DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FO	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	TE SURVEY MPLETED
		345354	B. WING			C 02/15/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/10/2013
				728 PINEY GROVE ROAD		
PINET GR	OVE NURSING AND RE			KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F OC	0		
	A complaint investiga from 2/13/19-2/15/19	ation survey was conducted				
	Immediate Jeopardy	was identified at:				
	CFR 483.25 at tag F689 at a scope and severity (J).					
	CFR 483.35 at tag F7 (J).	726 at a scope and severity				
	The tag F689 constitu Care.	uted Substandard Quality of				
	Immediate Jeopardy removed on 2/15/19.	began on 1/23/19 and was				
	A partial extended su	rvey was completed.				
	corrections to the dat jeopardy began and r the immediate jeopar	was amended to make es when the immediate removed. The correct date of dy beginning was 1/22/19 immediate jeopardy was and not 2/15/19.				
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 65	6		3/15/19
	implement a compret care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE		(X6) DATE
Electroni	cally Signed					03/11/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/26/2019 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345354	B. WING		02/15/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	-
PINEY GR	OVE NURSING AND REP	ABILITATION CENTER		728 PINEY GROVE ROAD KERNERSVILLE, NC 27284	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 656	or maintain the resider physical, mental, and required under §483.2 (ii) Any services that y under §483.24, §483. provided due to the re- under §483.10, include treatment under §483 (iii) Any specialized ser- rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the resider (iv)In consultation with resident's representat (A) The resident's goad desired outcomes. (B) The resident's pre- future discharge. Fact whether the resident's community was assess local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, i requirements set forth section. This REQUIREMENT by: Based on resident an record review, the fact plan that addressed of for 1 of 3 residents (R discharge planning.	 are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 6.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)- als for admission and eference and potential for ilities must document a desire to return to the ssed and any referrals to s and/or other appropriate 	F	Piney Grove Nursing and Center acknowledges rece Statement of Deficiencies a this Plan of Correction to th the summary of findings is correct and in order to mai	eipt of the and proposes he extent that factually intain
	Findings included:			correct and in order to mai compliance with applicable	

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

Event ID: 6U5311

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		ND HUMAN SERVICES				FOR	D: 03/26/2019 M APPROVEI D. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	COMF	E SURVEY PLETED
		345354	B. WING				C / 15/2019
NAME OF PF	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 02	10/2010
		HABILITATION CENTER		728	8 PINEY GROVE ROAD		
FINETOK	OVE NORSING 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	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page		F 6	56			
F 689	expected discharge p in a resident's compre	M an interview was dministrator. She stated she plans and goals be included	F 6	589	MDS Nurses were proactively in-servic by the DON on 2/26/19 on care plan development, including discharge plan and inclusion on the baseline care plar On 2/27/19 the administrator proactive in-serviced the social worker in the car plan development, including discharge plans and the inclusion on the baseline care plan. This in-service was complet on 2/27/19. All newly hire MDS Nurse Social Worker will receive this in-service during orientation. The DON and/or designee will audit ne admission and readmission baseline car plans to ensure the discharge plans and included on care plans for 3 months. The DON and/or designee will audit 100% of all comprehensive care plans monthly months to ensure that discharge plans addressed on each care plan. The Administrator will be responsible for implementing this plan of correction to ensure any issues of developing and implementing a discharge baseline car plan will be addressed through additior root cause analysis, process correction training, and monitoring.	s, h. ly e ted or ce ware e The of x 3 are or e hal	3/15/19
SS=J		5.					
	§483.25(d)(2)Each re	esident receives adequate					

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		MEDICAID SERVICES			OMB NO. 0938-0	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/15/2019	
		345354	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
		HABILITATION CENTER	;	728 PINEY GROVE ROAD		
FINET GR	OVE NORSING AND RE	HABILITATION CENTER	I	KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLET	
F 689	Continued From page	e 4	F 689			
	supervision and assist accidents.	stance devices to prevent				
	This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews, the facility failed to ensure repositioning techniques were followed when repositioning a resident in his wheelchair by pulling him under his arms for 1 of 3 sampled residents (Resident #1) reviewed for supervision to prevent accidents. The failure to properly reposition Resident #1 resulted in Resident #1 sustaining a large hematoma (an abnormal collection of blood), experiencing blood loss and			On 1/30/19 resident #1 was re-adm to the facility from acute care hospit remains stable at this time. Residents that require assistance w ADL's including transferring have th potential to be affected. On 1/29/29 100% audit of Resident Care Guide accuracy in guidance for transfer assistance of dependent residents w	al and ith e a s for	
	severe bruising to his sent to the hospital o with hematoma of ch	s chest. Resident #1 was n 1/26/19 and diagnosed est wall and acute blood loss returned to the facility on		completed by the facility consultant. resident care guides were accurate guidance in care delivery. Beginning 1/29/19, the staff facilitate	All for or (SF)	
	Immediate jeopardy began on 1/22/19 when nursing assistant (NA) #1 repositioned Resident #1 up in his wheelchair by pulling him under his arms which resulted in injury. Immediate Jeopardy was removed on 2/14/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level of "D" (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) for the facility to ensure monitoring systems put into place are effective.			initiated in-service for 100% of licen- nurses, nursing assistants, including agency staff, on appropriate transfe gait belt use. In-service completed 2/14/19. This in-service was added new staff orientation including agence staff. Yearly proactive education for licensed nurses, and nursing assista including agency staff, will occur sta in 2019 with this training and will be scheduled yearly thereafter. This in-service will ensure licensed n	g rs and on to cy ants, irting	
	Findings included:			and certified nursing assistants, incl agency, are aware of the expectatio related to safe transfers and gait be	ns It use.	
	7/22/14. The residen	nitted to the facility on t's diagnosis included: entia and atrial fibrillation.		This will ensure staff are competent related to resident transfers.		
				The Interdisciplinary Team (IDT) will		

