	-	ID HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES					D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			Сом	E SURVEY PLETED
		345039	B. WING				C / <b>08/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				48	5 VETERANS WAY		
SUMMER	SIONE HEALIH AND RE	HABILITATION CENTER		KE	ERNERSVILLE, NC 27284		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	-	(X5)
PREFIX TAG	<b>`</b>	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG		,			DEFICIENCY)		
F 000	INITIAL COMMENTS		F0	00			
			_				
	The survey team ent	ered the facility on 9/28/21					
	•	nt survey in conjunction with					
	a revisit (Event ID #7	QIJ12) and exited on					
		nformation was obtained on					
		Therefore, the exit date was					
	allegations were subs	None (0) of the 5 complaint					
		was identified at: CFR					
		a scope and severity (K)					
		ag F880 at a scope and					
		s F835 and F880 did not					
	constitute Substanda						
	Immediate Jeopardy removed on 9/30/21.	began on 9/27/21 and was					
F 580		jury/Decline/Room, etc.)	F 5	80			10/25/21
SS=E		,		00			10/23/21
	§483.10(g)(14) Notific						
	•	ediately inform the resident;					
		ent's physician; and notify, her authority, the resident					
	representative(s) whe						
		ving the resident which					
		as the potential for requiring					
	physician interventior						
		ge in the resident's physical,					
	mental, or psychosoc						
		n, mental, or psychosocial reatening conditions or					
	clinical complications	-					
	-	eatment significantly (that is,					
	a need to discontinue						
		erse consequences, or to					
	commence a new for						
	(D) A decision to tran						
	resident from the faci §483.15(c)(1)(ii).	inty as specified in					
	3-100.10(0)(1)(1).						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

**Electronically Signed** 

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

10/22/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/08/202 FORM APPROVE OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 10/08/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER	48	85 VETERANS WAY	
COMMEN			к	ERNERSVILLE, NC 27284	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	Continued From page	o 1	F 580		
1 300			F 200		
		ification under paragraph (g) , the facility must ensure that			
		ion specified in §483.15(c)(2)			
		ided upon request to the			
	physician.				
		also promptly notify the			
		dent representative, if any,			
	when there is-				
	(A) A change in room as specified in §483.	n or roommate assignment			
		lent rights under Federal or			
		ons as specified in paragraph			
	(e)(10) of this section				
		record and periodically			
	update the address (	mailing and email) and			
	phone number of the	resident			
	representative(s).				
	§483.10(g)(15)				
		osite distinct part. A facility			
		istinct part (as defined in			
	- ,	e in its admission agreement			
		tion, including the various			
		se the composite distinct y the policies that apply to			
		en its different locations			
	under §483.15(c)(9).				
		Γ is not met as evidenced			
	by:				
		views and record reviews, the		The statements made on this plan of	
		the residents' Responsible		correction are not an admission to and	do
	Party (RP) after a sha	ared glucose meter ed to complete blood glucose		not constitute an agreement with the	
	checks without being			alleged deficiencies. To remain in compliance with all federa	al
	multiple residents in			and state regulations the facility has ta	
		ctions. This occurred for 6		or will take the actions set forth in this	
		ng blood glucose monitoring		plan of correction. The plan of correction	on
	(Resident #1, Reside	ent #2, Resident #3, Resident		constitutes the facility□s allegation of	
	#4, Resident #5 and	Resident #6) and whose		compliance such that all alleged	

