PRINTED: 05/07/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		TE SURVEY
						С
		345039	B. WING _			04/01/2021
	ROVIDER OR SUPPLIER STONE HEALTH AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 485 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000		
	on 03/30/21 through	ation survey was conducted 04/01/21. 2 of the 7 were substantiated. Event				
F 677 SS=D		or Dependent Residents	F	577		4/26/21
	out activities of daily services to maintain of personal and oral hyd. This REQUIREMENT by: Based on observation and staff interviews, the assistance with groom of 1 resident observe sleepwear after 1:00 failed to provide time.	ns, record reviews, resident the facility failed to provide ming and hygiene care to 1 d and interviewed in p.m. (Resident #2) and ly incontinent care to 2 of 2		The statements made on this correction are not an admissio not constitute an agreement w alleged deficiencies. To remain in compliance with a and state regulations the facilit	n to and do ith the all federal	
	residents during the 7 (Residents #4 and ReFindings included:	11:00 p.m. to 7:00 a.m. shift esident #5).		or will take the actions set forth plan of correction. The plan of constitutes the facility ☐s allega compliance such that all allege deficiencies cited have been o	correction ation of ed	
	7/2/18 with diagnoses hypo-osmolality and latherosclerotic heart obstructive pulmonar	nyponatremia, disease, and chronic y disease.		F677 1. Corrective action for resid affected by the alleged deficier	ed. ent(s) nt practice:	
	#2 had an activities or related to impaired be included: the resident bathing, dressing and	required assistance with		Resident #2 was interviewed be Services Director on 04/26/202 determine if her daily preference being honored specifically requiregarding ADL so Resident #2 that her daily preferences are I	21 to ces were uests 2 did feel	
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	:	TITLE		(X6) DATE

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

(X6) DATE

Electronically Signed

04/26/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345039	B. WING				01/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
OUMANTED	TONE HEALTH AND D			4	85 VETERANS WAY				
SUMMERS	STONE HEALTH AND RI	EHABILITATION CENTER		K	ERNERSVILLE, 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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTT TAG CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPR			(X5) COMPLETION DATE		
F 677	3/10/21 indicated Re intact, required exter mobility and transfers staff for hygiene, dre always incontinent of incontinent of incontinent of bladde. During an observation 1:14 p.m., Resident at the side of her bed, let the side of her bed waiting for the nursin with dressing in day the bed. The resident required to use the more from the bed to her wound to walk. The resident in the time of the clock whenever she request the staff responded with the time of the clock whenever she request the staff responded with the time of the clock whould turn the caproviding care, promite always incontinent of the staff responded with the time of the clock whenever she request the staff responded with the time of the clock who would turn the caproviding care, promite the staff responded with the caproviding care, promite the caprovi	um data set (MDS) dated sident #2 was cognitively asive assistance with bed s, was total dependent on ssing and bathing, was fowels and frequently	F	677	honored. The ambassador for this resident has made weekly observation ensure that this resident has received timely ADL and incontinent care. Resident #4 has received incontinence care from staff. Documentation corroborates the care received from the Certified Nursing Assistant. Resident #5 has received incontinence care from staff. Documentation corroborates the care received from the Certified Nursing Assistant. 2. Corrective action for residents with the potential to be affected by the alleg deficient practice. All residents in the facility have the potential to be affected. On 04/01/2021, the Director of Nurses, Unit Managers, and Staff Nurses initiat daily random audits of at least 8 reside to identify any signs of prolonged incontinence care such as, double briefing, odor, and bed linens wet with urine or dried stains. Any issues discovered during the audits were addressed immediately. On 04/19/2021, the Social Services	e e n ed			
	with incontinent care throughout the night short staffed.				Director initiated interviews with all residents with a BIMS 13 or above to identify any daily preferences specifica ADL preferences to ensure that reside were receiving care in a timely manner	nts			
	12:15 p.m., Resident	#2 was in the hallway in her dent was well groomed,			according to their preferences. If the residents don their have a preference, the				

