DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FO	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		· · · ·	TE SURVEY MPLETED
		345354	B. WING			C 02/15/2019
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		2/10/2010
				728 PINEY GROVE ROAD		
PINET GR	OVE NURSING AND RE			KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	5	F OC	0		
	A complaint investiga from 2/13/19-2/15/19	ation survey was conducted				
	Immediate Jeopardy	was identified at:				
	(J).	689 at a scope and severity				
	CFR 483.35 at tag F7 (J).	726 at a scope and severity				
	The tag F689 constitu Care.	uted Substandard Quality of				
	Immediate Jeopardy removed on 2/15/19.	began on 1/23/19 and was				
	A partial extended su	rvey was completed.				
	corrections to the dat jeopardy began and r the immediate jeopar	was amended to make tes when the immediate removed. The correct date of dy beginning was 1/22/19 e immediate jeopardy was and not 2/15/19.				
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 65	6		3/15/19
	implement a compret care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					03/11/2019

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.

Internet of percences AND PLAN OF CORRECTION (A) PROVIDER USUPPLIER (DENTIFICATION NUMBER (A) MULTIPLE CONSTRUCTION A BUILDING (A) DUTTPLE CONSTRUCTION A BUILDING (-	ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/18/2019 RM APPROVED IO. 0938-0391	
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PHEPY GROVE NURSING AND REHABLITATION CENTER KERNERSVILLE, NC 27284 Image 10 PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTIONS HOLD BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREEX TAG PROVINCE STATEMENT OF CORRECTION (EACH CORRECTIVE ACTIONS HOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
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Based on resident and staff interviews and Piney Grove Nursing and Rehabilitation			I IS NOT MET AS EVIDENCED						
			nd staff interviews and			Piney Grove Nursing and Rehabili	tation		
record review, the facility failed to develop a care Center acknowledges receipt of the						Center acknowledges receipt of the			
plan that addressed discharge goals and plans Statement of Deficiencies and proposes						Statement of Deficiencies and prop	ooses		
for 1 of 3 residents (Resident #2) reviewed for this Plan of Correction to the extent that		-	Resident #2) reviewed for						
discharge planning. the summary of findings is factually correct and in order to maintain		discharge planning.					1		
Findings included:		Findings included:					nd		

Facility ID: 923023

If continuation sheet Page 2 of 28

		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	OMPLETED	
					С		
		345354	B. WING			02/15/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ		
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER		728 PINEY GROVE ROAD KERNERSVILLE, NC 27284			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		
F 656	Continued From page	e 2	F 65	6			
				provisions of quality of care of			
		nitted to the facility on		The Plan of Correction is subr			
		es that included, in part, cerebral infarction and		written allegation of compliance	e.		
2 	aphasia.			Piney Grove Nursing and Reh	abilitation		
				Center response to this Stater			
		erly Minimum Data Set		Deficiencies does not denote	•		
	· · · ·	ated 12/29/18 revealed		with the statement of Deficien			
		nitively intact. Further		does it constitute an admissio deficiency is accurate. Furthe	-		
	was an active dischar			Grove Nursing and Rehabilita	-		
	Resident #2 to return			reserves the right to refute any			
				deficiencies on this Statement	of		
		blan updated 1/3/19 revealed		Deficiencies through Informal			
		an that addressed discharge		Resolution, formal appeal pro-			
	planning.			and/or any other administrativ proceeding	e or legal		
	On 2/13/19 at 10:23 /	AM an interview was		proceeding			
		lent #2. She stated she was					
	on a waiting list for ar						
	community through a residents with housin	state program that assisted g.					
	On 2/14/19 at 9:42 A				undatadtha		
		icility Social Worker. She discharge plan was to return		On 2/29/19 the Social Worker care plan for Resident #2 to in			
		e community and Resident		discharge plan.			
	#2 had applied to five	e different housing					
		s on their waiting lists. The		On 2/15/19 the Minimum Data			
	Social Worker reporte	-		Nurse audited the last 7 days			
		had addressed discharge nt #2 they had not included it		admissions to ensure the base plans included discharge plan			
	in the comprehensive	-		Discharge baseline care plans			
				in the four new residents care	•		
	On 2/14/19 at 10:06 /			were admitted in the last 7 day	ys. On		
		DS Nurse. She stated that		2/26/19 the facility consultant			
	- · ·	goals were typically not		100% of care plans to ensure	-		
		nprehensive care plan. She e discharge planning was		plans are present on all care p	nalis.		

Event ID: 6U5311

Facility ID: 923023

If continuation sheet Page 3 of 28

	S FOR MEDICARE & DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	· · · ·	TE SURVEY MPLETED
ND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			C
		345354	B. WING			2/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
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F 656	Continued From pag	e 3	F 65	6		
				MDS Nurses were proactive by the DON on 2/26/19 on ca development, including disch and inclusion on the baseline On 2/27/19 the administrator	are plan narge plans, e care plan.	
	in a resident's compr			in-serviced the social worker plan development, including plans and the inclusion on the care plan. This in-service was on 2/27/19. All newly hire M Social Worker will receive the during orientation.	in the care discharge he baseline as completed DS Nurse or	
				The DON and/or designee w admission and readmission of plans to ensure the discharg included on care plans for 3 DON and/or designee will au all comprehensive care plans months to ensure that dischar addressed on each care plans	baseline care e plans are months. The udit 100% of s monthly x 3 arge plans are	
				The Administrator will be res implementing this plan of con ensure any issues of develop implementing a discharge ba plan will be addressed throug root cause analysis, process training, and monitoring.	rrection to ping and aseline care gh additional	
F 689 SS=J		ards/Supervision/Devices)(2)	F 68	9		3/15/19

