STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 000	INITIAL COMMENTS A complaint investigation survey was conducted on 03/30/21 through 04/01/21. 2 of the 7 complaint allegations were substantiated. Event ID# O7R611.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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 observations, record reviews, resident and staff interviews, the facility failed to provide assistance with grooming and hygiene care to 1 of 1 resident observed and interviewed in sleepwear after 1:00 p.m. (Resident #2) and failed to provide timely incontinent care to 2 of 2 residents during the 11:00 p.m. to 7:00 a.m. shift (Residents #4 and Resident #5). Findings included: 1. Resident #2 was admitted to the facility on 7/2/18 with diagnoses which included: hypo-osmolality and hyponatremia, atherosclerotic heart disease, and chronic obstructive pulmonary disease. The care plan dated 7/19/20 revealed Resident #2 had an activities of daily living (ADL) deficit related to impaired balance. Interventions included: the resident required assistance with bathing, dressing and undressing; and the resident required the use of the mechanical lift for	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #2 was interviewed by the Social Services Director on 04/26/2021 to determine if her daily preferences were being honored specifically requests regarding ADL□s. Resident #2 did feel that her daily preferences are being	4/26/21

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

Electronically Signed | 04/26/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 677	Continued From page 1 transfers. The quarterly minimum data set (MDS) dated 3/10/21 indicated Resident #2 was cognitively intact, required extensive assistance with bed mobility and transfers, was total dependent on staff for hygiene, dressing and bathing, was always incontinent of bowels and frequently incontinent of bladder. During an observation and interview on 3/30/21 at 1:14 p.m., Resident #2 was observed sitting on the side of her bed, looking out of the window. The resident was wearing her nightgown, no socks or shoes and her hair was not combed. She commented she had been and was still waiting for the nursing assistant (NA) to assist her with dressing in day clothing and getting out of the bed. The resident revealed the staff were required to use the mechanical lift to transfer her from the bed to her wheelchair because she was unable to walk. The resident stated she has had to wait 1-2 hours when she used her call light to request incontinent care assistance, especially at night. The resident indicated she always noticed the time of the clock on the wall in her room whenever she requested, and staff responded to her call light requests. She stated that sometimes the staff responded when she used the call light but would turn the call light off and leave without providing care, promising to return. She stated staff have told her they could only provide her with incontinent care assistance one time throughout the night because the facility was short staffed. During an observation and interview on 3/31/21 at 12:15 p.m., Resident #2 was in the hallway in her wheelchair. The resident was well groomed,	F 677	honored. The ambassador for this resident has made weekly observations to ensure that this resident has received timely ADL and incontinent care. Resident #4 has received incontinence care from staff. Documentation corroborates the care received from the Certified Nursing Assistant. Resident #5 has received incontinence care from staff. Documentation corroborates the care received from the Certified Nursing Assistant. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 04/01/2021, the Director of Nurses, Unit Managers, and Staff Nurses initiated daily random audits of at least 8 residents to identify any signs of prolonged incontinence care such as, double briefing, odor, and bed linens wet with urine or dried stains. Any issues discovered during the audits were addressed immediately. On 04/19/2021, the Social Services Director initiated interviews with all residents with a BIMS 13 or above to identify any daily preferences specifically ADL preferences to ensure that residents were receiving care in a timely manner according to their preferences. If the residents don□t have a preference, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 677	Continued From page 2 dressed in day clothes and hair combed. The resident stated the NA did not provide her ADL care and transfer her to the wheelchair until 12:00 p.m. When asked her preference, the resident stated always preferred to be dressed and out of bed at approximately 10:00 a.m. but usually had to wait due to not enough staff. On 4/1/21 at 6:00 a.m., an interview with Resident #2 revealed the resident only received incontinent care one time during 3rd shift, between 5:00 a.m. and 5:30 a.m. She reported the NA informed her that the nursing assistants provided incontinent care to the residents at only one time during the shift. During an interview on 4/1/2021 at 6:35 a.m., NA#1 revealed she usually worked on the 100 hall, but worked the 200 hall with 29 to 30 residents because 3 nursing assistants did not show up for work and one of the nursing assistants was moved from the 100/200 hall to work on the rehabilitative unit (300/400 halls). She stated the facility had been working "short" of staff during the night shift for some time which made it difficult to provide care for the residents. During an interview on 4/1/2021 at 6:45 a.m., Staff Nurse#1 revealed she sometimes worked as a nursing assistant on the unit when staff did not show up for work. She also revealed there had been nights when one nursing assistant worked both, the 100 and the 200 halls. She stated when staff did not come work, she would attempt to call management, but was often unsuccessful.	