DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		PLETED
		345039	B. WING				C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMMED				4	85 VETERANS WAY		
SUMMER	STONE REALTH AND RE	HABILITATION CENTER		ł	KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)- §483.10(f) Self-deterr The resident has the promote and facilitate through support of res not limited to the right (1) through (11) of this §483.10(f)(1) The res activities, schedules ( waking times), health care services consiste assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspect facility that are signifie §483.10(f)(3) The res with members of the of community activities to facility. §483.10(f)(8) The res participate in other activities to religious, and commu- interfere with the right facility. This REQUIREMENT by: Based on resident ar	<ul> <li>(3)(8)</li> <li>mination.</li> <li>right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f) s section.</li> <li>ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part.</li> <li>ident has a right to make s of his or her life in the cant to the resident.</li> <li>ident has a right to interact community and participate in both inside and outside the</li> <li>ident has a right to stivities, including social, inity activities that do not ts of other residents in the</li> <li>is not met as evidenced</li> <li>ind facility staff interviews,</li> </ul>		561	DEFICIENCY)		4/16/18
		onor the food choice of 1 of ht #5) who preferred softly breakfast.			Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or wil	I	
		SUPPLIER REPRESENTATIVE'S SIGNATUR			take the actions set forth in this Plan of		(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.

04/12/2018

						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	ATE SURVEY OMPLETED
						С
		345039	B. WING			03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER		485 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO
F 561	Continued From page	e 1	F 56	1		
				Correction. The Plan of Corre		
		n "Production, Use of		constitutes the facility's allega		
		ducts" (revised 9/2014)		compliance such that all allege		
		nt insists upon a fresh shell		deficiencies cited have been o		
	egg, cooked to less t	nan fully cooked, gs are to be purchased and		corrected by the date or dates F561 SELF-DETERMINAT		
	used."	Js are to be purchased and		The plan of correcting the spe		
				deficiency. The plan should ac		
	Resident #5 was adn	nitted to the facility on		processes that lead to the def		
		es which included multiple		cited;		
		mia and atherosclerotic		The facility failed to honor the		
	heart disease.			of 1 of 12 resident (Resident #		
	Boviow of the Dhysic	ian's Order dated 0/21/17		preferred softly cooked fried e breakfast.	ggs for	
		tian's Order dated 9/21/17 5 was to receive a regular		Resident #5. Facility has prom	noted and	
		e and thin consistency.		facilitated resident self-determ		
				through support of resident for		
	The Nutrition Assess	ment dated12/28/18		2 "sunnyside-up" fried eggs at	breakfast.	
		nt #5 was independent with		The procedure for implementing		
	-	eals in the dining room. The		acceptable plan of correction	or the	
		adequate, consuming		specific deficiency cited;		
		his meals. The resident's		On 3/24/18, the dietary depart		
	the time of the asses	th no nutritional concerns at		manager ensured to promote facilitate residents' honored fo		
		Sment.		reference to the facility's polic		
	The most recent qua	rterly Minimum Data Set		"Production, use of Pasteurize		
		7 indicated Resident #5 was		Products" for residents who ha		
		I required supervision with		preference and whose diets a	lowed.	
		<b>~</b>		On 3/26/18 the Dietary Manag	ler began	
		n the main dining room on		in-serving the Dietary Departn		
		., Resident #5 stated that the		facility has to promote and fac		
		a variety of food, especially		residents' self-determination th	-	
	at breakfast. The res	-		support of residents' food choi		
	-	y receiving scrambled eggs st because no other form of		"reference to the facility's polic "Production, use of Pasteurize		
		tesident #5 stated that he		Products" for residents who ha		
		quested 2-"sunnyside-up"		preference and whose diets a		
		s received powdered,		that the residents have a right		

Facility ID: 923294

If continuation sheet Page 2 of 36

		MEDICAID SERVICES				<u>IO. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
		345039	B. WING		C	C 3/22/2018
IAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
UMMER	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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 561	Continued From page	e 2	F 56	1		
	scrambled eggs. The that he once purchas requested the dietary eggs for him, but diet During an interview o the DM (Dietary Mana dietary department or and cooked, boiled eg was Corporate's polic cooked eggs; fresh ra by the facility. The DM #5 had requested friet the company did not safety reasons. The D prepared the resident from liquid eggs whic DM also stated that the not allowed to bring for outside sources. On 03/21/18 at 2:50 p facility's policy on the Pasteurized Egg Proto acknowledged she wa interview concerning shell eggs. She stated allow for the purchase The DM indicated she purchasing and prepa-	resident revealed stated ed fresh eggs, and department prepare fried ary refused. n 03/21/18 at 12:09 p.m., ager) revealed the facility's nly purchased liquid eggs ggs. The DM stated that it cy to only serve thoroughly aw eggs were not purchased M acknowledged Resident ed eggs and was informed purchase fresh, raw eggs for DM revealed she had to melets made prepared h the resident enjoyed. The ne dietary department was bood into the kitchen from D.m., after reviewing the "Production, Use of ducts", the DM as incorrect in her earlier not purchasing and serving d that the facility's policy did e of pasteurized eggs, only. e would immediately begin aring pasteurized shelled to prefer them and whose ated that she would inform		<ul> <li>activities, schedules ( includi and waking times), health ca of health care services consi or her interests, assessment care and other applicable pro- this part. The resident have a make choices about aspects life in the facility that are sign resident. The resident has a interact with members of the and participate in community both inside and outside the f resident has a right to partici- activities, including social, re- community activities that do with the rights of other reside facility.</li> <li>As of 4/16/2018 no dietary d employee will be allowed to training has been completed 4/16/2018, this training is inc into the new employee orien program. This information h integrated into the standard training and in the required in refresher courses for all emp- will be reviewed by the Qual Process to verify that the cha- been sustained.</li> <li>The monitoring procedure to the plan of correction is effect specific deficiency cited rem and/or in compliance with the requirements; The Dietary</li> </ul>	are providers istent with his is, and plan of ovisions of a right to o of his or her hificant to the right to o community activities acility. The pate in other ligious, and not interfere ents in the epartment work until the . Effective corporated tation as been orientation n-service oloyees and ity Assurance ange has e nsure that ctive and that ains corrected e regulatory Department	
	Resident #5 of this ch	nange.		specific deficiency cited rem and/or in compliance with the	ains corrected e regulatory Department ng 5 alert and 0, 2018 using	

	-	ID HUMAN SERVICES MEDICAID SERVICES					M APPROV D. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			COM	E SURVEY PLETED
		345039	B. WING _				C / <b>22/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER			5 VETERANS WAY ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 561 F 623 SS=B	Notice Requirements CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility trans resident, the facility n (i) Notify the resident representative(s) of th the reasons for the m language and manne facility must send a c representative of the Long-Term Care Oml (ii) Record the reasor discharge in the reside accordance with para and	Before Transfer/Discharge -(6)(8) before transfer. fers or discharges a nust- and the resident's he transfer or discharge and tove in writing and in a r they understand. The opy of the notice to a Office of the State budsman.		561	ensure that the facility is promoting an facilitating residents honored food cho for residents who had a preference an whose diets allowed. This will be done 4 weeks then monthly for 3 months. Reports will be presented to the week QA committee by the Director of Nursi to ensure corrective action for trends of ongoing concerns is initiated as appropriate. The weekly QA Meeting attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HI Dietary Manager and the Administrato The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursi Date of Compliance: April 16, 2018	ice id for ly ng pr is M, r	4/16/18

Facility ID: 923294

If continuation sheet Page 4 of 36

CENTER STATEMENT OF AND PLAN OF NAME OF PR	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER STONE HEALTH AND RE	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345039 HABILITATION CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	· /	ING _ S' 41 K	E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 85 VETERANS WAY KERNERSVILLE, NC 27284 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	FORM OMB NC (X3) DATE COMP ( 03/	22/2018 (X5) COMPLETION
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λTE	DATE
F 623	<ul> <li>(c)(8) of this section, f discharge required un made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section;</li> <li>(B) The health of indiv be endangered, under this section;</li> <li>(C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days.</li> <li>§483.15(c)(5) Conten notice specified in par must include the follow (i) The reason for tran (ii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for</li> </ul>	is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or inder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would er paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; insfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 atts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; nich the resident is rged; e resident's appeal rights, iddress (mailing and email), er of the entity which its; and information on how	F	623			