Facility ID: 923023

If continuation sheet Page 4 of 28

		MEDICAID SERVICES				0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LETED
		345354	B. WING			C 15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		HABILITATION CENTER		728 PINEY GROVE ROAD		
FINETOK	OVE NORSING AND RE	HABILITATION CENTER	1	KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 4	F 689			
	accidents.	stance devices to prevent Γ is not met as evidenced				
	by: Based on observation and physician intervie ensure repositioning a pulling him under his residents (Resident # to prevent accidents. reposition Resident # sustaining a large he collection of blood), e severe bruising to his sent to the hospital o	ons, record review and staff ews, the facility failed to techniques were followed resident in his wheelchair by arms for 1 of 3 sampled #1) reviewed for supervision The failure to properly #1 resulted in Resident #1 matoma (an abnormal experiencing blood loss and s chest. Resident #1 was n 1/26/19 and diagnosed est wall and acute blood loss		On 1/30/19 resident #1 was re-adm to the facility from acute care hospit remains stable at this time. Residents that require assistance w ADL's including transferring have th potential to be affected. On 1/29/29 100% audit of Resident Care Guide accuracy in guidance for transfer assistance of dependent residents w completed by the facility consultant. resident care guides were accurate guidance in care delivery.	al and ith e a s for vas All	
	anemia. Resident #1 1/30/19.	returned to the facility on		Beginning 1/29/19, the staff facilitate initiated in-service for 100% of licen		
	Immediate jeopardy began on 1/22/19 when nursing assistant (NA) #1 repositioned Resident #1 up in his wheelchair by pulling him under his arms which resulted in injury. Immediate Jeopardy was removed on 2/14/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level of "D" (no actual harm with potential for more than minimal harm that is not Immediate			nurses, nursing assistants, including agency staff, on appropriate transfe gait belt use. In-service completed 2/14/19. This in-service was added new staff orientation including agen staff. Yearly proactive education for licensed nurses, and nursing assista including agency staff, will occur sta in 2019 with this training and will be scheduled yearly thereafter.	rs and on to cy ants, arting	
		ility to ensure monitoring		This in-service will ensure licensed and certified nursing assistants, incl		
	Findings included:			agency, are aware of the expectation related to safe transfers and gait be	ons	
	7/22/14. The residen	nitted to the facility on t's diagnosis included:		This will ensure staff are competent related to resident transfers.		
	cerebral infarct, dem	entia and atrial fibrillation.		The Interdisciplinary Team (IDT) wil		

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				E CONSTRUCTION:		<u>8-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVE COMPLETED	ř
					С	
		345354	B. WING		02/15/201	19
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMP	X5) PLETIO ATE
F 689	Continued From page	e 5	F 689	9		
	Review of Resident # 12/19/18, revealed R assistance of one pe function of self-suffici one position to anoth The care plan goal w the necessary physic Interventions include two if fatigued. A Quarterly Minimum 1/1/19 indicated Resi impaired cognition ar assistance with one p transfers and utilized had limitation in rang left sides. A review of a progress dated 1/23/19 reveal to bruise on left chess described bruise on h of him by nursing sta elevated bruise of the noted a deep bruise of right axilla had not ch significant elevated s pectoralis major, was and non-fluctuant, vie of edema noted and	 #1's care plan, updated on esident #1 required rson to maintain maximum iency for transferring from er related to: unsteady gait. as for Resident #1 to receive eal assistance to transfer. d: assistance of one person, a Data Set (MDS) dated ident #1 had moderately nd required extensive person for bed mobility and a wheelchair. Resident #1 e of motion on his right and as note by the physician ed, "Seen for acute visit due t and slight cough. Patient his chest to be result of a tug ff. Noted a large non eright axillary fossa. There is right axillar the bruise in hanged however there was a oft mass over the entire right as a bleeding mass, was soft ew of the extensive amount the fact that it had developed emy initial evaluation of him, 		 review changes of Condition and in during am IDT meeting. The review include appropriate investigation, interventions, notification of attendi physician and responsible party. Tresults of the review will be shared the QAPI team on a monthly basis months. The DON, and ADON will present trin-service comments, supervision observations, and audit trends to the weekly as needed and monthly QA committee for three months. The II QAPI committee will focus on improstaff competency, including with restransfers. The results of the audits for Superv for accidents utilizing the Incident at tool will be shared with the QAPI teat the DON or QI nurse on a monthly for 3 months. Results of the on-go audits will be presented to the QAPI meeting x 3 months or until a time determined by the QAPI members sustained compliance. The Administrator will be responsible implementing this plan of correction ensure any issues of staff compete be addressed through additional roomation. 	v will ng he with for 3 he IDT PI DT and DVing sident ision udit am by basis ing PI for le for n to ncy will	
	at approximately 10:3 Resident #1 on 1/22/ and ordered a chest stated he did not see	facility physician on 2/13/19 30 AM revealed he examined 19 for increased confusion x-ray and a urinalysis. He any swelling or bruising to nest area that day but		cause analysis, process correction, training, and monitoring.		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	
		345354	B. WING				C / 15/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REP	HABILITATION CENTER			728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	examined him again of large swollen area an Doppler study and a of physician stated invasi be considered due to Resident #1's cardiac dementia. An interview on 2/13/ #1 who rounds with th physician saw Reside increased confusion a When the physician set there was swelling an area. She stated the far applying ice to the area A record review reveat dated 1/22/19 for a ch A record review reveat dated 1/23/19 for a D blood count. A review of the chest "interval development bibasilar infiltrates sim physician assistant, n initiated for Augmentii for 10 days, probiotic days, mucinex 600 m nebulizer treatments a A review of the Dopp revealed "fluid collect centimeters -different hematoma, cyst or ab	on 1/23/19 and observed the d bruising and ordered a complete blood count. The sive intervention would not the risk for infection and e status and diagnosis of 19 at 10:40 AM with Nurse he physician stated the ent #1 on 1/22/19 for and there was no bruising. aw Resident #1 on 1/23/19, d bruising to the right chest nurses were monitoring and ea. aled a physician's order nest x-ray. aled a physician's order oppler study and a complete x ray results revealed t of right perihilar and uce 11/22/2018" called to ew orders received and n 875 milligrams by mouth 1 cap by mouth daily for 21 illigrams by mouth and as needed. ler results done on 1/23/19 ion 9.65 x 5.71 x 5.46 ial included organizing	F	689	9		