F 677	certified nursing assistants and licensed nurses have been instructed to ask residents about preferences at the beginning of the shift. The audit was completed on 04/26/2021. All individual daily preferences identified during the audit were entered in the resident□s care plan and Kardex. On 04/23/2021, the QA Clinical Nurse consultant, the Director of Nurses, and Unit Managers initiated the following education to all licensed nurses and certified nursing assistants, full time, part time, agency, and PRN staff: " Rounds and Timely Incontinent Care " Call Bell Response " Timely ADL Care " What to do when there is a change in the schedule 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 04/26/2021, the Director of Nurses, Unit Managers, Support Nurse, and Minimum Data Set Nurses initiated education on Rounds and Timely Incontinence Care, Call Bell Response, ADL Care, and What to Do When There is a Change in the Schedule. The education on Rounds and Timely Incontinence Care, Call Bell Response, ADL Care, and What to Do When There is a Change in the Schedule will need to be completed by all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 677	Continued From page 3 2. Resident #4 was admitted to the facility on 8/30/18 with diagnoses which included: diabetes mellitus, dementia, anxiety, and depression. Review of the quarterly minimum data set dated 1/10/21 indicated Resident #4 was severely, cognitively impaired and was always incontinent of bowel and bladder. During an incontinent observation on 4/1/21 at 6:09 a.m., Resident #4 was observed in bed wearing 2-briefs and lying on an incontinent chux and a draw sheet. Nursing Assistant #1 (NA#1) removed the old brief which was slightly soiled with urine with blue streak indicator on outer brief and a moderate amount of feces. There were no skin concerns observed to the peri area. On 4/1/21 at 6:22 a.m. during an interview, NA#1 revealed she was assigned 29 or 30 residents on the 200 hall during the night shift and the other nursing assistant was assigned 29 residents on the 100 hall. NA#1 stated that the nursing assistants would sometimes put 2-briefs on the residents but would not give an explanation. During an interview on 4/1/2021 at 6:35 a.m., NA#1 revealed she usually worked on the 100 hall, but worked the 200 hall with 29 to 30 residents because 3 nursing assistants did not show up for work and one of the nursing assistants was moved from the 100/200 hall to work on the rehabilitative unit (300/400 halls). She stated the facility had been working "short" of staff during the night shift for some time which made it difficult to provide care for the residents. During an interview on 4/1/2021 at 6:45 a.m., Staff Nurse#1 revealed she sometimes worked	F 677	licensed nurses and nursing assistants, full-time, part-time, agency staff, and PRN staff. As of 04/29/2021 at 5 PM, any employee who has not received this education will not be allowed to work until the training has been completed. This includes licensed nurses and nursing assistants full time, part time, agency staff, and PRN staff. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will complete weekly audits to ensure there is sufficient staff to provide timely incontinent care and provide assistance with grooming and hygiene to the residents in a timely manner. The audits described above will be completed by auditing 10 residents using the Clinical QA Tool for ADL□s and 10 residents using the Clinical QA Tool for Incontinence to monitor for compliance with timely ADL care (grooming & hygiene) and timely incontinence care. These audits will be completed weekly for a period of 4 weeks and then monthly for a period of 3 months or until resolved by the QA committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses or the Administrator to ensure corrective action is initiated as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 677	Continued From page 4 as a nursing assistant on the unit when staff did not show up for work. She also revealed there had been nights when one nursing assistant worked both, the 100 and the 200 halls. She stated when staff did not come work, she would attempt to call management, but was often unsuccessful. 3. Resident #5 was admitted to the facility on 6/4/20 with diagnoses which included: dementia, diabetes mellitus, and hypertension. The quarterly minimum data set dated 1/3/21 indicated Resident #5 severely, cognitively impaired and was always incontinent of bowel and bladder. On 4/1/2021 at 6:22 a.m., an observation of was made as NA#1 provided incontinent care to Resident #5, with the assistance of the Assistant Director of Nursing (ADON). The resident was lying in bed wearing a brief and lying on 2-chux pads and a draw sheet. The resident's brief was soiled with tan colored urine saturated with feces that had soiled through the top chux pad. During an interview on 4/1/2021 at 6:35 a.m., NA#1 revealed she usually worked on the 100 hall, but worked the 200 hall with 29 to 30 residents because 3 nursing assistants did not show up for work and one of the nursing assistants was moved from the 100/200 hall to work on the rehabilitative unit (300/400 halls). She stated the facility had been working "short" of staff during the night shift for some time which made it difficult to provide care for the residents. During an interview on 4/1/2021 at 6:45 a.m.,	F 677	appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, and Dietary Manager. Date of Compliance: 04/29/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 677	Continued From page 5 Staff Nurse#1 revealed she sometimes worked as a nursing assistant on the unit when staff did not show up for work. She also revealed there had been nights when one nursing assistant worked both, the 100 and the 200 halls. She stated when staff did not come work, she would attempt to call management, but was often unsuccessful.	