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						NO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED	
						С	
		345354	B. WING		0	2/15/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		728 PINEY GROVE ROAD KERNERSVILLE, NC 27284			
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETIC	
F 689	Continued From page	e 5	F 68	9			
	12/19/18, revealed R assistance of one per function of self-suffici one position to anoth The care plan goal w the necessary physic Interventions included two if fatigued. A Quarterly Minimum 1/1/19 indicated Resi impaired cognition ar assistance with one p transfers and utilized had limitation in rang- left sides. A review of a progress dated 1/23/19 revealed to bruise on left chesi described bruise on h of him by nursing stat elevated bruise of the noted a deep bruise of significant elevated s pectoralis major, was	rson to maintain maximum ency for transferring from er related to: unsteady gait. as for Resident #1 to receive al assistance to transfer. d: assistance of one person, Data Set (MDS) dated dent #1 had moderately nd required extensive person for bed mobility and a wheelchair. Resident #1 e of motion on his right and es note by the physician ed, "Seen for acute visit due t and slight cough. Patient his chest to be result of a tug		 review changes of Condition during am IDT meeting. The include appropriate investigat interventions, notification of a physician and responsible paresults of the review will be sthe QAPI team on a monthly months. The DON, and ADON will printerventions, and audit trend weekly as needed and mont committee for three months. QAPI committee will focus of staff competency, including with the Construction of the DON or QI nurse on a month. The DON or QI nurse on a m for 3 months. Results of the audits will be presented to the meeting x 3 months or until a determined by the QAPI meeting. The Administrator will be results of the presented compliance. 	e review will atton, attending arty. The shared with basis for 3 esent the vision ds to the IDT hly QAPI The IDT and n improving with resident Supervision ident audit QAPI team by onthly basis on-going he QAPI a time mbers for		
	within 24 hours since Doppler and stat labs An interview with the at approximately 10:3	facility physician on 2/13/19 30 AM revealed he examined		implementing this plan of con ensure any issues of staff co be addressed through addition cause analysis, process corr training, and monitoring.	ompetency will onal root		
	and ordered a chest stated he did not see	19 for increased confusion x-ray and a urinalysis. He any swelling or bruising to nest area that day but					

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

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/26/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345354	B. WING		C 02/15/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	E, ZIP CODE
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		728 PINEY GROVE ROAD	
				KERNERSVILLE, NC 2728	4
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE DATE
F 689	Continued From page	<u>م</u>	F 6	380	
		ed a hemoglobin level of			
	Resident #1 for follow to right upper chest. the right upper chest extending from the st with some yellowing a dark echymotic area The results of the cor Doppler ultrasound re A statement by nurse taken by the Director telephone revealed N care for Resident #1 Restorative Aide #1 t up in the chair. The s Restorative Aide #1 t	4/19 revealed she saw v up on hematoma formation The progress note revealed had a raised, firm area, ternum to under the arm pit and light bruising to area. A on right rib cage was noted. mpete blood count and esults were reviewed. a aide (NA) #1 dated 1/25/19 of Nursing (DON) via IA#1 had been assigned to on 1/22/19 and she asked o help her pull Resident #1			
	revealed she was ass 1/22/19 on first shift (when she went into F 1/22/19 in the mornin bed to the wheelchain side of the bed becau pivot. NA #1 stated th #1 from his bed to his assistance. She state down in his wheelcha Aide #1 to assist her stated she couldn't re Resident #1 up under	19 at 1:13 PM with NA #1 signed to Resident #1 on 7AM -3PM). She stated Resident #1 's room on ig to transfer him from the r, she got him to sit on the use he was able to stand and hat she transferred Resident is wheelchair without any ed Resident #1 was sliding air so she asked Restorative to reposition him. She emember if she pulled r his arms to reposition him he recalled that she did not			