		ID HUMAN SERVICES MEDICAID SERVICES					PRINTED: (FORM A MB NO. 0	PPROVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		DNSTRUCTION		X3) DATE SU COMPLET	RVEY
		345354	B. WING _				C 02/15/	/2019
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER			PINEY GROVE ROAD RNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 689	12.9. A review of a progress practitioner dated 1/2 Resident #1 for follow to right upper chest. the right upper chest. the right upper chest. the right upper chest. adark echymotic area dark echymotic area the results of the corr Doppler ultrasound rest A statement by nurse taken by the Director telephone revealed N care for Resident #1 of pulled Resident #1 of side of the bed becau pivot. NA #1 stated th #1 from his bed to his assistance. She state down in his wheelchait Aide #1 to assist her stated she couldn't rest	ed a hemoglobin level of s note by the nurse 4/19 revealed she saw y up on hematoma formation The progress note revealed had a raised, firm area, ernum to under the arm pit and light bruising to area. A on right rib cage was noted. mpete blood count and esults were reviewed. aide (NA) #1 dated 1/25/19 of Nursing (DON) via IA#1 had been assigned to on 1/22/19 and she asked to help her pull Resident #1 tatement revealed eame to assist her and NA #1 o in the chair by pulling him 19 at 1:13 PM with NA #1 signed to Resident #1 on 7AM -3PM). She stated Resident #1 's room on g to transfer him from the r, she got him to sit on the use he was able to stand and hat she transferred Resident is wheelchair without any ed Resident #1 was sliding iir so she asked Restorative to reposition him. She	F	589				

