DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION		SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
			5.14/11/0				с
		345039	B. WING			11/	29/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER			485 VETERANS WAY		
					KERNERSVILLE, NC 27284		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IV.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	Ē	(X5) COMPLETION
PREFIX TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 550			F	550	2		12/20/17
SS=D	CFR(s): 483.10(a)(1)	(2)(b)(1)(2)					
	§483.10(a) Resident	Diabte					
		ght to a dignified existence,					
		nd communication with and					
		d services inside and					
	outside the facility, in	cluding those specified in					
	this section.						
	6400 40(-)(4) A f:!!!						
	s483.10(a)(1) A facilit with respect and dign	ty must treat each resident					
		and in an environment that					
		ce or enhancement of his or					
	· ·	ognizing each resident's					
	individuality. The facil	lity must protect and					
	promote the rights of	the resident.					
	§483.10(a)(2) The fac	cility must provide equal					
		e regardless of diagnosis,					
		or payment source. A facility					
		aintain identical policies and					
		ansfer, discharge, and the under the State plan for all					
	residents regardless	•					
	§483.10(b) Exercise of	of Rights.					
		right to exercise his or her					
	-	f the facility and as a citizen					
	or resident of the Unit	ted States.					
	8483 10(h)(1) The for	cility must ensure that the					
		his or her rights without					
		n, discrimination, or reprisal					
	from the facility.	· · ·					
		sident has the right to be					
		oercion, discrimination, and					
	-	ity in exercising his or her orted by the facility in the					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	-		TITLE		(X6) DATE

Electronically Signed

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.

12/20/2017

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/1 FORM APPR OMB NO. 0938	ROVED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	Y
		345039	B. WING		11/29/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE	
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY 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 (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE COMPI TO THE APPROPRIATE DA	(5) LETION ATE
F 550	Continued From page	e 1	F 5	50		
	subpart.	rights as required under this				
	interviews the facility manner to maintain the answering call bells the assistance with activit to one resident having placed on bed pan f (Resident #1) and an wet brief for 1.5 hours evident for 2 of 3 resi Findings included: 1. Resident # 1 was 10/04/17 with diagnost diabetes mellitus. A review of Resident date set (MDS) dated was cognitively intact person assistance wit toilet use, personal hy During an observation the call bell for room During an interview wa assigned to the 100 fr	ns, resident, family and staff failed to provide care in a ne resident's dignity by not imely for residents needing ties of daily living. This led g to wait for one hour to be for a bowel movement other resident staying in a s. (Resident #3). This was dents reviewed for dignity. admitted to the facility on ses of hypertension and #1's admission minimum 10/11/2017, revealed he s, required extensive 2 th bed mobility, transfers, ygiene and locomotion. n on 11/28/17 at 11:10 am 114 was noted to be on. <i>v</i> ith Nurse #1, who was hall, on 11/28/17 at 11:15 led that there were 2 nursing		The statements made of Correction are not an action of constitute an agreen alleged deficiencies. To compliance with all Fede Regulations the facility if take the actions set forth Correction. The Plan of constitutes the facility is compliance such that all deficiencies cited have is corrected by the date or F550 RESIDENT RIC OF RIGHTS. The plan of correcting th deficiency. The plan sho processes that lead to th cited; The facility failed to prov manner to maintain the by not answering call be residents needing assist activities of daily living. resident having to wait for placed on bed pan for a (Resident #1) and anoth staying in a wet brief for (Resident #3). This was resident reviewed for dig	Imission to and do nent with the remain in eral and State has taken or will in in this Plan of Correction a allegation of a laleged been or will be dates indicated. GHTS/EXERCISE he specific buld address the he deficiency <i>v</i> ide care in a resident □s dignity ells timely for tance with This led to one or one hour to be bowel movement her resident 1.5 hours evident for 2 of 3	
	assistants (NAs) for the hall. During this interv	he 22 residents on the 100 view Nurse #2 from the 200 and told to her to check room		Resident #1. Resident w assisted with toileting or Resident #3. Resident w assisted with toileting or The procedure for imple	vas promptly n 11/28/2017. vas promptly n 11/28/2017.	
	During an interview w	vith Nurse #2, who was		acceptable plan of corre		