Facility ID: 923294

If continuation sheet Page 5 of 36

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	): 05/04/2018 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345039	B. WING		_	( 03/:	C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY KERNERSVILLE, NC 27	7284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	hearing request; (v) The name, address telephone number of t Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailing telephone number of t the protection and add developmental disabil C of the Developmental and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dise email address and tel agency responsible for advocacy of individua established under the for Mentally III Individua §483.15(c)(6) Change If the information in the effecting the transfer of must update the recip as practicable once the becomes available. §483.15(c)(8) Notice i In the case of facility of the administrator of the written notification prior to the State Survey Ag State Long-Term Care the facility, and the recipention of the state survey ages the facility, and the recipention of the state survey ages the facility, and the recipention of the state survey ages the facility, and the recipention of the state survey ages the facility, and the recipention of the state survey ages the	s (mailing and email) and the Office of the State oudsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act. es to the notice. the notice changes prior to or discharge, the facility tients of the notice as soon he updated information in advance of facility closure closure, the individual who is he facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate	F 623				

Facility ID: 923294

If continuation sheet Page 6 of 36

		ND HUMAN SERVICES				FOF	ED: 05/04/20 RM APPROVE
		MEDICAID SERVICES					<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		TE SURVEY
		345039	B. WING _			0	C 3/22/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-	
				48	35 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	EHABILITATION 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	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	Continued From page	<b>e</b> 6	F 6	222			
1 020			ГО	523			
	by:	Γ is not met as evidenced					
	•	amily and staff interviews			The statements made on this Plan	of	
		e facility failed to provide the			Correction are not an admission to a		
		representative a written			not constitute an agreement with the	9	
		ason for transfer to the			alleged deficiencies. To remain in		
	-	send a copy of the notice to			compliance with all Federal and Sta		
		1 of 2 residents (Resident			Regulations the facility has taken or		
	#7) reviewed for hosp	pitalization.			take the actions set forth in this Plan	1 Of	
	Findings included:				Correction. The Plan of Correction		
	Findings included:				constitutes the facility's allegation of compliance such that all alleged		
	Resident #7 was adn	nitted to the facility on			deficiencies cited have been or will	he	
		ses that included, in part,			corrected by the date or dates indica		
		ulmonary disease (COPD)			F623 NOTICE REQUIREMENTS		
	and congestive heart				BEFORE TRANSFER/DISCHARGE The plan of correcting the specific		
	A review of the most	recent comprehensive			deficiency. The plan should address	the	
		IDS) assessment dated			processes that lead to the deficiency	ý	
		sident #7 had moderately			cited;		
	· •	A review of a quarterly MDS			The facility failed to provide the resident		
		12/18 revealed Resident #7			and resident representative a written		
	was cognitively intact	ι.			notification for the reason for transfe the hospital and did not send a copy		
	A review of the medic	cal record revealed Resident			notice to the Ombudsman for 1 of 2		
	#7's representative w				residents (Resident #7) reviewed fo hospitalization.	r	
	A review of the medic	cal record revealed Resident			Resident #7. Resident is currently ir	ı	
	#7 was transferred to	the hospital on 1/3/18 for			facility. Facility sent a copy of the no		
	-	dent was re-admitted from			a Long-Term Care Ombudsman as		
	-	cility on 1/5/18. She was			required as this was not being done		
	-	he hospital on 2/13/18 for			during the prior months. A record o		
		and re-admitted back to the			reasons for discharge or transfer are	ein	
	-	lo written notice of transfer			the resident's medical record.	0 11/20	
		nave been provided to the prov			The facility failed to ensure the notic sent to the resident and/or resident	e was	
	resident, resident lep				representative because the regulation	on was	
	On 3/22/18 at 8:37 A	M an interview was			not being followed by the facility.		
		dent #7. She stated when			The procedure for implementing the		

Facility ID: 923294

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		MEDICAID SERVICES			OMB NO.	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345039	B. WING		C 03/22	2/2018
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP		
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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 623	Continued From page		F 62	-		
		hospital in both January not receive a written notice from the facility.		acceptable plan of correc specific deficiency cited; On 4/4/2018, the Adminis that a notification was ma	trator ensured	
	had been at the facilit	dministrator. She said she ty for about three weeks and		resident and the resident (s) for all residents who w or discharged and the fac	vere transferred cility send a copy	
	Sent to the Ombudsm On 3/22/18 at 12:14 F			of the notice to a represe Office of the State Long- Ombudsman.		
	completed with Resid reported he did not re	lent #7's representative. He eceive a written notice of		4/10/2018, the Staff Deve Coordinator in serviced th	ne Director of	
	to the hospital on both	hen the resident transferred h 1/3/18 and 2/13/18.		nursing, Social Worker, E Manager, Health Informa Nurses (Registered Nurse	tion Manager, all es, License	
	Administrator reveale	PM an interview with the d that notices of ould be sent to the resident		PRN) and Admissions de before a facility transfers	partment that	
	and/or resident's repr is transferred to the h	esentative when a resident ospital. The Administrator		resident, the facility must resident and the resident	: notify the 's representative	
		it been sent prior to her in March but that they mpleted and		(s) of the transfer or disch reasons for the move in v language and manner the	vriting and in a	
	residents/resident rep	presentatives notified when pital. She further stated		The facility must send a c to a representative of the State Long-term Care On	copy of the notice Office of the	
	Ombudsman's office a sending copies of the to the Ombudsman of	transfer/discharge notices		Record the reasons for the discharge in the resident? The notice of transfer or c	s medical record.	
				required must be made b least 30days before the re transferred or discharged	esident is . The notice	
				must be made as soon as before transfer or dischar safety of individuals in the	ge when the	
				endangered, the presider improves sufficiently to al immediate transfer or disc	nt's health Iow a more	

Event ID: 80N511

Facility ID: 923294

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		ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 05/04/201 DRM APPROVEI NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345039	B. WING _				C 03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	00/22/2010
		EHABILITATION CENTER		48	5 VETERANS WAY		
SUMMER	SIONE REALIN AND RE			K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From page	e 8	F	523	immediate transfer or discharge is required by the resident's urgent med- needs and a resident has not resided the facility for 30days. The written no- must include the reason for transfer of discharge, the effective date of transf discharge, the location to which the resident is transferred or discharged, statement of the resident's appeal rig including the name, address (mailing email), and telephone number of the which receives such requests ; and information on how to obtain an appe form and assistance in completing the form and submitting the appeal hear request, the name, address (mailing email) and telephone number of the O of the State Long-term Ombudsman. the information in the notice changes to effecting the transfer or discharge, facility must update the recipients of the notice as soon as practicable once the updated information becomes availab. In the case of facility closure, the administrator of the facility must provi- written notification prior to the impendi- closure to the State Survey Agency, the Office of the Long-Term Care Ombudsman, resident of the facility, at the resident representatives, as well at the plan for the transfer and adequate relocation of the residents. As of 4/16/2018 interdisciplinary team member will not be allowed to work u the training has been completed. Effect 4/16/2018, this training is incorporate into the new employee orientation program. This information has been	l in tice or a hts, g and entity al e ng and Office If prior the ble. ding the and as e on til e	

Event ID: 80N511

Facility ID: 923294

If continuation sheet Page 9 of 36

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/04/2018 RM APPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY IPLETED
		345039	B. WING				C 3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0.	5/22/2010
0.000				48	5 VETERANS WAY		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		KE	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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From page	9	F 6	223	integrated into the standard orientatio training and in the required in-service refresher courses for all employees ar will be reviewed by the Quality Assura Process to verify that the change has been sustained. The monitoring procedure to ensure the the plan of correction is effective and is specific deficiency cited remains correct and/or in compliance with the regulator requirements; Starting 4/20/18 the Administrator will review each transfer/discharge weekly using a quality assurance (QA) survey to ensure that the resident, resident representative(s) have been notified of transfer or discharge, that the facility fisend a copy of the notice to a representative of the Office of the Stat Long-Term Care Ombudsman as required, and that there is a record of reasons for the transfer or discharge i the resident's medical record. This will done for 4 weeks then monthly for 3 months. Reports will be presented to the week QA committee by the Director of Nurs to ensure corrective action for trends of ongoing concerns is initiated as appropriate. The weekly QA Meeting attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HI Dietary Manager and the Administrato The title of the person responsible for implementing the acceptable plan of correction;	nd ince nat that ected ory / tool f the nas the n I be ly ing or is M,	