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/18/2019 FORM APPROVED MB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRU G			3) DATE SURVEY COMPLETED	
		345354	B. WING			C 02/15/2019		
NAME OF PI	ROVIDER OR SUPPLIER		T	STREET ADD	DRESS, CITY, STATE, ZIP CO	DE	02,10,2010	
	OVE NURSING AND RE	HABILITATION CENTER		728 PINEY (GROVE ROAD			
				KERNERS	VILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From page	e 8	F 6	89				
	have a gait belt. She remember seeing an Resident #1's body.	stated she did not y swelling or bruising on						
	1/25/19 revealed she assist her to pull up F wheelchair. She ente observed NA #1 pulli wheelchair with her a	ent by Restorative Aide #1 on was asked by NA #1 to Resident #1 on 1/22/19 in his red the room to assist and ng Resident #1 back in the urm under his left arm. She NA #1 not to do that.						
	entered Resident #1' help to pull Resident # observed Resident # wheelchair and assis his wheel chair. She toward the back of Re by the back of his par would do the same the resident, but when she NA #1 pulling Reside She told NA #1 that we never supposed to life	She stated on 1/22/19, she s room after NA #1 asked for #1 up in his wheelchair. She						
	bruising or swelling fo On 1/25/19 a nurse '	led no documentation of or Resident #1 until 1/25/19. s note was written indicating						
		s visiting and was concerned Id bruising on Resident #1.						
	revealed she was the	19 at 2:17 PM with Nurse #2 nurse assigned to Resident he resident was sent to the						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/18/2019 RM APPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345354	B. WING		02	2/15/2019	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD			
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	hospital. She stated s exactly what happend the hospital, but she pain in his shoulder. A physicians order da Resident #1 was sen Department for pain a bruising on right ches request. A review of the hospi 1/30/19 revealed Res emergency department to the chest wall that Resident #1 was in a of 150, complaining of shoulder pain. Hemo from baseline on adm He remained hemody received parenteral in supplement with follo Troponin is elevated ischemia and most lift An attempt to intervite 2/14/19 at 1:32 PM w An interview on 2/14/ AM with Physical The was very familiar with worked with him often Resident #1 going to had variable levels of days stand and pivot and other days requin assistance. PT #1 sta resistant to getting ou	she couldn't remember ed or why she sent him to recalled he was in a lot of ated 1/26/19 revealed t to the Emergency and increased swelling and at and right side per family tal discharge summary dated sident #1 "presented to the ent after son noted swelling occurred 3 days ago. trial fibrillation with heart rate of chest wall pain and globin was down 4 grams hission and stabilized at 8.9. ynamically stable. He fon and will discharge on iron w up as an outpatient. but not consistent with kely related to trauma. ew the hospital physician on vas unsuccessful. (19 at approximately 11:00 erapist (PT) #1 revealed he in Resident #1 and had in. He stated prior to the hospital on 1/26/19, he if unctioning and could some with stand by assistance, red more hands on ated Resident #1 could be	F 689				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345354	B. WING				C 15/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEY GR	OVE NURSING AND REP	HABILITATION CENTER			28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	right shoulder pain ar and reminded to lay of stated it was important they were doing and of process things as he PT#1 stated staff sho transfer residents to p An observation of Resident back with eyes open. observed to Resident bruising in various sta Resident #1's chest at on right side. The resident bruising in various sta Resident #1's chest at on right side. The resident occurred. An interview on 2/13/ director of nursing (Dr Administrator told her 1/25/19 and she bega interviewed NA #1 an was determined that the Resident #1's chest of transfer/repositioning A follow up interview of revealed she didn't re- informed about the sw stated it was never at resident by pulling the staff should have a ga transfer residents pro An initial interview on Administrator reveale swelling and bruising	ad needed to be encouraged on his back or left side. He nt for staff to explain what give Resident #1 time to did have impaired cognition. uld utilize gait belts to orevent injury. sident #1 on 2/13/19 at esident #1 lying in bed on There was swelling #1's right chest and ages of healing observed to at midline, toward axilla and ident was unable to state swelling on his chest 19 at 1:35 PM with the ON) revealed the about the bruising on an an investigation. She d Restorative Aide #1 and it the swelling and bruising on becurred from the improper	F	689			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345354	B. WING				C / 15/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEY GR	OVE NURSING AND REP	ABILITATION CENTER			728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 689	about it. She stated s member about the sw investigation into how interview with the Adr revealed she knew at because she made no on that day and Resid team meeting. On 2/14/19 at 1:00 Pl and Corporate Nurse Immediate Jeopardy. acceptable credible a Jeopardy removal on The allegation of imm was as follows: How corrective action those residents found the deficient practice: On 1/22/19 resident # certified nursing assis belt, using resident's due to failure to follow result of knowledge d On 1/22/19 resident # facility for cough. On 1/23/19 abnormal "interval development bibasilar infiltrates sin physician assistant, n initiated for Augmentii Probiotic 1 cap daily o PO and Neb treatment	he talked to the family relling and bruising and the r to ccurred. A follow up ninistrator on 2/14/19 bout bruising on the 24th bets about it in her planner dent #1 was discussed in M, the facility's Administrator were informed of the The facility provided an llegation of Immediate 2/15/19 at 11:06 AM. ediate jeopardy removal will be accomplished for to have been affected by at 1 was transferred by that #1 without use of gait chest and arms to assist y transfer procedure as a eficit. 1 received a chest x-ray in chest x-ray results of c of right perihilar and ce 11/22/2018" called to ew orders received and n 875 mg x 10 days, c 21 days, Mucinex 600 mg	F	689	9		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345354	B. WING				C 15/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINEY GR	OVE NURSING AND REP	ABILITATION CENTER			728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	Therapy) during morn for change in conditio antibiotics. Physician the bruise not availab On 1/23/19 resident # medical director, in fa abnormal chest x-ray, resident to also have order received for ultr Vitamin B-12, Vitamin for visit not received to On 1/24/19 resident # clinical team (DON, A Therapy) during morn for abnormal chest x hematoma (bruise). D administrator instructe assistant director of n staff to determine cau On 1/24/19 director of director of nursing be interviews related to to On 1/25/19 director of director of nursing ob certified nursing assis #1 was not transferred procedure. On 1/25/19 resident # of nursing, assistant of therapy manager rega	DON, MDS, administrator, ing meeting (Cardinal IDT) n related to cough, and note from 1/23/19 indicating le at time of review. 1 was seen by physician, cility for follow-up to Progress note reflected bruise on left chest. New asound of chest area, CBC, D, and BMP. Progress note by facility until 1/24/19. 1 was discussed by the DON, MDS, administrator, ing meeting (Cardinal IDT) ray, diet downgrade, and During Cardinal IDT, ed director of nursing and ursing to start interviewing use of hematoma (bruise). f nursing and assistant gan contacting staff for bruising on resident #1. f nursing and assistant tained statements from two stants that indicated resident d according to transfer sulted in a resident being n mechanical lift until	F	689			

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES). 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILD	ING			C
		345354	B. WING				_ 15/2019
NAME OF PI	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
				·	728 PINEY GROVE ROAD		
PINETGR	OVE NURSING AND REP	ABILITATION CENTER			KERNERSVILLE, NC 27284		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
1/10		,			DEFICIENCY)		
F 689	Continued From page	e 13	F	689	9		
		1's care plan was updated					
	to reflect change in transfer technique to 2 person mechanical lift by the minimum data set nurse. Residents care plan includes the care guide (ICSP) which communicates to nursing staff						
	-						
	-	-					
	-	sing assistants and agency					
	staff a resident's trans	sfer technique.					
	On 1/26/19 resident #	4 1 was sent to emergency					
		f increased size of bruising,					
	swelling and pain on I	•					
		ursing assistant # 1 was					
	-	aining by assistant director s and gait belt use which					
		a chair and poor position,					
	return demonstration						
		ssistant # 1 was provided					
		ait belts are available at					
	nurse's stations and s	staff facilitator office.					
	On 1/30/19 resident #	41 was re-admitted to facility					
	from acute care hosp	-					
		vas evaluated and added to					
		, speech, and occupational as appropriate, including					
	change in transfer ab						
		sident was picked up by					
	therapy services for p	hysical, occupational, and					
	-	/31/19. Therapy goals					
		e 1 person assistance with					
	have a tolerable pain	stand- pivot, resident will level with range of					
	movement.						
		isciplinary team (DON,					
	ADON, administrator,	and therapy) utilized					