Facility ID: 923294

If continuation sheet Page 2 of 12

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	
		345039	B. WING		C 11/29/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/20/2017	
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETIC	
F 550	Continued From page	2	F 55	0		
	11:21 AM, revealed th assigned to the 200 h During an interview w 11/28/2017 at 11:28 A that he had put his ca have a bowel movem pan. He stated he put knew it was 11 am be just came on. Resident #1 indicated himself (with bowel m so long for the staff to Resident #1 stated th Nursing Assistant (NA call bell and stated sh him. Resident #1 stated for that evening. Resident #1 indicated took because he knew Resident #1 stated it	hall for 17 residents. with Resident #1 on AM, Resident #1 indicated all bell on because he had to ent and needed the bed t his call bell on at 11 on, he ecause the Price is Right had a last week he had soiled toovement) because it took to answer his call bell. at his call bell was on and A) #13 came in, cut off his he would be back to help ed NA #13 was not his NA a that he knew how long it w what was coming on TV. was a bad feeling waiting so		 specific deficiency cited; On 12/18/2017 through 12/20/2017 Director of Nursing, Social Worke Data Set (MDS) Coordinator s interviewed all alert and oriented s in the facility to ensure that call be timely answered when they needed assistance with activities of daily I 12/18/2017 through 12/20/2017, T Director of Nursing, Social Worke Data Set (MDS) Coordinator s of and monitored the units to ensure calls bells were timely answered f residents needing assistance with activities of daily living. On 12/4/2017 to 12/20/2017, the I of Nursing and Regional Staff Development Nurse began in serv Nurses, Nursing Assistants and a staff (Full time, Part time and PR All facility personnel must be awa lights at all times. Answer ALL cal promptly whether or not you are a 	r, Mini residents ells were ed iving. On The er, Mini bserved e that for n Director vicing all II Facility N) that: re of call I lights assigned	
	himself. Resident #1 happened a lot at nig indicted that all his co to the facility by his ro During an interview w assigned to Resident 12noon, that she had recall Resident #1's c indicated another NA	be put on the bed pan that he soiled . Resident #1 revealed he felt sad and this led a lot at night after 11pm. Resident #1 If that all his concerns had been reported acility by his roommate and family. an interview with the NA #14 who was led to Resident #1, revealed on 11/28/17 at a, that she had lunch at 11:15 does not tesident #1's call bell being on. NA #14 led another NA or Nurse could have ed the call bell and put Resident #1 on the n.		 to the resident. For bedside call light and a sound will appear and heard over the door of the resider room and on the board at the nursi station. For emergency call lights in bathmand shower and tub rooms, a light continuous sound will appear ove door of the room and on the board nursing station. Answer call lights prompt, calm, courteous manner; the call light as soon as you enter room. Never make the resident fe are too busy to give assistance; or source of the room and sistence; or source of the room and source of the resident fe are too busy to give assistance; or source of the room and source of the room and source of the resident fe are too busy to give assistance; or source of the room and source of the room and source of the room and source of the resident fe are too busy to give assistance; or source of the room and source of the roo	be nt⊡s sing ooms t and a r the d at the in a turn off the el you	