Facility ID: 923294

If continuation sheet Page 2 of 27

			0.000			0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	. ,	E SURVEY PLETED
		345039	B WING			С
	ROVIDER OR SUPPLIER	345039		STREET ADDRESS, CITY, STATE, 2		/08/2021
NAME OF P	ROVIDER OR SUPPLIER			485 VETERANS WAY		
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY)	(X5) COMPLETION DATE
F 580	Continued From page	e 2	F 58	30		
		were checked by an agency		deficiencies cited have	been or will be	
		signed to care for them.		corrected by the dates		
	The findings included	1:		F 580		
	1-a) Resident #1 was	admitted to the facility on		1. How corrective act	ion will be	
	8/4/21 with a cumulat			accomplished for those	residents found to	
	included Type 2 diab	etes.		have been affected by	the deficient	
	A roviow of Posidont	#1's Electronic Medical		practice:		
		led a family member was		On 10.07.2021, the res	sponsible parties	
		P and contact information for		for each resident (#1, #		
	-	in the record. The facility's		#6) were notified that the		
		reported to be Resident #1's		their blood sugar check		
	physician.			glucometer that had no		
	The residentia educia	sian Minimum Data Cat		with an approved EPA	agent between	
		sion Minimum Data Set revealed Resident #1 had		residents.		
	· · · ·	s for daily decision making.		The Director of Nurses	(DON) notified the	
		ie fer dany declerent mannig.		Medical Director of the		
	The physician's order	rs for Resident #1 included		on 09.28.2021. On 09.	29.2021 the DON	
		1 which instructed blood		notified the Medical Dir	ector of the steps	
	glucose testing to be and at bedtime each	completed before meals day.		taken to correct the def	icient practice.	
				The DON notified the F		
		mber 2021 Medication		Health Department of the		
		d (MAR) and/or EMR vital		practice and of the step		
	U	Nurse #1 documented she ucose check for this resident		the deficient practice or	1 09.29.2021.	
		W and on $9/28/21$ at 6:44		2. How the facility wil	l identify other	
	AM.			residents having the po	-	
	Further review of the	racidant's EMD was		affected by the same d		
	Further review of the	resident's EMR was 1 and included the Progress		All residents who have	orders for	
		and Documents. No		accuchecks have the p		
		dentified to indicate Resident		affected. On 09.28.202		
	#1's RP was informed			identified 100% of all re		
		he blood glucose monitoring		for accuchecks. On, 9.		
	conducted for this res	sident on 9/27/21 and		reviewed 100% of all re	esidents identified	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/08/2021 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	СОМ	E SURVEY PLETED
		345039	B. WING _				C / <b>08/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SUMMED		EHABILITATION CENTER		48	5 VETERANS WAY		
JUNIMER	STONE REALTH AND RE			K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From page	a 3	F 5	80			
1 000	• • • • • • • • • • • • • • • • • • •			00	aa baying andana fan aasyskaalys ta		
	9/28/21.				as having orders for accuchecks to ensure that each resident had their or		
	1-h) Resident #2 was	admitted to the facility on			individual glucometer and that they di		
		ative diagnoses which			have their blood sugar checked with t		
	included Type 2 diab				shared glucometer. No other resider		
	51				were noted to have had their blood su		
	A review of Resident	#2's EMR revealed a family			checked on the shared glucometer, n	0	
		ated as her RP and contact			other notifications of change were		
		P was provided in the record.			needed.		
	-	Director was reported to be					
	Resident #2's physici	ian.			3. Address what measures will be p		
	The physician's order	re for Regident #2 included			place or systematic changes made to		
		rs for Resident #2 included 0/28/20 which instructed			ensure that the deficient practice will reoccur:	ΠΟΙ	
		to be completed in the					
		ay, Wednesday and Friday			Beginning 10.15.2021, all licensed nu	irses	
	due to her diagnosis				Registered Nurses and Licensed Pra		
	Ū				Nurses full time, part time, prn, and		
		I MDS dated 7/6/21 revealed			agency staff were educated by the		
		erely impaired cognitive skills			Director of Nursing or designee on the		
	for daily decision mal	king.			requirement to notify the resident, the		
		ducted with Numer #4 an			responsible party and the MD when the		
		ducted with Nurse #1 on fter the completion of her			are any significant changes that result the residents sharing a glucometer ar		
		n pass. During the interview,			not disinfecting the glucometer with a		
		Il the blood glucose checks			EPA approved disinfectant placing the		
		arlier that morning while			risk for exposure.		
		meter. She reported these			·		
		ood glucose check for			The DON will ensure that any of the		
		esult of 160 milligrams (mg) /			above identified staff who do not com		
	deciliter (dL).				the in-service training by 10.25.2021		
	Fronth and 1 11				not be allowed to work until the trainin	ng is	
		resident 's EMR was			completed.		
		1 and included the Progress and Documents. No			This in-service was incorporated into	the	
		dentified to indicate Resident			new employee facility orientation for t		
	#2's RP was informed				above identified staff.		
		ne blood glucose monitoring					
	conducted for this res				4. Monitoring Procedure to ensure	that	

