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 _____	R-C 03/03/2025

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 An onsite revisit was conducted from 2/25/25 through 2/27/25. All tags were corrected as of 2/4/25. Additional information was obtained on 3/3/25. Therefore, the exit date was changed to 3/3/25. A repeat tag was cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J Tag F689 constituted Substandard Quality of Care. Non-noncompliance began on 1/26/25. The facility came back in compliance effective 2/4/25. A partial extended survey was conducted.	F 000		
{F 689} SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner (NP), and Responsible Party (RP) interviews, the facility failed to protect a cognitively impaired resident, Resident #6, when he was allowed to exit the facility through the locked main entrance door. Nurse Aide (NA) #1	{F 689}	Past noncompliance: no plan of correction required.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	R-C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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{F 689}	Continued From page 1	{F 689}		

unlocked and opened the door for Resident #6 and allowed him to leave the facility, in the dark, on the evening of 1/26/25. Resident #6 was found in the parking lot of a restaurant near a gas station 1.4 miles from the facility. There were multiple roads between the facility and where the resident was found including a divided 4 lane road, a 4-lane highway, sidewalks, posted speed limits of up to 45 miles per hour, in 38-degree Fahrenheit weather while wearing shoes, pajamas, a coat, and a hat. Upon being unable to locate Resident #6 Nurse #1 failed to immediately implement and activate the elopement process, which included notifying the police, when she became aware Resident #6 had left the building. After the facility initiated the elopement process, the resident was discovered by police who returned the resident to the facility. Due to the facility's noncompliance through allowing the resident to exit the facility followed by the failure to immediately contact the police, the resident's cognitive impairment, exposure to cold weather, time of day when the resident exited the facility, distance traveled by the resident, and having to traverse on sidewalks, possibly the road, and cross multiple roads there was the high likelihood of serious harm. The deficient practice was found for 1 of 2 residents reviewed for supervision to prevent accidents (Resident #6).

Findings included:

Resident #6 was admitted to the facility on 1/20/25 with diagnoses including dementia and congestive heart failure. The resident was discharged on 2/10/25.

The admission wandering assessment dated 1/20/25 showed Resident #6 scored a two on 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 _____	R-C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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{F 689}	Continued From page 2	{F 689}		

wandering risk assessment, which is low risk for elopement.

The care plan dated 1/22/25 revealed Resident #6 was a "wanderer" and at risk for elopement due to wandering behavior and being disoriented due to new placement at the facility with a goal to minimize risks for elopement through current interventions over the next 90 days. Interventions included redirection away from exits as needed, provide diversional activities, and notifying the Director of Nursing (DON) of any exit seeking behaviors.

During an interview with Nurse #2, Nursing Supervisor, on 2/25/25 at 3:07 pm, she indicated she completed Resident #6's care plan and that all residents who have at risk for elopement added to their care plans scored something other than zero on their assessment. She reported that Resident #6 had been admitted less than a week and had exhibited no exit-seeking behaviors. Nurse #2 stated, Resident #6 would be seen walking up and down the halls at times or sitting in the common area watching television.

The admission Minimum Data Set (MDS) assessment dated 1/26/25 revealed Resident #6 had moderate cognitive impairment and wandering behaviors were indicated for 1 to 3 days. The MDS also indicated Resident #6 ambulated independently.

A handwritten, undated, statement by NA #1 documented, around 11:00 pm, Resident #6 walked up and asked NA #1 to let him out of the building which NA #1 did because NA #1 thought Resident #6 was visiting. NA #1 wrote Resident #6 told NA #1 he had fallen asleep and that he

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 _____	R-C 03/03/2025

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 689}	Continued From page 3	{F 689}		

needed to get home to Winston-Salem. NA #1 also wrote that they both walked together to the main entrance and the NA opened the door. Resident #6 then walked out of the building.

