PRINTED: 02/24/2020 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 01/21/2020	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284		1 017	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	1	F	000			
F 658 SS=D	conduct a recertification investigation survey a Additional information. Therefore, the exit date Event ID# 0Q5611.  3 of the 20 complaint substantiated resulting Immediate Jeopardy 483.25 at tag F697 at 2 residents and Immediate Jeopardy 483.45 at tag F755 at one resident.  The tag F697 constitution Care  Resident #1 Immediate 12-13-19 and was removed.  A partial extended sure Services Provided Me CFR(s): 483.21(b)(3) Compression of the Event Point Provided Me CFR(s): 483.21(b)(3) Compression of the Event Provided Me CFR(s): 483.21(b)(s) Compression of the Event Provided Me CFR(s): 483.21(b)(s) Compression of the Event Provided Me CFR(s): 483.21	and exited on 1-11-20. In were obtained on 1-21-20. In were obtained on 1-20-20. In were obtained on 1-20-20. In were obtained on 1-20 of the Jeopardy began on moved on 1-10-20. In were obtained on 1-10-20. In were obtained on 1-20. In were obtained on 1-20-20. In were obtained on 1-	F	658			1/21/20
	The services provided as outlined by the commust- (i) Meet professional	d or arranged by the facility, mprehensive care plan,					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		 TITLE			(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/30/2020

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.

**Electronically Signed** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345039	B. WING _	<del>-</del>	0	/21/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
CHMMED	STONE HEALTH AND	REHABILITATION CENTER		485 VETERANS WAY			
SUMMERS	SIONE REALIR AND	REHABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO		(X5) COMPLETION	
TAG	,	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH	E APPROPRIATE	DATE	
F 658	Continued From p	page 1	F 6	58			
	by:						
	•	review, resident interview,		The statements made on th	is Plan of		
	family interview, p	physician interview and the		Correction are not an admiss	sion to and do		
		acy interview, the facility failed		not constitute an agreement	with the		
		discharge orders by not		alleged deficiencies. To rema			
		esidents (Resident #1)		compliance with all Federal			
		her admission to the facility.		Regulations the facility has t			
				take the actions set forth in t	his Plan of		
	Findings included	:		Correction. The Plan of Cor	rection		
				constitutes the facility□s alle	gation of		
		admitted to the facility on		compliance such that all alle	ged		
		oximately 6:45pm with multiple		deficiencies cited have been	or will be		
	diagnoses that included posterior spinal fusion of			corrected by the date or date			
		pain syndrome, cellulitis of the		F 658 Services Provided	Meet		
		nd history of pulmonary		Professional Standards			
	embolism.			Corrective Action:			
				Resident #1 Resident discha	arged		
		spital discharge summary dated		12/14/2019	-4l		
		d an order for the following		Identification of other resider	-		
		nex 1mg (milligram) 2 times a		be involved with this practice			
		tion last received on 12-13-19 at spital prior to discharge to the		All current residents have the be affected by the alleged pr			
		25mg 2 times a day for high		1/10/2020 a chart audit was			
		st received on 12-13-19 at		current residents. The audit			
		ospital, Flonase 50 mcg		completed by the Assistant of			
		oray each nostril 2 times a day		nursing, Unit Support nurses			
		eceived on 12-13-19 at 10:39am		of Nursing to ensure that all			
		Ivair 100-50mcg 1 puff every 12		their medications per physic			
	· ·	ss of breath last received on		available. The audit also ens			
		am in the hospital and Prilosec		residents received medication			
	20mg daily for aci			ordered and signed for on th			
				Administration Record. The			
	An interview with	the admitting nurse, Nurse #1,		ensured that pain medication			
		0 at 1:10pm. Nurse #1 said "the		administered as ordered. Th	e Assistant		
		o the building right before the		Director of Nursing and Unit	support		
	end of my shift at	7:00pm." Nurse #1 stated she		nurses, checked all medicati	ion carts and		
		medications for Resident #1		compared to the physician o			
	from the pharmac	y because she "did not have		ensured that all medications			
	her (the resident)	discharge paperwork from the		available and medications a	dministered		

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		345039	B. WING		04/5	; 21/2020
NAME OF PE	ROVIDER OR SUPPLIER	1 0.000	<del>                                     </del>	STREET ADDRESS, CITY, STATE, ZIP CODE	01/2	21/2020
TAPAWIE OF TH	TO VIDER OR GOLT EIER					
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER		485 VETERANS WAY		
				KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	Continued From page	e 2	F 65	8		
	hospital."			per order. All current residents h	nave	
	nospital.			medications available and medic		
	Resident #1 was inte	rviewed by telephone on		administered per order. All audits		
		Resident #1 stated she		completed on 1/10/2020.		
		on the evening of 12-13-19		Systemic Changes:		
		aff member escorted her to		All Full Time and Part Time and	as	
	her room and took he			needed (PRN) Nursing Staff (Nu	rses and	
	paperwork but did no	t remember the name or title		Nursing assistants (which include	es any	
		She also stated she did not		Nursing assistants who are med		
		heduled medications on		aides}) will be educated on the fo	-	
		and the last dose of her		by the Director of Nursing. Educa	ation	
	medications that she			began on 1/10/2020.	0/0000 :	
		narge on the evening of		Education was completed on 1/1		
		1 stated she left the facility 19) with a family member and		reference to how to order and remedication and following dischar		
	went home.	19) Will a laililly member and		orders.	ye	
	went nome.			Education included:		
	Nurse #2 was intervie	ewed on 1-8-20 at 1:25pm.		The facility must ensure that the	services	
		m 7:00pm to 11:00pm on the		provided or arranged by the facil		
		She said she did not receive		outlined by the comprehensive c		
	a resident report from	n Nurse #1 prior to starting		meet professional standards of o	uality. All	
	her shift at 7:00pm. N	lurse #2 also indicated she		scheduled medications will be		
		dent's pain medications		administered as ordered by phys	sician.	
		(in) on 12-13-19 but did not		The monitoring will be done by the		
		nt any medication and was		Director of Nursing or Assistant I		
		t1's scheduled medications		Nursing Or Unit Support Nurses		
		n the pharmacy since she		include reviewing the Point of ca		
	did not receive a repo	ort from the previous shift.		dashboard; Med Passes in the la		
	An intonvious with Nur	rse #3 occurred on 1-8-20 at		hours for each assignment every ensure that all medications have	-	
		orked 11:00pm to 7:00am		administered as ordered and als		
		and remembered Resident		reviewing the Not Administered I	•	
	~	she did not receive a report		passes in last 24 hours on the da		
		e beginning her shift. The		checking the # of documentation		
		ot administer any medication		as not administered.		
		her shift and was not aware		PRN medications will be adminis	stered as	
		uled medications had not		ordered by physician. The monitor		
	been ordered through	n the pharmacy since she did		be done by the Director of Nursir		
	not receive a report of	on Resident #1 from the prior		Assistant Director of Nursing or I	Jnit	

Facility ID: 923294

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D. WILLO			1	0
		345039	B. WING _			01/	21/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIIMMED	STONE HEALTH AND DE	HABILITATION CENTER		48	85 VETERANS WAY		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 658	Continued From page	e 3	F6	658			
	(MAR) was reviewed	ition Administration Record for 12-13-19 and revealed			Support Nurses and will include review the Point of Care dashboard; Administered PRN medication in the la 24 hours for each assignment every day	st	
	of her scheduled med				to ensure that PRN medications have been administered as ordered. What to do when a drug is not available		
		4-19 at 9:00am revealed esident #1 received her n.			" If the medication is an OTC (over counter drug), check the medication O stock supply located at each Medicatio room (Located at each nursing station)	TC n	
	on 1-7-20 at 1:25pm, revealed Resident #1	vith the pharmacy manager the pharmacy manager 's medications were not y until after 3:00pm on			you are unable to locate it there, proce to the Central Supply Room. If you are unable to locate it there, proceed to the other medication carts to see if the OT available there. If the medication is still unavailable, contact the DON or Nurse	e e C is	
	revealed Resident #1 did not leave the pha	ng slip dated 12-14-19 's scheduled medications rmacy until 3:00pm on ned into the facility by Nurse			Manager for further guidance.  " If the medication is a prescription drug, you would first check the Medispense system located at the Rehall nurses station medication room (100/200hall). If the medication is not in	nab	
	Nurse #1 was intervied 1-8-20 at 1:15pm. Nurse #1 from 7:00pm to 7:00pm administer any medications were pharmacy. She also set to go back and put the available 12-14-19 at			the Medispense system, then immedia notify pharmacy so it can be obtained from back up. If the prescription medication ordered will be delayed mo than one hour, notify the physician for additional orders or directions.  Medications must be given in the form ordered by the Physician unless the M	re any D		
	at 3:30pm. The Medic resident was admitted contact him or the ph resident's information been ordered. He als	was interviewed on 1-9-20 cal Director said when a d to the facility, staff would ysician assistant with the and medications that had o stated, admissions that day would sometimes			gives an order to dose differently. If at time you have questions regarding the medication administration process, ple contact the DON or Nurse Manager.  " Ordering Medications from the Provider Pharmacy for new admission, readmissions, new orders, and for curr residents (reordering).	ase	