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	-		FORM APPROVED OMB NO. 0938-0391				
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
	IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345354 B. WING INME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP PINEY GROVE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP (V4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL) (EACH DEPICIENCY MUST BE PRECEDED BY FULL) (EACH CORRECTIVA) ID PREFIX F 689 Continued From page 14 investigation and the "5 whys" to determine the root cause of the resident injury was staff failure to follow procedure related transfers due to knowledge deficit. F 689 How the facility will identify other residents having the potential to be affected by the same deficient practice: F 689 On 1/29/19 the director of nursing (DON) and assistant director of nursing (DON) and assistant director of nursing (DON) completed an audit of resident care guides for all residents based on each resident's current status. All care guides were correct with no negative findings noted. This audit was documented on a census. On 1/29/19 the DON and ADON completed transfer observations of all residents currently in the facility to ensure transfer observed was completed per care guide. No negative findings noted. This audit was documented on a census. On 1/29/19 the DON and ADON completed transfer observations of all resident care usus. On 1/29/19, the ADON initiated in-service for 100% of licensed nurses, and nursing assistants, including agency staff and certified nursing assistant #1, on appropriate ransfers with and without gait belt, including not repositioning residents using arms, use of draw sheet when gait be			C 15/2019			
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINEY GR	OVE NURSING AND REP	HABILITATION CENTER					
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	investigation and the root cause of the reside to follow procedure residences of the residence of the residence of the root cause of the residence of the procedure residence of the process of the proces of the process of the proces	"5 whys" to determine the dent injury was staff failure elated transfers due to lentify other residents having ected by the same deficient or of nursing (DON) and bursing (ADON) completed are guides for all residents proper transfer status ent's current status. All care with no negative findings documented on a census. and ADON completed of all residents currently in transfer observed was uide. No negative findings documented on a census. N initiated in-service for ses, and nursing assistants, f and certified nursing opriate transfers with and uding not repositioning , use of draw sheet when ate and resident in bed, and service was added to new iding agency staff. In-service all nursing staff (CNAs, agency staff) on 2/14/19. To iffective beginning 2/13/19 DN will complete random ansfers 5 times weekly, to	F	589			
		nifts, and agency staff, for The audit will be completed					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPI F		(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· , ,				LETED
							C
		345354	B. WING			02/	15/2019
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REI	ABILITATION CENTER			28 PINEY GROVE ROAD		
				n	ERNERSVILLE, NC 27284		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F 689	Continued From page	15	E	589			
1 000		sfer and ensuring transfer		209			
		ased on the resident care					
		edure including correct use					
		belt use is appropriate. The					
	audit will be documer tool.	ted on the transfer audit					
		isciplinary team discussed					
		idents or occurrences					
	related to resident tra	nsfer technique. No other					
	issues noted.						
		e put into place or systemic					
	-	sure the deficient practice					
	will not occur:						
	On 1/29/19, the ADO	N initiated in-service for					
	100% of licensed nur	ses, and nursing assistants,					
	including agency staf						
		opriate transfers with and iding not repositioning					
		use of draw sheet when					
	-	ate, and gait belt use. This					
		to new staff orientation,					
		f. In-service was 100% sing staff (CNAs, licensed					
	-	taff) on 2/14/19. To ensure					
		beginning 2/13/19 the DON,					
		nplete random audits of 5					
		mes weekly, to include all gency staff, for transfer					
		it will be completed by					
		r and ensuring transfer					
		ased on the resident care					
		edure including use of gait					
	belt when appropriate documented on the tr						
	Gait belts are provide	d to nursing staff during					

Event ID: 6U5311

Facility ID: 923023

If continuation sheet Page 16 of 28

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	: 03/18/2019 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
	345354	B. WING			C 02/1	; 5/2019
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
PINEY GROVE NURSING AND REP	ABILITATION CENTER		28 PINEY GROVE ROAD ERNERSVILLE, NC 272	84		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
 stations, and staff dev On 2/14/19 the DON, reviewing all progress resident (all residents shifts, all halls) x 12 v areas, including bruis on and investigated if documented on the si ensure any bruising h when appropriate. On 2/14/19 the DON, will review POC skin a all shifts, all halls) x 1 alerts, including bruis on and investigated if documented on the si ensure any bruising h when appropriate. On 2/14/19 the DON, will review POC skin a all shifts, all halls) x 1 alerts, including bruis on and investigated if documented on the si ensure any bruising h when appropriate. The performance improve 1/28/19. The medical the plan on 1/28/19 a How the facility plans to make sure solution Beginning 1/28/19, th communication in the communication in the communication, and audit f provides residents wir accidents by providing 	so available at nursing velopment. and/or ADON began s notes entered for any s) 5x weekly (to include all veeks to ensure new skin ing have been followed up f needed. This audit will be kin audit tool. This audit will has been investigated timely ADON, and/or MDS nurse alerts 5x weekly(to include 2 weeks to ensure skin ing, have been followed up f needed. This audit will be kin audit tool. This audit will has been investigated timely f needed. Thi	F 689				