Event ID: 80N511

Facility ID: 923294

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					с
		345039	B. WING		03/22/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		85 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 623	Continued From page	e 10	F 623	Administrator and /or Director of Nur	sing.
F 625 SS=B	Notice of Bed Hold P CFR(s): 483.15(d)(1)	olicy Before/Upon Trnsfr (2)	F 625	Date of Compliance: April 16th 2018	4/16/18
00-0		bed-hold policy and return-			
	nursing facility transfe the resident goes on nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facilit bed-hold periods, whi paragraph (e)(1) of th resident to return; and (iv) The information s	provide written information to nt representative that e state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any; y's policies regarding ich must be consistent with is section, permitting a			
	the time of transfer of hospitalization or ther facility must provide to resident representation specifies the duration described in paragrap This REQUIREMENT by:	apeutic leave, a nursing o the resident and the ve written notice which of the bed-hold policy oh (d)(1) of this section. is not met as evidenced amily and staff interviews		The statements made on this Plan of Correction are not an admission to a	

Facility ID: 923294

If continuation sheet Page 11 of 36

		MEDICAID SERVICES					IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		STRUCTION	· · ·	E SURVEY
			A. BUILDING	3			
		245020					С
		345039	B. WING			0	3/22/2018
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER					
	1			KERN	ERSVILLE, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 625	Continued From page	e 11	F 62	25			
	notification of the bed			-	eged deficiencies. To remain in		
		the hospital for 1 of 2			mpliance with all Federal and Sta	te	
	residents (Resident #	•			egulations the facility has taken or		
	hospitalization.				ke the actions set forth in this Plar		
				Co	prrection. The Plan of Correction		
	Findings included:				nstitutes the facility's allegation of		
					mpliance such that all alleged		
		nitted to the facility on			ficiencies cited have been or will		
		uses that included, in part,			rrected by the date or dates indic		
	-	ulmonary disease (COPD)			25 NOTICE OF BED HOLD P EFORE/UPON TRANSFER.	OLICY	
	and congestive hear	l lallure (CHF).			e plan of correcting the specific		
	A review of the most	recent comprehensive			ficiency. The plan should address	the	
	minimum data set (M			ocesses that lead to the deficiency			
		sident #7 had moderately			ed;	,	
		A review of a quarterly MDS		Th	he facility failed to provide the resi	dent	
	assessment dated 1/	12/18 revealed Resident #7		an	d resident representative a written	า	
	was cognitively intac	t.			tification of the bed hold policy up sident's transfer to the hospital for		
	A review of the medie	cal record revealed Resident			sidents (Resident #7) reviewed fo		
	#7's representative w	vas a family member.			spitalization.		
				Re	esident #7. Resident is currently ir	n	
		cal record revealed Resident			cility. All residents currently in the		
		the hospital on 1/3/18 for			cility, who, within the last 30 days		
	-	dent was re-admitted from			arch 1st had been transferred to the		
		cility on 1/5/18. She was the hospital on 2/13/18 for			nergency room or to an acute care		
	•	and re-admitted back to the			spital received a copy of the bed licy.		
		further review of the medical			ne facility failed to ensure the polic	v was	
		e was no written notice of the			int with the resident because the	,	
		ded to the resident or			gulation was not being followed by	y the	
		ve when she was transferred			cility.		
	to the hospital.			Th	e procedure for implementing the		
					ceptable plan of correction for the	•	
	On 3/22/18 at 8:37 A				ecific deficiency cited;		
	-	dent #7. She stated when			h 4/10/2018, the Administrator ens		
		e hospital in both January			at the facility provided a written no		
		d not receive a written notice			d hold policy and return to the res		
	or the facility's bed he	old policy, nor was she		or	resident representative for all tran	isiers	

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		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		. ,	IPLETED
						С
		345039	B. WING		03	8/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 625	Continued From page	e 12	F 62	5		
	contacted and asked bed at the facility.	if she wanted to hold her		or discharges for the m	ionth.	
	Resident #7 transferr 2/13/18. She stated transferred to the hos resident's representa transfer but didn't ser resident or to the resi to the bed hold policy On 3/22/18 at 12:14 I completed with Resid reported he did not re facility's bed hold pol facility called him and	e #2 who was on duty when red to the hospital on when Resident #7 spital she called the tive and informed him of the nd any information with the ident's representative related 7. PM an interview was dent #7's representative. He eccive a written notice of the icy and said nobody from the d asked if he wanted to hold ttil she returned from the		4/10/2018, the Staff Decoordinator in serviced nursing, All Nurses (Recoordinator in serviced nursing, All Nurses (Recoordinator) (Recoordinator) PRN) Social Worker, B Manager, Health Inform and Admissions depart nursing facility transfers hospital or the resident therapeutic leave, the r provide written informa or resident representation the duration of the state any, during which the re- to return and resume re- nursing facility, the rese- policy in the state plan facility's policies regard periods which must be permitting a resident to	d the Director of egistered nurse, : Full time, Part and Business office nation Manager ment that before a s a resident to a : goes on hursing facility must tion to the resident ive that specifies : e bed-hold policy, if esident is permitted esidence in the erve bed payment if any, the nursing ting bed-hold consistent with	
	completed with the Director of Admissions. She said that a copy of the bed hold policy was supposed to be sent with a resident when they transferred to the hospital. She further stated that because the facility had plenty of beds, "We can admit them back. We haven't needed to follow up with residents and resident representatives because we are able to hold that bed until they come back."			of transfer of a resident or therapeutic leave, a must provide to the res resident representative which specifies the dur bed-hold policy. As of 4/16/2018 interdis member will not be allo	t for hospitalization nursing facility sident and the e written notice ration of the sciplinary team owed to work until	
	the Director of Admis the bed hold policy w	M a follow up interview with sions revealed that a copy of as not sent with Resident #7 I to the hospital on 1/3/18		the training has been c 4/16/2018, this training into the new employee program. This information integrated into the stan training and in the requirefresher courses for a	is incorporated orientation tion has been idard orientation lired in-service	

Facility ID: 923294

If continuation sheet Page 13 of 36

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C
		345039	B. WING		03/22/2018
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•
SUMMER	STONE HEALTH AND R	EHABILITATION CENTER		485 VETERANS WAY KERNERSVILLE, NC 27284	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 625 F 655 SS=E	hold policy informatic and/or resident's rep was transferred to the Baseline Care Plan CFR(s): 483.21(a)(1	ed that she expected the bed on be sent to the resident resentative when a resident le hospital.	F 62	<ul> <li>will be reviewed by the Quality Assi Process to verify that the change h been sustained.</li> <li>The monitoring procedure to ensure the plan of correction is effective ar specific deficiency cited remains co and/or in compliance with the regul requirements;</li> <li>Starting 4/20/18 the Administrator w review each transfer/discharge wee using a quality assurance (QA) sur to ensure that the facility provided a written notice of bed hold policy and to the resident or resident represent for all transfers or discharges. This done for 4 weeks then monthly for months.</li> <li>Reports will be presented to the wee QA committee by the Director of Nut to ensure corrective action for trend ongoing concerns is initiated as appropriate. The weekly QA Meeti attended by the Director of Nursing Wound Nurse, MDS Coordinator, L Manager, Support Nurse, Therapy, Dietary Manager and the Administr</li> <li>The title of the person responsible implementing the acceptable plan of correction; Administrator and /or Director of Nur- Date of Compliance: April 16th 201</li> </ul>	as e that hd that prrected atory will ekly vey tool a d return htative will be 3 eekly ursing ds or ng is l, Jnit HIM, ator for of