During a phone interview with NA #1 on 2/25/25 at 2:25 pm, NA #1 reported not letting any residents out of the building. NA #1 reported seeing Resident #6 leaving the building around 11:00 pm but did not let Resident #6 out and was unaware who may have unlocked the door. NA #1 explained not recognizing Resident #6 as living at the facility because the NA had never worked with him, so the NA did not stop Resident #6 from leaving. NA #1 also indicated it wasn't unusual to see visitors coming and going at all times during the night, so the NA didn't question seeing someone leaving at that time. NA #1 indicated noticing Resident #6 was wearing dark shoes, a coat, and a hat the night of 1/26/25. NA #1 added not noticing Resident #6 was wearing flannel pajamas the night of 1/26/25. NA #1 explained the contradiction between the written statement provided regarding Resident #6 leaving the building compared to information shared during the interview was because the facility had NA #1 write what was in the written statement.

A handwritten statement, undated, by Nurse #1 read, she saw Resident #6 walking down the hall toward the lobby. Nurse #1 indicated she redirected Resident #6 by having him follow her back toward his room. Nurse #1 wrote she went into the room next door to assist that resident and when she came out of that room several minutes later, she didn't see Resident #6 in the hallway anymore. Nurse #1 reported after looking for him around other units, she was advised by NA #1 that the NA saw the resident and that the NA let

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	345039	A. BUILDING _____ B. WING _____	R-C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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{F 689}	Continued From page 4	{F 689}		

Resident #6 out of the building assuming he was a visitor. Nurse #1 documented all of the staff began searching for the resident and the Nursing Supervisor (Nurse #2) called the police and the DON (Director of Nursing).

During an interview with Nurse #1 on 2/25/25 at 3:10 pm, she stated she was assigned to Resident #6 for the 7pm-7am shift on 1/26/25. Nurse #1 indicated Resident #6 liked to walk a lot but she had not seen him show any exit-seeking behaviors such as attempting to open outside doors. Nurse #1 reported she saw Resident #6 walking toward the lobby area from the 300 hall around 11:00 pm wearing his flannel pajamas and shoes. She indicated he wasn't wearing a hat or coat when she saw him walking in the hallway. Nurse #1 stated she had Resident #6 follow her back down the 300 hall toward his room where Nurse #1 left him as she went into Resident #6's neighbor's room to assist. Nurse #1 indicated that Resident #6 didn't seem distraught or express to her anything was wrong. Nurse #1 reported several minutes later, she came out of the room and noticed Resident #6 was not in the hallway anymore, so she looked in Resident #6's room, assuming he may have gone to bed, and then proceeded to look in all the rooms on the 300 hall without finding Resident #6. Nurse #1 then stated she expanded her search to other units before meeting NA #1 on the 100 hall who told her the NA let someone who matched the description of Resident #6 out of the building earlier. Nurse #1 explained the NA was unable to provide her with the exact time of when the resident had left the facility. Nurse #1 then reported she went out the front door and proceeded to look for Resident #6 throughout the facility parking lot, both the whole front and then the back lot where employees

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 _____	R-C 03/03/2025

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 689}	Continued From page 5	{F 689}		

park, and to the street in front of the building before returning to the facility. Upon returning inside the facility Nurse #1 explained she went to find Nurse #2, Nursing Supervisor, to let her know Resident #6 was missing. Nurse #1 stated she searched for Resident #6 outside for only 5-10 minutes before coming back in. She stated she didn't think about finding the Nursing Supervisor first to let her know before searching outside herself because she was anxious to find Resident #6. Nurse #1 stated she hoped the resident would be right outside on the sidewalk, which led to looking in the parking lot, and then she went to the street.

An incident note, which was documented in the nurses' notes, dated1/27/25 at 6:44 am made by Nurse #2 stated on the evening of 1/26/25 around 11:30 pm, Resident #6 was let outside of the building by a Nurse Aide (NA) #1. Nurse #1 had stated she went outside looking for the resident for about 30 minutes prior to telling the supervisor that a resident was out the facility. She stated she then came back into the building, went to the nurses' station on 100 hall and informed the Nursing Supervisor that a resident had left the building, and she could not find him. Nurse #2 wrote she called the (Director of Nursing) DON, and 911 who was informed of the resident missing from the facility with a detailed description of him and what he was wearing when he was last seen. The staff was alerted that a resident was missing from the facility. The DON called Nurse #2 while she was in her car and said the police had found the resident and he was safely brought back to the facility.