Facility ID: 923023

If continuation sheet Page 17 of 28

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345354	B. WING			C 02/15/2019		
NAME OF PF	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
PINEY GR	OVE NURSING AND REP	HABILITATION CENTER			28 PINEY GROVE ROAD ERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	failure to supervise to Beginning 1/28/19, th present the in-service observations, and au as needed and month months. The IDT and on improving resident of accidents, including The administrator and recommendations of to QAPI committee to th for additional recomm and continued compli The administrator will implementing this pla jeopardy to ensure an supervision to preven addressed through ac process correction, the Piney Grove Nursing removal of IJ as of 2/2 The facility's credible Jeopardy removal wa 1:30 PM. The validati interviews with both li nursing staff on gait b where to locate them and using draw sheet of on-going inservice and non-licensed staff belt use and when no them not positioning to	er factors contributing to prevent accidents. e DON, and ADON will comments, supervision dit trends to the IDT weekly by QAPI committee for six d QAPI committee for six d QAPI committee will focus ts' safety through prevention g resident transfers. d/or DON will present the the daily IDT and monthly e quarterly QAPI committee hendations for monitoring ance. be responsible for n of removal of immediate hy issues of failure to provide t accidents will be dditional root cause analysis, aining, and monitoring. and Rehabilitation alleged 14/19. allegation of Immediate is validated on 2/15/19 at on was evidenced by censed and non-licensed belt use and when not to use, not positioning under arms is when appropriate. Review records revealing licensed ff were in-serviced on gait t to use, where to locate under arms and using draw	F	589				
	updated care plan an	ate. Review of Resident #1's d care guide reflecting atus. Review of on-going						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/18/201 FORM APPROVEI OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		345354	B. WING		C 02/15/2019
	ROVIDER OR SUPPLIER	HABILITATION CENTER	STR 728 KEF	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 689	audits, documented review of audit of all residents to ensure care guides correct and transfer status correct.		F 689		
F 726 SS=J	Competent Nursing S CFR(s): 483.35(a)(3) §483.35 Nursing Serv	(4)(c)	F 726		3/15/19
	The facility must have sufficient nursing state the appropriate competencies and skills see provide nursing and related services to as resident safety and attain or maintain the h practicable physical, mental, and psychose well-being of each resident, as determined resident assessments and individual plans and considering the number, acuity and diagnoses of the facility's resident populate accordance with the facility assessment re at §483.70(e).				
	licensed nurses have and skill sets necessaneeds, as identified th	cility must ensure that the specific competencies ary to care for residents' nrough resident escribed in the plan of care.			
	limited to assessing,	ng care includes but is not evaluating, planning and it care plans and responding			
	to demonstrate comp techniques necessary needs, as identified th assessments, and de	ire that nurse aides are able etency in skills and y to care for residents'			

Facility ID: 923023

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	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MI II TI	PLE CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	, <i>'</i>	G	· · ·	MPLETED	
					с		
		345354	B. WING		0	2/15/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				728 PINEY GROVE ROAD			
PINETGR	OVE NURSING AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S		(X5) COMPLETIO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE	
F 726	Continued From pag	e 19	F 7	26			
		on, record review and staff		On 1/30/19 resident #1 was re	admitted to		
		ews, the facility failed to		the facility from an acute care h			
		irsing assistant was trained		currently remains in the facility			
		e allowing the nursing		condition.			
		1 of 3 (NA #1) agency					
		viewed. The failure to ensure		Resident that require assistance			
		nd competent resulted in an		ADL's including transferring ha			
		d repositioning of Resident		potential to be affected. On 1/2			
		Resident #1 under his arms		100% audit of Resident care gu			
		nt #1 in his wheelchair, esident #1 sustained a large		accuracy in guidance for transf assistance of dependent reside			
		mal collection of blood),		completed by the facility consu			
		oss and severe bruising to		residents care guides were acc			
		1 was sent to the hospital on		guidance in care delivery.			
		ed with hematoma and acute		g			
	•	Resident #1 returned to the		On 1/29/19, the Assistant Direc	tor of		
	facility on 1/30/19.			Nursing (ADON) initiated proac			
	-			in-service for 100% of licensed	nurse,		
	Immediate jeopardy	began on 1/22/19 when		nursing assistants, and certified	d nursing		
		A) #1 repositioned Resident		assistant #1, on appropriate tra	insfers, not		
	-	air by pulling him under his		repositioning residents using a			
	arms which resulted			gait belt use. In-service was co			
		red on 2/14/19 when the		on 2/14/19. This in-service was			
		an acceptable allegation of		new staff orientation, including	• •		
	Immediate Jeopardy	-		staff. Return demonstration co will be accomplished through o			
		liance at a scope and no actual harm with potential		audits by the DON and/or ADO			
		al harm that is not Immediate			1N.		
		ility to ensure monitoring		Beginning 1/29/19, the staff fac	ilitator (SF)		
	systems put into place			Initiated in-service for 100% of			
				nurses, nursing assistants, incl			
	Findings included:			agency staff, on appropriate tra	ansfers and		
				gait belt use. In-service comple			
		nitted to the facility on		2/14/19. This in-service was a			
	-	ncluded: cerebral infarct,		new staff orientation, including			
	nempegia, dementia	a and atrial fibrillation.		staff. Yearly proactive education licensed nurses, and nursing as			
	Peview of Resident t	#1's care plan, updated on		including agency staff, will occu			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION			LETED
		345354	B. WING _				C 15/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE	1 02/	10/2013
				728 PINEY GROV	E ROAD		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		KERNERSVILLE	E, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 726	Continued From page	e 20	F7	26			
	person to maintain m			-	yearly thereafter.		
1	to another related to: The care plan goal w the necessary physic Interventions include two if fatigued.		and certifier agency, are related to s This will en	rice will ensure licensed nu d nursing assistants, includ e aware of the expectation afe transfers and gait belt sure staff are competent esident transfers.	ding s		
	A Quarterly Minimum 1/1/19 indicated Res impaired cognition ar assistance with one p transfers and utilized had limitation in rang left sides.		began rand resident tra weeks and audit will be transfer and correct bas	9 the DON, and/or ADON lom observation audits of insfers 5 times weekly x 4 then weekly x 8 weeks. T e completed by observing t d ensure transfer techniqu ed on the resident care pla	the e is an		
	dated 1/23/19. "Seer on left chest and slig bruise on his chest to nursing staff. Noted a of the right axillary fo bruise right axilla. Th	s note by the physician of or acute visit due to bruise ht cough. Patient described be result of a tug of him by a large non elevated bruise ssa. There is noted a deep e bruise in right axilla had		staff is com The audit w transfer aud audits will b committee	procedure. This will ensure petent in transfer procedu vill be documented on the dit tool. The results of the be shared with the QAPI monthly for three months.	re.	
	elevated soft mass o major, was a bleedin non-fluctuant view of edema noted and the	r there was a significant ver the entire right pectoralis g mass, was soft and the extensive amount of e fact that it had developed e my initial evaluation of him, s ordered."		brought to s for discussi Team mem QAPI meet audits will b Meeting x 3	the observation audits will stand down meeting on-go ion with the Interdisciplinar bers (IDT) and to the mon ing. Results of the on-goir be presented to the QAPI 3 months or until a time I by the QAPI members for	ning Ty thly ng	
	revealed "fluid collec	ler results done on 1/23/19 tion 9.65 x 5.71 x 5.46 tial included organizing bscess".		sustained c The IDT me Plan of Cor	-	the tor is	
	taken by the Director	e aide (NA) #1 dated 1/25/19 of Nursing (DON) via IA#1 had been assigned to		The Admini	istrator will be responsible ng this plan of correction to	for	