Facility ID: 923294

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · ·	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3		OMPLETED
		345039	B. WING			C 10/08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		10/00/2021
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER		485 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From page	e 4	F 58	0		
		admitted to the facility on Ilative diagnoses which etes.		the plan of correction is effore specific deficiency cited ren and/or in compliance with r requirements:	mains corrected	
	member was designation for the RI	#3's EMR revealed a family ated as her RP and contact P was provided in the record. Director was reported to be ian.		The Director of Nursing or use the F580 QA Tool audi observations of blood suga week x 4 weeks and then 5 of blood sugar checks per months to identify any defic	t 5 ir checks per 5 observations month x 3	
	cognitive skills for da	had severely impaired		shared glucometers where was not properly disinfecte registered disinfectants and notification of change was Reports will be presented t	d with EPA d that no required.	
	an order dated 10/17 glucose testing to be and at bedtime each	/20 which instructed blood completed before meals day.		Quality Assurance committ Director of Nursing to ensu action is initiated as approp Compliance will be monitor	ee by the re corrective oriate. red and the	
	The resident's September 2021 MAR and/or EMR vital sign record revealed Nurse #1 documented she completed a blood glucose check for this resident on 9/27/21 at 10:56 PM and on 9/28/21 at 6:13 AM.			ongoing auditing program r weekly Quality Assurance I weekly QA Meeting is atter Administrator, Director of N Nurse, Therapy Manager, I Nurses, Health Information	Meeting. The nded by the Iursing, MDS Unit Support	
	notes, Assessments, documentation was in #3's RP was informed concerns related to th	1 and included the Progress and Documents. No dentified to indicate Resident		the Dietary Manager. Plan of Correction Complia 10.25.2021	nce Date:	
	1-d) Resident #4 was 4/9/18 with a cumula included Type 2 diab	-				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	ECONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			C
		345039	B. WING				08/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER			185 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	member was designa information for the RF The facility's Medical Resident #4's physicia The resident's quarter revealed Resident #4 for daily decision mak The physician's order an order dated 11/2/2 glucose testing to be due to her diagnosis of The resident's Septer vital sign record revea she completed a bloo resident on 9/28/21 at Further review of the conducted on 10/7/21 notes, Assessments, documentation was in #4's RP was informed concerns related to th conducted for this res 1-e) Resident #5 was 8/19/21 with a cumula included Type 2 diabe A review of Resident 1 member was designal information for the RF The facility's Medical Resident #5's physicia	<ul> <li>#4's EMR revealed a family ted as her RP and contact P was provided in the record. Director was reported to be an.</li> <li>rly MDS dated 8/3/21 had cognitively intact skills sing.</li> <li>s for Resident #4 included 0 which instructed blood completed each morning of diabetes.</li> <li>mber 2021 MAR and/or EMR aled Nurse #1 documented d glucose check for this t 6:06 AM.</li> <li>resident's EMR was and included the Progress and Documents. No lentified to indicate Resident d of infection control le blood glucose monitoring ident on 9/28/21.</li> <li>admitted to the facility on ative diagnoses which etes.</li> <li>#5's EMR revealed a family ted as her RP and contact P was provided in the record. Director was reported to be an.</li> </ul>	F	580			
	information for the RF The facility's Medical Resident #5's physicia	9 was provided in the record. Director was reported to be					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345039	B. WING				_ 08/2021
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			485 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	for daily decision mak The physician's order an order dated 8/27/2 glucose testing to be and at bedtime each of The resident's EMR v Nurse #1 documented glucose check for this 11:12 PM. An interview was con 9/28/21 at 6:45 AM at scheduled medication the nurse identified at she had completed ea using a shared glucor included a blood gluc with a result of 201 m Further review of the conducted on 10/7/21 notes, Assessments, documentation was in #5's RP was informed concerns related to th for this resident at on 9/2 1-f) Resident #6 was 12/28/18 with a cumu included Type 2 diabe A review of Resident	had cognitively intact skills sing. s for Resident #5 included 1 which instructed blood completed before meals day. ital sign record revealed d she completed a blood a resident on 9/27/21 at ducted with Nurse #1 on fter the completion of her n pass. During the interview, I the blood glucose checks arlier that morning while meter. These checks ose check for Resident #5 g/dL. resident's EMR was and included the Progress and Documents. No tentified to indicate Resident d of infection control the blood glucose monitoring 27/21 and 9/28/21. admitted to the facility on lative diagnoses which	F	580			
	Director was reported physician.	to be Resident #6's					

		ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 11/08/202 ORM APPROVE <u>NO. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _				C 10/08/2021
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER		EHABILITATION CENTER		485	5 VETERANS WAY		
COMMEN				KE	RNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 580	Continued From pag	e 7	F 5	580			
	The resident's quarter	erly MDS dated 8/9/21 5 had cognitively intact skills					
	The physician's orders for Resident #6 included an order dated 10/21/20 which instructed blood glucose testing to be completed once daily at 6:45 AM as well as before meals and at bedtime each day.						
	EMR vital sign record documented she con	npleted a blood glucose nt on 9/27/21 at 11:07 PM					
	notes, Assessments, documentation was i #6 was informed of in related to the blood g	1 and included the Progress and Documents. No dentified to indicate Resident nfection control concerns					
	at 2:38 PM with the f (DON). During the ir Medical Director was control concerns rela monitoring for the six jeopardy was identific confirmed physician	orders were received and plete vital sign checks every					
	at 2:38 PM, the DON circumstances would	erview continued on 10/7/21 I was asked what I prompt the facility to notify a reported the RP would					

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TATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345039	B. WING				。 08/2021
	ROVIDER OR SUPPLIER	HABILITATION CENTER		48	REET ADDRESS, CITY, STATE, ZIP CODE 5 VETERANS WAY ERNERSVILLE, NC 27284	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	in condition or medica this notification would Change of Condition Progress Note within DON was also asked notified for the 6 resid control concerns relation monitoring conducted	d if a resident had a change ations and documentation of l typically be noted on a	F	580			
F 835 SS=K	enables it to use its re efficiently to attain or practicable physical, well-being of each res	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial		835			10/22/21
	Based on observatio record reviews, the fa orientation and educa availability of individu (glucometers) assign blood glucose monito to provide education glucometer used for r accordance with the r This was evident for observed who was ne	ation to nursing staff on the al blood glucose monitors ed to each resident requiring ring. The facility also failed on how to disinfect a shared			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 tak or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 835 1. How corrective action will be	l ken	
		oegan on 9/27/21 when nurse) did not receive an			accomplished for those residents found have been affected by the deficient	l to	