Facility ID: 923294

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 01/21/2020		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/2	2 1/2020	
					85 VETERANS WAY			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER	KERNERSVILLE, NC 27284					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From page 4		F	658				
F 658	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 cause a delay in administering the admitted resident's medication but "it is the facility's goal to administer medications as ordered by the physician."  A nursing note dated 12-14-19 at 7:10pm documented Resident #1 being alert, oriented and able to make her needs known and Resident #1 stating she had not been assessed in 26 hours or received any of her medications.			658	1) Medication orders are written on a medication order form and transmitted the pharmacy. The written entry include Date ordered, Whether the order is new or a repeat order (refill), include the prescription number. Resident s name Medication name and strength, when indicated. Directions for use, if a new order, or direction changes to a previous order.  2) Repeat medications (refills) are ordered by peeling the top label from the unit do card and placing it in the appropriate and ordered as follows:  a) Reorder medication (three to four) d in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (such as Schedule II controlled substances, Department of Veterans Affairs prescriptions), order at least (seven days) in advance of need. b) The nurse who reorders the medication responsible for notifying the pharmacof changes in directions for use or previous labeling errors. c) The refill order is called in, faxed, or otherwise transmitted to the pharmacy. 3) New medications, except for emergency or stat medications, are ordered as follows: a) If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivered and request	es: w a a e. us ered ose rea ays atte tion cy		
					and request delivery within (4) hours.	71 y		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
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				KI	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 5	F	658	b) Timely delivery of new orders is required so that medication administratis not delayed.  The emergency kit is used when the resident needs a medication prior to pharmacy delivery.  4) Stat and emergency medications are ordered as follows:  a) During regular pharmacy hours, the emergency or stat order is phoned or faxed to the pharmacy. Such medication are delivered and administered within (hours. If available, the initial dose is obtained from the emergency kit, when necessary.  5) When phoning or faxing a medication order to the pharmacy, the following information is given:  a) Resident s name.  b) Prescription number if a refill.  c) Complete order if a new medication order or direction changes to a previou order.  d) Name of prescriber if a new order.  e) Indication for use.  f) Name of person calling in order.  6) New Admission Orders:  a) When calling/faxing medication order or a newly admitted resident, the pharmacy is also given all ancillary ord allergies, and diagnoses to facilitate generation of a patient profile and computer summary sheet, and permit initial medication use assessment.  b) The medication order form is also us to notify the provider pharmacy of changes in dosage, directions for use, of current medications.  This in service was completed by	e ons 2) n	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  485 VETERANS WAY  KERNERSVILLE, NC 27284				
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F 658	Continued From page	ne 6	F 65	1/10/2020. Any nursing staff (full tipart time, and PRN) who did not rein-service training will not be allowed work until training is completed. The information has been integrated integr	ceive ed to is o the the es for by the y that  istant will 0, and ctor of rsing clude ard; r each at all ed as Not 4 hours f  nsure for new vill be chen be ittee by Data  priate. bught to rator will be			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	•		
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F 658	Continued From pag	ge 7	F 6	reviewed at the Weekly Quality Meeting. Weekly QA Committe is attended by Administrator, D Nursing, MDS Coordinator, Un Support Nurse, Therapy, HIM( Information Management), Die Manager, Wound Nurse. Date of Compliance: 1/21/2020	ee meeting Director of hit Manager, Health stary		
F 697 SS=J	provided to resident consistent with profe the comprehensive and the residents' go	nagement. sure that pain management is s who require such services, essional standards of practice, person-centered care plan, bals and preferences. T is not met as evidenced	F 6:	-		1/21/20	
	Based on record refamily, staff, nurse practitioner and phymanage residents' predication as order residents (Resident reviewed for pain manage resident #1 "crying pillow due to the pail ultimately leaving the medical advice. Rese a scale of 10+ (0 be worst pain) and ultimemergency room for Immediate Jeopardy Resident #1, who was facility with hospital	view, interviews with resident, practitioner, Orthopedic nurse sician, the facility failed to pain by not administering pain ed by the physician for 2 of 2 #1 and Resident #2) anagement. This resulted in and screaming" into her in being "terrible" and refacility the next day against aident #2 experienced pain at aing no pain and 10 being the mately was sent to the repain management.  If began on 12-13-19 when as newly admitted to the discharge orders for multiple in the receive her pain		The statements made on this Correction are not an admission not constitute an agreement walleged deficiencies. To remain compliance with all Federal an Regulations the facility has tak take the actions set forth in this Correction. The Plan of Corrections the facility sallegate compliance such that all alleged deficiencies cited have been of corrected by the date or dates F 697 Pain Management Corrective Action:  Resident #1 Resident discharge 12/14/2019  Resident #2 Medications available administered as ordered. Identification of other residents.	on to and do ith the in in d State ien or will s Plan of ction ation of ed r will be indicated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345039	B. WING_		01	/21/2020	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		12 1/2020	
TO THE OT T	TO VIDER OR GOLF EIER			485 VETERANS WAY	_		
SUMMER	STONE HEALTH AND	REHABILITATION CENTER					
				KERNERSVILLE, NC 27284		T	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 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	
F 697	Continued From բ	page 8	F 6	97			
	•	ting in the resident experiencing		be involved with this practice:			
		and leaving the facility the next		All current residents have the			
		s Immediate Jeopardy began on		be affected by the alleged pra	•		
		ident #2 did not receive his pain		assessments ordered for all c			
		ise the facility ran out the		residents on 1/10/2020 to be			
		ng in the resident experiencing		every shift daily by nurse. Pai	•		
		and the resident was		assessments to be document			
		hospital emergency room to		electronic medication adminis			
		mmediate Jeopardy was		record (EMAR). A complete a	udit of all		
	removed on 1-10-	-20 when the facility provided		current residents was comple	ted on		
	and implemented	an acceptable credible		1/10/2020 by the Nurse Cons	ultant,		
	allegation of Imm	ediate Jeopardy removal. The		Assistant Director of Nursing	and Unit		
		ut of compliance at a lower		support nurses to ensure that	all residents		
		ty of "D" (no harm with the		had a pain assessment comp			
	·	than minimal harm that is not		pain assessments have been	-		
		rdy) to ensure monitoring		on all current residents on 1/1			
	systems put in pla	ace are effective.		audit also ensured that pain n			
				are administered as ordered.			
	Findings included	:		was notified for any resident v			
	4 5	1 20 14 0 6 22		complained of a new onset of	-		
		as admitted to the facility on		reported severe pain that was			
		eximately 6:45pm with multiple		with current interventions. Any			
		cluded posterior spinal fusion of pain syndrome, cellulitis of the		for pain medications were obt orders faxed to pharmacy so			
		nd history of pulmonary		medication from back up phar			
	embolism.	id filstory of pullflorially		Medications administered as			
	CITIDONOITI.			audits were completed on 1/1			
	Resident #1's hos	spital discharge summary dated		Systemic Changes:	0/2020.		
		d an order for the following pain		All Full Time and Part Time ar	nd as		
		axin 500mg (milligrams) 3 times		needed (PRN) Nursing Staff (			
		spasms, Percocet 10-325mg		Nursing assistants) will be ed			
		needed for pain, Belbuca Film		the following by the Director of			
		ams) every 12 hours for pain,		Education began on 1/10/202	-		
	, J.	grams applied to the skin every		Education was completed on			
		ed for pain and Lyrica 50mg		reference to Pain managemen			
	twice a day for pa			assessment, Medication error			
	·			how to order and reorder med			
	Resident #1 left th	ne facility against medical advice		Education included:			
		proximately 7:00pm. There was		The facility must ensure that	pain		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	0-0000	1	STREET	ADDRESS, CITY, STATE, ZIP CODE	01	/21/2020	
NAME OF T	TOVIDEN ON 301 1 EIEN				, , ,			
SUMMERS	STONE HEALTH AND	REHABILITATION CENTER			TERANS WAY			
				KERNE	ERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 697	Continued From p	page 9	F 6	697				
		r a Minimum Data Set			inagement is provided to residents	s who		
	completed.	a Minimani Bata Got			uire such services, consistent wit			
	'				ofessional standards of practice, th			
	Resident #1's faci	lity's admission nursing			mprehensive person-centered car			
		ed by Nurse #1 dated 12-13-19			n, and the resident□s goals and			
	revealed Residen	t #1 was alert, oriented and had		pre	eferences. Pain assessment will be	•		
	a pain level of zer	0.			mpleted on each resident every sh			
					nurse daily. Pain assessments w			
		the admitting nurse, Nurse #1,			mpleted for each new admissions	or		
		0 at 1:10pm. Nurse #1 said she			admissions upon admission. Pain			
		ed Resident #1's room on			dications will be administered as	***		
		" 6:50pm to introduce herself			lered by physician. The monitoring	-		
		ursing assessment in the nic medical record but did not			done by the Director of Nursing o sistant Director of Nursing Or Unit			
		rsing assessment or ask about			pport Nurses and will include revi			
		n level. The Nurse stated, "she			Point of care dashboard; Med Pa	-		
		e was in pain." Nurse #1 stated,		l l	the last 24 hours for each hall	0000		
		e into the building right before			signment every day to ensure that	all		
		t at 7:00pm." The nurse also			edications have been administered			
		not comfortable completing an		ord	lered and also by reviewing the N	ot		
	admission assess	ment on Resident #1 because		Ad	ministered Med passes in last 24	hours		
	she "did not have	her (the resident) discharge		on	the dashboard checking the # of			
	' '	ne hospital." Nurse #1 indicated			cumentations saved as not			
		Resident #1's admission to the			ministered. Changes in a patient			
	on-coming nurse	at 7:00pm.			ndition occur for many different			
	D: -! + #4 :			l l	sons. New onset of pain or comp			
		nterviewed by telephone on			pain or worsening pain unrelieved			
		n. Resident #1 stated she ity on the evening of 12-13-19			erventions should be addressed base for all resident in the facility.	•		
		staff member escorted her to			nat to do if a resident has a new o	neat		
		k her hospital discharge			pain or complains of pain or worse			
		e did not remember the name or			n unrelieved by interventions.	9		
		ember. She also indicated a		"	If you are not a nurse, then notif	v the		
		entered her room and obtained		nur	rse immediately of the pain chang	•		
		e did not see a nurse. Resident			ı have noticed. Even small pain			
		sted to see a nurse for some		1 -	anges can be very important since	they		
		several" times on the evening of			y indicate bigger problems to com	-		
		not provided with either of her		"	Nurses should assess the patien			
	requests. The res	ident also expressed she felt		pai	n upon notification. Assessment	needs		