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 04/01 /	/2021	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	<u> </u>	04/01/	2021	
(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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 677	resident stated the N care and transfer he p.m. When asked he stated always prefer bed at approximately to wait due to not en On 4/1/21 at 6:00 a. #2 revealed the residents care one time during and 5:30 a.m. She rethat the nursing assicare to the residents shift. During an interview on NA#1 revealed she whall, but worked the residents because 3 show up for work an assistants was move work on the rehabilit She stated the facilit staff during the night made it difficult to propose the property of the prope	es and hair combed. The IA did not provide her ADL or to the wheelchair until 12:00 er preference, the resident red to be dressed and out of 10:00 a.m. but usually had ough staff. m., an interview with Resident dent only received incontinent 3rd shift, between 5:00 a.m. eported the NA informed her estants provided incontinent at only one time during the con 4/1/2021 at 6:35 a.m., usually worked on the 100 200 hall with 29 to 30 nursing assistants did not	F	certified nursing assistants and nurses have been instructed to residents about preferences at beginning of the shift. The audicompleted on 04/26/2021. All daily preferences identified duraudit were entered in the residiplan and Kardex. On 04/23/2021, the QA Clinical consultant, the Director of Nurse Unit Managers initiated the folleducation to all licensed nurse certified nursing assistants, full time, agency, and PRN staff: "Rounds and Timely Incontime, agency, and PRN staff: "And Timely ADL Care in the schedule and Timely Incontimence Care, Call Bell Reponse, ADL Care, and What to Do Whath a Change in the Schedule. The on Rounds and Timely Incontime, and Timely Incontine, and Timely Incontime, and Timely	o ask t the dit was individual ring the dent □s car al Nurse ses, and lowing es and ll time, par tinent Car a change ges to ed deficien f Nurses, e, and iated ely esponse, nen There ne education ence Car e, and Wha e in the	re rt e in is on re, at		

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 _	B. WING		C 04/01/2021	
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	,	• 1/2021
				48	5 VETERANS WAY		
SUMMERS	STONE HEALTH AND R	EHABILITATION CENTER		KE	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	· ·			(X5) COMPLETION DATE
F 677	Continued From pag	e 3	F6	577			
	2. Resident #4 was 8/30/18 with diagnos mellitus, dementia, a Review of the quarte 1/10/21 indicated Recognitively impaired of bowel and bladde During an incontinen 6:09 a.m., Resident wearing 2-briefs and and a draw sheet. N removed the old brie with urine with blue s	admitted to the facility on ses which included: diabetes inxiety, and depression. In the facility on the facility of the facility on the facility of the facility on the facility of the facility on the faci			licensed nurses and nursing assistants full-time, part-time, agency staff, and P staff. As of 04/29/2021 at 5 PM, any employee who has not received this education will not be allowed to work ut the training has been completed. This includes licensed nurses and nursing assistants full time, part time, agency staff, and PRN staff. The in-service will incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure th the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.	RN ntil be at nat	
	revealed she was as the 200 hall during the nursing assistant was the 100 hall. NA#1 seems assistants would sor residents but would a During an interview of NA#1 revealed she whall, but worked the residents because 3 show up for work and assistants was moved work on the rehability She stated the facility staff during the night made it difficult to produce the state of the state o	m. during an interview, NA#1 signed 29 or 30 residents on the night shift and the other is assigned 29 residents on tated that the nursing metimes put 2-briefs on the mot give an explanation. on 4/1/2021 at 6:35 a.m., usually worked on the 100 200 hall with 29 to 30 mursing assistants did not indicate of the nursing and from the 100/200 hall to eative unit (300/400 halls). It is a the point of the shift for some time which povide care for the residents.			The Director of Nurses or designee will complete weekly audits to ensure there sufficient staff to provide timely inconting care and provide assistance with grooming and hygiene to the residents a timely manner. The audits described above will be completed by auditing 10 residents using the Clinical QA Tool for ADL□s and 10 residents using the Clinical QA Tool for Incontinence to monitor for compliance with timely ADL care (grooming & hygiene) and timely incontinence care. These audits will be completed weekly a period of 4 weeks and then monthly for a period of 3 months or until resolved by the QA committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses or the Administrator to ensure corrective action is initiated as	e is nent in ng for for	