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/26/201 FORM APPROVEI MB NO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ISTRUCTION		X3) DATE SURVEY COMPLETED
		345354	B. WING _				C 02/15/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1	
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		728 PI	NEY GROVE ROAD		
				KERN	IERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From page	e 8	F 6	89			
	have a gait belt. She remember seeing an Resident #1's body.	stated she did not y swelling or bruising on					
	1/25/19 revealed she assist her to pull up F wheelchair. She ente observed NA #1 pulli wheelchair with her a	ent by Restorative Aide #1 on e was asked by NA #1 to Resident #1 on 1/22/19 in his ered the room to assist and ng Resident #1 back in the urm under his left arm. She NA #1 not to do that.					
	entered Resident #1' help to pull Resident # observed Resident # wheelchair and assis his wheel chair. She toward the back of Re by the back of his par would do the same the resident, but when she NA #1 pulling Reside She told NA #1 that we never supposed to life	She stated on 1/22/19, she s room after NA #1 asked for #1 up in his wheelchair. She					
	bruising or swelling fo On 1/25/19 a nurse '	led no documentation of or Resident #1 until 1/25/19. s note was written indicating					
		s visiting and was concerned Id bruising on Resident #1.					
	revealed she was the	19 at 2:17 PM with Nurse #2 e nurse assigned to Resident the resident was sent to the					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/26/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345354	B. WING				C /15/2019
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER			28 PINEY GROVE ROAD ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	hospital. She stated s exactly what happene the hospital, but she ip pain in his shoulder. A physicians order da Resident #1 was sem Department for pain a bruising on right ches request. A review of the hospit 1/30/19 revealed Res emergency department to the chest wall that Resident #1 was in a of 150, complaining of shoulder pain. Hemody received parenteral in supplement with follo Troponin is elevated ischemia and most lik An attempt to intervie 2/14/19 at 1:32 PM w An interview on 2/14/ AM with Physical The was very familiar with worked with him ofter Resident #1 going to had variable levels of days stand and pivot and other days requir assistance. PT #1 star resistant to getting ou	she couldn't remember ed or why she sent him to recalled he was in a lot of ated 1/26/19 revealed t to the Emergency and increased swelling and at and right side per family tal discharge summary dated sident #1 "presented to the ent after son noted swelling occurred 3 days ago. trial fibrillation with heart rate of chest wall pain and globin was down 4 grams hission and stabilized at 8.9. mamically stable. He on and will discharge on iron w up as an outpatient. but not consistent with cely related to trauma. w the hospital physician on ras unsuccessful. 19 at approximately 11:00 erapist (PT) #1 revealed he a Resident #1 and had h. He stated prior to the hospital on 1/26/19, he functioning and could some with stand by assistance, red more hands on ated Resident #1 could be	F	589			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345354	B. WING				15/2019
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REP	ABILITATION CENTER			28 PINEY GROVE ROAD ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	and reminded to lay of stated it was important they were doing and g process things as he PT#1 stated staff sho transfer residents to p An observation of Res 10:45 AM revealed Re back with eyes open, observed to Resident bruising in various sta Resident #1's chest a on right side. The resi how the bruising and occurred. An interview on 2/13// director of nursing (D Administrator told her 1/25/19 and she bega interviewed NA #1 an was determined that th Resident #1's chest of transfer/repositioning A follow up interview of revealed she didn't re informed about the sw stated it was never ac resident by pulling the staff should have a ga transfer residents pro An initial interview on Administrator reveale swelling and bruising	ad needed to be encouraged on his back or left side. He at for staff to explain what give Resident #1 time to did have impaired cognition. uld utilize gait belts to orevent injury. sident #1 on 2/13/19 at esident #1 lying in bed on There was swelling #1's right chest and ages of healing observed to t midline, toward axilla and ident was unable to state swelling on his chest 19 at 1:35 PM with the ON) revealed the about the bruising on an an investigation. She d Restorative Aide #1 and it the swelling and bruising on recurred from the improper	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	CONNECTION		A. BUILDI	NG _		с			
		345354	B. WING			02/15/2019			
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
PINEY GR	OVE NURSING AND REP	HABILITATION CENTER		728 PINEY GROVE ROAD KERNERSVILLE, NC 27284					
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CTION SHOULD BE COMPLETIN D THE APPROPRIATE DATE			
F 689	member about the sw investigation into how interview with the Adr revealed she knew at because she made no on that day and Resid team meeting. On 2/14/19 at 1:00 Pl and Corporate Nurse Immediate Jeopardy. acceptable credible a Jeopardy removal on The allegation of imm was as follows: How corrective action those residents found the deficient practice: On 1/22/19 resident # certified nursing assis belt, using resident's of due to failure to follow result of knowledge d On 1/22/19 resident # facility for cough. On 1/23/19 abnormal "interval development bibasilar infiltrates sin physician assistant, n initiated for Augmentin Probiotic 1 cap daily > PO and Neb treatmer	he talked to the family velling and bruising and the vit occurred. A follow up ministrator on 2/14/19 bout bruising on the 24th otes about it in her planner dent #1 was discussed in M, the facility's Administrator were informed of the The facility provided an llegation of Immediate 2/15/19 at 11:06 AM. rediate jeopardy removal will be accomplished for I to have been affected by f 1 was transferred by stant #1 without use of gait chest and arms to assist v transfer procedure as a eficit. f 1 received a chest x-ray in chest x-ray results of t of right perihilar and ice 11/22/2018" called to rew orders received and in 875 mg x 10 days, x 21 days, Mucinex 600 mg int ordered as needed.	F	589					
	On 1/23/19 abnormal "interval development bibasilar infiltrates sin physician assistant, n initiated for Augmentii Probiotic 1 cap daily > PO and Neb treatmen	t of right perihilar and lice 11/22/2018" called to lew orders received and n 875 mg x 10 days, x 21 days, Mucinex 600 mg							