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I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
345039	B. WING _				C <b>21/2020</b>	
		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 01/	21/2020	
			, , ,			
BILITATION CENTER						
		IXL	·		I	
MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)		×	(EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
0	F 6	697				
ed her pain as ng" and stated, "I breaming into my pillow to terrible" throughout the to the next day 12-14-19 ars. Resident #1 stated ext day (12-14-19) with a thome.  Inursing assistant (NA) #1 at NA was assigned to hing of 12-13-19 and hit using her call light two 00pm-7:00am) and ion for her back. NA #1 Nurse #2 and Nurse #3 of repain medication and medication was not hacy. The NA revealed macing, grunting or crying depain medication. NA #1 and any activities of daily 1.  Bed on 1-8-20 at 1:25pm.  Bed on 1-8-20 at 1:25pm.		597	reviewed in order to determine if a patihad a condition that may explain the siand symptoms they are experiencing.  " If interventions are available by use the standing orders, patient current orders, or items identified in the plan of care then they should be implemented appropriate. This may include Tylenol fever, prn pain medication etc.  Administer pain medications as ordere by physician.  " Pain Interventions should be implemented promptly when pain chan is identified. Administer pain medication as ordered by physicians.  " Pain Assessment results and interventions must be documented in the medical record.  " Immediate Notification of physician required when there is a new onset of pain or the pain is severe and current interventions are not effective.  Documentation of this notification should be completed, and new orders obtaine and documented. Administer pain medications per physician orders.  " Phone numbers for physicians are located at the nursing stations. If a physician does not respond to an emergency or If you are unable to react the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the	ent gns ing f as for d ge ons n is		
THE CONTRACT OF THE STATE FOR	BILITATION CENTER  MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)  Ded her pain as ang" and stated, "I reaming into my pillow terrible" throughout the to the next day 12-14-19 ars. Resident #1 stated ext day (12-14-19) with a thome.  Inursing assistant (NA) #1 and the NA was assigned to sing of 12-13-19 and to sing of	BILITATION CENTER  MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)  Ded her pain as ang and stated, "I reaming into my pillow to terrible" throughout the to the next day 12-14-19 urs. Resident #1 stated ext day (12-14-19) with a thome.  nursing assistant (NA) #1 and NA was assigned to a thome.  nursing of 12-13-19 and the total thome and the properties of the pain and the properties of the properties	BILITATION CENTER  MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)  The definition of the pain as angle and stated, "I reaming into my pillow to terrible" throughout the to the next day 12-14-19 urs. Resident #1 stated ext day (12-14-19) with a thome.  The nursing assistant (NA) #1 and the NA was assigned to ining of 12-13-19 and the training of 12-13-19 and the pain medication and the information of the back. NA #1 and the nursing are with the precedent of the pain in th	BILITATION CENTER  BILITATION CENTER  MENT OF DEFICIENCIES UST BE PRECEDED BY PULL IDENTIFYING INFORMATION)  20 de her pain as right and stated, "I reaming into my pillow to terrible" throughout the to the next day 12-14-19 usrs. Resident #1 stated at thome.  21 and the pain as the thome.  22 and the pain as the thome.  23 and stated, "I reaming into my pillow to terrible" throughout the to the next day 12-14-19 usrs. Resident #1 stated at thome.  24 thome.  25 and stated 12-13-19 and the policy of the pain and the pain an	STREETADDRESS, CITY, STATE, ZIP CODE  #STREETADDRESS, CITY, STATE, ZIP CODE  ##STREETADDRESS, CITY, STATE, ZIP  ##STREETADDRESS, CITY, STATE, ZIP CODE  ##STREETADRESS, CITY, STATE, ZIP CODE  ##STREETADDRESS, CITY, STATE, ZIP  ##STREETADDRESS, C	

Facility ID: 923294

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	
			D 14/11/0				
		345039	B. WING _			01/2	21/2020
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIIMMEDS	STONE HEALTH AND DI	EHABILITATION CENTER		48	85 VETERANS WAY		
SUMMERS	TONE REALITY AND KI	ENABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			COMPLETION DATE
F 697	697 Continued From page 11		F	697			
	Resident #1 complai	ned of pain and stated she			not call back within 30 minutes then the	د	
	•	e resident any medication.			nurse is to contact the Director of Nursi		
					immediately for further instructions.	9	
	An interview with Nu	rse #3 occurred on 1-8-20 at			" Notify the responsible party and		
		vorked 11:00pm to 7:00am			document this in the nursing notes.		
		and remembered Resident			" If the physician orders for the resid	lent	
	•	e did not complete an			to be transferred to an acute care hosp		
		ent on Resident #1 because			for evaluation, orders will be followed a		
	"the admitting nurse	should have completed the			implemented. If resident refuses to be		
	assessment." Nurse	#3 stated she did not receive			transferred to the acute care hospital o	r if	
	a report on Resident #1 before beginning her				resident representative refuses for the		
	shift. She stated "(N	urse #2) didn't know much			resident to be transferred to the acute		
		get a report from (Nurse			care hospital, Physician will be notified	of	
	#1)." Nurse #3 indica	ited she did not have any			the refusal. Document notification of		
	interaction with Resid		physician on such situations, and follo				
		nt requesting any pain			and document physician orders and/or		
		id not look to see if Resident			directives. Notify resident representativ	е	
	- ·	lication available. The nurse			of resident⊡s refusal and also of		
		inister any medication to			physician notification and of any new		
	Resident #1 during h	er shift.			orders or directives.		
					Pain assessments are documented in t	he	
		ed on 1-9-20 at 4:10pm. NA			electronic health record. This includes		
	// = 01010 0 0 110 110 110 110 110 110 110	d on 12-14-19 from 7:00am			nursing user defined assessments; vita		
	· · · · · · · · · · · · · · · · · · ·	essigned to care for Resident			signs tab, and the electronic medication		
		red Resident #1 activating			records. Verbal or visual pain scales ca		
	J	mes" complaining of pain on iid when Resident #1 would			be used to assist patients who are able verbalize pain. Nonverbal scales are us		
		ould make a grimacing face			when patients are not able to verbalize		
		icated she informed Nurse			pain intensity.		
		12-14-19 of the resident's			Verbal Pain Scale		
		old Resident #1 that staff was			(Ask the resident: "On a scale of 0 to 1	0	
	waiting for the physic				with 0 being no pain, 1-3 being mild pa		
		said she had not provided			4-6 being moderate pain, and 7-10 being		
		living care to Resident #1			severe pain, with 10 being the worst pa	•	
		t did not request any care.			you can imagine, what number would y		
					say best describes your pain right now		
	The facility's narcotic	count sheet dated 12-13-19			,	′	
	•	et 10-325mg tablet was			Visual Pain Scale		
		edication cart by Nurse #1 on			(Say to the resident: "There are six face	es	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _		<del></del>	l	21/2020
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From particles of the continued From th	ge 12 m for Resident #1. cation Administration Record er 2019 revealed there was no medications were sident #1 on 12-13-19 or  viewed a second time on Nurse #1 worked on 12-14-19 Opm and remembered aining of pain. She said she nt that her medications were he pharmacy. Nurse #1 ot administer any medications  with the pharmacy manager n, the pharmacy manager 10-325mg tablet and Robaxin delivered to the facility at 9 by the facility's back up said the rest of Resident #1's ot delivered to the facility until		697		y ce w a es tain e? the TC n . If ed e e c e C is	
	protocol to have nu assessments every medication required administration and of of a pain medication specify that the nur complete a pain assessments	rsing staff perform pain shift. She also stated, If a d a pain assessment prior to a follow-up after administration n, the physician's orders would sing staff would need to			drug, you would first check the Medispense system located at the Reh hall nurses station medication room (100/200hall). If the medication is not in the Medispense system, then immedia notify pharmacy so it can be obtained from back up. If the prescription medication ordered will be delayed mothan one hour, notify the physician for additional orders or directions.	n tely re	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345039	B. WING _		01	/21/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				485 VETERANS WAY			
SUMMERS	STONE HEALTH AND	REHABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 697	Continued From p	page 13	F	597			
F 697	post-surgery. She spinal fusion of he have been in excr resident would no prescriptions for prevealed Residen hindered and recopain medication.  The Medical Direct at 3:30pm. The M resident was adm contact him or the resident's informat been ordered. He happened later in cause a delay in a resident's medical administer medical administer medical administer medical physician."  Resident #1's famt telephone on 1-10 member said upon the facility, the resident #1 crying and stating medications. The called the facility to	Resident #1 in the hospital stated Resident #1 had a er L3-pelvis area and would ruciating pain and that the thave been discharged without rain medication. The PA that's mobility would have been overy prolonged by not receiving ettor was interviewed on 1-9-20 redical Director said when a litted to the facility, staff would end physician assistant with the tion and medications that had also stated, admissions that the day would sometimes administering the admitted tion but "it is the facility's goal to retire a sordered by the sident #1's admission to sident was able to walk with oderate to severe back pain. For stated she received a call on 12-13-19 and 12-14-19 she did not receive any of her family member revealed she to inquire about Resident #1's was informed by Nurse #1 that	F	Medications must be given ordered by the Physician urgives an order to dose differ time you have questions regmedication administration p contact the DON or Nurse Management of the provider Pharmacy for new readmissions, new orders, a residents (reordering).  1) Medication orders are wrated medication order form and the pharmacy. The written of the pharmacy. The written or a repeat order (refill), include prescription number. Reside Medication name and strengindicated. Directions for use order, or direction changes order.  2) Repeat medications (refill by peeling the top label from card and placing it in the ap and ordered as follows:  a) Reorder medication (three in advance of need to assur supply is on hand. When remedication that requires spendication that requires spendication substances, Depoveterans Affairs prescription least (seven days) in advance	nless the MD rently. If at any garding the rocess, please Manager. rom the admission, and for current itten on a transmitted to entry includes: order is new ne order is a the ent s name. gth, when a, if a new to a previous  Is) are ordered in the unit dose propriate area e to four) days re an adequate ordering ecial ule II artment of ins), order at		
	the facility was sti order the resident member said she Resident #1 home family member sta	Il waiting for the physician to 's medication. The family drove to the facility and took e against medical advice. The ated Resident #1 was in could "barley walk" out of the		<ul> <li>b) The nurse who reorders is responsible for notifying to of changes in directions for previous labeling errors.</li> <li>c) The refill order is called in otherwise transmitted to the</li> </ul>	the medication he pharmacy use or n, faxed, or		