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		MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		345354	B. WING		C	5/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/10	
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER		728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 726	Resident #1 on 1/22/ and she asked Resto pull Resident #1 up in revealed Restorative and NA #1 pulled Rest under his arm. An interview on 2/13/ revealed she was ass 1/22/19 on first shift (when she went into F 1/22/19 in the mornin bed to the wheelchair side of the bed becau pivot. NA #1 stated th #1 from his bed to his assistance. She stated down in his wheelchair. Stated she couldn't re Resident #1 up under in his wheelchair. She have a gait belt. She remember seeing any Resident #1's body. A review of a statement 1/25/19 revealed she assist her to pull up F wheelchair. She enter observed NA #1 pullin wheelchair with her a stated she instructed An interview on 2/13.	19 on the 7AM - 3 PM shift rative Aide #1 to help her in the chair. The statement Aide #1 came to assist her sident #1 up by pulling him 19 at 1:13 PM with NA #1 signed to Resident #1 on 7AM -3PM). She stated Resident #1's room on g to transfer him from the r, she got him to sit on the use he was able to stand and hat she transferred Resident is wheelchair without any ed Resident #1 was sliding hir so she asked Restorative to reposition him. She emember if she pulled r his arms to reposition him he recalled that she did not stated she did not y swelling or bruising on ent by Restorative Aide #1 on was asked by NA #1 to Resident #1 on 1/22/19 in his red the room to assist and ng Resident #1 back in the rm under his left arm. She NA #1 not to do that. /19 at 1:30 PM with	F 72	ensure any issues of staff competitional cause analysis, process correction training, and monitoring.	root	
	Restorative Aide #1. entered Resident #1'	She stated on 1/22/19, she s room after NA #1 asked for #1 up in his wheelchair. She				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345354	B. WING				C 15/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PINEY GR	OVE NURSING AND REP	ABILITATION CENTER			28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	wheelchair and assist his wheel chair. She s toward the back of Re by the back of his par would do the same the resident, but when she NA #1 pulling Resider She told NA #1 that we never supposed to lift She did not observe a Resident #1. A physicians order da Resident #1. A physicians order da Resident #1 was sent Department for pain a bruising on right chess request. A review of the hospit 1/30/19 revealed Ress emergency departmen noted swelling to the days ago. Resident # heart rate of 150, con and shoulder pain. He transporting oxygen in 13.5 - 17.5) was down admission and stabiliz hemodynamically stal iron and will discharg follow up as an outpa laboratory test to differ infarction and unstabil consistent with ischer most likely related to An interview on 2/14/ AM with Physical The	ted NA #1 to pull him up in stated she got to the left side esident #1 and pulled him up nts. She assumed NA #1 ing on the other side of the e looked up, she observed nt #1 up under his arms. vas wrong and they were residents under their arms. any swelling or bruising on ted 1/26/19 revealed to the Emergency and increased swelling and t and right side per family and ischarge summary dated ident #1 "presented to the nt after a family member chest wall that occurred 3 1 was in atrial fibrillation with nplaining of chest wall pain emoglobin (responsible for n the blood; normal range n 4 grams from baseline on zed at 8.9. He remained ble. He received parenteral e on iron supplement with tient. Troponin level (a erentiate between myocardial e angina) is elevated but not mia (reduced blood flow) and	F	726			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/18/2019 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345354	B. WING				C / 15/2019
NAME OF P	ROVIDER OR SUPPLIER	I		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER			728 PINEY GROVE ROAD		
					KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	Continued From page	23	F	726	3		
	prevent injury.						
	10:45 AM revealed R back with eyes open. observed to Resident bruising in various sta Resident #1's chest a on right side. The res	U					
	An interview on 2/14/19 at 8:50 AM with the Staff Development Coordinator revealed orientation for new hires included a video about transfers and lifting. It included information about using gait belts for transfers and she stated every staff member should receive one during orientation and have it with them at all times when working. She stated there was an orientation for agency staff as well with a check list that included a review of the safe resident handling and movement policy which stated "staff will follow the movement and handling safety interventions/procedures for each resident as individually determined through the admission/re-entry admission process", including, "use approved resident handling aids, i.e. gait belts, in accordance with instructions and training".						
	revealed the only ories she started working a	19 at 10:02 AM with NA #1 entation she received when it the facility was orientation e stated she never watched rs and lifting.					
		19 at 2:30 PM with the Nursing revealed NA #1's					