Facility ID: 923294

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/08/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED C
		345039	B. WING		10/08/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 835	Continued From page	<u>-</u> 9	F 83	5	
	orientation to the faci	lity and began blood glucose s on her assigned hall using		practice:	
	was removed on 9/30 provided and implem allegation of Immedia facility will remain out scope and severity le a potential for minima Jeopardy) to ensure in put in place and to co Agency staff in-service The findings included This tag is cross refer F880 - Based on obs and record review, th approved disinfectant clean and disinfect a (glucometer) used for have their blood gluce #2, #3, #4, #5 and #6 be contaminated with and disinfected after product and procedur	ction Agency infectant. Immediate jeopardy D/21 when the facility ented an acceptable credible ate Jeopardy removal. The t of compliance at a lower vel of E (no actual harm with al harm that is not Immediate monitoring of systems are omplete facility employee and ce orientation and training. I: renced to: ervations, staff interviews, e facility failed to use an t product and procedure to shared blood glucose meter r 6 of 6 residents required to ose checked (Resident #1, b). Shared glucometers can a blood and must be cleaned each use with an approved		<ul> <li>Professional Unit Support N facility s glucometer policy 09.28.2021. Nurse #1 has the facility since 09.28.2021</li> <li>2. How the facility will ide residents having the potent affected by the same deficient of the same deficient of the same deficient of the scuchecks have the potent affected. On 9.29.2021, the reviewed the schedule for the and identified different ager medication aides that are a scheduled to work. The Dir Nurses and Assistant Direct (ADON), reached out to the were scheduled to work to p with the agency orientation includes glucometer training importance of using a resid individually assigned glucor need to disinfect using an E chemical. 100% of all agen were scheduled to work 09.</li> </ul>	r on not worked at 1. ntify other ial to be ent practice : ers for ttial to be e scheduler he next 7 days noy nurses or lready rector of tor of Nurses e nurses who provide them packets that g and the ent □s meter and the EPA registered noy nurses that .29.2021 have
	infections. An interview was con	Jucometer potentially the spread of blood borne ducted on 9/29/21 at 10:45 Scheduler. The Scheduler		orientation packet. No age member will be allowed to v 09.29.2021 until the agency packet has been completed 3. Address what measure	work after / orientation I.
	reported she was res	ponsible for scheduling both ssistants. While the facility		place or systematic change ensure that the deficient pra reoccur:	es made to

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES				APPROVE . 0938-039
ATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S COMPL	SURVEY
		345039	B. WING		10/0	; )8/2021
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZI		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 835	Continued From page	e 10	F 8	35		
F 033	Scheduler reported sl staffing agencies to h of the facility on an as An interview was con AM with the facility's I The DON was asked process utilized for bo She reported the facil orient Agency nurses herself tried to comple first day a new Agence start of his/her shift. conduct the orientation a Unit Manager would new nurse. The DON last minute fill-in for th been made aware thi in to work her first shi A review of the form of Nursing Student Orie The form included co following topics: Meo Treatments; Emerger Documentation; Falls Injuries of Unknown O Prevention/Investigat Medications; and Per Neither blood glucose	he utilized five temporary help meet the staffing needs is needed basis. ducted on 9/29/21 at 11:35 Director of Nursing (DON). about the orientation oth staff and Agency nurses. lity had a form she used to . The DON stated she ete this orientation on the cy nurse came in prior to the lf she was not able to on, one of her staff nurses or d go over the form with the N reported Nurse #1 was, "a he shift" and she had not is Agency nurse was coming iff at the facility. entitled, "Agency Nurse and ntation" was conducted. ntent on each of the dication Administration; ncy Situations; c; Elopement; Restraints; Drigin and Abuse ion; Pressure Ulcers; sonal Protective Equipment.	F 8	On 09.29.2021, the Direct (DON), Assistant Directo (ADON), LPN Unit Suppo Human Resources staff r facility scheduler were ed Quality Assurance Nurse the importance for ensur agency staff receive the prior to the beginning of f scheduler and/or Human or designee will print age education packets for ag have not previously beer the agency education pa packets will be placed in a designated box with the name for review and sign beginning of their shift. T notify the agency nurses scheduled for future date packets are located in th in the copy room and tha signed and placed under Nurses door, which is loo hall from the copy room of The scheduler will also p new agency staff to the D and the facility on-call nu Director of Nurses or des that all agency staff are e	or of Nurses ort Nurse, the member, and ducated by the e Consultant on ing that all orientation packet their shift. The resources staff ency orientation ency nurses that n oriented using cket. These the copy room in e agency nurses nature at the The scheduler will who are es that the e designated box at they should be the Director of cated across the once completed. Provide a list of Director of Nurses irse weekly. The signee will ensure	
	at 12:04 PM with the facility's Quality Assu Consultant. When as outline provided woul	sked, the DON reported the		the agency orientation pa emergency as needed ag scheduled and approved of Nurses, Assistant Dire LPN (Licensed Profession Support Nurse. Addition packets will be placed in	gency staff are I by the Director ector of Nurses, or onal Nurse) Unit al orientation	