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 _			l	01/ 2021	
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 0-11	01/2021	
				485	VETERANS WAY			
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER		KE	RNERSVILLE, NC 27284			
(X4) ID PREFIX TAG			ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 677	Continued From pag	e 4	F 6	677				
	as a nursing assistar not show up for work had been nights whe worked both, the 100 stated when staff did	nt on the unit when staff did a. She also revealed there on one nursing assistant and the 200 halls. She not come work, she would gement, but was often			appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrate Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, and Die Manager.	or,		
	3. Resident #5 was admitted to the facility on 6/4/20 with diagnoses which included: dementia, diabetes mellitus, and hypertension. The quarterly minimum data set dated 1/3/21 indicated Resident #5 severely, cognitively impaired and was always incontinent of bowel and bladder.				Date of Compliance: 04/29/2021			
	made as NA#1 provide Resident #5, with the Director of Nursing (All lying in bed wearing a pads and a draw she	a.m., an observation of was ded incontinent care to assistance of the Assistant ADON). The resident was a brief and lying on 2-chux set. The resident's brief was ad urine saturated with feces gh the top chux pad.						
	NA#1 revealed she used hall, but worked the 2 residents because 3 show up for work and assistants was move work on the rehabilities. She stated the facility staff during the night made it difficult to pro-	nursing assistants did not						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _		C 04/01/2021
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 677	as a nursing assista not show up for wor had been nights who worked both, the 10 stated when staff die	ge 5 led she sometimes worked nt on the unit when staff did k. She also revealed there en one nursing assistant 0 and the 200 halls. She d not come work, she would agement, but was often	F 6	77	
F 725 SS=D	the appropriate comprovide nursing and resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the factordance with the at §483.70(e). §483.35(a)(1) The factor sufficient number types of personnel conursing care to all resident care plans:	at Staff. We sufficient nursing staff with petencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by ts and individual plans of care number, acuity and cility's resident population in facility assessment required acility must provide services as of each of the following on a 24-hour basis to provide esidents in accordance with	F 7	25	4/26/21
	limited to nurse aide §483.35(a)(2) Excep paragraph (e) of this	ot when waived under s section, the facility must d nurse to serve as a charge			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345039	B. WING			С	
NAME OF D		345039	B. WING _	OTDEET ADDRESS SITV STATE ZID SODE	•	4/01/2021	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER	485 VETERANS WAY				
00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 725	Continued From page	e 6	F 7	25			
	This REQUIREMENT is not met as evidenced by:						
	Based on observatio and staff interviews, t sufficient nursing staf	ns, record reviews, resident the facility failed to provide if to provide activities of daily of 5 residents reviewed for #2, #4, and #5.		The statements made on this properties of the correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with a	n to and do th the		
	This tag is cross refer	renced to tag F677.		and state regulations the facility or will take the actions set forth plan of correction. The plan of correction.	n in this correction		
	Findings included:			constitutes the facility □s allega compliance such that all allege deficiencies cited have been or	d		
		tions, record reviews, erviews, the facility failed to		corrected by the dates indicate	d.		
	•	ith grooming and hygiene t observed and interviewed		F725			
		00 p.m. (Resident #2).		Corrective action for reside affected by the alleged deficien	` '		
	_	n and interview on 3/30/21 at		B			
	the side of her bed, lo	2 was observed sitting on poking out of the window.		Resident #2 was interviewed by Services Director on 04/26/202	21 to		
	socks or shoes and h She commented she	aring her nightgown, no er hair was not combed. had been and was still		determine if her daily preference being honored specifically requ regarding ADL□s. Resident #2	uests 2 did feel		
	with dressing in day of	g assistant (NA) to assist her clothing and getting out of t revealed the staff were		that her daily preferences are be honored. The ambassador for	this		
	required to use the m from the bed to her w	echanical lift to transfer her heelchair because she was		resident has made weekly obse ensure that this resident has re timely ADL and incontinent care	eceived		
	unable to walk. The resident stated she has had to wait 1-2 hours when she used her call light to request incontinent care assistance, especially at night. The resident indicated she always noticed the time of the clock on the wall in her room			Resident #4 has received incorcare from staff. Documentation corroborates the care received Certified Nursing Assistant.	n		
	her call light requests the staff responded w	sted, and staff responded to She stated that sometimes Then she used the call light Il light off and leave without		Resident #5 has received incorcare from staff. Documentation corroborates the care received	n		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
				-		С		
		345039	B. WING _		04/01/2021			
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	ODE			
				485 VETERANS WAY				
SUMMER	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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 725	Continued From p	page 7	F 7	25				
		omising to return. She stated they could only provide her		Certified Nursing Assistant.				
	with incontinent ca	are assistance one time tht because the facility was		 Corrective action for rethe potential to be affected deficient practice. All residents in the facility has a contraction. 	by the alleged			
	During an interview on 4/1/2021 at 6:35 a.m., NA#1 revealed she usually worked on the 100			potential to be affected.				
	hall, but worked the 200 hall with 29 to 30 residents because 3 nursing assistants did not show up for work and one of the nursing assistants was moved from the 100/200 hall to			On 04/01/2021, the Director Unit Managers, and Staff N daily random audits of at lea to identify any signs of proto	urses initiated ast 8 residents			
	work on the rehabilitative unit (300/400 halls). She stated the facility had been working "short" of staff during the night shift for some time which			incontinence care such as, briefing, odor, and bed liner urine or dried stains. Any is	double ns wet with			
		provide care for the residents.		discovered during the audit addressed immediately.	s were			
	Staff Nurse#1 revias a nursing assis not show up for whad been nights worked both, the stated when staff attempt to call maunsuccessful.	w on 4/1/2021 at 6:45 a.m., ealed she sometimes worked stant on the unit when staff did ork. She also revealed there when one nursing assistant 100 and the 200 halls. She did not come work, she would nagement, but was often		On 04/19/2021, the Social S Director initiated interviews residents with a BIMS 13 or identify any daily preference ADL preferences to ensure were receiving care in a tim according to their preference residents don thave a pre- certified nursing assistants nurses have been instructed	with all rabove to es specifically that residents ely manner es. If the ference, then and licensed d to ask			
2. Based on observations, record revier staff interviews, the facility failed to province incontinent care to 2 of 2 residents during 11:00 p.m. to 7:00 a.m. shift (Residents Resident #5).		ne facility failed to provide timely to 2 of 2 residents during the a.m. shift (Residents #4 and		residents about preferences beginning of the shift. The completed on 04/26/2021. daily preferences identified audit were entered in the replan and Kardex.	audit was All individual during the			
	NA#1 revealed sh hall, but worked th residents because	w on 4/1/2021 at 6:35 a.m., the usually worked on the 100 the 200 hall with 29 to 30 the 3 nursing assistants did not and one of the nursing		On 04/23/2021, the QA Clin consultant, the Director of N Unit Managers initiated the education to all licensed nu	lurses, and following			