Facility ID: 923294

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY LETED
		345039	B. WING				22/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER			185 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	<ul> <li>§483.21(a) Baseline ( §483.21(a)(1) The fact implement a baseline that includes the instree ffective and person- that meet professional The baseline care pla (i) Be developed within admission.</li> <li>(ii) Include the minimu necessary to properly including, but not limit (A) Initial goals based (B) Physician orders.</li> <li>(C) Dietary orders.</li> <li>(D) Therapy services.</li> <li>(E) Social services.</li> <li>(F) PASARR recomming s483.21(a)(2) The fact comprehensive care plan if the comption (i) Is developed within admission.</li> <li>(ii) Meets the requirer (b) of this section (excet this section).</li> <li>§483.21(a)(3) The fact resident and their rep of the baseline care plan imited to:</li> <li>(ii) The initial goals of (ii) A summary of the dietary instructions.</li> <li>(iii) Any services and</li> </ul>	Care Plans Sility must develop and care plan for each resident uctions needed to provide centered care of the resident I standards of quality care. n must- n 48 hours of a resident's Im healthcare information care for a resident red to- I on admission orders. endation, if applicable. Sility may develop a olan in place of the baseline rehensive care plan- n 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not the resident. residents to be acility and personnel acting	F	655			

Facility ID: 923294

If continuation sheet Page 15 of 36

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/04/20 <sup>-</sup> M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		E SURVEY PLETED
		345039	B. WING		03	C / <b>22/2018</b>
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	
				485 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 655	Continued From page	a 15	F 65	5		
1 000			F 00			
		rmation based on the details				
	-	e care plan, as necessary. F is not met as evidenced				
	by:	is not met as evidenced				
	•	ns, record reviews, resident		The statements made on this	Plan of	
		ne facility failed to complete		Correction are not an admiss		
		eline care plan for three of		not constitute an agreement		
		missions. (Residents #46,		alleged deficiencies. To rema		
	30 and 304).	$\frac{1}{1}$		compliance with all Federal a		
	The findings included	l.		Regulations the facility has ta		
				take the actions set forth in th		
	1. Resident #46 was	admitted to the facility on		Correction. The Plan of Corr		
		es that included fall with		constitutes the facility's allega		
	fracture left hip and fi			compliance such that all alleg		
	pressure ulcer on the			deficiencies cited have been		
	psychosis, hallucinat	ions, anxiety, and urinary		corrected by the date or date	s indicated.	
	tract infection.			F655 BASELINE CARE P	LAN.	
	Record review reveal	led no baseline care plan for		The plan of correcting the spe	ecific	
	the resident.			deficiency. The plan should a	ddress the	
	Interview with the Dir	ector of Nursing on 3/21/18		processes that lead to the de	ficiency	
	at 4:20 PM revealed			cited;		
		on the computer goal and		The facility failed to complete		
		for the resident for a care		individualized baseline care p		
	-	supposed to do a care plan		of four sampled new admission		
		ot just give the initial orders		(Residents #46, 30 and 304).		
	to the resident/respon	nsible party (RP).		Resident #46. Resident indiv		
				comprehensive care plan is c		
		Jurse #1 on 03/21/18 at 9:13		and summary provided to the	resident and	
	AM revealed the floor			their representative. Resident #30. Resident indivi	idualizad	
		esponsible for completing n. It would include goal				
		resident was admitted for		comprehensive care plan is c and summary provided to the		
		s. She explained one copy		their representative.		
		e resident, the other copy		Resident #304. Resident indi	vidualized	
	would be given to the would be in the chart			comprehensive care plan is c		
				and summary provided to the		
	Interview with Nurse	#1 on 3/21/18 at 3:25 PM		their representative.		
	revealed she printed	off a copy of the physician		The procedure for implement	ing the	

Facility ID: 923294

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	. ,	MPLETED
						С
		345039	B. WING		(	3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	PCODE	
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 A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 655	Continued From page	<b>-</b> 16	F 65	55		
1 000	the MDS nurses did t		1 00	specific deficiency cited;		
		ion orders were given to the		On 4/10/2018, the Direct		
		nd they signed indicating it		MDS (Mini Data Set) cod	-	
		In the explained, the one		Unit Managers ensured		
		as a "batch" type order that		individualized baseline c		
	auto populated when	admission orders were put		developed for all new ad	missions within	
	in the computer.			48hours of a resident's a	admission and / or	
				a comprehensive care p		
				baseline care plan is dev	-	
		admitted to the facility on		new admissions within 4		
		s that included Influenza or injuries, cystitis, diabetes		residents admission and		
		and a wound on his big toe.		summary of the baseline comprehensive care pla		
		and a wound on his big toe.		the resident and their re		
	Record review reveal	ed no baseline care plan for				
	the resident.			4/10/2018, the Staff Dev	elopment	
				Coordinator in serviced t	he MDS	
	Review of the admiss	sion orders revealed		Coordinators, Director of	f Nursing, unit	
	treatment with an ant	ibiotic for a bladder infection		Manager, Administrator,		
		ment for Influenza B, wound		nursing, All Nurses (RN,		
		and medications. A "Goal to		Part and PRN) Social W		
	-	comfort during transition to		Director and Dietary Mar	-	
		. Pain management as		facility must develop and	-	
	ordered by physician	d behavioral services as		baseline care plan for ea includes the instructions		
	admission orders.			provide effective and per		
				care of the resident that		
	Observations on 3/19	9/18 at 10:30 AM revealed		standards of quality of ca		
	Resident #30 was on			care plan must be devel		
				hours of a resident's adr	nission, include	
	On 3/19/18 at 10:46 /			the minimum healthcare		
		lent #30. The resident		necessary to properly ca		
		been to a care plan meeting		including but not limited	-	
	since he was admitte	a.		based on admission order		
	Intonyiow with the Ad	ministrator on 3/21/19 st		orders, dietary orders, th		
		ministrator on 3/21/18 at ne facility had not completed		social services and PAS recommendation if appli		
		n for the resident. She		may develop a compreh		
		area that had been		in place of the baseline of		

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
						С
		345039	B. WING		0	3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	- <b>·</b>	STREET ADDRESS, CITY, STATE, ZI	P 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 A CROSS-REFERENCED T	ACTION SHOULD BE	(X5) COMPLETIO DATE
				DEFICIE	ENCY)	
F 655	Continued From page	e 17	F 6	55		
		Quality Assurance (QA)		comprehensive care pla	n is developed	
	process and she was	•		within 48hours of the res	•	
	implementing plans for	•		admission. The facility m		
				resident and their repres	-	
	3. Resident #304 wa	s admitted to the facility on		summary of the baseline		
	2/15/18 with diagnose	-		includes but is not limite		
		hand, right shoulder and		goals of the resident, a s		
		had a history of stroke,		resident's medications a	-	
		and was admitted with a		instructions, any service	-	
	feeding tube for total	nutrition and an indwelling		to be administered by th		
	urinary catheter.	5		personnel acting on beh	•	
		ed no baseline care plan for		any updated information		
	the resident.			details of the compreher		
				On admission or within t		
	Review of the admiss	sion orders dated 2/15/18		of admission, the admitti		
		a gastrostomy tube, non-		will provide the resident		
		right arm, pain medication,		resident representative a		
		estive heart failure, and use		of the baseline care plan		
		ry catheter. The orders		nurse and resident and/	•	
		naintain safety and comfort		representative will sign t		
		facility. Pain		summary of the baseline		
	-	ded. Therapy and behavioral		charge nurse will give a	•	
	services as ordered b			signed baseline care pla		
		51 5		the resident and/ or resident	-	
	Interview with the Dire	ector of Nursing on 3/21/18		representative and the o		
	at 4:20 PM revealed	0		placed in the residents n	0	
		on the computer goal and				
		for the resident for a care				
		supposed to do a care plan		As of 4/16/2018 any em	ployee who was	
		ot just give the initial orders		required to be in service		
	to the resident/respor			allowed to work until the completed. Effective 4/1	training has been	
	Interview with MDS N	lurse #1 on 03/21/18 at 9:13		training is incorporated i		
	AM revealed the floor			employee orientation pro		
		esponsible for completing		information has been int		
		n. It would include goal		standard orientation train		
		resident was admitted for		required in-service refree		
		s. She explained one copy		all employees and will be		
		e resident, the other copy		Quality Assurance Proce		