Facility ID: 923294

			0.00			<u>VO. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY
			A. BUILDING	i		С
		345039	B. WING			0/08/2021
NAME OF P	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODI		0/06/2021
				485 VETERANS WAY	-	
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIOI DATE
F 835	Continued From page	e 11	F 83	5		
	start of his/her first sh	nift. However, she confirmed		box in the copy room. Anytim	e a new	
		eive the orientation as		agency person is sent to the fa		
	outlined on this form.			on-call nurse will contact them	by phone	
				and will ensure that they retrie		
	9/30/21 at 11:45 AM	nterview was conducted on with the facility's DON.		and sign the agency orientatic	-	
		the DON reported she would		The DON will ensure that any		
		ty's staff nurses to complete		above identified staff who do r		
		working independently on		the in-service training by 10.2		
		The DON also stated she otified if a new Agency nurse		not be allowed to work until th	e training is	
		ing in to work at the facility		completed.		
		a designated staff member		This in-service was incorporat	ed into the	
		rse to review the facility's		new employee facility orientat		
	orientation packet.	,		above identified staff.		
		M, the facility's Regional		4. Monitoring Procedure to		
		linical Consultant, and DON		the plan of correction is effect		
	were informed of the	immediate jeopardy.		specific deficiency cited remai		
	The facility many data d			and/or in compliance with regi	ulatory	
		a credible allegation of removal on 9/29/21 at 7:40		requirements:		
		of immediate jeopardy		The Director of Nurses or des	ianee will	
	removal indicated:			monitor for compliance by auc		
				schedule to ensure all agency		
	The facility failed to p	provide orientation and		scheduled have a signed orier		
	education to Nurse #	1 (an Agency nurse) on the		packet completed and on file.	The	
		al glucometers assigned to		Director of Nurses or designed		
		ng blood glucose monitoring.		complete the audit weekly x 4		
		d to educate Nurse #1 on		monthly x 3 months. Results		
		ared glucometer according to		documented on the F835 Qua	-	
	manufacturer's instru multiple residents.			Assurance Tool. Reports will presented to the weekly Quali		
				Assurance committee by the I		
	Component 1: Identi	fy those recipients who have		Nurses to ensure corrective a		
		to suffer, a serious adverse		initiated as appropriate. Comp		
		of the noncompliance; and		be monitored and the ongoing		
				program reviewed at the week	dy Quality	
	On 9/28/21 residents	#1, #2, #3, #4, #5, and #6		Assurance Meeting. The wee	kly Quality	

Event ID: LV2C11

Facility ID: 923294

If continuation sheet Page 12 of 27

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY PLETED
ND PLAN UI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C
		345039	B. WING		1	0/08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETIO DATE
F 835	had their blood sugar glucometer that had r approved EPA agent the facility was notifie the Licensed Practica (LPN) promptly remo- cart. The LPN Unit S medication cart to en- glucometers on the car found on the cart. Ac LPN verified that each #5, and #6) had their their room. If a new a needs an individual g sanitized glucometers medication rooms. Additionally, on 9/29/2 the schedule for the r different agency nurs are already scheduled ADON, has reached o provide them with the includes the importan- individually assigned disinfect using an EP/ 100% of all agency m 9/29/21 have been ec orientation packet inc- using a resident's ind glucometer and the n EPA registered chem material will have a co- instructions that have disinfecting procedure	c checked using the same not been disinfected with an between residents. Once d of the deficient practice, al Nurse Unit Support Nurse wed the glucometer from the upport Nurse checked each sure there were no art. No glucometers were dditionally, on 9/28/21 the h resident (#1, #2, #3, #4, own individual glucometer in admission comes in and lucometer, the cleaned and s are located in the unit 21, the scheduler reviewed hext 7 days and identified es or medication aides that d to work. The DON, out to these nurses to e orientation packets that icce of using a resident's glucometer and the need to A registered chemical. urses that are scheduled for ducated utilizing agency cluding the importance of ividually assigned eed to disinfect using an ical. The orientation opy of the Manufacturer's the cleaning and es for glucometers. No will be allowed to work until	F 83	5 Assurance Meeting is attende Administrator, Director of Nur Nurse, Therapy Manager, Un Nurses, Health Information M the Dietary Manager. Compliance Date: 10.22.2021	sing, MDS it Support anager, and	