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 04/01/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	1 0-70	1/2021	
				485 VETERANS WAY				
SUMMER	SIONE HEALIH AND RE	HABILITATION CENTER	KERNERSVILLE, NC 27284					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 725	assistants was move	d from the 100/200 hall to	F 7	certified nursing assistant		art		
	work on the rehabilita She stated the facility staff during the night made it difficult to pro During an interview of Staff Nurse#1 reveals as a nursing assistant not show up for work had been nights whe worked both, the 100 stated when staff did	ative unit (300/400 halls). A had been working "short" of shift for some time which ovide care for the residents. An 4/1/2021 at 6:45 a.m., Bed she sometimes worked to the unit when staff did. Ashe also revealed there in one nursing assistant and the 200 halls. She not come work, she would gement, but was often		" Rounds and Timely I " Call Bell Response " Timely ADL Care " What to do when the the schedule Additionally, the Director continued to post open per Position Manager the em software to fill open license certified nurse □ sassistant Director of Nurses or destrompleted weekly intervier positions. The Director of hired 4 licensed nurses a nursing assistants betweet □ April 26, 2021. 3. Measures/Systemic prevent reoccurrence of a practice: Education: On 04/26/2021, the Director of Minimum Data Set Nurse education on Rounds and Incontinence Care, Call Expensed in the Schedule on Rounds and Timely In Call Bell Response, ADL to Do When There is a Cl Schedule will need to be licensed nurses and nurses."	of Nurses has ositions into apployment hirinsed nurses and to positions. To apployment hirinsed nurses has ews for open of Nurses has and 5 certified en April 01, 20 changes to alleged deficient of Nurses, Nurse, and to alleged deficient own of Nurses, and to allege deficient own of Nurses, Nurse, and to allege deficient own of Nurses, Nurse, and to allege deficient own	e in s ang and The 221 ent all		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			1	C 01/2021	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, 485 VETERANS W KERNERSVILLE		1 04/	01/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From page	ge 9	F	full-time, par staff. As of employee we education we the training includes lice assistants for staff, and Plincorporated facility orien. 4. Monitor the plan of complete we sufficient stace and progrooming are a timely man The audits of completed by the Clinical residents us incontinence with timely Anygiene) and These audit a period of a period of a period of a period of a sufficient of a period of	ring Procedure to ensure the correction is effective and the correction is effective and the correction process of the correction of the c	I be nat hat cted		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345039	B. WING				C	
NAME OF PI	ROVIDER OR SUPPLIER	04000			REET ADDRESS, CITY, STATE, ZIP CODE		01/2021	
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From page	2 10	F 7	25	monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrate Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, and Die Manager.	or,		
F 732 SS=C	must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categunlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must perspecified in paragrapically basis at the beguii) Data must be post (A) Clear and readabuit (B) In a prominent plaresidents and visitors	affing Information. Equirements. The facility and the actual hours worked gories of licensed and aff directly responsible for t: s. I nurses or licensed defined under State law). des. g requirements. but the nurse staffing data in (g)(1) of this section on a inning of each shift. and a follows: le format. and ce readily accessible to	F7	32	Date of Compliance: 04/29/2021		4/26/21	
	§483.35(g)(3) Public	access to posted nurse						
			1	- 1				