Facility ID: 923294

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR( DEFICIENCY)	ILD BE COMPLETIO
F 655	Continued From page	e 18	F 655	5	
	would be in the chart.			the change has been sustained.	
	revealed she printed orders, but did not do the MDS nurses did t explained the admiss resident and/or RP at was received. She fu goal on the orders, w	#1 on 3/21/18 at 3:25 PM off a copy of the physician o a care plan and explained the care plans. She sion orders were given to the nd they signed indicating it urther explained, the one as a "batch" type order that admission orders were put		The monitoring procedure to ensure the plan of correction is effective at specific deficiency cited remains of and/or in compliance with the regule requirements; Starting 4/20/18 the Director of nur- Unit Manager will review all admiss during daily clinical meeting (Mono- through Friday) using a quality ass (QA) survey tool to ensure that an individualized baseline care plan we developed for all new admissions we 48hours of a resident's admission at a comprehensive care plan in place baseline care plan is developed for new admissions within 48hours of residents admission and that the summary of the baseline care plan comprehensive care plan is provide the resident and their representative will be done for 4 weeks then mont 3 months. Reports will be presented to the we QA committee by the Director of Ne to ensure corrective action for trent ongoing concerns is initiated as appropriate. The weekly QA Meetia attended by the Director of Nursing Wound Nurse, MDS Coordinator, U Manager, Support Nurse, Therapy, Dietary Manager and the Administr The title of the person responsible implementing the acceptable plan correction; Administrator and /or Director of Nur- Date of Compliance: April 16th 201	nd that prected latory sing or sions day urance as within and / or e of the all the or ed to re. This hly for eekly ursing ds or ng is , Juit HIM, ator for of ursing.

Facility ID: 923294

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 05/04/201 DRM APPROVE NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ISTRUCTION		
		345039	B. WING _				
NAME OF P	ROVIDER OR SUPPLIER		- I	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	TONE 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	Continued From page	e 19	F 6	89			
F 689 SS=D		ards/Supervision/Devices	F 6	89			4/16/18
	§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						
	supervision and assis accidents.	esident receives adequate stance devices to prevent is not met as evidenced					
	Based on observatio and record review the supervision during m at risk for choking du	ns, staff and family interview e facility failed to provide eals for a resident that was e to swallowing problems for on aspiration precautions.		Co no al	he statements made on this Pla prrection are not an admission t of constitute an agreement with leged deficiencies. To remain in ompliance with all Federal and S	to and do the	
	Resident # 30. The findings included	:		ta	egulations the facility has taken ke the actions set forth in this P orrection. The Plan of Correction	lan of	
	2/15/18 with a history	mitted to the facility on of a fall with fractures of the and, dysphagia, Parkinson ' itia.		cc de cc Fé	onstitutes the facility's allegation ompliance such that all alleged eficiencies cited have been or w orrected by the date or dates inc 689 FREE OF ACCIDENT AZARDS/SUPERVISION /DEVI	rill be dicated.	
	indicated Resident #3	sion orders dated 2/16/18 30 received total nutrition by gastrostomy tube and was uth.).		Tł de pr cit	ne plan of correcting the specific eficiency. The plan should addre ocesses that lead to the deficie ted;	c ess the ncy	
	indicated Resident #3 pharyngeal dysphagi	n evaluation dated 2/16/18 30 had severe oral a with silent aspiration. The ech therapy caseload from		du ris pr as	ne facility failed to provide supe uring meals for a resident that w sk for choking due to swallowing oblems for one of one residents spiration precautions Resident # esident #30. Resident is at risk	vas at 3 s on ¢30.	
		um Data Set dated 2/22/18		ch	oking due to swallowing proble on aspiration precautions. Resi	ms and	

Facility ID: 923294

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						IO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING	2		С
		345039	B. WING		0	3/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		0/22/2010
				485 VETERANS WAY		
SUMMER	SIONE HEALIH AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	<u>&gt;</u> 20	F 68	30		
		30 had long and short- term	1 00	assessed by registered n	urse and no	
	memory impairment,			signs of aspiration were n		
		ff for activities of daily living,		was supervised during all		
		and hydration by a feeding		nursing staff.		
	tube.			The procedure for implem	-	
				acceptable plan of correc	tion for the	
		an dated 2/22/18 included a		specific deficiency cited;	an of Niccola an oral	
	problem of nutrition b	to keep the head of the bed		On 4/11/2018, the Director Unit Managers ensured th		
		liquids and observe for		who were at risk for choki		
	aspiration.			swallowing problems wer	-	
				during all meals by facility		
	An order was written	by Speech Therapist #1,				
		t, of puree (dysphagia		On 4/10/2018, the Staff D	evelopment	
		ar consistency (liquids).		Coordinator in serviced a		
		for the resident to be fed in		Registered Nurses, Licen		
		supervision, sit upright, and		nurse, Med Techs and Nu		
	alternate small bites	with sips.		time, Part time and PRN)	•	
	Boviow of a appacht	herapy note dated 3/16/18		must ensure that the resid remains as free of accide		
		0 she was found to have no		possible and each resider		
		pharyngeal phase. A CT		adequate supervision and		
		stroke was present and		devices to prevent accide		
		e. A trial of thin liquids		residents who are at risk		
	revealed a delayed sy	-		to swallowing problems o	r on aspiration	
		ed the resident remain NPO		precautions must be supe		
	and trials to be done	by speech therapy only.		meals by facility nursing s	staff.	
	Record review of nurs	se 's notes dated 3/16/18		As of 4/19/2018 any emp	loyee who was	
		went to the emergency		required to be in serviced		
		al pain. The feeding tube		allowed to work until the t		
	was removed.			completed. Effective 4/19		
	Boyiow of the appear	thorapy recortification		training is incorporated in		
		h therapy recertification es of 3/16/18 to 4/14/18		employee orientation prog		
		's current functional level		standard orientation traini		
	included nectar thick			required in-service refres		
		d she required verbal and		all employees and will be		
	visual cues for eating			Quality Assurance Proces		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/04/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345039	B. WING				C /22/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER			85 VETERANS WAY ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 689	Continued From page	21	F	689	the change has been sustained		
	Resident #30 was set a family member. Th attendance in the dini observation. Observa revealed she had thin meat with noodles on indicated the nectar th through and thin liquid The diet of puree was Observations of the m coughed one time aft Interview with Speech 3/21/18 at 8:42 AM re- the diet to mechanica Resident #30 had poor explained ST#2 had v and upgraded her to a Resident #30 would n under supervision of 3 Interview with NA #1 revealed Resident #3 set-up. She ate in the would keep a check of go back and sit with h NA#1 was asked if a with her during the m replied it would be "O her. Observations on 3/21 Resident #30 was in a eating lunch. There w resident during the m with the resident and	ing room during this ations of the food and drink a liquids, small cubes of her tray. The tray ticket hick liquids were marked ds was written on the ticket. a marked through. esident revealed she er a sip of the thin liquid. Therapist (ST) #1 on evealed she had upgraded al soft a few weeks ago, but cketing of the food. She worked with her on 3/20/18 thin liquids. ST#1 explained eceive an upgraded diet ST only. on 3/21/18 at 10:30 AM 0 could feed herself after e dining room and the staff on her, pass trays and then her. During the interview, family member could stay eals instead of staff and she K" and she would check on /18 at 1:25 PM revealed the dining room and was were no staff with the eal. A family member was			the change has been sustained. The monitoring procedure to ensure the plan of correction is effective and is specific deficiency cited remains correct and/or in compliance with the regulated requirements; Starting on 4/20/2018 the Director of nursing or Unit Manager will review 5 residents weekly using a quality assurance (QA) survey tool who are a risk for choking due to swallowing problems or on aspiration precautions ensure that they are supervised by fact staff during meals. This will be done for weeks then monthly for 3 months. Reports will be presented to the week QA committee by the Director of Nursit to ensure corrective action for trends of ongoing concerns is initiated as appropriate. The weekly QA Meeting attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HI Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursit Date of Compliance: April 19, 2018	t t to cility or f ly ng or is M, r	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMP	SURVEY LETED
		345039	B. WING			22/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMERS	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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE
F 689	Continued From page	22	FORM / OMB NO.     Market Construction     A Building      B. WING      B. WING      STREET ADDRESS, CITY, STATE, ZIP CODE     485 VETERANS WAY     KERNERSVILLE, NC 27284  LL     PROVIDER'S PLAN OF CORRECTION     (EACH CORRECTIVE ACTION SHOULD BE     CROSS-REFERENCED IN THE APPROPRIATE     DEFICIENCY)      F 689  ily unch d not meal le     f     f 689  rrapy ly  dday d d er     inter     n the     M			
	member who was with on 3/20/18 and again revealed an aide or n stayed with her on Tu when he visited. He had not stayed with th when she was eating explained she could of Interview with Nurse a revealed Resident #3 meant she had to be Resident #30 had swa asked who fed her lun family member had fe Interview with ST #2 of revealed the family m	drink the regular coffee. #1on 3/21/18 at 2:00 PM 0 had a red napkin which fed by staff. She explained allowing precautions. When nch, Nurse #1 replied the ed her. on 3/22/18 at 2:24 PM rember had attended therapy				
	provided training for h precautions. She was member had given th at lunch. ST#2 explain she would be comfort and assisting until she	She had not specifically him on swallowing s not aware the family e resident thin liquids today ned she would have said table with him feeding her e was informed he gave her ligh the thickened was on the				
F 690 SS=D	revealed she would e resident due to aspira explained she would	not expect the staff to rely o be with the resident. inence, Catheter, UTI	F 69	90		4/16/18