During an interview with Nurse #2 on 2/25/25 at 3:07 pm, she stated she was the Nursing

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 _____	R-C 03/03/2025

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 689}	Continued From page 6	{F 689}		

Supervisor, and she was made aware of Resident #6 exiting the building by Nurse #1 right before midnight on 1/26/25. Nurse #2 stated Nurse #1 told her she had been searching for Resident #6 for 30 minutes outside and had not been able to locate him. Nurse #2 reported, following the elopement policy, she immediately notified all staff to begin looking for Resident #6 and also notified the DON who advised her to call 911 immediately, which she did. Nurse #2 stated she got in her own car and began driving around the area near the facility looking for Resident #6. Nurse # 2 explained looking for a resident in her own car was not part of the policy, but she was hoping it would result in finding the resident quicker. Nurse #2 reported the DON called her on her cell phone while she was driving, advised her the police had located the resident, and had just returned him to the facility. Nurse #2 stated she returned to the facility and completed an assessment of Resident #6.

A police report dated 1/27/25 read police were dispatched at 12:04 am after a staff member called stating an aide let a resident out of the building. Staff made the dispatcher aware Resident #6 had cognitive impairments. Resident #6 was located on NC Hwy 66 near the gas station and was transported back to the facility. The report further stated, NA #1 told the police the NA did not know Resident #6 was a resident at the facility and thought he was letting out a family member after visiting. NA #1 informed the police the doors to the facility were locked and only staff members open the doors. The report also documented the facility searched for Resident #6 for approximately 30 minutes after being made aware the resident had left the building. The resident was unharmed 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 _____	R-C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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{F 689}	Continued From page 7	{F 689}		

required no medical attention. The time Resident #6 was returned to the building was not documented.

During an interview with the responding Police Officer on 3/3/25 at 4:35 pm, he indicated he was dispatched at approximately midnight on 1/26/25 and advised there was a resident missing from the facility. He stated Resident #6 was found around a fast restaurant and gas station approximately 1 ½ miles away from the facility and was wearing a hat, shoes, long pajamas and a dark overcoat. He stated Resident #6 appeared unharmed and told him he needed to get home to Winston-Salem. The officer reported he spoke with NA #1 after returning Resident #6 to the facility who told the officer he let Resident #6 out by accident thinking he was a family member there visiting. The officer added that he was told by an unnamed staff member that the facility had been searching for Resident #6 for about 30 minutes before dialing 911.

Observation of the facility layout from Resident #6's room to the door where the resident was allowed egress revealed the following: a right turn has to be made when coming out of Resident #6's room, followed by a short walk in the 300 hall until a mid-point in the hall, and then a right turn must be made to the middle hall. From the middle hallway the front common areas can be accessed, to the left of the common areas, there was a double door entrance which had locks controlled by a magnetic lock system, and there was a visible keypad which allowed the magnetic lock to be disengaged by entering a code which would allow the two automatic doors to be opened.

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	345039	A. BUILDING _____ B. WING _____	R-C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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{F 689}	Continued From page 8	{F 689}		

Observation of Google map on 2/25/25 at 4:25 pm revealed the following information about the roads located between the facility and where the resident was discovered by the police. Upon exiting the facility and going through the parking lot there was a two-lane road with a sidewalk on each side of the road, a left turn on the two-lane road would take an individual to an intersection of a 4-lane divided road, where there was also a sidewalk on each side of the road. A right turn would be needed at the 4-lane intersection to travel in the direction of where the resident was found. The 4-lane road had a posted speed limit of 40 miles per hour, had streetlights, and traveled through a mostly wooded area with one commercial building. There was an intersection with a 4-lane highway where a left turn would need to be made to get onto the 4-lane highway with a posted speed limit of 45 miles per hour. There were sidewalks on each side of the 4-lane highway. According to the police report and police interview, Resident #6 was discovered at a closed fast food restaurant parking lot near a gas station on the other side of the 4-lane highway. According to the map, the distance between the facility and the restaurant and gas station where Resident #6 was found was 1.4 miles.