Facility ID: 923294

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345039	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	1 0.0000	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		1/21/2020	
WAWL OF T	NOVIDEN ON OUT FIEN						
SUMMER	STONE HEALTH AND RI	HABILITATION CENTER		485 VETERANS WAY			
				KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 697	Continued From pag	e 14	F 69	97			
	pain medication that	·		3) New medications, except for emergency or stat medications ordered as follows:  a) If needed before the next requelivery, phone the medication the pharmacy	s, are gular		
	documented Resider and able to make he	nt #1 being alert, oriented r needs known and Resident of been assessed in 26 hours		immediately upon receipt. Infor pharmacy of the need for prom and request			
	or received any of he Documentation revea ambulating down the wheelchair with the r			delivery within (4) hours. b) Timely delivery of new order required so that medication adr is not delayed. The emergency kit is used whe	ministration		
	12-14-19 at 7:00pm.  An interview was cor	ducted with the orthopedic		resident needs a medication pr pharmacy delivery. 4) Stat and emergency medica	ior to		
	spinal physician assi on 1-9-20 at 5:40pm.	stant (OSPA) by telephone The (OSPA) revealed the been in excruciating pain		ordered as follows:  a) During regular pharmacy horemergency or stat order is pho	urs, the		
	without receiving her because of the type	pain medication as ordered of surgery she received. The		faxed to the pharmacy. Such mare delivered and administered	nedications I within (2)		
		esident's mobility would have the increased pain and g recovery.		hours. If available, the initial do obtained from the emergency k necessary.  5) When phoning or faxing a m	kit, when		
	12-3-18 with multiple Parkinson's, chronic	dmitted to the facility on diagnoses that included obstructive pulmonary and chronic kidney disease.		order to the pharmacy, the follo information is given: a) Resident⊡s name. b) Prescription number if a refil	owing		
	a goal that he would	an dated 11-15-19 revealed verbalize adequate relief of cope with incomplete relief.		<ul><li>c) Complete order if a new med order or direction changes to a order.</li><li>d) Name of prescriber if a new</li></ul>	previous		
	The interventions ass in part; anticipate nee the effectiveness of p physician if intervent	sociated with that goal were ed for pain relief, evaluate pain interventions, notify the ons are unsuccessful and rt to the nurse any signs and		e) Indication for use. f) Name of person calling in orc 6) New Admission Orders: a) When calling/faxing medicat for a newly admitted resident, t	der. ion orders		

Facility ID: 923294

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _				21/ <b>2020</b>	
NAME OF P	ROVIDER OR SUPPLIER		ı.	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				48	5 VETERANS WAY			
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER		KI	ERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 697	Continued From page	e 15	F6	597				
F 697	The annual Minimum 12-2-19 revealed Recognitively impaired a constantly in pain wit activities due to a pai (no pain) to 10 (the worevealed Resident #2 medication) 7 out of The physician orders medications for Resid (milligrams) 1 tablet to spasms, Baclofen 10 muscle spasms, Gabtimes a day for pain, times a day for pain to available.  During an interview work 8:45am, the resident pain in his back due to because the discs an scheduled pain medication in not until "the middle of administered a different 5-325mg. The reside nurse that Norco was "excruciating" pain. To pain at a level of 10+	bal pain.  Data Set (MDS) dated sident #2 was minimally and coded as almost h decrease sleep and in level of 10 on a scale of 0 vorst pain). The MDS also	F6	697	pharmacy is also given all ancillary ordallergies, and diagnoses to facilitate generation of a patient profile and computer summary sheet, and permit initial medication use assessment.  b) The medication order form is also use to notify the provider pharmacy of changes in dosage, directions for use, of current medications.  This in service was completed by 1/10/2020. Any nursing staff (full time, part time, and PRN) who did not receiv in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained Monitoring:  The Director of Nursing and/or Assistant Director of Nursing, Unit Manager will review weekly starting on 1/24/2020, and during quality of life meeting. The monitoring will be done by the Director Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each assignment every day to ensure that all medications have been administered as ordered and pain assessments are completed on each resident every shift the nurse and pain medications administered as ordered, and also by	eed etc. e o e the at of c c c c c l s		
	had to go to the eme relief.	rgency room to receive pain			reviewing the Not Administered Med passes in last 24 hours on the dashboachecking the # of documentations save			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345039	B. WING _		C 01/21/2020
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 485 VETERANS WAY KERNERSVILLE, NC 27284	•
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE COMPLETION DATE
F 697	1-9-20 at 3:30pm. "often" complained inform the nurse. #2 was having pay with his activities on the move around and and and and and and and and and a	(NA) #6 was interviewed on The NA stated Resident #2 d of pain and that she would She also stated when Resident in she had to assist him more of daily living because "he could	F 6	as not administered. This weekly basis for 4 weeks the 3 months. Reports will be pweekly QA Committee by the Nursing and/or Mini Data Secondinators to ensure continitiated as appropriate. An concerns will be brought to Nursing or Administrator for action. Compliance will be ongoing auditing program of Weekly Quality of Life Mee QA Committee meeting is a Administrator, Director of Necondinator, Unit Manager, Nurse, Therapy, HIM(Healt Management), Dietary Management), Dietary Management, Date of Compliance: 1/21/2	nen monthly for presented to the ne Director of net (MDS) rective action y immediate the Director of r appropriate monitored and reviewed at the ting. Weekly attended by lursing, MDS , Support h Information nager, Wound