Facility ID: 923294

If continuation sheet Page 3 of 12

TATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION		O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· /			CON	IPLETED
							С
		345039	B. WING			11	/29/2017
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				48	35 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE	
F 550	Continued From page	3 3	F 5	50			
1 000			F J	50	room When providing care to resident		
	0	#1 on 11/29/2017 at 5 AM 22 to 25 residents during			room. When providing care to resident be sure to position the call light	5	
		nt. NA #34 indicated it was			conveniently for the resident to use. Te	-11	
	•	all bells within 15 to 30			the resident where the call light is and		
		vas another NA scheduled			show him/her how to use the call light.		
		meet the needs of the			Orient all new residents to the call ligh		
		nanner. NA #34 added it			the bedside as well as the call light in t		
	-	it they needed more staff			bathroom and in the shower or tub roo	ms.	
	during this shift.				Have the resident demonstrate the use	e of	
					the call light to be sure he/she		
		/ith NA #33, on 11/29/17 at			understands your instructions. Be sure	e all	
		d they were short staffed			call lights are placed on the bed at all		
	during this shift and n			times, never on the floor or bedside sta	and.		
	to help with residents			The resident has a right to a dignified			
		evealed she had used the			existence, self-determination, and		
	done."	e the "work needed to get			communication with and access to persons and services inside and outside	40	
	done.						
	During on interview w	vith Nurse #3 on 11/29/2017			the facility. The facility must treat each resident with respect and dignity and c		
		because the residents were			for each resident in a manner and in a		
		acility felt that 1 NA per hall			environment that promotes maintenan		
	· •	t was not true. She stated			or enhancement of his or her quality or		
		ints that need two staff for			life, recognizing each resident s		
	care and treatment a				individuality. The facility must protect a	and	
	residents are not asle	ep all night and call bells			promote the rights of the resident. The		
	are going off left and	right. Nurse # 3 indicated			facility must provide equal access to		
	that call bells were no	ot answered and care was			quality of care regardless of diagnosis		
		me manner because they			severity of condition, or payment source		
	were short staffed du	ring this shift.			The facility must establish and maintai		
					identical policies and practices regardi	-	
	•	vith NA #41 on 11/29/17 at 11			transfer, discharge, and the provision	of	
		ring the day it was hard to			services under the State plan for all		
		n 15 minutes because it took			residents regardless of payment source		
	time to provide morni				The resident has the right to exercise l		
		wel movements. She added			or her right as a resident of the facility.		
		s do not change resident but			The facility must ensure that the reside can exercises his or her rights without		
	-	ut the call bell off. NA #41 had beepers that told them			interferences, coercion, discrimination		
		ervices but if you were			reprisal from the facility. The resident l		

Facility ID: 923294

If continuation sheet Page 4 of 12

						OMB NO	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMPI	
		345039	B. WING			C 11/29/2017	
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	11/4	29/2017
		HABILITATION CENTER	485 VETERANS WAY				
					ERNERSVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 550	Continued From page	e 4	F 55	50			
		other resident the other call			the right to be free of interference,		
		wered for 30 minutes or			coercion, discrimination, and reprisal fro	om	
	, ,	ey needed another NA			the facility in exercising his or her rights		
		his would cut down on wait			and to be supported by the facility in the		
		. NA #41 indicated that the			exercise of his or her rights.		
	staff was all aware of	what happened yesterday in					
	room 114 and that Re	esident #1 had to wait over			As of 12/20/17 no employee will be		
	an hour to use the be	d pan.			allowed to work until the training has be	een	
					completed.		
	-	vith Director of Nursing			Effective 12/20/2017, this training is		
	. ,	t 11:30 AM she indicated that			incorporated into the new employee		
		for all staff to answer call			orientation program.		
		es. Her expectation would			This information has been integrated in		
	dignity while providing	esidents with respect and			the standard orientation training and in required in-service refresher courses for		
					all employees and will be reviewed by t		
	2. Resident # 3 wa	as admitted to the facility on			Quality Assurance Process to verify that		
		es of hypertension and			the change has been sustained.	ii ii	
					The monitoring procedure to ensure that	at	
	A review of Resident	#3's admission minimum			the plan of correction is effective and th		
	date set (MDS) dated	09/28/17, revealed he was			specific deficiency cited remains correct	ted	
		uired extensive 2 person			and/or in compliance with the regulator	у	
		fers and one person physical			requirements;		
	assist for toilet use, p	ersonal hygiene and			The Director of Nursing and/or Social		
	locomotion.				Worker will interview 5 alert and oriente	ed	
		itte Danidanet //O			residents to ensure that call bells were		
	During an interview w				timely answered when they needed		
		AM, revealed he had some			assistance with activities of daily living.		
	-	nd how long it took the staff Is at night for him and his			This will be done on weekly basis to include the weekend for 4 weeks then		
		1). Resident #3 indicated			monthly for 3 months.		
	-	1.5 hours for staff to change			The Director of Nursing and /or Social		
		ealed that he reported this to			Worker and /or Mini Data Set (MDS)		
		I going on. Resident #3 also			Coordinator s will observe and monito	r	
		ht during the third shift he			the units five times a week to include th		
	-	all bell and was wet from 12			weekend, to ensure that calls bells we		
		ent #3 revealed that "he felt			timely answered for residents needing		
	bad waiting so long to	b be changed, but if the			assistance with activities of daily living.		