A review of the data from the National Weather Service (NWS) web site the hourly temperatures beginning at 10:54 pm on 1/26/25 were as follows: 10:54 pm-38 degrees, 11:54 pm-40 degrees, 12:54 am-40 degrees, and 1:54 am-38 degrees. There was no precipitation documented.

A progress note by the facility's Nurse Practitioner dated 1/27/25 read that Resident #6 had a normal exam and he had no signs of any injury related to

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 _____	R-C 03/03/2025

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 689}	Continued From page 9	{F 689}		

the elopement.

During an interview with the Nurse Practitioner (NP) on 2/25/25 at 4:20 pm, he stated he saw and examined Resident #6 on the morning of 1/27/25. He reported an exam with no injuries as a result of the elopement. When asked if he thought there was a higher likelihood of harm to Resident #6 based on his current physical condition and cognition he stated, although Resident #6 could ambulate independently, he had only seen the resident once before and didn't feel like he had enough information yet to make that determination.

During an interview with both the Director of Nursing (DON) with the Regional Nurse Consultant (RNC) present on 2/25/25 at 4:45 pm the DON stated she reported to the facility as soon as Nurse #2 alerted her Resident #6 had exited the building. The DON stated NA #1 should have never unlocked the door to let anyone out who was unfamiliar without verifying the person was not a resident. The DON also stated Nurse #1 should have immediately implemented the elopement process which stated the secondary search procedure is to be initiated by the Nursing Supervisor in charge which would have been Nurse #2. The Nursing Supervisor, in turn, would notify all staff of a missing resident, contact the DON, and then the police. Nurse #1 did not follow procedure when she failed to alert her supervisor immediately after she was unable to locate Resident #6 on her unit and learned he had left the building. The RNC also stated the facility immediately began a plan of correction for all staff members regarding the elopement process.

The facility's Administrator was notified of

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 _____	R-C 03/03/2025

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 689}	Continued From page 10	{F 689}		

immediate jeopardy on 2/25/25 at 6:04 pm.

The facility implemented the following corrective action plan:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #6 is an 84-year-old male who was admitted on 1/20/25 with falls, balance issues, and vascular dementia. Resident #6's Brief Interview for Mental Status (BIMS) was 8 which suggests moderate cognitive impairment. On admission Resident #6 scored a two on the wandering risk assessment, which is low risk for wandering. A low risk indicates the resident has not exhibited wandering behaviors and has no history of wandering. Resident #6's care plan indicated he was at risk for falls, risk for elopement, and was displaying inappropriate behaviors. During Resident #6's stay at the facility, he showed no signs of wandering or exit seeking behaviors according to nurse notes and staff interviews, he was ambulatory in his room only. He did have behaviors such as urinating in the trash can, on his bed, and on his floor, in his room. On 1/26/25 around 11:30pm, Resident #6 walked up to Nurse Aide (NA) #1 and asked to let him out of the building. NA #1 thought Resident #6 was a family member visiting a resident. Resident #6 stated to NA #1 he fell asleep at facility, he lived in Winston-Salem and needed to go home. Nurse Aid #1 walked Resident #6 to the main entrance, manually unlocked the front door by turning the knob, opened the door, and Resident #6 walked out of the facility. According to Nurse Aid #1 Resident #6 was wearing a white short- sleeve tee shirt, a plaid button-down long