Facility ID: 923023

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345354	B. WING				C 15/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REP	ABILITATION CENTER			28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Therapy) during morn for change in conditio antibiotics. Physician the bruise not availab On 1/23/19 resident # medical director, in fa abnormal chest x-ray, resident to also have order received for ultr Vitamin B-12, Vitamin for visit not received to On 1/24/19 resident # clinical team (DON, A Therapy) during morn for abnormal chest x hematoma (bruise). D administrator instructe assistant director of n staff to determine cau On 1/24/19 director of director of nursing be interviews related to to On 1/25/19 director of director of nursing ob certified nursing assis #1 was not transferred procedure. On 1/25/19 resident # of nursing, assistant of therapy manager regative	DON, MDS, administrator, ing meeting (Cardinal IDT) n related to cough, and note from 1/23/19 indicating le at time of review. 4 1 was seen by physician, cility for follow-up to . Progress note reflected bruise on left chest. New asound of chest area, CBC, n D, and BMP. Progress note by facility until 1/24/19. 4 1 was discussed by the .DON, MDS, administrator, hing meeting (Cardinal IDT) ray, diet downgrade, and During Cardinal IDT, ed director of nursing and ursing to start interviewing use of hematoma (bruise). f nursing and assistant gan contacting staff for bruising on resident #1. f nursing and assistant tained statements from two stants that indicated resident d according to transfer 41 was discussed by director director of nursing, and arding change in transfer sulted in a resident being n mechanical lift until	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345354	B. WING				C 15/2019
NAME OF PF	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REP	HABILITATION CENTER			28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	9 13	F	689			
	to reflect change in tra- mechanical lift by the Residents care plan in (ICSP) which commu- including certified nur- staff a resident's trans On 1/26/19 resident # room for evaluation of swelling and pain on 1 On 1/29/19 certified in provided in-service tra- of nursing on transfer- included residents in return demonstration completed. Nursing a with gait belt. Extra ga nurse's stations and s On 1/30/19 resident # from acute care hosp On 1/31/19 resident w caseload for physical therapy for treatment change in transfer ab therapy evaluation re- therapy services for p speech services on 1 include resident will b bed mobility, transfer have a tolerable pain movement.	 1 was sent to emergency f increased size of bruising, left side of chest. aursing assistant # 1 was aining by assistant director s and gait belt use which a chair and poor position, of resident transfer ssistant # 1 was provided ait belts are available at staff facilitator office. 4 was re-admitted to facility ital. was evaluated and added to speech, and occupational as appropriate, including ility. As a result of the sident was picked up by hysical, occupational, and /31/19. Therapy goals e 1 person assistance with stand- pivot, resident will level with range of 					
	On 1/29/19 the interd ADON, administrator,	isciplinary team (DON, and therapy) utilized					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345354	B. WING				C 15/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER			28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	investigation and the root cause of the resi to follow procedure re- knowledge deficit. How the facility will id the potential to be affi practice: On 1/29/19 the direct assistant director of m an audit of resident ca currently in facility for based on each reside guides were correct w noted. This audit was On 1/29/19 the DON transfer observations the facility to ensure the completed per care g noted. This audit was On 1/29/19, the ADO 100% of licensed num including agency staff assistant #1, on appro- without gait belt, inclu- residents using arms, gait belt not appropria gait belt use. This in- staff orientation, inclu- 100% complete with a licensed nurses, and ensure in-service is e the DON, and/or ADC audits of 5 resident tr- include all halls, all sh	"5 whys" to determine the dent injury was staff failure elated transfers due to entify other residents having ected by the same deficient or of nursing (DON) and jursing (ADON) completed are guides for all residents proper transfer status ent's current status. All care with no negative findings documented on a census. and ADON completed of all residents currently in ransfer observed was uide. No negative findings documented on a census.	F	589			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345354	B. WING				C 15/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REP	HABILITATION CENTER			28 PINEY GROVE ROAD ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	technique is correct b plan and facility proce of gait belt when gait audit will be document tool. On 1/29/19 the interd any other resident indor related to resident tra- issues noted. What measures will b changes made to ensi- will not occur: On 1/29/19, the ADOI 100% of licensed nur- including agency staff assistant #1, on appro- without gait belt, inclu- residents using arms, gait belt not appropria- in-service was added including agency staff complete with all nurs nurses, and agency staff complete transfers 5 til halls, all shifts, and ag observation. The aud observing the transfer technique is correct b plan and facility proce belt when appropriate documented on the transfer	sfer and ensuring transfer ased on the resident care edure including correct use belt use is appropriate. The ited on the transfer audit isciplinary team discussed idents or occurrences nsfer technique. No other e put into place or systemic ure the deficient practice N initiated in-service for ses, and nursing assistants, f and certified nursing opriate transfers with and iding not repositioning use of draw sheet when ate, and gait belt use. This to new staff orientation, f. In-service was 100% sing staff (CNAs, licensed taff) on 2/14/19. To ensure beginning 2/13/19 the DON, nplete random audits of 5 mes weekly, to include all gency staff, for transfer it will be completed by r and ensuring transfer ased on the resident care edure including use of gait e. The audit will be	F	689			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345354	B. WING				C / 15/2019
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND REP	HABILITATION CENTER			728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	stations, and staff dev On 2/14/19 the DON, reviewing all progress resident (all residents shifts, all halls) x 12 w areas, including bruis on and investigated if documented on the sl ensure any bruising h when appropriate. On 2/14/19 the DON, will review POC skin a all shifts, all halls) x 1 alerts, including bruis on and investigated if documented on the sl ensure any bruising h when appropriate. The performance improve 1/28/19. The medical the plan on 1/28/19 a How the facility plans to make sure solution Beginning 1/28/19, th communication in the communication to nur daily interdisciplinary education, and audit f provides residents wit	so available at nursing velopment. and/or ADON began s notes entered for any 5 5x weekly (to include all veeks to ensure new skin ing have been followed up i needed. This audit will be kin audit tool. This audit will has been investigated timely ADON, and/or MDS nurse alerts 5x weekly(to include 2 weeks to ensure skin ing, have been followed up i needed. This audit will be kin audit tool. This audit will has been investigated timely rovement plan was ved by the quality assurance ment (QAPI) committee on director was made aware of nd is in agreement with plan. to monitor its performance s are sustained. e facility increased form of: verbal rsing staff by in-service and team (IDT) meetings, written forms to ensure the facility th supervision to prevent	F	689			
	accidents by providing	th supervision to prevent g safe transfers. The IDT, continue to monitor the					