Facility ID: 923294

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,		· · · ·	DMPLETED
						С
		345039	B. WING			11/29/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER		485 VETERANS WAY 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 550	Continued From page	e 5	F 55	0		
		f this would not be a problem hird shift, that not good."		This will be done for 4 weeks monthly for 3 months.	s then	
				Reports will be presented to		
	Resident #3 indicated took because of the	d that he knew how long it		QA committee by the Director to ensure corrective action for		
		was a bad feeling waiting so		ongoing concerns is initiated		
		nd for staff to give you your		appropriate. The weekly QA		
	call bell.			attended by the Director of N	•	
	During an interview w	with NIA #34 who was		Wound Nurse, MDS Coordin Manager, Support Nurse, Th		
		#3 on 11/29/2017 at 5 AM 22 to 25 residents during		Dietary Manager and the Ad		
		nt. NA #34 indicated it was		The title of the person respo	nsible for	
	-	all bells within 15 to 30		implementing the acceptable		
		cated that if there was		correction;		
		d they would be able to meet		Administrator and /or Directo		
		dents in a timely manner. a great facility but they		Date of Compliance: Decem 2017	ber 20th,	
		ring this shift. NA #34		2017		
		ber the incident of Resident				
		ged but she indicated she				
		get back to him as soon as				
		ed more help on this shift."				
		e does not recall Resident #3i bell from 12 AM until 6 AM.				
	•	vith NA #33, on 11/29/17 at				
		d they were short staffed				
		needed another staff person s that needed 2 person				
		revealed she had used the				
	lift by herself because done."	e the "work needed to get				
	-	vith Nurse #3 on 11/29/2017				
		because the residents were				
		acility felt that 1 NA per hall twas not true. She stated				
		ents that need two staff for				

If continuation sheet Page 6 of 12

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/11/2 FORM APPROV OMB NO. 0938-03
ATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 11/29/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
SUMMERS	TONE HEALTH AND RE	EHABILITATION CENTER		485 VETERANS WAY	
				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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION SHOULD BE DATE
F 550	Continued From page	e 6	F 5	50	
	care and treatment a				
		eep all night and call bells			
		right. Nurse # 3 indicated			
		ot answered and care was ime manner because they			
	were short staffed du	-			
		-			
		vith NA #41 on 11/29/17 at 11 ring the day it was hard to			
		n 15 minutes because it took			
	time to provide morni				
		wel movements. She added			
		s do not change resident but ut the call bell off. NA #41			
		had beepers that told them			
	-	ervices but if you were			
		other resident the other call			
	•	wered for 30 minutes or			
		ey needed another NA nis would cut down on wait			
		. NA #41 indicated that the			
		what happened yesterday in			
		esident #1 had to wait over			
	an hour to use the be	eu pari.			
		vith Director of Nursing			
		t 11:30 AM she indicated that			
	•	for all staff to answer call es. Her expectation would			
		residents with respect and			
	dignity while providing				
F 725	Sufficient Nursing Sta		F 72	25	12/20/17
SS=D	CFR(s): 483.35(a)(1)	(2)			
	§483.35(a) Sufficient	Staff.			
		e sufficient nursing staff with			
	the appropriate comp	etencies and skills sets to			
		related services to assure			