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/04/20 <sup>7</sup> MAPPROVE D. 0938-039
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345039	B. WING				C 1 <b>22/2018</b>
NAME OF PF	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
		EHABILITATION CENTER		485	VETERANS WAY		
				KE	RNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 690	Continued From page	a 23		690			
1 030	1.0			090			
	§483.25(e) Incontine	cility must ensure that					
		nent of bladder and bowel on					
		ervices and assistance to					
		unless his or her clinical					
	condition is or becom	nes such that continence is					
	not possible to mainta	ain.					
	§483.25(e)(2)For a re	esident with urinary					
	incontinence, based						
		ssment, the facility must					
	ensure that-						
	(i) A resident who ent	ters the facility without an					
	indwelling catheter is	not catheterized unless the					
		ndition demonstrates that					
	catheterization was n						
		iters the facility with an					
	U	r subsequently receives one					
		val of the catheter as soon e resident's clinical condition					
		theterization is necessary;					
	and	inclenzation is necessary,					
		incontinent of bladder					
		treatment and services to					
		infections and to restore					
	continence to the ext	ent possible.					
	§483.25(e)(3) For a r	esident with fecal					
	incontinence, based						
		ssment, the facility must					
		t who is incontinent of bowel					
		treatment and services to					
		nal bowel function as					
	possible.	L is not mot as suidarsed					
		Γ is not met as evidenced					
	by: Based on observation	ons, record review and			The statements made on this Plan of		
		erviews, the facility failed to			Correction are not an admission to ar		
			1		CONCOUNT ARE HUL AT AUTHISSIULI LU AL	u uU	1

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/04/2018 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING			0	C 3/22/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMED		EHABILITATION CENTER		48	35 VETERANS WAY		
JOWIWIER	STONE REALTH AND RE			K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 690	Continued From page	e 24	F	690			
	justification for an ind (Resident #90) reside use. Findings included: Resident #254 was a 3/8/18 from the hospidiagnosis. The medic diagnosis for an indw An observation on 3/ Resident #254 lying i hanging on bed. An observation on 3/2 revealed Resident #2 drainage bag hanging An interview with Reso on 3/19/18 at 10:03 A catheter was put in w and she thought it wa ankle as she was una left leg. A medical record revid did not indicate an or catheter. A review of the Admis (MDS) assessment d still in progress at the Resident #254 was con AM with the Unit Coo process for a residen	welling catheter for 1 of 1 ents reviewed for catheter dmitted to the facility on ital with multiple medical cal record did not indicate a relling catheter. 19/18 at 10:03 AM revealed n bed with a drainage bag 20/18 at approximately 11:30 254 lying in bed with a g on bed. Sident #254 was conducted AM. She revealed the then she went to the hospital as because of her broken able to bear weight on her ew on 3/20/18 at 9:15 AM der for an indwelling ession Minimum Data Set ated 3/15/18 revealed it was a time of the survey.			alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or w 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 date or dates indicate F690 BOWEL/BLADDER INCONTINENCE, CATHETER, UTI. The plan of correcting the specific deficiency. The plan should address th processes that lead to the deficiency cited; The facility failed to obtain a physician order and have medical justification fo indwelling catheter for 1 of 1 (Residen #254) residents reviewed for catheter Resident #254. MD notified that reside had an indwelling catheter with no physician orders and with no medical justification noted on the medical reco Resident notified of new orders. New orders for indwelling catheter in place 3/22/2018. Indwelling catheter was discontinued on 3/26/2018 per physici orders and resident notified. The facility missed that the resident has catheter on admission and an order wasn't entered. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 4/10/2018, the Director of Nursing Unit Managers ensured that all resider who have indwelling catheters have a physician order and a medical justificat for the indwelling catheter.	f ed. ne s r an t use. ent rd. on an ad a and nts	

Event ID: 80N511

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLETED
					С
		345039			03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 690	diagnosis for the cath physician is called to get catheter discontin A follow up interview 11:15 AM with the Ur she was assisting wit and completed the ad stated she noted the educated the residen removing it and the p keeping it in place an have it removed. The revealed there was m the notification of the An attempt was made 3/22/18 at 4:30 PM. An interview was con PM with the Administ residents admitted with	heter. If no reason, the either obtain a diagnosis or nued. was conducted on 3/22/18 at hit Coordinator. She revealed th this resident's admission dmission assessment. She presence of the catheter and t on the importance of ossible adverse effects of id the resident refused to a Unit Coordinator further hiscommunication regarding physician. e to contact the physician on	F 69		g staff ctical es: Full facility continent n to her uch that itain. For ce based ure that without eterized ition was the or essed n as ical a dder id facility s ropriate

Facility ID: 923294

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/04/2018 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345039	B. WING _				C /22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	
	STONE HEALTH AND RE	HABILITATION CENTER		485	VETERANS WAY		
				KEF	RNERSVILLE, 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	Continued From page	≥ 26	F 6		DEFICIENCY) medical justification for the use of the catheter. As of 4/16/2018 any employee who w required to be in serviced will not be allowed to work until the training has completed. Effective 4/16/2018, this training is incorporated into the new employee orientation program. This information has been integrated into t standard orientation training and in the required in-service refresher courses all employees and will be reviewed by Quality Assurance Process to verify the the change has been sustained. The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains corre- and/or in compliance with the regulate requirements; Starting 4/20/18 the Director of nursin Unit Manager will review 5 residents weekly using a quality assurance (QA survey tool who have indwelling cathe- to ensure that they physician orders a also a medical justification for the use the indwelling catheter. This will be defined to ensure that they physician orders a	he been he for the hat that that ected ory g or g or b ter ind of	
					for 4 weeks then monthly for 3 month Reports will be presented to the week QA committee by the Director of Nurs to ensure corrective action for trends ongoing concerns is initiated as appropriate. The weekly QA Meeting attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Uni Manager, Support Nurse, Therapy, H Dietary Manager and the Administrate	dy ing or is t IM,	
					The title of the person responsible for		