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State New Core Desidencies (x1) Provider Stupping State New Core (x2) MULTPLE CONSTRUCTION (x3) MULTPLE CONSTRUCTION (x4) MULTPLE CONSTRUCTION			ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345354 B. WING 02/15/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY, STATE_2P CODE PINEY GROVE ROAD REHABILITATION CENTER STREET ADDRESS CITY, STATE_2P CODE T28 PINEY GROVE ROAD REGULTION CENTER DEPROVIDER OND COMPACTION SUBJECT REPECTION OF DEPICIENCES DEPROVIDER YOUNDER OND BE FORMATION COMPACTION SUBJECT REPECTION SUBJECT REPECTION SUBJECT REPECTION SUPPORTATION DEPROVIDER YOUNDER OND SUBJECT REPECTION SUBJECT REPECTIO	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY.STREE. JP CODE PINET GROVE NURSING AND REHABILITATION CENTER T28 PINEY GROVE ROAD KERNERSVILLE, NO 27284 (94) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY WUST ER PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLANOF CORRECTION (EACH DEFICIENCY WUST ER PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLANOF CORRECTION (EACH DEFICIENCY WUST ER PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLANOF CORRECTION (EACH DEFICIENCY WUST ER PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLANOF CORRECTION (EACH DEFICIENCY) OWNET (EACH DEFICIENCY) F 689 Continued From page 17 facility to identify other factors contributing to failure to supervise to prevent accidents. F 689 F 689 Beginning 128/19, the DON, and ADON will present the in-service comments, supervision observations, and audit trends to the IDT weekly as needed and monthig QAPI committee for additional recommendations of the daily IDT and monthly QAPI committee to the quartery QAPI committee for additional recommendations for monitoring and continued compliance. The administrator and/or DON will present the recommendations of failure to provide supervision to prevent accidents will be addressed through additional root cause analysis, process correction, training, and monitoring. Piney Grove Nursing and Rehabilitation alleged removal of UJ as of 21/419. The facility's credible allegation of Immediate Jeopardy removal was validated on 21/51/9 at 13.0 PM. The validation was evalued and non-licensed interviews with both licensed and non-licensed interviews with both licensed and non-licensed interviews with both licensed and no			345354	B. WING _				-
PINEP VGROVE NURSING AND REHABILITATION CENTRE KERNERSVILLE, NC 27284 (M) ID PREFIX TNG SUMMARY STATEMENT OF DEFICIENCIES RECOLLATORY OR LSC DENTIFYING INFORMATION) ID PREFIX RECOLLATORY OR LSC DENTIFYING INFORMATION) PROVIDE PREFIX RECOLLATORY OR LSC DENTIFYING INFORMATION) PROVIDE PREFIX TAG PROVENCES PROVIDE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 000 F 689 Continued From page 17 failure to supervise to prevent accidents. F 689 F 689 Beginning 1/28/19, the DON, and ADON will present the in-service comments, supervision observations, and audit frends to the IDT weekly as needed and monthly QAPI committee will focus on improving residents' safety through prevention of accidents, including resident transfers. F 689 The administrator and/or DON will present the recommendations of the daily IDT and monthly QAPI committee to the quarterly QAPI committee for additional recommendations for monitoring and continued compliance. F ne administrator will be responsible for implementing this plan of removal of immediate jeopardy to ensure any issues of failure to provide supervision to prevent accidents will be addressed through additional root cause analysis, process correction, training, and monitoring. F netoclifty's credible allegation of Immediate Jeopardy removal was validated on 215/19 at 1:3:0 PM. The validation was evidenced by interviews with both licensed and non-licensed nursing staff on gaib tell use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of on-going inservice records revealing licensed	NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
Precision TxG REGULATORY OR LSC IDENTIFYING INFORMATION) Precision TxG CECACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY) F 689 Continued From page 17 facility to identify other factors contributing to failure to supervise to prevent accidents. F 689 Beginning 1/28/19, the DON, and ADON will present the in-service comments, supervision observations, and audit trends to the IDT weekly as needed and monthly QAPI committee for six months. The IDT and QAPI committee will focus on improving residents' safety through prevention of accidents, including resident transfers. F 689 The administrator will be responsible for implementing this plan of removal of immediate jeopardy to ensure any issues of failure to provide supervision to prevent accidents will be addressed through additional root cause analysis, process correction, training, and monitoring. Priney Grove Nursing and Rehabilitation alleged removal of IJ as of 2/14/19. The facility's credible allegation of Immediate Jeopardy removal was validated on 2/15/19 at 1:30 PM. The validation was evidenced by interviews with both licensed and non-licensed nursing staff on gait bet use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of on-going inservice records revealing licensed	PINEY GR	OVE NURSING AND REP	ABILITATION CENTER					
facility to identify other factors contributing to failure to supervise to prevent accidents. Beginning 1/28/19, the DON, and ADON will present the in-service comments, supervision observations, and audit trends to the IDT weekly as needed and monthly QAPI committee for six months. The IDT and QAPI committee for six months, including resident transfers. The administrator and/or DON will present the recommendations of the daily IDT and monthly QAPI committee to the quarterly QAPI committee for additional recommendations for monitoring and continued compliance. The administrator will be responsible for imprementing this plan of removal of immediate jeopardy to ensure any issues of failure to provide supervision to prevent accidents will be addressed through additional root cause analysis, process correction, training, and monitoring. Piney Grove Nursing and Rehabilitation alleged removal of U as of 2/14/19. The facility's credible allegation of Immediate Jeopardy removal was validated on 2/15/19 at 1:30 PM. The validation was evidenced by interviews with both licensed and non-licensed nursing staff on gait belt use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of on-going inservice records revealing licensed	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
belt use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of Resident #1's updated care plan and care guide reflecting change in transfer status. Review of on-going	F 689	facility to identify other failure to supervise to Beginning 1/28/19, the present the in-service observations, and aud as needed and monthe months. The IDT and on improving resident of accidents, including The administrator and recommendations of to QAPI committee to the for additional recommendations and continued compli The administrator will implementing this plat jeopardy to ensure an supervision to preven addressed through ad process correction, tra Piney Grove Nursing removal of IJ as of 2/7 The facility's credible Jeopardy removal wa 1:30 PM. The validation interviews with both linursing staff on gait be where to locate them and using draw sheet of on-going inservice and non-licensed staff belt use and when no them not positioning us sheet when appropria	er factors contributing to prevent accidents. e DON, and ADON will comments, supervision dit trends to the IDT weekly by QAPI committee for six d QAPI committee will focus is' safety through prevention g resident transfers. d/or DON will present the the daily IDT and monthly e quarterly QAPI committee hendations for monitoring ance. be responsible for n of removal of immediate my issues of failure to provide t accidents will be dditional root cause analysis, aining, and monitoring. and Rehabilitation alleged 14/19. allegation of Immediate s validated on 2/15/19 at on was evidenced by censed and non-licensed helt use and when not to use, not positioning under arms is when appropriate. Review records revealing licensed f were in-serviced on gait t to use, where to locate under arms and using draw tte. Review of Resident #1's d care guide reflecting	F	689			