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _				21/2020
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		485	REET ADDRESS, CITY, STATE, ZIP CODE 5 VETERANS WAY ERNERSVILLE, NC 27284	, <u> </u>	172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 697	times a day until Oxy which she stated she 1-1-20. Nurse #4 said the pain medication of and the resident requested from the around 4:00am for second 6:00pm on 1-1-20.  A review of Resident Norco 5-325mg table had not been docum 1-1-20.  Nurse #4's documen 2:45am revealed Reserver back pain and by the pain medicatic administered. Documen	(Norco 5-325mg 1 tablet 4 codone 15mg is available) administered at 10:00pm on did the resident informed her was not controlling his pain lested to go to the enurse stated the resident gency room on 1-2-20 evere pain.  The count sheet revealed if Norco 5-325mg 1 tab at the revealed the medication ented as administered on the trace of the medication dated 1-2-20 at sident #2 was complaining of the pain was not relieved.	F	697			
	revealed communica	tation on 1-2-20 at 3:05am tion with the nurse rs to send Resident #2 to the					
	1-2-20 at 5:34am rev treated for chronic lo (pain medication) 50 and Roxicodone (pai	artment documentation dated realed Resident #2 was w back pain with Toradol mg intramuscular (injection) n medication) 5mg by mouth. revealed Resident #2's pain					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 01/21/2020	
	ROVIDER OR SUPPLIER  STONE HEALTH AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 485 VETERANS WAY KERNERSVILLE, NC 27284	, ZIP CODE	01/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 697	The pharmacy manager telephone on 1-9-20 manager stated they Oxycodone 5mg to dand an order for Oxydoses on 1-2-20. The orders were filled on facility around 4:00pr.  An interview with the occurred on 1-9-20 a would not expect Resymptoms from missi Oxycodone but would increased pain and m She also stated she was and we can fax a pharmacy."	ger was interviewed by at 10:48am. The pharmacy received an order for aspense 3 tablets on 1-2-20 codone 15mg 1 tablet for 4 pharmacist stated the 1-2-20 and delivered to the n on 1-2-20.  Nurse Practitioner (NP) to 12:30pm. The NP said she sident #2 to suffer withdrawal ng a few doses of his dexpect the resident to have nore difficulty with mobility. I would not expect a resident dication "staff just has to call script over to the limited at 12:10pm. On 1-10-20 at	F	DEFI:	CIENCY)		
	12/13/19 at approxim stay status post revision/lumbar fusion included cellulitis of a Staphylococcus aure anticoagulation and a	mitted to the facility on ately 6:45 PM after hospital ion of L3-pelvis n. Resident diagnoses					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING				C <b>21/2020</b>
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		48	REET ADDRESS, CITY, STATE, ZIP CODE 5 VETERANS WAY ERNERSVILLE, NC 27284	1 0111	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 697	12/13/2019 and 12/1 receive medication a discharged against in 12/14/2019. Nurse # pharmacy and reque medications to be de 12/13/2019 Nurse #3 report of pain from the resident any pair to 7am shift. On 12/1 pharmacy and reque medications to be de Root cause for the in Nurse #1 did not adre to lack of knowledge with Resident #1 is Near pain medication due cause for the incident #3 did not administer of knowledge Resident #2. Resident #2 had an abecause of his diagn On 1/1/2020 resident during day shift and according to a 1-10 spain level was 0 per administration record not receive Oxycodo pm and at 9:00 pm. Or resident received paper physician orders until medication receorders. On 1/1/2020 Practitioner was notiful severe back pain a hospital and that resident received agains and spital and that resident received pain and spital and that resident received pain and spital and that resident received pains and spital and spit	cated no pain was noted. On 4/2019 resident did not sordered. Resident nedical advice on 1 on 12/13/2019 did not call st for back up pharmacy for divered upon admission. On 3 did not remember any ne resident and did not give nedication during the 11pm 4/2019 Nurse #2 did not call st for back up pharmacy for divered.  Incident with Resident #1 is ninister pain medication due. Root cause for the incident durse #2 did not administer to lack of knowledge. Root at with Resident #1 is Nurse pain medication due to lack of the had pain seale. Resident responded electronic medication did ne 15mg at 12:00 noon, 5:00 On 1/1/2020 10:30 pm in medication Norco 5/325mg as Oxycodone was on hold ived from pharmacy per at 11:30pm Nurse fied of resident complaining and requesting to go to the	F	697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(×	(X3) DATE SURVEY COMPLETED	
		245020	B. WING			С	
		345039	B. WING_		<u>_</u>	01/21/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE		
SUMMER	STONE HEALTH AND	REHABILITATION CENTER		485 VETERANS WAY			
				KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 697	Continued From pa	age 20	F 6	697			
F 697	anything for him. A Tylenol and continue the hospital. Nurse 12:03am on 1/2/20 one-time dose of R hours before giving 1/2/2020 at 12:10a medication Robaxi 2:30am resident re 5/325mg when nur physician orders. In wanted to go to the was notified, and re hospital on 1/2/202 did not receive Oxy Root cause for the Nurse #1 did not a to lack of knowledg Pain assessments residents on 1/10/2 shift daily by nurse documented in the administration reco of all current reside 1/10/2020 by the N Director of Nursing ensure that all resi completed on all cur The audit also ens administered as or for any resident wh of pain or reported treated with curren for pain medication to pharmacy so as	At 11:50pm resident refused used to state he wants to go to a practitioner notified at 120 of the above, and ordered a Robaxin 500mg and to wait 4 granother Norco 5/325mg. On am resident received pain in 500mg. On 1/2/2020 at 1/2/2020	F	697			
	ordered. All audits	. Medications administered as were completed on 1/10/2020. the entity will take to alter the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			1	21/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	
CHMMED	STONE HEALTH AND DE	EHABILITATION CENTER		48	5 VETERANS WAY		
SOMMEN	STONE HEALTH AND RE	ENABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
					DEFICIENCY)		
F 697	Continued From page	e 21	F 6	597			
	process or system fa	ilure to prevent a serious					
	adverse outcome from	m occurring or recurring, and					
	when the action will b	pe complete.					
	I .	t Time and as needed (PRN)					
	,	s and Nursing assistants) will					
	I .	ollowing by the Director of					
	Nursing. Education b						
		leted on 1/10/2020 in					
		nagement and assessment, include how to order and					
	reorder medication.	iliciade flow to order and					
	Education included:						
		l be completed on each					
		y the nurse daily. Pain					
	_	completed for each new					
		issions upon admission.					
	Pain medications will	be administered as ordered					
	by physician. The mo	onitoring will be done by the					
	Director of Nursing o	r Assistant Director of					
	Nursing Or Unit Supp	oort Nurses and will include					
	_	f care dashboard; Med					
	Passes in the last 24						
	assignment every da	<u> </u>					
		en administered as ordered					
		g the "Not Administered" Med					
	passes in last 24 hou						
		cumentation saved as "not					
		ges in a patient condition ent reasons. New onset of					
		pain or worsening pain					
		ntions should be addressed					
	by nurse for all reside						
	1 -	ent has a new onset of pain					
		or worsening pain unrelieved					
	by interventions.	zz.osig pani amonovod					
		nurse, then notify the nurse					
		ain changes you have					
		pain changes can be very					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 1/21/2020	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 485 VETERANS WAY KERNERSVILLE, NC 27284		1/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 697	Continued From pag	je 22	F6	97			
	important since they problems to come.  "Nurses should a upon notification. As depending on the pasigns/symptoms  "The patient's chorder to determine if may explain the sign experiencing.  "If interventions a standing orders, patiedentified in the plan implemented as app Tylenol for fever, proper Administer pain mediphysician.  "Pain Intervention promptly when pain Administer pain mediphysicians.  "Pain Assessment must be documented.  "Immediate Notification required when there pain is severe and ceffective. Documents should be completed and documented. Accept physician orders in Phone numbers the nursing stations. The reach the attending physician the attending physician orderous reach the facility in minutes of contacting the attending physician provide an appropriate in the provide an appropriate in th	may indicate bigger assess the patient for pain assessment needs will vary attent 's complaint or that as and symptoms they are are available by using the ient current orders, or items of care then they should be ropriate. This may include a pain medication etc. dications as ordered by the should be implemented change is identified. It is and interventions at in the medical record. The medical record. The is an interventions at in the medical record. The is an ew onset of pain or the current interventions are not atton of this notification did, and new orders obtained diminister pain medications					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
							С		
		345039	B. WING		<del></del>	01/	/21/2020		
NAME OF P	ROVIDER OR SUPPLIER		•	STRI	EET ADDRESS, CITY, STATE, ZIP CODE				
				485	VETERANS WAY				
SUMMER	SIONE HEALIH AND	REHABILITATION CENTER		KEF	NERSVILLE, NC 27284				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 697	Continued From p	page 23	F	697					
	contact the Direct	or of Nursing immediately for							
	further instructions								
	this in the nursing	ponsible party and document							
	_	an orders for the resident to be							
		acute care hospital for							
		will be followed and							
		esident refuses to be transferred							
	l .	hospital or if resident							
	representative ref	uses for the resident to be							
	transferred to the	acute care hospital, Physician							
	will be notified of t	the refusal. Document							
		sician on such situations and							
		ent physician orders and/or							
		resident representative of							
		and of physician notification and							
	of any new orders								
		s are documented in the							
		ecord. This includes nursing ssments; vital signs tab, and							
		dication records. Verbal or visual							
		e used to assist patients who							
		ize pain. Nonverbal scales are							
		ts are not able to verbalize pain							
	intensity.	•							
	What to do when	a drug is not available?							
	" If the medicat	tion is an OTC (over the counter							
	drug), check the n	nedication OTC stock supply							
		edication room (Located at							
	_	on). If you are unable to locate it							
		the Central Supply Room. If							
	1 *	locate it there, proceed to the							
		carts to see if the OTC is							
		the medication is still					1		
		act the DON or Nurse Manager							
	for further guidance						1		
	ii the medical	tion is a prescription drug, you							
		the Medispense system located					1		
	at the renabilian	nurses station medication room							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE ( A. BUILDING		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345039	B. WING _			C 01/21/2020
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CIT 485 VETERANS WAY KERNERSVILLE, NO		1 01/21/2020
(X4) ID PREFIX TAG			ID PREFI TAG	(EACH CO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 697	Medispense system, pharmacy so it can be the prescription medidelayed more than or for any additional ord Medications must be the Physician unless dose differently. If at regarding the medical please contact the DO " Ordering Medical Pharmacy for new addorders, and for currer 1) Medication orders order form and transmy written entry includes order is new or a repois a repeat order (refinumber. Resident's in strength, when indication order.  2) Repeat medication peeling the top label placing it in the approfollows:  a) Reorder medication advance of need to a on hand. When reord requires special processor controlled substances. Affairs prescriptions), in advance of need. b) The nurse who recresponsible for notify in directions for use of the second substances.	medication is not in the then immediately notify to obtained from back up. If cation ordered will be the hour, notify the physician ters or directions. Given in the form ordered by the MD gives an order to any time you have questions tion administration process, DN or Nurse Manager. The tions from the Provider thission, readmissions, new that residents (reordering). The care written on a medication mitted to the pharmacy. The cat order (refill). If the order the part order the prescription ame. Medication name and ted. Directions for use, if a n changes to a previous the card and opriate area and ordered as the first order that the same ordered as the card and opriate area and ordered as the card and the ca	F	697		