Facility ID: 923294

If continuation sheet Page 7 of 12

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/11/2018 RM APPROVED O. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345039	B. WING		11	C 1/29/2017	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 725	practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil accordance with the fa- at §483.35(a)(1) The fac- by sufficient numbers types of personnel or nursing care to all res- resident care plans: (i) Except when waive this section, licensed (ii) Other nursing per- limited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on observatio family interview, staff reviews the facility fa- staffing of sufficient q incontinence care, to for residents who req affected 2 out of 5 res Resident # 3) Findings included: This tag is cross refer	ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and ity's resident population in facility assessment required cility must provide services a of each of the following n a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not s. when waived under section, the facility must nurse to serve as a charge f duty. T is not met as evidenced ins, resident interviews, interviews and record iled to provide nursing uantity and quality to provide ileting and answer call bells uired assistance. This sidents. (Resident #1 and	F 72	The statements made on this F Correction are not an admission not constitute an agreement wit alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Correc constitutes the facility □s allegat compliance such that all alleged deficiencies cited have been or corrected by the date or dates i F725 SUFFICIENT NURSIN The plan of correcting the speci	n to and do h the in I State en or will Plan of tion tion d will be ndicated. IG STAFF.		

Event ID: UIIN11

Facility ID: 923294

If continuation sheet Page 8 of 12

TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	· · · · · · · ·	· · ·	MPLETED
						С
		345039	B. WING			11/29/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLETIC
F 725	Continued From page	2 8	F 72	5		
		ne facility failed to provide		deficiency. The plan should	d address the	
		naintain the resident's dignity		processes that lead to the		
		bells timely for residents		cited;	-	
	-	ith activities of daily living.		The facility failed to provide		
		ent having to wait for one		staffing of sufficient quantit		
	hour to be placed or	•		provide incontinence care,	•	
	-	#1) and another resident		answer calls for residents		
		for 1.5 hours. (Resident #3). 2 of 3 residents reviewed for		assistance. This affected 2 residents. (Resident #1 an		
	dignity.			Resident #1. Resident was		
	dignity.			assisted with toileting on 1		
	An observation of the	facility on 11/29/17 at 5 AM		Resident #3. Resident was		
		I nursing assistant (NA)		assisted with toileting on 1		
		residents residing on the NA present to care for 19		The procedure for impleme acceptable plan of correcti	-	
	residents on the 200	-		specific deficiency cited;		
		e for 19 resident on the 300		On 12/18/2017 through 12	/20/2017, the	
	hall.			Director of Nursing, Social Data Set (MDS) Coordinat	Worker, Mini	
	During an interview w	ith the NA #14 who was		interviewed all alert and or		
	-	#1, revealed on 11/28/17 at		in the facility to ensure that		
		lunch at 11:15 does not		timely answered when the		
		all bell being on. NA #14		assistance with activities o		
	indicated another NA			12/18/2017 through 12/20/		
		I and put Resident #1 on the		Director of Nursing , Socia		
	bed pan.			Data Set (MDS) Coordinat		
	During an interview w	ith NA #34 who was		and monitored the units to calls bells were timely ans		
	During an interview w assigned to Resident	#1 on 11/29/2017 at 5 AM		residents needing assistar		
		1 22 to 25 residents during		activities of daily living.		
		nt. NA #34 indicated it was				
	-	all bells within 15 to 30		The facility has actively hir	ed and added	
	minutes and if there v	vas another NA scheduled		19 staff members to its nu		
		meet the needs of the		11/29/17. This includes 6		
		manner. NA #34 added it		Nurses and 13 Certified N	-	
		it they needed more staff		assistants to assist with co		
	during this shift.			shifts including weekends.	-	
		rith NA #33, on 11/29/17 at		continues the hiring proces utilizes a corporate web sit		