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			1	C 01/2021
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284		5 VETERANS WAY		
(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 CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 732	staffing data. The far written request, make available to the public exceed the communi §483.35(g)(4) Facility requirements. The far posted daily nurse st 18 months, or as req is greater. This REQUIREMENT by: Based on observation interview, the facility data was posted daily through 3/30/21. Findings included: During the initial tour 11:45 a.m., there was nursing staff data. Review of the facility nursing staff postings 1/1/20 through 9/3/20 staff postings available through 3/30/21. During an interview of Nursing Staff Schedulaily nursing staff poetings staff podulaily nursing staff podulaily n	cility must, upon oral or enurse staffing data concentration action of the tenurse staffing data control to the standard. If data retention actility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced ons, record reviews, and staff failed to ensure nursing staff y and maintained from 9/4/20 If the facility on 3/30/21 at a no posting of the daily are records revealed the daily are records revealed the daily are records review from 9/4/20 If the were no daily nursing the for review from 9/4/20 If and 3/31/21 at 4:17 p.m., the alter confirmed the missing stings were either not	F7	732	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F732 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to include the daily resident census on the staff postings.	al ken on	
	she assumed the res Staff Scheduler approafter the previous sch	t maintained. She revealed ponsibility as the Nursing eximately two weeks ago neduler's employment with e stated she searched but te daily nursing staff			 Corrective action for resident(s) affected by the alleged deficient practic On 03/30/2021, The Director of Nurses ensured that the daily nurse staffing 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
	345039	B. WING					
NAME OF PROVIDED OR SUPPLIED	345039	B. WING _	OTDEET ADDRESS SITV STATE 710 C		04/01/2021		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE			
SUMMERSTONE HEALTH AND REHABILITATION CENTER			485 VETERANS WAY				
			KERNERSVILLE, NC 27284				
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCE TO THE APPRODEFICIENCY) F 732 postings have been posted and the completed postings are stored in a manner to allow for easy review upon request. Corrective action for residents with a potential to be affected by the alleged deficient practice. On 04/26/2021, the staffing sheets or reviewed by the Director of Nurses at the Administrator from 04/01/2021 to 04/26/2021 to ensure that daily now staffing postings reflected a daily post for each day. 2. Measures /Systemic changes to prevent reoccurrence of alleged definant initiated education on Post Nurse Staffing Information to the following objectives: On 04/23/2021, the QA Clinical Nurse Staffing Information to the following objectives: To identify the regulatory requirements of F 732 for Posted Nursing Staff Information To monitor that the requirements Public access to posted nurse staffind data, and Facility data retention		ere end rough ested owing on 1 es: ment for ata		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345039	039 B. WING			C 04/01/2021		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	01/2021	
NAME OF PROVIDER OR SUPPLIER					485 VETERANS WAY			
SUMMERSTONE HEALTH AND REHABILITATION CENTER			KERNERSVILLE, NC 27284					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	· ·			(X5) COMPLETION DATE	
F 732	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR		that at that rected s, or lizing ekly eeks view m for thly to of the the e by es to is iitored rance tor of		