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 1	IPLE CO	INSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,				MPLETED
		345354	B. WING			0	C 2/15/2019
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER			PINEY GROVE ROAD INERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 18	F	689			
	audits, documented r residents to ensure c transfer status correc	are guides correct and					
F 726 SS=J	Competent Nursing S CFR(s): 483.35(a)(3)		F	726			3/15/19
	the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil	e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and lity's resident population in facility assessment required					
	licensed nurses have and skill sets necess needs, as identified th	cility must ensure that the specific competencies ary to care for residents' hrough resident escribed in the plan of care.					
	limited to assessing,	ing care includes but is not evaluating, planning and nt care plans and responding					
	to demonstrate comp techniques necessar needs, as identified th assessments, and de	ure that nurse aides are able betency in skills and y to care for residents'					

Facility ID: 923023

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	, ,	G	COMPL	
			AL BOILDIN		c	
		345354	B. WING			5/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				728 PINEY GROVE ROAD		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETIO DATE
				DEFICIENCY)		
F 726	Continued From pag	o 10				
1 720			F 72			
		on, record review and staff		On 1/30/19 resident #1 was re		
		ews, the facility failed to		the facility from an acute care h		
		rsing assistant was trained e allowing the nursing		currently remains in the facility condition.	III STADIE	
		1 of 3 (NA #1) agency				
				Resident that require assistance	o with	
		viewed. The failure to ensure nd competent resulted in an		ADL's including transferring ha		
		d repositioning of Resident		potential to be affected. On 1/2		
		Resident #1 under his arms		100% audit of Resident care gi		
		nt #1 in his wheelchair,		accuracy in guidance for transf		
		esident #1 sustained a large		assistance of dependent reside		
		rmal collection of blood),		completed by the facility consu		
		oss and severe bruising to the hospital on		residents care guides were acc guidance in care delivery.		
				guidance in care delivery.		
	-	ed with hematoma and acute		On 1/20/10, the Assistant Direc	tor of	
		Resident #1 returned to the		On 1/29/19, the Assistant Direc		
	facility on 1/30/19.			Nursing (ADON) initiated proad in-service for 100% of licensed		
	Immodiate iconardy	bagan an 1/22/10 when		nursing assistants, and certified		
		began on 1/22/19 when A) #1 repositioned Resident		assistant #1, on appropriate tra	•	
		air by pulling him under his		repositioning residents using a		
	-	• •		gait belt use. In-service was co		
	arms which resulted	red on 2/14/19 when the		on 2/14/19. This in-service was		
		an acceptable allegation of		new staff orientation, including		
	Immediate Jeopardy			staff. Return demonstration co	• •	
		liance at a scope and		will be accomplished through o		
		no actual harm with potential		audits by the DON and/or ADO		
		al harm that is not Immediate				
		ility to ensure monitoring		Beginning 1/29/19, the staff fac	cilitator (SF)	
	systems put into place			Initiated in-service for 100% of		
				nurses, nursing assistants, incl		
	Findings included:			agency staff, on appropriate tra	-	
	i mango moladod.			gait belt use. In-service compl		
	Resident #1 was adr	nitted to the facility on		2/14/19. This in-service was a		
		ncluded: cerebral infarct,		new staff orientation, including		
	-	a and atrial fibrillation.		staff. Yearly proactive education		
				licensed nurses, and nursing a		
				inconsect nurses, and nursing a	0010101110,	
	Review of Resident +	#1's care plan, updated on		including agency staff, will occu	ir starting	