Facility ID: 923294

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						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	ATE SURVEY OMPLETED
			A. BUILDIN	IG		С
		345039	B. WING			11/29/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		11/29/2017
0.002 01 11				485 VETERANS WAY		
SUMMER	STONE HEALTH AND R	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 725	Continued From pag	e 0	E 7	25		
1725			F 7			
	during this shift and	ed they were short staffed needed another staff person s that needed 2 person		professional web based site walk in applications to fill st		
	· ·	revealed she had used the		On 12/4/2017 to 12/20/2017	7, the Director	
	lift by herself becaus	e the "work needed to get		of Nursing and Regional Sta	aff	
	done."			Development Nurse began		
				Nurses ,Nursing Assistants	-	
		with Nurse #3 on 11/29/2017		staff (Full time, Part time a	,	
		because the residents were		All facility personnel must b		
		acility felt that 1 NA per hall at was not true. She stated		lights at all times. Answer A	-	
		ents that need two staff for		to the resident. For bedside	-	
	care and treatment a			light and a sound will appea	-	
		eep all night and call bells		heard over the door of the r		
		right. Nurse # 3 indicated		room and on the board at th		
		ot answered and care was		station.	·	
	not being given in a	time manner because they		For emergency call lights in		
	were short staffed du	uring this shift.		and shower and tub rooms, continuous sound will appe	ar over the	
		with NA #41 on 11/29/17 at 11		door of the room and on the		
		uring the day it was hard to		nursing station. Answer call	•	
		in 15 minutes because it took		prompt, calm, courteous ma		
	time to provide morn	owel movements. She added		the call light as soon as you room. Never make the resid		
		s do not change resident but		are too busy to give assista	-	
		sut the call bell off. NA #41		further assistance before yo		
	-	Il had beepers that told them		room. When providing care		
	-	ervices but if you were		be sure to position the call I		
		other resident the other call		conveniently for the residen		
		wered for 30 minutes or		the resident where the call	-	
		ney needed another NA		show him/her how to use th	-	
		his would cut down on wait		Orient all new residents to t	-	
		s. NA #41 indicated that the		the bedside as well as the c	•	
		f what happened yesterday in esident #1 had to wait over		bathroom and in the showe Have the resident demonstr		
	an hour to use the be			the call light to be sure he/s		
				understands your instructio		
	During an interview	with Director of Nursing		call lights are placed on the		
		at 11:30 AM she indicated that		times, never on the floor or		

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		ND HUMAN SERVICES MEDICAID SERVICES			I	INTED: 01/11/2018 FORM APPROVED B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345039	B. WING			C 11/29/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE	
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY		
				KERNERSVILLE, NC 27284	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 725	her expectation was bells within 3-5 minut be that all staff treat r dignity while providing indicated that her exp	for all staff to answer call res. Her expectation would residents with respect and g care for them. DON also pectation would be that the staff to provide care for	F	 The facility must have staff with the appropria and skills sets to provire lated services to ass and attain or maintain practicable physical, mpsychosocial well-bein as determined by reside and individual plans of considering the number diagnoses of the facility population in accordar assessment. The facility services by sufficient massessment. The facility license nurses to serve on each tour of duty. As of 12/20/17 no empallowed to work until the completed. Effective 12/20/2017, finite information program. This information has be the standard orientation program. This information has be the change has been set the plan of correction is specific deficiency cite and/or in compliance work or requirements; 	ate competencies de nursing and sure resident safety the highest nental, and og of each resident, dent assessments f care and er of acuity and ty s resident nce with the facility ity must provide numbers of each of personal on a de nursing care to nce with resident <i>y</i> must designate a e as a charge nurse bloyee will be ne training has been this training is new employee ween integrated into on training and in the resher courses for be reviewed by the ocess to verify that sustained.	

Event ID: UIIN11

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		X MEDICAID SERVICES	(X2) MULTIPLE	E CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,			IPLETED
		345039	B. WING		11	C / /29/2017
NAME OF F	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND F	REHABILITATION CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 725	Continued From page	ge 11	F 725	The Director of Nursing and/or S Worker will interview 5 alert and residents to ensure that call bells timely answered when they need assistance with activities of daily This will be done on weekly basi include the weekend for 4 weeks monthly for 3 months. The Director of Nursing and /or S Worker and /or Mini Data Set (M Coordinator □ s will observe and the units five times a week to ind weekend, to ensure that calls be timely answered for residents ne assistance with activities of daily This will be done for 4 weeks the monthly for 3 months. Reports will be presented to the QA committee by the Director of to ensure corrective action for tre ongoing concerns is initiated as appropriate. The weekly QA Me attended by the Director of Nurs Wound Nurse, MDS Coordinator Manager, Support Nurse, Thera Dietary Manager and the Admini The title of the person responsib implementing the acceptable pla correction; Administrator and /or Director of Date of Compliance: December 2017	oriented s were ded living. s to s then Social DS) monitor dude the ells were eeding living. en weekly Nursing ends or eting is ing, c, Unit by, HIM, strator le for n of Nursing.	

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