F 677		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 725		4/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 725	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide sufficient nursing staff to provide activities of daily living (ADL) care to 3 of 5 residents reviewed for ADL care. Residents #2, #4, and #5. This tag is cross referenced to tag F677. Findings included: 1. Based on observations, record reviews, resident and staff interviews, the facility failed to provide assistance with grooming and hygiene care to 1 of 1 resident observed and interviewed in sleepwear after 1:00 p.m. (Resident #2). During an observation and interview on 3/30/21 at 1:14 p.m., Resident #2 was observed sitting on the side of her bed, looking out of the window. The resident was wearing her nightgown, no socks or shoes and her hair was not combed. She commented she had been and was still waiting for the nursing assistant (NA) to assist her with dressing in day clothing and getting out of the bed. The resident revealed the staff were required to use the mechanical lift to transfer her from the bed to her wheelchair because she was unable to walk. The resident stated she has had to wait 1-2 hours when she used her call light to request incontinent care assistance, especially at night. The resident indicated she always noticed the time of the clock on the wall in her room whenever she requested, and staff responded to her call light requests. She stated that sometimes the staff responded when she used the call light but would turn the call light off and leave without	F 725	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F725 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #2 was interviewed by the Social Services Director on 04/26/2021 to determine if her daily preferences were being honored specifically requests regarding ADL□s. Resident #2 did feel that her daily preferences are being honored. The ambassador for this resident has made weekly observations to ensure that this resident has received timely ADL and incontinent care. Resident #4 has received incontinence care from staff. Documentation corroborates the care received from the Certified Nursing Assistant. Resident #5 has received incontinence care from staff. Documentation corroborates the care received from the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 725	Continued From page 7 providing care, promising to return. She stated staff have told her they could only provide her with incontinent care assistance one time throughout the night because the facility was short staffed. During an interview on 4/1/2021 at 6:35 a.m., NA#1 revealed she usually worked on the 100 hall, but worked the 200 hall with 29 to 30 residents because 3 nursing assistants did not show up for work and one of the nursing assistants was moved from the 100/200 hall to work on the rehabilitative unit (300/400 halls). She stated the facility had been working "short" of staff during the night shift for some time which made it difficult to provide care for the residents. During an interview on 4/1/2021 at 6:45 a.m., Staff Nurse#1 revealed she sometimes worked as a nursing assistant on the unit when staff did not show up for work. She also revealed there had been nights when one nursing assistant worked both, the 100 and the 200 halls. She stated when staff did not come work, she would attempt to call management, but was often unsuccessful. 2. Based on observations, record reviews, and staff interviews, the facility failed to provide timely incontinent care to 2 of 2 residents during the 11:00 p.m. to 7:00 a.m. shift (Residents #4 and Resident #5). During an interview on 4/1/2021 at 6:35 a.m., NA#1 revealed she usually worked on the 100 hall, but worked the 200 hall with 29 to 30 residents because 3 nursing assistants did not show up for work and one of the nursing	F 725	Certified Nursing Assistant. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 04/01/2021, the Director of Nurses, Unit Managers, and Staff Nurses initiated daily random audits of at least 8 residents to identify any signs of prolonged incontinence care such as, double briefing, odor, and bed linens wet with urine or dried stains. Any issues discovered during the audits were addressed immediately. On 04/19/2021, the Social Services Director initiated interviews with all residents with a BIMS 13 or above to identify any daily preferences specifically ADL preferences to ensure that residents were receiving care in a timely manner according to their preferences. If the residents don□t have a preference, then certified nursing assistants and licensed nurses have been instructed to ask residents about preferences at the beginning of the shift. The audit was completed on 04/26/2021. All individual daily preferences identified during the audit were entered in the resident□s care plan and Kardex. On 04/23/2021, the QA Clinical Nurse consultant, the Director of Nurses, and Unit Managers initiated the following education to all licensed nurses and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 725	Continued From page 8 assistants was moved from the 100/200 hall to work on the rehabilitative unit (300/400 halls). She stated the facility had been working "short" of staff during the night shift for some time which made it difficult to provide care for the residents. During an interview on 4/1/2021 at 6:45 a.m., Staff Nurse#1 revealed she sometimes worked as a nursing assistant on the unit when staff did not show up for work. She also revealed there had been nights when one nursing assistant worked both, the 100 and the 200 halls. She stated when staff did not come work, she would attempt to call management, but was often unsuccessful.	