Facility ID: 923023

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	S FOR MEDICARE &	MEDICAID SERVICES				<u>10. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345354	B. WING			C 2/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				728 PINEY GROVE ROAD		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		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 (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 726	Continued From pag	e 20	F7	26		
	person to maintain n			scheduled yearly therea	after.	
		: unsteady gait, hemiparesis.		The in-service will ensu		
		vas for Resident #1 to receive		and certified nursing as		
		cal assistance to transfer. ed: assistance of one person,		agency, are aware of th related to safe transfers		
	two if fatigued.	a assistance of one person,		This will ensure staff are		
	two in latiguea.			related to resident trans		
	A Quarterly Minimun	n Data Set (MDS) dated				
	1/1/19 indicated Res	ident #1 had moderately		On 1/2/9/19 the DON, a	nd/or ADON	
		nd required extensive		began random observat		
		person for bed mobility and		resident transfers 5 time	•	
		a wheelchair. Resident #1		weeks and then weekly		
	left sides.	e of motion on his right and		audit will be completed transfer and ensure tran		
				correct based on the res	-	
	A review of a progre	ss note by the physician		and facility procedure.	•	
		for acute visit due to bruise		staff is competent in trai		
	on left chest and slig	ht cough. Patient described		The audit will be docum		
	bruise on his chest t	o be result of a tug of him by		transfer audit tool. The	results of the	
	-	a large non elevated bruise		audits will be shared wit		
		ossa. There is noted a deep		committee monthly for t	hree months.	
	-	ne bruise in right axilla had				
	-	er there was a significant over the entire right pectoralis		Results of the observati brought to stand down r		
		ig mass, was soft and		for discussion with the I		
	•	f the extensive amount of		Team members (IDT) a		
		e fact that it had developed		QAPI meeting. Results	-	
		e my initial evaluation of him,		audits will be presented		
	Doppler and stat lab	s ordered."		Meeting x 3 months or u	until a time	
				determined by the QAP	I members for	
		oler results done on 1/23/19		sustained compliance.		
		tion 9.65 x 5.71 x 5.46			oononoible fer the	
	hematoma, cyst or a	tial included organizing bscess".		The IDT members are n Plan of Correction and t responsible for sustaine	he Administrator is	
	-	e aide (NA) #1 dated 1/25/19				
		r of Nursing (DON) via		The Administrator will be		
	telephone revealed I	NA#1 had been assigned to		implementing this plan of	of correction to	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPLI	
		345354	B. WING		C	5/2019
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		0,2010
PINEY GF	ROVE NURSING AND REI	HABILITATION CENTER		28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 726	Resident #1 on 1/22/ and she asked Resto pull Resident #1 up in revealed Restorative and NA #1 pulled Res under his arm. An interview on 2/13/ revealed she was ass 1/22/19 on first shift (when she went into F 1/22/19 in the mornin bed to the wheelchair side of the bed becau pivot. NA #1 stated th #1 from his bed to his assistance. She stated down in his wheelchair. Stated she couldn't re Resident #1 up under in his wheelchair. She have a gait belt. She remember seeing any Resident #1's body. A review of a statemen 1/25/19 revealed she assist her to pull up F wheelchair. She ente observed NA #1 pullin wheelchair with her a stated she instructed An interview on 2/13.	19 on the 7AM - 3 PM shift rative Aide #1 to help her in the chair. The statement Aide #1 came to assist her sident #1 up by pulling him 19 at 1:13 PM with NA #1 signed to Resident #1 on 7AM -3PM). She stated Resident #1's room on g to transfer him from the r, she got him to sit on the use he was able to stand and hat she transferred Resident is wheelchair without any ed Resident #1 was sliding hir so she asked Restorative to reposition him. She emember if she pulled r his arms to reposition him he recalled that she did not stated she did not y swelling or bruising on ent by Restorative Aide #1 on was asked by NA #1 to Resident #1 on 1/22/19 in his red the room to assist and ng Resident #1 back in the rm under his left arm. She NA #1 not to do that.	F 726	ensure any issues of staff compete be addressed through additional in cause analysis, process correction training, and monitoring.	root	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 345354 (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 345354 STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345354 B. WING 02/15/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD			345354	B. WING				-
	NAME OF PI	ROVIDER OR SUPPLIER						
PINEY GROVE NURSING AND REHABILITATION CENTER KERNERSVILLE, NC 27284	PINEY GR	OVE NURSING AND REP	HABILITATION CENTER					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
F 726 Continued From page 22 wheelchair and assisted N4 #1 to pull him up in his wheel chair. She stated she got to the left side toward the back of Resident #1 and pulled him up by the back of his pants. She assumed NA #1 would do the same thing on the other side of the resident, but when she looked up, she observed NA #1 pulling Resident #1 up under his arms. She told NA #1 that was wrong and they were never supposed to lift residents under their arms. She did not observe any swelling or bruising on Resident #1. A physicians order dated 1/26/19 revealed Resident #1 was sent to the Emergency Department for pain and increased swelling and bruising on right chest and right side per family request. A review of the hospital discharge summary dated 1/30/19 revealed Resident #1 'up resented to the emergency department after a family member noted swelling to the chest wall that occurred 3 days ago. Resident #1 was in that forillation with heart rate of 150, complaining of chest wall pain and shoulder pain. Hemoglobic for transporting oxygen in the blocd; normal range 13.5 - 17.5) was down 4 grams from baseline on admission and stabilized at 8.9. He remained hemodynamically stable. He received parenteral irron and will discharge on irron supplement with follow up as an outpatient. Troponin level (a laboratory test to differentiate between myccardial infarction and unstable angina) is elevated but not consistent with ischemia (reduced blood flow) and most likely related to trauma". An interview on 2/14/19 at approximately 11:00 AM with Physical Therapisi (PT) #1 revealed staff should utlize gat belts to transfer residents to	F 726	wheelchair and assist his wheel chair. She s toward the back of Re by the back of his par would do the same the resident, but when she NA #1 pulling Resider She told NA #1 that we never supposed to lift She did not observe a Resident #1. A physicians order da Resident #1. A physicians order da Resident #1 was sent Department for pain a bruising on right chess request. A review of the hospit 1/30/19 revealed Ress emergency departmen noted swelling to the days ago. Resident # heart rate of 150, con and shoulder pain. He transporting oxygen in 13.5 - 17.5) was down admission and stabiliz hemodynamically stal iron and will discharg follow up as an outpa laboratory test to differ infarction and unstabil consistent with ischer most likely related to An interview on 2/14/ AM with Physical The	ted NA #1 to pull him up in stated she got to the left side esident #1 and pulled him up nts. She assumed NA #1 ing on the other side of the ne looked up, she observed int #1 up under his arms. vas wrong and they were tresidents under their arms. any swelling or bruising on ted 1/26/19 revealed to the Emergency and increased swelling and it and right side per family tal discharge summary dated ident #1 "presented to the nt after a family member chest wall that occurred 3 1 was in atrial fibrillation with inplaining of chest wall pain emoglobin (responsible for in the blood; normal range in 4 grams from baseline on zed at 8.9. He remained ble. He received parenteral e on iron supplement with tient. Troponin level (a erentiate between myocardial le angina) is elevated but not mia (reduced blood flow) and trauma". 19 at approximately 11:00 erapist (PT) #1 revealed staff	F	726			

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/26/201 RM APPROVE NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		DNSTRUCTION		ATE SURVEY
		345354	B. WING _				C)2/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
	OVE NURSING AND RE	HABILITATION CENTER		728 I	PINEY GROVE ROAD		
				KER	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 726	Continued From page	e 23	F 7	26			
	prevent injury.						
	10:45 AM revealed R back with eyes open. observed to Resident bruising in various sta Resident #1's chest a on right side. The res how the bruising and occurred.	t #1's right chest and ages of healing observed to at midline, toward axilla and ident was unable to state swelling on his chest					
	how the bruising and swelling on his chest occurred. An interview on 2/14/19 at 8:50 AM with the Staff Development Coordinator revealed orientation for new hires included a video about transfers and lifting. It included information about using gait belts for transfers and she stated every staff member should receive one during orientation and have it with them at all times when working. She stated there was an orientation for agency staff as well with a check list that included a review of the safe resident handling and movement policy which stated "staff will follow the movement and handling safety interventions/procedures for each resident as individually determined through the admission/re-entry admission process", including, "use approved resident handling aids, i.e. gait belts, in accordance with instructions and	hator revealed orientation for video about transfers and rmation about using gait d she stated every staff ve one during orientation a tall times when working. an orientation for agency neck list that included a sident handling and ch stated "staff will follow the ing safety ures for each resident as ed through the dmission process", including, ent handling aids, i.e. gait					
	revealed the only original she started working a	19 at 10:02 AM with NA #1 entation she received when at the facility was orientation e stated she never watched rs and lifting.					
		19 at 2:30 PM with the Nursing revealed NA #1's					