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 _____	R-C 03/03/2025

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 689}	Continued From page 11	{F 689}		

sleeve shirt, a black coat, long pajama pants, and hard bottom black shoes. During the time Resident #6 was let out of the facility by NA #1 he was not identified as a wandering risk during this time as an elopement risk, therefore he was not in the elopement book. According to Nurse #1 Resident #6 was wearing long pants, a coat, a shirt, and shoes during her shift that evening which began at 7:00pm. Interview with Nurse #1, "I do not know what time it was when I realized Resident #6 was missing but it was some time after 10:30pm." Nurse #1 immediately went to Resident #6's room and he was not there. Nurse #1 then walked down the hallway to the living room near the main entrance and did not see Resident #6. She then walked to 200 hall and he was not there. Nurse #1 then saw NA #1 and asked if Resident #6 had been seen in the facility. NA #1 then told Nurse #1 Resident #6 was mistaken for a visitor and let out the main entrance per the resident's, who thought was a visitor, request. Nurse # 1 immediately unlocked the front door and exited the main entrance to find Resident #6. Nurse #1 left the property on foot and searched to the main road but did not visualize Resident #6. Nurse #1 came back to the facility and reported to the Night Shift Supervisor immediately the missing resident. The Night Shift Supervisor then activated code pink (the facility's code for a missing resident), this was around 11:55pm. The Night Shift Supervisor called the Director of Nursing and local police department. Nurse # 1 contacted the Responsible Party and made her aware. Resident #6 was returned to the facility at 12:30am on 1/27/25 by the local police department. According to local police, Resident #6 was found 1.4 miles away from the facility at a gas station trying to make a phone call. The resident was placed on 1:1, an intervention where

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 _____	R-C 03/03/2025

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 689}	Continued From page 12	{F 689}		

1 staff member is assigned to 1 Resident. Resident #6 was not able to verbalize where he had been or what he had done when he returned to the facility. A head-to-toe assessment was completed by Nurse #1 on duty at 12:40am. Resident #6's skin was intact and all vital signs were stable. The resident's Provider was notified. New orders received to place resident on 1:1 and place an elopement transmitter to the left lower extremity, the careplan, and Kardex were updated to reflect the elopement risk and the elopement transmitter. Resident #6's Responsible party was made aware. The three elopement books were also updated to reflect Resident #6 was an elopement risk. Resident #6 discharged on 2/10/25 to home with his family.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 1/27/25 the Director of Nursing (DON) identified current residents who were potentially impacted by this practice by completing a 100% audit on all current residents to ensure they were all present and accounted for. The audit was completed on 1/27/25. The results concluded: 107 of 107 residents were present and accounted for in the facility.
On 1/27/25 the DON identified current residents who were potentially impacted by the deficient practice by completing a 100% audit on all current residents to ensure wandering assessments were accurate and residents identified as at risk or high risk to wander had appropriate interventions including: elopement transmitters, updated information in the elopement books, and or 1:1. This was completed on 1/27/25. The results concluded:

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	345039	A. BUILDING _____ B. WING _____	R-C 03/03/2025

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{F 689}	Continued From page 13 107 of 107 residents had correct wandering assessments completed. There were elopement books located at each nurse's station and front desk with pictures of residents and physical description. On 1/27/25 3 of 3 elopement books were checked by the Activities Director to ensure they were up to date for all current residents that had been identified as potential to elope and they were accurate and up to date. 107 of 107 current residents had elopement risk audits completed on 1/27/25 by the Director of Nursing to ensure they were completed accurately. The results revealed no negative findings. All risk assessments had been completed accurately. All new admission risk assessments will be reviewed daily Monday through Friday in the clinical meeting to ensure risk assessments are completed accurately. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 1/27/25, the Staff Development Clinician (SDC) initiated an in-service for all staff (including agency) on the Elopement Prevention policy. This training will include all current staff including agency. This training included: -When a resident is assessed as being high risk for elopement a transmitter bracelet is placed on the resident. Staff should check the placement of the transmitter bracelet and battery. The task of batteries being checked by using the transmitter checking device is assigned to the floor nurses on the unit then documented in the Medication Administration Record (MAR) every shift. -New admissions with high risk or at risk to wander will be monitored or placed with a sitter	{F 689}		