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 01/21/2020	
	ROVIDER OR SUPPLIER  STONE HEALTH AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 485 VETERANS WAY KERNERSVILLE, NC 27284		7172172020	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 697	"stat" medications, a a) If needed before to phone the medication immediately upon re need for prompt delivery within (4) ho b) Timely delivery of that medication adm The emergency kit is needs a medication 4) "Stat" and emerge as follows: a) During regular phe emergency or "stat" the pharmacy. Such and administered within initial dose is obtained when necessary. 5) When phoning or the pharmacy, the for a) Resident's name. b) Prescription numb c) Complete order if direction changes to d) Name of prescribe e) Indication for use. f) Name of person ca 6) New Admission O a) When calling/faxin newly admitted resid given all ancillary or to facilitate generation computer summary si medication use asses b) The medication of notify the provider pl	except for emergency or re ordered as follows: he next regular delivery, n order to the pharmacy ceipt. Inform pharmacy of the very and request ours. new orders is required so inistration is not delayed. In the prior to pharmacy delivery. In the prior is phoned or faxed to medications are delivered that (2) hours. If available, the red from the emergency kit, faxing a medication order to a previous order. In the pharmacy is given:  The prior to pharmacy is also ders, allergies, and diagnoses on of a patient profile and sheet, and permit initial	F 6	97			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			ATE SURVEY DMPLETED
		345039	B. WING _			C 01/21/2020
	ROVIDER OR SUPPLIER  STONE HEALTH AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 697	Continued From pa	-	F6	997		
F 755 SS=J	nursing staff (full tin did not receive in-seallowed to work unt information has been orientation training a refresher courses for Immediate Jeopard.  The credible allegate removal was validate which removed the 1-10-20 as evidence in-service record rein-service included re-ordering medicate management, type scales, what to do available, types of refacility's policy and administration.  Pharmacy Srvcs/Pr CFR(s): 483.45(a)(b)  §483.45 Pharmacy The facility must prodrugs and biological them under an agree §483.70(g). The facility must prodrugs and biological them under an agree §483.70(g). The facility must prodrugs and biological them under an agree §483.45(a) Procedu pharmaceutical sentiat assure the accordispensing, and adirections.	y Removal Date: 1/10/2020.  ion for Immediate Jeopardy ted on 1-11-20 at 10:00am Immediate Jeopardy on ed by staff interviews, views and observations. The information on ordering and ions, pain assessments, pain of pain and the different pain when a medication is not nedication errors and the procedures on medication occedures/Pharmacist/Records 0)(1)-(3)  Services ovide routine and emergency Is to its residents, or obtain	F7	755		1/21/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ATE SURVEY OMPLETED	
		345039	B. WING _			C 01/21/2020
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	Continued From pag		F 7	755		
	- , ,	Consultation. The facility in the services of a licensed				
		les consultation on all sion of pharmacy services in				
	- , , , ,	ishes a system of records of on of all controlled drugs in able an accurate				
	order and that an act is maintained and per This REQUIREMEN	mines that drug records are in count of all controlled drugs criodically reconciled. T is not met as evidenced				
	practitioner interview implement effective predication was avain the residents. This was (Resident #2) review This resulted in Resident #2	resident interview and nurse the facility failed to procedures to assure pain lable to meet the needs of the facility failed to procedures to assure pain lable to meet the needs of the facility facility facility facility and only facility facility facility and ultimately having to be		The statements made on this Correction are not an admission not constitute an agreement wind alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Correctionstitutes the facility sallegate compliance such that all alleged deficiencies cited have been or	on to and do ith the in in d State en or will s Plan of ction ation of d r will be	
	Resident #2 did not a because the facility of 1-1-20 resulting in the excruciating pain and transferred to the emmanagement. Immediately a significant transferred to the emmanagement.	began on 1-1-20 when receive his pain medication ran out of the medication on the resident experiencing double the resident being hergency room for pain diate Jeopardy was removed a facility provided and		corrected by the date or dates F 755 Pharmacy Srvcs/Procedures/Pharmacist/ Corrective Action: Resident #2 Medications availa administered as ordered. Identification of other residents be involved with this practice: All current residents have the p	Records able and who may	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				_		,	c l
		345039	B. WING _			01/	21/2020
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
0				48	35 VETERANS WAY		
SUMMER	SIONE HEALIH AND F	REHABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	F 755 Continued From page 28 implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not Immediate		F7	755	be affected by the alleged practice. On 1/10/2020 a chart audit was initiated fo current residents. The audit was completed by the Assistant director of nursing, Unit Support nurses and Director of the completed by the Assistant director of the completed by the Assistant director of the complete of th	r all	
	Jeopardy) to ensure place are effective. Findings included:	e monitoring systems put in			of Nursing to ensure that all residents he their medications per physician order available. The audit also ensured that residents received medications as	nad	
	The facility's policy and procedure (not dated) for ordering and receiving medications from the pharmacy was reviewed and revealed in part the following: "repeat medications (refills) are ordered by peeling the top label from the unit dose card				ordered and signed for on the Medicati Administration Record. The audit also ensured that pain medications were administered as ordered. The Assistan Director of Nursing and Unit support	t	
	as follows; reorder radvance of need to on hand. When reor	appropriate area and ordered medication 3 to 4 days in assure an adequate supply is rdering medication that seessing (such as schedule 2			nurses, checked all medication carts and compared to the physician orders, and ensured that all medications were available and medications administered per order. All current residents have		
	advance of need." " faxed or otherwise t	es), order at least 7 days in The refill order is called in, transmitted to the pharmacy."			medications available and medications administered per order. All audits were completed on 1/10/2020 Systemic Changes:		
	Resident #2 was ad 12-3-18 with multipl Parkinson's disease pulmonary disease,			All Full Time and Part Time and as needed (PRN) Nursing Staff (Nurses a Nursing assistants {which includes any Nursing assistants who are medication aides}) will be educated on the followin			
	12-2-19 revealed Ro Interview for Mental and coded as almost decrease sleep and of 10 (0 no pain, 10 revealed Resident # medication) during	m Data Set (MDS) dated esident #2 had a Brief Status (BIMS) score of 13 st constantly in pain with activities due to a pain level worst pain). The MDS also #2 received opioid (pain 7 out of 7 days of the look	began on 1/10/2020.  Education was completed on 1/10 reference to how to order and reormedication.  Education included:  The facility must provide routine a emergency drugs and biologicals.		by the Director of Nursing. Education began on 1/10/2020. Education was completed on 1/10/2020 reference to how to order and reorder medication. Education included: The facility must provide routine and emergency drugs and biologicals to its	) in	
	behind period.  The physician order	rs revealed the following pain			residents or obtain them per physician orders. The facility may permit unlicens personnel to administer drugs if State I		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		345039	B. WING _			0	C 1/21/2020
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/2 1/2020
					85 VETERANS WAY		
SUMMERS	STONE HEALTH AND	REHABILITATION CENTER			KERNERSVILLE, NC 27284		
				- 1	T		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	Continued From p	page 29	F	755			
	medications for Re	esident #2; Robaxin 500mg			permits, but only under the general		
		et twice a day for muscle			supervision of a licensed nurse. The		
		10mg 1 tablet 3 times a day for			facility must provide, pharmaceutical		
	•	Gabapentin 800mg 1 tablet 3			services (including procedures that		
	•	in, Oxycodone 15mg 1 tablet 4			assure the accurate acquiring, receiving	na.	
		in, Norco 5-325mg 1 tablet 4			dispensing and administering of all dru		
		in until Oxycodone 15mg is			and biologicals) to meet the needs of	9-	
	available.	- ,			each resident. The facility must emplo	v or	
					obtain the services of a licensed	,	
	During an intervie	w with Resident #2 on 1-8-20 at			pharmacist who provides consultation	on	
	8:45am, the reside	ent stated he had constant pain			all aspects of the provision of pharmac		
	in his back due to	"my spine is falling apart			services in the facility. Establishes a		
	because the discs	are bad" but his regularly			system of records of receipt and		
	scheduled pain m	edication, Oxycodone 15mg			disposition of all controlled drugs in		
	(milligrams), work	ed well controlling his pain.			sufficient detail to enable an accurate		
		d "about a week ago" the facility			reconciliation and determines that drug	g	
		pain medication (Oxycodone			records are in order and that an accou		
		ning and that it was not until "the			of all controlled drugs is maintained ar		
	_	t" the facility administered a			periodically reconciled. Pain medication	ns	
		lication that, the resident stated,			will be administered as ordered by		
		pain. The resident described			physician. The monitoring will be done	by	
		of 10+ "all day." Resident #2			the Director of Nursing or Assistant		
		be transferred to the emergency			Director of Nursing Or Unit Support		
	room to receive pa	ain reliet.			Nurses and will include reviewing the		
	Danislant #Ola Mar	dication Advainistantian Decard			Point of care dashboard; Med Passes		
		dication Administration Record			the last 24 hours for each assignment		
		y 2020 revealed an order for			every day to ensure that all medication		
		1 tablet 4 times a day at , 5:00pm and 9:00pm. On			have been administered as ordered at		
		e was documented as			also by reviewing the Not Administere Med passes in last 24 hours on the	u	
		e resident at 9 am. On 1-1-20,			dashboard checking the # of		
		locumented as not available for			documentations saved as not		
	-	he resident at 12pm, 5pm, and			administered.		
	9pm.	no resident at 12pm, opm, and			PRN pain medications will be		
	Opini.				administered as ordered by physician.		
	The facility's parce	otic count sheet revealed			The monitoring will be done by the		
		ved Norco 5-325mg 1 tab at			Director of Nursing or Assistant Direct	or of	
	10:00pm on 1-1-2	•			Nursing or Unit Support Nurses and w		<b> </b>
	· · -				include reviewing the Point of Care		

