule and documentation in system for ADLs. This in-service will be completed by June 19, 2017. After June 19, 2017 no CNA staff will be allowed to work until in-service is completed. This information will also be added to the orientation process.</p> <p>An in-service on Bathing & Showers per Resident Choice for all licensed nursing staff on how to document bathing/shower refusals; that the refusal must be followed up on by the nurse then documented in PCC. This in-service will be completed by June 19, 2017. After June 19, 2017 no licensed nurses will be allowed to work</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2017
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	Continued From page 2 she gave Resident #5 a partial bed bath on that day but did not document it. The Director of Nursing was interviewed on 6/10/17 at 10:40 AM. She stated the nursing expectation was for residents to receive their preference of either a shower or bed bath. She said the admission paperwork asked the resident preference for showers or bed baths and then this information was put on the care guide and care plan.	F 242	until in-service is completed. This information will also be added to the orientation process. The Director of Nursing/Designee will audit 100% of residents weekly x 6 weeks to ensure showers/baths were given or refusal documented. Then 50% of residents will be audited weekly x 6 weeks to ensure showers/baths were given per resident choice and refusal documented. The results of the audits will be presented by the DON/Designee to the monthly QI meeting for recommendations.		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and family interview the facility failed to provide consistent baths or showers for 2 (Resident #3 and Resident #4) of 4 sampled residents dependent on staff for bathing assistance. Findings included: 1. Resident #3 was admitted to the facility on 3/29/17 and had the diagnoses of a fracture of the left shoulder, fracture of the ribs, aneurysm of artery of lower extremity, diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Resident #3's admission minimum data set	F 312	F312 DON/Designee interviewed Resident #1, #3, #4, #5 to ensure their ADL bathing & showers are documented by 6/14/17. New interview form completed on each of these residents found to have been affected or the potential to be affected. All residents will be showered/bathed according to preference and shower schedule. Showers or refusals will be documented. An in-service has been initiated for all CNA staff on following the shower/bathing	6/19/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2017
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 3</p> <p>assessment dated 6/7/17 coded her as totally dependent on one person for bathing with range of motion impairment on an upper extremity on one side.</p> <p>The care plan dated 3/31/17 revealed a focus area, "Requires assistance/potential to restore or maintain maximum function of self-sufficiency for bathing related to: impaired mobility, physical limitations." The interventions stated, "Bathing: One person; total dependence, encourage resident to participate in self-care as ability permits, and prefers shower."</p> <p>A family member of Resident #3 was interviewed on 6/9/17 at 11:55 AM. The family member revealed she bathed Resident #3 daily because, "Baths are a problem. I found they were just not getting done. If they provided a daily bath it would be amazing, even every other day would be great."</p> <p>The bath schedule revealed Resident #3 was to receive a bath on the 3 PM to 11 PM shift every Tuesday and Friday. The nursing assistant documentation revealed Resident #3 had inconsistently received bathing assistance since admission.</p> <p>Nursing Assistant (NA) #1, was interviewed on 6/9/17 at 4:50 PM. NA #1 revealed it was difficult to get all of the baths or showers done on the 3 PM to 11 PM shift. NA #1 revealed the focus of the nurse aides was to provide incontinence care, eating assistance, and safety with baths or showers as the lesser priority. NA #1 could not confirm if Resident #3 had received baths on the third shift.</p>	F 312	<p>ADL documentation. An in-service has also been initiated for all licensed nursing staff regarding documentation of shower refusal.</p> <p>An in-service on Bathing & Showers per Resident Choice and ADL Documentation for all CNA staff on how to follow the shower/bathing schedule and ADL documentation. This in-service will be completed by June 19, 2017. After June 19, 2017 no CNA staff will be allowed to work until in-service is completed. This information will also be added to the orientation process.</p> <p>An in-service on Bathing & Showers per Resident Choice for all licensed nursing staff on how to document bathing/shower refusals; that the refusal must be followed up on by the nurse then documented in PCC. This in-service will be completed by June 19, 2017. After June 19, 2017 no licensed nurses will be allowed to work until in-service is completed. This information will also be added to the orientation process.</p> <p>The Director of Nursing/Designee will audit 100% of residents weekly x 6 weeks to ensure showers/baths were given and ADLs documented or refusal documented. Then 50% of residents will be audited weekly x 6 weeks to ensure showers/baths were given per resident choice, ADL documentation completed and refusal documented. This audit will be presented to the QI committee for review.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2017
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 4</p> <p>NA #2, was interviewed on 6/9/17 at 5:05 PM. NA #2 revealed if the bath or shower was not completed on the 3 PM to 11 PM shift another shift completed the task. NA #2 revealed, "We keep them dry, safe, and fed. If we don't have time to give a bath or a shower we tell the nurse so it can be done on another shift." NA #2 could not confirm if Resident #3 had received baths on the third shift.</p> <p>NA #3 was interviewed on 6/10/17 at 9:50 AM. NA #3 revealed she was able to at least give her residents a "quick wash up," everyday or a shower if they needed it. She said the [family member] of Resident #3 was giving her a bath every day.</p> <p>Nurse #1 was interviewed on 6/10/17 at 1:30 PM. Nurse #1 stated she knew that one day last week Resident #3 received a full bath. She stated it was difficult to give Resident #3 a full bath before lunch because there just wasn't time. Nurse #1 stated, "It wouldn't be as big an issue if [family member] gave the CNA (certified nursing assistants) more time to get the bath done. There are a lot of heavy care patients on the hall where [Resident #3] is."</p> <p>An interview with the physician for Resident #3 on 6/10/17 at 2:20 PM revealed the resident was not physically able to get out of bed due to her medical condition.</p> <p>2. Resident #4 had diagnoses of aphasia, dementia, and cerebral vascular accident.</p> <p>Resident #4 was coded on a quarterly minimum data set assessment dated 4/11/17 as totally dependent on one person for bathing.</p>	F 312	The results of the audits will be presented by the DON/Designee to the monthly QI meeting for recommendations		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2017
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 5 The care plan dated 2/7/17 revealed a focus area, "Requires assistance/potential to restore or maintain maximum function of self-sufficiency for bathing related to: physical limitations, impaired cognition." Interventions included, "Bathing: one person, extensive assistance to total dependence for showers/bed baths and encourage resident to participate in self-care as ability permits." The bath schedule revealed Resident #4 was to receive a shower on the 7 AM to 3 PM shift on Wednesday and Saturday. Nurse aide documentation for Resident #4 for the month of June 2017 revealed the named resident inconsistently received showers and full baths on the assigned bath days, with several days not receiving any baths. An interview was conducted with a family member of Resident #4 on 6/9/17 at 12:50 PM. The family member revealed, "Baths and showers are supposed to be given twice a week. It doesn't get done on the day it is supposed to or it doesn't get done at all." NA #3 was interviewed on Saturday, 6/10/17 at 9:50 AM. She stated she was not always assigned to Resident #3 but she would give him a shower that day (6/10/17). NA #3 was interviewed again on 6/10/17 at 3:15 PM. She stated she had not given Resident #3 a shower because he refused. Documentation for 6/10/17 of the nurse aide care for Resident #3 was blank for bathing. The Director of Nursing (DON) was interviewed on 6/10/17 at 10:40 AM. She stated the nursing expectation was for residents to receive a full bed bath twice a week or a shower depending on the	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2017
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 6 resident's preference as dictated by the bathing schedule. She stated a partial bed bath was done every day if the resident was not getting a full bath or shower. The DON revealed if a person was on the schedule to receive a shower then they received it that day unless there was not enough staff then a resident might receive a bed bath instead of a shower.	F 312			