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{F 689}	Continued From page 14	{F 689}		

until they can be re-evaluated by the Interdisciplinary Team and an appropriate intervention is implemented which can include: continued sitter, application of elopement transmitter device, careplan and Kardex will be updated to reflect and information added to elopement books.
-Risk assessments will be completed on admission, quarterly and/or as needed on all residents.
-Any resident identified to be at High Risk for elopement or wandering will be discussed with the interdisciplinary team, documentation of interventions noted, and the careplan updated to reflect interventions, and the elopement books will be updated to reflect resident is and elopement risk.
-Location of the three elopement books and when and how to reference them.
-Never let a person out of the facility unless you reference the elopement book and ask nurse if the person can exit the facility.
Initial Search Procedure
-As soon as a resident is noted to be missing ALL staff will search their assigned areas and report to the nursing station. All other areas will then be checked including but not limited to linen rooms, storage rooms, general baths, bathrooms and closets.
-If the resident is not located during the initial search then initiate a secondary search.
-Secondary Search Procedure:
-The charge nurse will assign staff members to search the outdoor facility grounds and report back to charge person.
-If the resident has not been found on the secondary search in the facility and facility Grounds, the person in charge will notify the local police or sheriff department. Inform them a

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{F 689}	Continued From page 15	{F 689}		

search is in progress and request search assistance. This will be done immediately after confirming the secondary search is unsuccessful.
- This search should be completed timely and involve all members of the team so that more ground can be covered in a shorter time period. The search for a resident should not be for more than 30 minutes without activating police involvement
-The Charge Nurse will assemble all staff at the Nurses' station by announcing over the paging system "Missing Resident". This should be completed timely.
The Director of Nursing will ensure that any of the above identified staff who do not complete the in-service training by 1/28/25 will not be allowed to work until the training is completed.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
The Director of Nursing and Unit Manager will audit all admission and readmission risk assessments beginning 1/29/25 weekly for 2 weeks and then monthly for 3 months using the Quality Assurance Elopement Tool. This tool will consist of accurate completion of risk assessment on admission, identification of high or at risk to wander residents, and as changes occur, elopement transmitter is in place, care plan and Kardex revised, and if the elopement book has been updated to reflect elopement risk.
Staff knowledge checks will also be completed beginning 1/29/25 using the Mock Elopement Drill Knowledge Checks Audit Tool weekly x2 weeks and monthly x3 months. 5 Random employees from all different departments will be asked when and how to implement code pink for missing residents. These knowledge checks will include:
Have you been educated on code pink initial

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{F 689}	Continued From page 16	{F 689}		

search to start immediately with all staff searching assigned areas and reporting to charge nurse; Have you been educated on code pink secondary search which is when a resident is not found inside the facility timely; When should you call code pink; Who should be involved in code pink; Should you let a person out the door if you don't know if he or she is a resident or visitor, What do you do?
Reports of the results will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action is implemented and effective. Compliance will be monitored through an ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, Minimum Data Set (MDS) Coordinator, Therapy, Health Information Manager, and the Dietary Manager.

The alleged IJ removal date is 1/29/25.

The alleged date of compliance will be 2/4/25.

On 2/25/25, the facility's corrective action plan was validated on-site by record review, observations, and interviews. Individual interviews of current staff members working all reported to have completed the elopement process training dated 1/27/25. Record review of the in-service documents dated 1/27/25 and 1/28/25 noted the DON and the Staff Development Coordinator completed the in-person training. Signed staff rosters were reviewed with no issues or concerns. Interviews conducted with multiple staff members revealed they had received training about the elopement process and were able to identify what processes to put into place in the event a resident cannot be located. All new staff

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{F 689}	Continued From page 17 members will also complete the training before their first shift at the facility. Observation of the three elopement books showed they were current and now also included photographs of residents. Review of audits showed the facility completed new wandering assessments on all residents. The facility's immediate jeopardy removal date of 1/29/25 was validated. The date of compliance was validated as 2/4/25.	{F 689}		