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345039	B. WING _		01	C / <b>21/2020</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, ,	72172020	
				485 VETERANS WAY			
SUMMERS	STONE HEALTH AND R	EHABILITATION 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 OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From pag	ge 30	F 7	55			
		for 1-1-20 revealed the Norco		dashboard; Administered PRN in the last 24 hours for each as every day to ensure that PRN have been administered as ord	signment nedications		
	2:45am revealed Re severe back pain an by the pain medicati administered. Docur Resident #2 request room.	mentation also revealed ed to go to the emergency ntation on 1-2-20 at 3:05am		What to do if a resident has a rof pain or complains of pain or pain unrelieved by intervention.  If interventions are availabed the standing orders, patient current orders, or items identified in the care then they should be imple appropriate. This may include fever, prn pain medication etc.  Administer pain medications as	new onset worsening s. le by using rrent e plan of mented as Tylenol for		
	practitioner and order emergency room.	ers to send Resident #2 to the		by physician.  What to do when a drug is not  " If the medication is an OTO	available?		
	1-2-20 at 5:34am rev treated for chronic lo (pain medication) 50 and Roxicodone (pa Documentation also	vealed Resident #2 was by back pain with Toradol lmg intramuscular (injection) in medication) 5mg by mouth. revealed Resident #2's pain he resident was transferred		counter drug), check the medic stock supply located at each M room (Located at each nursing you are unable to locate it there to the Central Supply Room. If unable to locate it there, proceed other medication carts to see if available there. If the medication	eation OTC edication station). If e, proceed you are ed to the the OTC is		
	1-9-20 at 11:23am. I #2 on 1-1-20 and sta his Oxycodone after 9:00am dose on 1-1 Nurse #4 the resider She also said the me request on it but as a reorder the medicati informed the nurse.	A) #1 was interviewed on MA #1 worked with Resident ated the resident ran out of she administered the -20. She stated she informed int was out of his medication. edication card had a refill a MA she was not allowed to on and that was why she		unavailable, contact the DON of Manager for further guidance.  " If the medication is a presording, you would first check the Medispense system located at hall nurses station medication (100/200hall). If the medication the Medispense system, then in notify pharmacy so it can be obtained from back up. If the prescription medication ordered will be delated.	or Nurse cription the Rehab coom is not in mmediately otained n		
	_	with Nurse #4 on 1-9-20 at ated she was not made		than one hour, notify the physic additional orders or directions.	Jan IOI any		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345039	B. WING				21/ <b>2020</b>
NAME OF P	ROVIDER OR SUPPLIER	0.000	<del> </del>		TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	21/2020
NAME OF T	NOVIDER OR SOLT EIER						
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			85 VETERANS WAY		
				<u> </u>	KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 755	Continued From page	e 31	F7	755			
1- 7-33	aware Resident #2 w. 1-1-20 until the 9:00p administered. She state to obtain an order for available in the facility system and informed Nurse #4 stated Resihours after the new p that the pain medicatirequested to go to the stated Resident #2 w. room around 4:00am medications were recresident's electronic rwas a MA on the medication needed to During an interview w. 12:11pm, she said if the medication the nurse pharmacy to see if the then the nurse could them fax over the scripharmacy would have deliver the medication. The pharmacy manages 1-9-20 at 10:48am. The stated they received a to dispense 3 tablets Oxycodone 15mg 1 ta The pharmacist state.	as out of his Oxycodone on m dose was to be ated she called the physician a pain medication that was y's inventory management MA #2 of the new order. dent #2 complained about 2 ain medication was given fon was not working and the emergency room. She as sent to the emergency on 1-2-20. The nurse stated ordered through the medical record but if there dication cart, then the MA the nurse that the orbe reordered.  With Nurse #5 on 1-10-20 at the resident ran out of their would first call the ere were refills and if not, call the physician and have int to the pharmacy and the ere were back up pharmacy		755	Medications must be given in the form ordered by the Physician unless the MI gives an order to dose differently. If at time you have questions regarding the medication administration process, plecontact the DON or Nurse Manager.  "Ordering Medications from the Provider Pharmacy for new admission, readmissions, new orders, and for curresidents (reordering).  1) Medication orders are written on a medication order form and transmitted the pharmacy. The written entry include Date ordered, Whether the order is a repeat order (refill), include the prescription number. Resident sname Medication name and strength, when indicated. Directions for use, if a new order, or direction changes to a previous order.  2) Repeat medications (refills) are order by peeling the top label from the unit do card and placing it in the appropriate at and ordered as follows:  a) Reorder medication (three to four) d in advance of need to assure an adequation supply is on hand. When reordering medication that requires special processing (such as Schedule II controlled substances, Department of Veterans Affairs prescriptions), order a least (seven days) in advance of need.  b) The nurse who reorders the medication responsible for notifying the pharmacof changes in directions for use or	any ase ent to es: v a e. us ered ose rea ays ate	
	A review of Resident revealed Oxycodone administered to the re				previous labeling errors. c) The refill order is called in, faxed, or otherwise transmitted to the pharmacy.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		ATE SURVEY DMPLETED
		345039	B. WING			C <b>01/21/2020</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0 1/2 1/2020
				485 VETERANS WAY		
SUMMER	STONE HEALTH AND R	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
()(1) ID	STIMMADAS	TATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CO	ODDECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 755	Continued From pag	ge 32	F 75			
				3) New medications, except	for	
	An interview with the	e Nurse Practitioner (NP)		emergency or stat medicatio	ns, are	
	occurred on 1-9-20	at 12:30pm. The NP said she		ordered as follows:		
	would not expect a r	esident to run out of their		a) If needed before the next	regular	
	_	t has to call us, and we can		delivery, phone the medication	on order to	
	fax a script over to the	he pharmacy."		the pharmacy		
				immediately upon receipt. In		
		sing (DON) was interviewed		pharmacy of the need for pro	ompt delivery	
	I .	am. The DON stated the		and request		
		) should have reordered		delivery within (4) hours.		
		odone. She also said she had		b) Timely delivery of new ord		
		vice in December 2019 on		required so that medication a	administration	
		medications due to a similar er and would be re-educating		is not delayed.  The emergency kit is used w	than tha	
		er process per the facility's		resident needs a medication		
	policy and procedure	· · · · · · · · · · · · · · · · · · ·		pharmacy delivery.	prior to	
	policy and procedure			4) Stat and emergency medi	cations are	
	During a telephone i	interview with the Director of		ordered as follows:		
		-21-20 at 2:50pm, the DON		a) During regular pharmacy	hours, the	
	<b>,</b> ,	were delivered and dispensed		emergency or stat order is p		
	I .	d when there were 8 doses of		faxed to the pharmacy. Such		
	a resident's medicat	ion left, the vertical line of the		are delivered and administer	ed within (2)	
	last 8 doses would b	e in a different color alerting		hours. If available, the initial	dose is	
	the nurse to remove	the re-order sticker from the		obtained from the emergence	y kit, when	
		e-order sheet and fax the		necessary.		
		pharmacy. She also stated		5) When phoning or faxing a		
		dering narcotic medication		order to the pharmacy, the fo	ollowing	
	was the same.			information is given:		
	T. D. ( (A)			a) Resident⊡s name.	C.I.	
	I .	sing and the Corporate Nurse		b) Prescription number if a re		
	Consultant were notified of the Immediate Jeopardy on 1-10-20 at 4:50pm. On 1-10-20 at			c) Complete order if a new m		
	· •	•		order or direction changes to	a previous	
		provided the following f Immediate Jeopardy		order. d) Name of prescriber if a ne	w order	
	removal:	i illineulale Jeopaluy		e) Indication for use.	w oluel.	
	Tomoval.			f) Name of person calling in	order	
	Identify those recipie	ents who have suffered, or		6) New Admission Orders:	ordor.	
		serious adverse outcome as		a) When calling/faxing medic	cation orders	
	a result of the nonco			for a newly admitted residen		