Event ID: 80N511

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/04/20 RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		TE SURVEY MPLETED
		345039	B. WING		0	C 3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		85 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 690	Continued From page		F 690	implementing the acceptable plan correction; Administrator and /or Director of N Date of Compliance: April 16th 20 <sup>.</sup>	lursing.	
F 758 SS=D	CFR(s): 483.45(c)(3)	rchotropic Meds/PRN Use (e)(1)-(5)	F 758			4/16/18
	affects brain activities processes and behave	ppic Drugs. hotropic drug is any drug that associated with mental vior. These drugs include, drugs in the following				
	Based on a comprehe resident, the facility n	ensive assessment of a nust ensure that				
	psychotropic drugs an unless the medication	ents who have not used re not given these drugs n is necessary to treat a diagnosed and documented				
	drugs receive gradua behavioral interventio	ents who use psychotropic I dose reductions, and ons, unless clinically n effort to discontinue these				
	unless that medicatio	ursuant to a PRN order n is necessary to treat a ondition that is documented				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I				PRINTED: 05/0 FORM APPI OMB NO. 093	ROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVE COMPLETED	
	345039	B. WING _		C 03/22/20	18
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
SUMMERSTONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY		
			KERNERSVILLE, NC 27284		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COME TO THE APPROPRIATE D	(X5) PLETION DATE
F 758 Continued From page	28	F 7	758		
are limited to 14 days §483.45(e)(5), if the a prescribing practitione appropriate for the PF beyond 14 days, he o rationale in the reside indicate the duration f §483.45(e)(5) PRN or drugs are limited to 14 renewed unless the a prescribing practitione the appropriateness of This REQUIREMENT by: Based on record revit the facility failed to co AIMs (Abnormal Invol assessment on admiss receiving antipsychoti of five residents for un Residents # 46 and 44 The findings included 1. Resident #46 was a 2/27/18 with diagnose fracture left hip and fir pressure ulcer on the psychosis, hallucination tract infection. Record review revealed for an antipsychotic m milligrams 1 tablet two with behavioral disturb	er believes that it is RN order to be extended r she should document their nt's medical record and for the PRN order. ders for anti-psychotic 4 days and cannot be ttending physician or er evaluates the resident for of that medication. is not met as evidenced ew and staff observations mplete an assessment for untary Movement) esion for two residents c medications in a sample nnecessary medications. D. admitted to the facility on es that included fall with st lumbar vertebrae, sacrum, unspecified ons, anxiety, and urinary ed an order dated 2/26/18 hedication, Risperdal 0.5 o times a day for dementia		The statements made of Correction are not an act not constitute an agreer alleged deficiencies. To compliance with all Fed Regulations the facility f take the actions set forth Correction. The Plan of constitutes the facility's compliance such that all deficiencies cited have f corrected by the date or F758 FREE FROM U PSYCHOTROPIC MED The plan of correcting th deficiency. The plan sho processes that lead to th cited; The facility failed to corr assessment for AIMs (A Involuntary Movement) admission for two reside	dmission to and do nent with the remain in eral and State has taken or will h in this Plan of f Correction allegation of I alleged been or will be t dates indicated. JNNEC S/PRN USE he specific buld address the he deficiency hplete an bonormal assessment on	

Facility ID: 923294

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. ( (X3) DATE SU	RVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLE	ΓED
		245020	B. WING		C	
		345039	D. WING	STREET ADDRESS, CITY, STATE, ZIP	03/22	/2018
NAME OF P	ROVIDER OR SUPPLIER			485 VETERANS WAY	CODE	
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIC DATE
F 758	Continued From page	<u>-</u> 20	F 75	.8		
1 700	not been completed u		F / 3	antipsychotic medications	in a sample of	
		for abnormal involuntary		five residents for unneces		
		ossible side effects from the		medications. Residents #4	•	
	use of the antipsycho			Resident #46. AIMs (Abno		
				Movement) assessment c	ompleted on	
	Interview on 3/22/18			3/22/2018. No abnormaliti		
		OON) revealed the unit		Resident #40. AIMs (Abno	-	
		the AIMS assessment. She		Movement) assessment c		
	-	ment would be completed		3/22/2018. No abnormaliti		
	an antipsychotic med	e resident was admitted on		The procedure for implem acceptable plan of correct	-	
		xplained she had been the		specific deficiency cited;		
		ident #46. After becoming		On 3/25/18 and 4/10/18, tl	ne Nurse	
		position was not filled.		Consultant and Unit Mana		
		ealed it would have been her		that all residents who are	-	
		plete the AIMs and it was		antipsychotic medications	have an AIMs	
	missed due to humar	n error.		(Abnormal Involuntary Mo	-	
				assessment completed as	required.	
		nsulting Pharmacist on				
		evealed she would expect to		On 4/10/2018, the Staff De		
		As assessment for a new		Coordinator in serviced all		
	ordered. The purpos	tipsychotic medication		(Registered Nurses, Licen nurse: Full time, Part time		
		ice for future assessments		a psychotropic drug is any	-	
	for abnormal involunt			affects brain activities ass		
		view was completed on		mental processes and beh		
	3/14/18 by another co			drugs include, anti-psycho		
				anti-depressant, anti-aanx		
				hypnotic. The facility must		
		s admitted to the facility on		residents who have not us		
	2/23/18.			drugs are not given these	-	
	Diagnosis include in	part, of Dementia and		the medication is necessa specific condition as diagr	-	
	Psychosis.	part, or Dementia and		documented in the clinical		
				Residents who use psycho		
	A review of the Admis	ssion Minimum Data Set		receive gradual dose redu	_	
	assessment dated 3/2	2/18 revealed Resident #40		behavioral interventions, u		
		on, exhibited behaviors of		contraindicated, in an effo		
	a ana amainan an diamumhi	ve sounds and refused care.		these drugs. Resident do	4 1	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	IPLE	CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:				· /	IPLETED
							С
		345039	B. WING			03	8/22/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER			35 VETERANS WAY ERNERSVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 758	Continued From page	e 30	F 7	58			
	Symptoms of psycho				psychotropic drugs pursuant to a PRN	ı	
		ed extensive assistance of			order unless that medication is necess		
		tivities of Daily Living			to treat a diagnosed specific condition	-	
	(ADL's).				is documented in the clinical record. F		
					orders for psychotropic drugs are limit	ed	
		iew revealed Resident #40			to 14days except if the attending		
	-	ital on 3/5/18 because she stomy tube. She returned to			physician or prescribing practitioner believes that it is appropriate for the P		
		day and was started on			order to be extended beyond 14days,		
		ns three times a day.			or she should document their rational		
	3	· · · · · · · · · · · · · · · · · · ·			the resident's medical record and indi		
	A medical record rev	iew revealed Resident #40			the for the PRN order. PRN orders for		
		sician on 3/7/18 for a urinary			anti-psychotic drugs are limited to 14c	lays	
	tract infection, uncon				and cannot be renewed unless the		
		rs of yelling out. She was tic and the physician noted			attending physician or prescribing practitioner evaluates the resident for	the	
	the resident was on \$				appropriateness of that medication. A		
					AIMS (Abnormal Involuntary Moveme		
	A medical record rev	iew revealed a nurses note			assessment has to be completed for a		
	date dated 3/13/18 ir	ndicating "resident			residents receiving antipsychotic		
		nroughout the day" and			medication on admission, every six		
		sician with new medication			months, and PRN by the Mini Data Se	et	
	changes.				(MDS) Coordinators.		
	A review of the physi	cian orders for March 2018			As of 4/16/2018 any employee who w	as	
		r on 3/13/18 for Seroquel 50			required to be in serviced will not be	40	
		s a day for psychosis,			allowed to work until the training has b	been	
	increased from 25 m	illigrams three times a day.			completed. Effective 4/16/2018, this		
					training is incorporated into the new		
		iew revealed Resident #40			employee orientation program. This	L _	
		visician on 3/14/18 for an			information has been integrated into the		
		s behaviors. The Physician ve tapered since colleague			standard orientation training and in the required in-service refresher courses		
		roquel yesterday, no yelling			all employees and will be reviewed by		
		oday" and "started on			Quality Assurance Process to verify th		
	Macrobid for urinary	tract infection due to being			the change has been sustained.		
	resistant to Cipro".				The monitoring procedure to ensure th	nat	
	A medical record rev	iew did not indicate that an			the plan of correction is effective and		