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 03/18/2019 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345354		(X1) PROVIDER/SUPPLIER/CLIA	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		B. WING			02/15/2019				
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER			28 PINEY GROVE ROAD				
			ID	<u> </u>	ERNERSVILLE, NC 27284		0.5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 726	Continued From page	o 24	E.	726					
1 720		wasn't completed. She	E .	/ 20					
		#1 on the phone on 2/14/19							
	and completed the orientation checklist.								
	Positioning/reposition	ning wasn't completed.							
	On 2/14/19 at 1:00 P	M, the facility's Administrator							
		were informed of the							
	Immediate Jeopardy.								
		allegation of Immediate							
	· ·	2/14/19. The allegation of removal was as follows:							
	those residents found	n will be accomplished for d to have been affected by							
	the deficient practice:	: # 1 was transferred by							
		stant #1 without use of gait							
	belt, using resident's	chest and arms to assist							
	due to failure to follow								
	On 1/23/19 resident #	# 1 was noted to have bruise							
		# 1 was sent to emergency							
	room for evaluation o swelling and pain on	of increased size of bruising,							
	care hospital from en								
	On 1/29/19 certified r	nursing assistant # 1 was							
		aining by assistant director							
	of nursing on transfer On 1/26/19 resident #	rs and gait belt use. # 1 was admitted to acute							
		nergency room with primary							
	-	rillation with rapid ventricular dary diagnosis including							
	hematoma of chest w								
	On 1/30/19 resident #	#1 was re-admitted to facility							
	from acute care hosp								
		lisciplinary team (DON, , and therapy) utilized							
		"5 whys" to determine the							

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DEPART CENTER		FORM APPROVED OMB NO. 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345354	B. WING				C 15/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEY GR	OVE NURSING AND REP	ABILITATION CENTER			28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 726	to follow procedure reknowledge deficit. How the facility will id the potential to be affe practice: On 1/29/19, the ADOI 100% of licensed nurs including agency staff assistant #1, on appror repositioning resident use. In-service was added including agency staff competency will be ad as outlined below. Beginning 1/29/19 the complete random auc times weekly x 12 we completed by observi transfer technique is of resident care plan and audit will ensure staff procedure. The audit transfer audit tool. On 1/29/19 the interdi any other resident tra- issues noted. What measures will b changes made to ens- will not occur:	dent injury was staff failure elated to transfers due to entify other residents having ected by the same deficient N initiated in-service for ses, and nursing assistants, f and certified nursing opriate transfers, not s using arms, and gait belt ompleted on 2/14/19. This to new staff orientation, f. Return demonstration ccomplished through audits e DON, and/or ADON will lits of resident transfers 5 eks. The audit will be ng the transfer and ensure	F	726			

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/18/2019 RM APPROVED O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345354	B. WING _			02	C 2/15/2019
NAME OF P	ROVIDER OR SUPPLIER	•	·	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				728	PINEY GROVE ROAD		
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER		KE	RNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 726	in-service for 100% of assistants, including a transfers and gait bell on 2/14/19. This in-set staff orientation, inclu proactive education for nursing assistants, in occur starting in 2019 scheduled yearly ther This in-service will en- certified nursing assis aware of the expectar transfers and gait bell are competent related The performance improve 1/28/19. The medical the plan on 1/28/19 a How the facility plans to make sure solution Beginning 1/28/19, the communication in the communication by in- the DON, ADON, and interdisciplinary team education, and audit provides residents wi accidents by providin QAPI committee will of facility to identify othe competency including Beginning 1/28/19, the present the in-service observations, and au as needed and month	f licensed nurses, nursing agency staff, on appropriate t use. In-service completed ervice was added to new iding agency staff. Yearly or licensed nurses, and cluding agency staff, will 9 with this training and will be reafter. Issure licensed nurses and stants, including agency, are tions related to safe t use. This will ensure staff d to resident transfers. Forovement plan was wed by the quality assurance ement (QAPI) committee on director was made aware of nd is in agreement with plan. to monitor its performance is are sustained. ie facility increased	F	726			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354		(X1) PROVIDER/SUPPLIER/CLIA	. ,	LE CONSTRUCTION	(X3) DAT	<u>O. 0938-039</u> E SURVEY IPLETED C			
		B. WING		0	2/15/2019				
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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
F 726	on improving staff cor resident transfers. The administrator and recommendations of to QAPI committee to the for additional recommand and continued complia The administrator will implementing this pla removal to ensure an will be addressed through analysis, process commonitoring. Piney Grove Nursing removal of IJ as of 2/ The facility's credible Jeopardy removal wa 1:30 PM. The validatii interviews with both lin nursing staff on gait be where to locate them and using draw sheet of on-going in-service and non-licensed staff belt use and when no them not positioning to sheet when appropria updated care plan an change in transfer staff audits, documented rest	mpetency, including with d/or DON will present the the daily IDT and monthly be quarterly QAPI committee hendations for monitoring fance. I be responsible for n of immediate jeopardy y issues of staff competency bugh additional root cause rection, training, and and Rehabilitation alleges 14/19. allegation of Immediate is validated on 2/15/19 at on was evidenced by icensed and non-licensed belt use and when not to use, not positioning under arms t when appropriate. Review e records revealing licensed off were in-serviced on gait of to use, where to locate under arms and using draw ate. Review of Resident #1's d care guide reflecting atus. Review of on-going eview of audit of all are guides correct and	F 72	6					

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