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/26/20 FORM APPROVE /IB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING			C 02/15/2019			
NAME OF PI	ROVIDER OR SUPPLIER		I	s	STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		7	28 PINEY GROVE ROAD			
				۲ I	CERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 726	Continued From page	o 24		726				
1720		wasn't completed. She		/20				
		#1 on the phone on 2/14/19						
	and completed the or	•						
	•	ning wasn't completed.						
		M, the facility's Administrator						
	and Corporate Nurse were informed of the							
	Immediate Jeopardy. The facility provided an acceptable credible allegation of Immediate							
		2/14/19. The allegation of						
	· ·	removal was as follows:						
	those residents found	n will be accomplished for d to have been affected by						
	the deficient practice	: # 1 was transferred by						
		stant #1 without use of gait						
		chest and arms to assist						
	due to failure to follow							
		# 1 was noted to have bruise						
	on left chest.	# 1 was cant to amorgonay						
		# 1 was sent to emergency of increased size of bruising,						
	swelling and pain on	-						
		# 1 was admitted to acute						
	care hospital from en							
		nursing assistant # 1 was						
	of nursing on transfer	aining by assistant director						
		# 1 was admitted to acute						
		nergency room with primary						
	-	rillation with rapid ventricular						
	-	dary diagnosis including						
	hematoma of chest w	vall. #1 was re-admitted to facility						
	from acute care hosp	-						
		lisciplinary team (DON,						
	ADON, administrator	, and therapy) utilized						
	investigation and the	"5 whys" to determine the						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345354	B. WING				C 15/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEY GR	OVE NURSING AND REP	ABILITATION CENTER			28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 726	to follow procedure reknowledge deficit. How the facility will id the potential to be affe practice: On 1/29/19, the ADOI 100% of licensed nurs including agency staff assistant #1, on appror repositioning resident use. In-service was added including agency staff competency will be ad as outlined below. Beginning 1/29/19 the complete random auc times weekly x 12 we completed by observi transfer technique is of resident care plan and audit will ensure staff procedure. The audit transfer audit tool. On 1/29/19 the interdi any other resident tra- issues noted. What measures will b changes made to ens- will not occur:	dent injury was staff failure elated to transfers due to entify other residents having ected by the same deficient N initiated in-service for ses, and nursing assistants, f and certified nursing opriate transfers, not s using arms, and gait belt ompleted on 2/14/19. This to new staff orientation, f. Return demonstration ccomplished through audits e DON, and/or ADON will lits of resident transfers 5 eks. The audit will be ng the transfer and ensure	F	726			

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FO	ED: 03/26/2019 RM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED	
	345354	B. WING		0	C 2/15/2019	
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E		
			728 PINEY GROVE ROAD			
PINEY GROVE NURSING AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
assistants, including transfers and gait be on 2/14/19. This in-si- staff orientation, inclu- proactive education f nursing assistants, in occur starting in 2019 scheduled yearly the This in-service will en- certified nursing assi aware of the expecta- transfers and gait be are competent relate The performance improve 1/28/19. The medica the plan on 1/28/19 a How the facility plans to make sure solution Beginning 1/28/19, th communication in the communication by in the DON, ADON, and interdisciplinary team education, and audit provides residents w accidents by providin QAPI committee will facility to identify othe competency including Beginning 1/28/19, th present the in-service observations, and au	of licensed nurses, nursing agency staff, on appropriate It use. In-service completed ervice was added to new uding agency staff. Yearly for licensed nurses, and neluding agency staff, will 9 with this training and will be reafter. nsure licensed nurses and stants, including agency, are tions related to safe It use. This will ensure staff d to resident transfers. orovement plan was wed by the quality assurance ement (QAPI) committee on I director was made aware of and is in agreement with plan. s to monitor its performance ns are sustained. ne facility increased	F 72				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345354		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI A. BUILDING	(X3) DAT	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		B. WING		C 02/15/2019		
	ROVIDER OR SUPPLIER	HABILITATION CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 726	resident transfers. The administrator and recommendations of t QAPI committee to the for additional recomm and continued compli The administrator will implementing this pla removal to ensure an will be addressed thro analysis, process com monitoring. Piney Grove Nursing removal of IJ as of 2/ The facility's credible Jeopardy removal wa 1:30 PM. The validati interviews with both li nursing staff on gait b where to locate them and using draw sheet of on-going in-service and non-licensed staff belt use and when no them not positioning u sheet when appropria updated care plan an change in transfer staff audits, documented re	mpetency, including with d/or DON will present the the daily IDT and monthly e quarterly QAPI committee nendations for monitoring ance. be responsible for n of immediate jeopardy y issues of staff competency bugh additional root cause rection, training, and and Rehabilitation alleges 14/19. allegation of Immediate s validated on 2/15/19 at on was evidenced by censed and non-licensed relt use and when not to use, not positioning under arms when appropriate. Review e records revealing licensed f were in-serviced on gait t to use, where to locate under arms and using draw tte. Review of Resident #1's d care guide reflecting tus. Review of on-going eview of audit of all are guides correct and	F 726			

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