F 725	certified nursing assistants, full time, part time, agency, and PRN staff: " Rounds and Timely Incontinent Care " Call Bell Response " Timely ADL Care " What to do when there is a change in the schedule Additionally, the Director of Nurses has continued to post open positions into Position Manager the employment hiring software to fill open licensed nurses and certified nurse□s assistant positions. The Director of Nurses or designee has completed weekly interviews for open positions. The Director of Nurses has hired 4 licensed nurses and 5 certified nursing assistants between April 01, 2021 □ April 26, 2021. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 04/26/2021, the Director of Nurses, Unit Managers, Support Nurse, and Minimum Data Set Nurses initiated education on Rounds and Timely Incontinence Care, Call Bell Response, ADL Care, and What to Do When There is a Change in the Schedule. The education on Rounds and Timely Incontinence Care, Call Bell Response, ADL Care, and What to Do When There is a Change in the Schedule will need to be completed by all licensed nurses and nursing assistants,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 725	Continued From page 9	F 725	full-time, part-time, agency staff, and PRN staff. As of 04/29/2021 at 5 PM, any employee who has not received this education will not be allowed to work until the training has been completed. This includes licensed nurses and nursing assistants full time, part time, agency staff, and PRN staff. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will complete weekly audits to ensure there is sufficient staff to provide timely incontinent care and provide assistance with grooming and hygiene to the residents in a timely manner. The audits described above will be completed by auditing 10 residents using the Clinical QA Tool for ADL□s and 10 residents using the Clinical QA Tool for Incontinence to monitor for compliance with timely ADL care (grooming & hygiene) and timely incontinence care. These audits will be completed weekly for a period of 4 weeks and then monthly for a period of 3 months or until resolved by the QA committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses or the Administrator to ensure corrective action is initiated as appropriate. Compliance will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 725	Continued From page 10	F 725	monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, and Dietary Manager. Date of Compliance: 04/29/2021	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		4/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 732	Continued From page 11 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interview, the facility failed to ensure nursing staff data was posted daily and maintained from 9/4/20 through 3/30/21. Findings included: During the initial tour of the facility on 3/30/21 at 11:45 a.m., there was no posting of the daily nursing staff data. Review of the facility's records revealed the daily nursing staff postings were maintained from 1/1/20 through 9/3/20. The were no daily nursing staff postings available for review from 9/4/20 through 3/30/21. During an interview on 3/31/21 at 4:17 p.m., the Nursing Staff Scheduler confirmed the missing daily nursing staff postings were either not completed and or not maintained. She revealed she assumed the responsibility as the Nursing Staff Scheduler approximately two weeks ago after the previous scheduler's employment with the facility ended. She stated she searched but was only able to locate daily nursing staff	F 732	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F732 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to include the daily resident census on the staff postings. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 03/30/2021, The Director of Nurses ensured that the daily nurse staffing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 732	Continued From page 12 postings from 1/1/20 to 9/3/20.	F 732	postings have been posted and the completed postings are stored in a manner to allow for easy review upon request. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 04/26/2021, the staffing sheets were reviewed by the Director of Nurses and the Administrator from 04/01/2021 through 04/26/2021 to ensure that daily nurse staffing postings reflected a daily posting for each day. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 04/23/2021, the QA Clinical Nurse Consultant initiated education on Posted Nurse Staffing Information to the following staff, the Director of Nurses, Administrator, Unit Manager for Station 1 and Station 2, and the 2 Nurse Schedulers, on the following objectives: Objectives: " To identify the regulatory requirement of F 732 for Posted Nursing Staff Information " To monitor that the requirement for F732 is met daily and includes the data requirements, posting requirements, Public access to posted nurse staffing data, and Facility data retention requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY 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 732	Continued From page 13	F 732	3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory/requirements. The Administrator, Director of Nurses, or designee will monitor compliance utilizing the F732 Quality Assurance Tool weekly for daily nursing staff postings x 2 weeks then monthly x 3 months they will review to ensure there is a daily posting form for each day. They will also review monthly to ensure there is a form for each day of the month. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/29/2021	