CLIVILIN	3 FOR MEDICARE &	WEDICAID SERVICES				CIVID INC	7. 0930 <del>-</del> 0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						(	c
		345039	B. WING _				21/2020
NAME OF PI	ROVIDER OR SUPPLIER	I .	<del>-                                    </del>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	21/2020
				48	5 VETERANS WAY		
SUMMERS	STONE HEALTH AND R	EHABILITATION CENTER			ERNERSVILLE, NC 27284		
	OLIMA AN ENVIO	TATEMENT OF REFIGIENCIES		1	<u>`</u>		0.47)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 755	Continued From pag	je 33	F 7	55			
					pharmacy is also given all ancillary ord	ers,	
	Resident #2 had an	order for pain medication			allergies, and diagnoses to facilitate		
	because of his diagn	nosis of spinal spondylosis.			generation of a patient profile and		
	On 1/1/2020 residen	t was assessed for pain			computer summary sheet, and permit		
	during day shift and				initial medication use assessment.		
		scale. Resident responded			b) The medication order form is also us	sed	
		electronic medication			to notify the provider pharmacy of		
	administration record			changes in dosage, directions for use,	etc.		
		one 15mg at 12:00 noon, 5:00			of current medications.		
		On 1/1/2020 10:30 pm			This in service was completed by		
	resident received pa			1/10/2020. Any nursing staff (full time,			
	· · · ·	as Oxycodone was on hold			part time, and PRN) who did not receiv		
		eived from pharmacy per			in-service training will not be allowed to	)	
	orders. On 1/1/2020	fied of resident complaining			work until training is completed. This information has been integrated into the	^	
		and requesting to go to the			standard orientation training and in the		
	hospital and that res	· · · · · · · · · · · · · · · · · · ·			required in-service refresher courses for		
	-	him earlier did not do			all employees and will be reviewed by		
	_	11:50pm resident refused			Quality Assurance Process to verify that		
		ed to state he wants to go to			the change has been sustained	••	
		practitioner notified at			Monitoring:		
		0 of the above and ordered a			The Director of Nursing and/or Assista	nt	
		baxin 500mg and to wait 4			Director of Nursing, Unit Manager will		
		another Norco 5/325mg. On			review weekly starting on 1/24/2020, a	nd	
	1/2/2020 at 12:10am	resident received pain			during quality of life meeting. The		
	medication Robaxin	500mg. On 1/2/2020 at			monitoring will be done by the Director	of	
	2:30am resident refu	ised pain medication Norco			Nursing or Assistant Director of Nursing	9	
	5/325mg when nurse	e offered medication per			Or Unit Support Nurses and will include	9	
		esident refused and stated he			reviewing the Point of care dashboard;		
		nospital. Nurse Practitioner			Med Passes in the last 24 hours for ea		
	· ·	sident was transferred to the			assignment every day to ensure that a		
		at 2:45am. 1/3/2019 resident			medications have been administered a		
	did not receive Oxyc	odone 15mg at 12:00 noon.			ordered and also by reviewing the Not		
	D46 6 "	in tident with D. 11 1 10			Administered Med passes in last 24 ho	urs	
		e incident with Resident #2 is			on the dashboard checking the # of		
		minister pain medication due			documentations saved as not	o to	
		of how to order and reorder			administered. The audit will also ensur		
	was not reordered in	timely, as the pain medication			check all medication carts and compar-		
	was not redidered in	i uiiio.	1		the physician orders, and ensure that a	ш	1

	CATION NUMBER:	A. BUILDIN	G		(X3) DATE SURVEY COMPLETED
	345039	B. WING _			C <b>01/21/2020</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	0172172020
			485 VETERANS WAY		
SUMMERSTONE HEALTH AND REHABILITATION	ON CENTER		KERNERSVILLE, NC 27284		
(X4) ID SUMMARY STATEMENT OF DI PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT	
On 1/10/2020 a chart audit was in current residents. The audit was of the Assistant director of nursing, I nurses and Director of Nursing to residents had their medications proder available. The audit also en residents received medication Adm Record. The audit also ensured the medications were administered as Assistant Director of Nursing and nurses, checked all medication can compared to the physician orders that all medications were available medications administered per orderesidents have medications available medications available medications available medication administered per orderesidents have medication available medication administered per orderesidents and per orderesidents and per orderesidents and per orderesidents available medications available medication available medications available medication available medications available medication available medications available medication available medication available medications available medication available medications available medication available medication available medications available medication available medication available medication available medication available medications availab	completed by Unit Support ensure that all er physician sured that s ordered and inistration nat pain s ordered. The Unit support arts and is, and ensured e and ler. All current able and ler. All audits  ake to alter the ent a serious or recurring, and  s needed (PRN) g assistants stants who are ed on the ng. Education  0/2020 in order medication.	F7	medications are available done on weekly basis for monthly for 3 months. Represented to the weekly the Director of Nursing and Set (MDS) Coordinators corrective action initiated Any immediate concerns the Director of Nursing or for appropriate action. Commonitored and ongoing a reviewed at the Weekly Commonitored Meeting. Weekly QA Commonitored by Administration Nursing, MDS Coordinates Support Nurse, Therapy, Information Management Manager, Wound Nurse. Date of Compliance: 1/21	4 weeks then eports will be QA Committee and/or Mini Data to ensure as appropriate will be brought Administrator ompliance will be uditing program Quality of Life amittee meeting ator, Director of or, Unit Manage HIM(Health t), Dietary	e. t to pe m

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		345039	B. WING _			C 1/21/2020
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 485 VETERANS WAY KERNERSVILLE, NC 27284		1/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 755	Nursing Or Unit Supreviewing the Point Passes in the last 2 every day to ensure been administered a reviewing the "Not A last 24 hours on the documentation save PRN pain medication ordered by physicial by the Director of Ni Nursing or Unit Supreviewing the Point Administered PRN refor each assignmen PRN medications had ordered.  What to do if a residuary or complains of pair by interventions.  If interventions standing orders, patidentified in the plant be implemented as include Tylenol for feadminister pain metals.  What to do when a description of the physician.	or Assistant Director of oport Nurses and will include of care dashboard; Med 4 hours for each assignment that all medications have as ordered and also by administered" Med passes in dashboard checking the # of ed as "not administered".  Ins will be administered as an. The monitoring will be done cursing or Assistant Director of port Nurses and will include	F 7	755		
	drug), check the me located at each Med each nursing station there, proceed to the you are unable to lo	dication OTC stock supply				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING				C <b>21/2020</b>
NAME OF PROVIDER OR SUPPLIER  SUMMERSTONE HEALTH AND REHABILITATION CENTER				48	REET ADDRESS, CITY, STATE, ZIP CODE  5 VETERANS WAY  ERNERSVILLE, NC 27284	1 011	21/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	If the medication would first check the at the Rehab hall nu room (100/200 hall). Medispense system, pharmacy so it of the prescription medelayed more than ophysician for any admedications must be the Physician unless dose differently. If at regarding the medicaprocess, please community for new and orders, and for currently includes order form and transwritten entry includes order is new or a repis a repeat order (ref number. Resident's strength, when indication orders.  2) Repeat medication peeling the top label	e medication is still ntact the DON or Nurse guidance.  In is a prescription drug, you Medispense system located rses station medication If the medication is not in the In then immediately notify It can be obtained from back up. If the medication is not in the In the immediately notify It can be obtained from back up. It can be	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING			1	C <b>21/2020</b>
NAME OF PROVIDER OR SUPPLIER  SUMMERSTONE HEALTH AND REHABILITATION CENTER				48	REET ADDRESS, CITY, STATE, ZIP CODE  5 VETERANS WAY  ERNERSVILLE, NC 27284	1 01/	21/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 755	a) Reorder medical advance of need to a on hand. When reord requires special processor controlled substances. Affairs prescriptions in advance of need.  b) The nurse wheresponsible for notifying in directions for use of the content of the refill order otherwise transmitted.  3) New medications, are all fineeded befor phone the medication immediately upon receive the need for prompt of the need for prompt of the need for prompt of the needs a medication and the emergency kit is needs a medication processor and the pharmacy. Such and the pharmacy. Such and delivered and addivered and additional additiona	cation (three to four) days in source an adequate supply is ering medication that essing (such as Schedule II is, Department of Veterans is), order at least (seven days)  or reorders the medication is not the pharmacy of changes or previous labeling errors.  It is called in, faxed, or it to the pharmacy.  Except for emergency or it to the pharmacy.  For each of the pharmacy of eight. Inform pharmacy of delivery and request delivery.  By of new orders is required diministration is not delayed.  For except medications are ordered in pharmacy delivery.  The pharmacy hours, the order is phoned or faxed to	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING		C 01/21/2020	
NAME OF PROVIDER OR SUPPLIER  SUMMERSTONE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COMPRESTIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY		JLD BE COMPLETION	
F 755	the pharmacy, the factor of the pharmacy, the factor of the prescription of the prescr	r faxing a medication order to following information is given:  number if a refill. der if a new medication order is to a previous order. escriber if a new order. escriber if a new order. Orders:  g/faxing medication orders for esident, the pharmacy is also orders, allergies, and ate generation of a patient er summary sheet, and permit in use assessment.  tion order form is also used to charmacy of changes in for use, etc. of current  completed by 1/10/2020. Any me, part time, and PRN) who ervice training will not be ill training is completed. This en integrated into the standard and in the required in-service or all employees.	F 75	,		
	nursing staff (full tir	conder and reorder  completed by 1/10/2020. Any ne, part time, and PRN) who ervice training will not be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345039	B. WING			C 01/21/2020	
NAME OF PROVIDER OR SUPPLIER  SUMMERSTONE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, Z 485 VETERANS WAY KERNERSVILLE, NC 27284		7172172020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 755	allowed to work until information has been orientation training ar refresher courses for Immediate Jeopardy  The credible allegation removal was validate which removed the Interpretation 1-10-20 as evidenced in-service record revision-service included in re-ordering medication medication is not available.	training is completed. This integrated into the standard of in the required in-service all employees.  Removal Date: 1/10/2020.  In for Immediate Jeopardy of on 1-11-20 at 10:00am and integrated interviews, lews and observations. The formation on ordering and ins, what to do when a illable, types of medication is policy and procedures on	F	755			