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · ·	ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	Co	OMPLETED
		345039	B. WING			C 03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (		00/22/2010
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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 758	Continued From page	e 31	F 75	8		
	been completed for R An interview was con AM with the interim D She was the Unit Mar and her position had revealed it is the Unit complete the assess effects if a resident is antipsychotic and wh started after admissic is covering for both si and the assessment the missed. She further re- that the assessment the effects be done per the An interview was con- with the Administration	ducted on 3/22/18 at 10:30 birector of Nursing (DON). nager on the 300/400 halls not been replaced. She Managers responsibility to ment for extrapyramidal side admitted on an en an antipsychotic is on. The other Unit Manager ides and filling in on the hall for this Resident #40 got evealed the expectation was for extrapyramidal side ne facility policy. ducted on 3/22/18 at 3:47 r. She revealed the facility ting the assessments for effects or monitoring		specific deficiency cited re and/or in compliance with a requirements; Starting 4/20/18 the Direct Unit Manager will review 5 weekly using a quality assi- survey tool who are receiv antipsychotic medication to they have an AIMS (Abnor Movement) assessment co- required. This will be done then monthly for 3 months Reports will be presented to QA committee by the Direct to ensure corrective action ongoing concerns is initiate appropriate. The weekly C attended by the Director of Wound Nurse, MDS Coord Manager, Support Nurse, Dietary Manager and the A The title of the person resp implementing the acceptate correction;	the regulatory or of nursing or residents urance (QA) ing o ensure that mal Involuntary ompleted as for 4 weeks to the weekly ctor of Nursing of or trends or ed as QA Meeting is f Nursing, dinator, Unit Therapy, HIM, Administrator oonsible for oble plan of	
F 865 SS=D	QAPI Prgm/Plan, Dis CFR(s): 483.75(a)(2)	closure/Good Faith Attmpt (h)(i)	F 86	Administrator and /or Direc Date of Compliance: April 5	-	4/16/18
	§483.75(a) Quality as improvement (QAPI)	ssurance and performance program.				
		it its QAPI plan to the State er than 1 year after the egulation;				
	§483.75(h) Disclosure A State or the Secret					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		<u>O. 0938-03</u> E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	·	СОМ	PLETED
		245020				С
	ROVIDER OR SUPPLIER	345039	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03	/22/2018
NAME OF P	ROVIDER OR SUPPLIER			485 VETERANS WAY		
SUMMER	STONE HEALTH AND RI	EHABILITATION CENTER				
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 865	Continued From pag	o 22	E 00	r.		
1 000	Continued From pag		F 86	5		
		ords of such committee uch disclosure is related to				
	-	ch committee with the				
	requirements of this					
	§483.75(i) Sanctions					
		by the committee to identify				
		eficiencies will not be used as				
	a basis for sanctions					
	This REQUIREMEN	T is not met as evidenced				
	by:					
		views and record reviews, the		The statements made on this Plan	n of	
		essment and Assurance		Correction are not an admission to		
		Q) failed to implement,		not constitute an agreement with t	he	
		s needed the action plan		alleged deficiencies. To remain in		
		certification survey dated		compliance with all Federal and S		
	2/16/17, in order to a	s for one recited deficiency		Regulations the facility has taken take the actions set forth in this Pl		
		urvey on 3/22/18. The		Correction. The Plan of Correction		
		area of unnecessary		constitutes the facility's allegation		
		ontinued failure of the facility		compliance such that all alleged	•	
		irveys of record show a		deficiencies cited have been or wi	ll be	
		s inability to sustain an		corrected by the date or dates indi		
	effective Quality Ass	urance Program.		F865 QAPI PRGM/PLAN,		
	The findings included	<b>d</b> :		DISCLOSURE /GOOD FAITH ATT The plan of correcting the specific deficiency. The plan should addre		
	This tag is cross refe	renced to:		processes that lead to the deficien cited:	ю	
	F329: The recertification	ation survey on 2/16/17 cited		The facility's Quality Assessment a	and	
		to obtain lab work for		Assurance Committee (QA and Q)		
	monitoring of blood s	sugars for a resident on		to implement, monitor and revise a	as	
		f 5 residents for unnecessary		needed the action plan developed		
	medications. Resider	nt #43		recertification survey dated 2/16/2 order to achieve and sustain comp		
	The recertification su	rvey on 3/22/18 cited the		This was for one recited deficiency		
	facility at F 758 for fa			recertification survey on 3/22/2018		
	abnormal involuntary			deficiency was in the area of unne		
		itoring of two sampled		medications. The continued failure		

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY		
ND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		345039	B. WING		C 03/22/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER	485 VETERANS WAY 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET		
F 865	residents on antipsyc sample of 5 residents medications. Reside Interview with the Ad 3:47 PM revealed QA monthly with review of The QA did not include using the AIMs assess completed. The new	chotic medications in a s for unnecessary ents #40 and 46. ministrator on 3/22/18 at A meetings were held of antipsychotic medications. de review of the monitoring assment to ensure it was admissions have not been ntipsychotic meds and	F 865	<ul> <li>facility during two federal surveys of record show a pattern of the facility inability to sustain an effective Qual Assurance Program.</li> <li>This tag is cross referenced to: F329: The recertification survey on 2/16/2017 cited the facility for failur obtain lab work for monitoring of bld sugars for a resident on insulin in a sampled of 5 residents for unnecess medications. Resident #43.</li> <li>The recertification survey on 3/22/2 cited the facility at F758 for failure to complete an abnormal involuntary movement (AIMS) assessment for monitoring of two sampled resident antipsychotic medications in a sam residents for unnecessary medicati Resident #40 and 46.</li> <li>The procedure for implementing the acceptable plan of correction for the specific deficiency cited;</li> <li>This tag is cross reference to F758 failure to complete an abnormal involuntary movement (AIMS) assessment for monitoring of two sampled residents on antipsychotic medications. Resident #40 and 46.</li> <li>On 4/12/2018, The Quality Assurar Nurse in serviced the Administrator reference to the Quality Assessment and assurance committee consisting at a minimum The director of nursing services;(ii)</li> </ul>	r's lity e to bod sary 2018 to 2016 to 2018 to 2016 to 20 t 2016 to 2016 to 20 t 20 t 20 t 20 to 20 t 20 t 20 t		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/04/2018 FORM APPROVED OMB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 03/22/2018
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 185 VETERANS WAY	•
COMMERC				KERNERSVILLE, NC 27284	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 865	Continued From page	e 34	F 865		ho must be ard member hip role; nd Meet at to ies such as to which ance ) Develop ns of action ciencies;(h) ate or the losure of except in ated to the with the ) Sanctions. hmittee to ciencies will ctions. g is loyee mation has ard equired r all d by the verify that d. hsure that ve and that hs corrected egulatory

Event ID: 80N511

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					OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 03/22/2018
VAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
SUMMER	STONE HEALTH AND R	REHABILITATION CENTER	4	185 VETERANS WAY	
COMMEN			ŀ	KERNERSVILLE, NC 27284	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 865	Continued From page	ge 35	F 865	failure to complete an abnormal involuntary movement (AIMS) assessment for monitoring of two sampled residents on antipsychoti medications in a sample of resider unnecessary medications. Resider and 46. Starting 4/20/18, to ensure complia Administrator or Director of Nursin monitor this issue using a quality assurance (QA) survey tool. Facilit monitor compliance of QA for F758 will be done on weekly basis for 4 then monthly for 3 months by Administrator and reviewed month the Quality Assurance Nurse Const to ensure compliance. Reports will presented to the weekly QA Comm the Administrator or Director of Nursi Administrator for appropriate actio Compliance will be monitored and ongoing auditing program reviewe Weekly Quality of Life Meeting. We QA Committee meeting is attended Administrator, Director of Nursing, Coordinator, Unit Manager, Suppo Nurse, Therapy, HIM, Dietary Man Wound Nurse The title of the person responsible implementing the acceptable plan correction; Administrator and /or Director of N Date of Compliance: April 16th 201	nts for nt #40 ance, g will ty will 3. This weeks ly by sultant be nittee by rsing to s rns will ng or n. d at the eekly d by MDS rt ager, for of ursing.

Event ID: 80N511

Facility ID: 923294

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