Facility ID: 923294

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/08/2021 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345039	B. WING _					C 08/2021
	ROVIDER OR SUPPLIER STONE HEALTH AND RE			485	EET ADDRESS, CITY, STATE, ZIP CO VETERANS WAY RNERSVILLE, NC 27284	DE		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BI		(X5) COMPLETION DATE
F 835	prevent a serious adv occurring or recurring complete. On 9/29/21, the Direct Assistant Director of I Support Nurses, the I scheduler were educa Assurance Nurse Con for ensuring that all a orientation packet priv- shift. The scheduler education packets for not previously been of packet. These packet room in a designated name for review and their shift. The scheduler educates are locate the packets are locate the packets are locate the copy room and the and placed under the located across the hat completed. The scheduler will als agency staff to the fact staff member to ensu was reviewed and sig questions that they m As needed agency st approved by the DON Support Nurse. Addit be placed in the design	ess or system failure to verse outcome from ), and when the action will be etor of Nurses (DON), Nurses (ADON), LPN Unit HR staff member, and ated by the Quality insultant on the importance gency staff receive the or to the beginning of their and/or HR staff will print agency nurses that have oriented using the education ets will be placed in the copy box with the agency nurses signature at the beginning of duled for future dates that ed in the designated box in at they should be signed DON's door, which is all from the copy room once so provide a list of new cility on-call nurse each day. ccurs, the facility on-call lity and talk to the agency re that the education packet gned and will address any	F 8	35				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 10/08/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•
		EHABILITATION CENTER		485 VETERANS WAY	
				KERNERSVILLE, NC 27284	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE         REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIA         DEFICIENCY       DEFICIENCY		TION SHOULD BE COMPLET THE APPROPRIATE DATE	
F 835	Continued From pag	e 14	F 83	5	
		rse will contact them by	1 00		
		e that they retrieve, review			
	Component 3: Date	of completion 9/30/21			
On 9/30/21 from 8:02 AM throu		-			
		lucted with facility staff during s. During an interview, the			
	facility's Scheduler d				
	identifying when a new Agency nurse was coming				
		. The Scheduler reported			
		in advance by the temporary			
		ame of the nurse who would			
	-	a shift. She stated anytime a			
		icked up a shift at the facility, DON and ADON. When			
	-	r reported the administrative			
		d even if there was a last			
		ency nurses assigned to			
	work at the facility. I	nterviews were conducted			
		nd ADON with regards to the			
		n for facility staff and Agency			
		nd ADON confirmed they			
	-	ouble check" of the next chedule to ensure orientation			
	and education (inclu				
		lucose monitoring) were			
		efore starting work at the			
	-	e staff interviews, the credible			
		ted and the immediate			
F 000	jeopardy was remove		F 00		10/00/0
F 880 SS=K			F 88	5U	10/22/2
	§483.80 Infection Co				
	-	ablish and maintain an			
	infection prevention a	and control program			

Facility ID: 923294

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP		
		345039	B. WING				08/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER			485 VETERANS WAY KERNERSVILLE, NC 27284			
(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 BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 880	designed to provide a comfortable environm development and tran diseases and infection §483.80(a) Infection p program. The facility must estat and control program ( a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based u conducted according accepted national stat §483.80(a)(2) Written procedures for the pro but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura depending upon the in involved, and	a safe, sanitary and tent and to help prevent the asmission of communicable asmission of communicable asmission of communicable asmission and control blish an infection prevention IPCP) that must include, at ving elements: arm for preventing, identifying, g, and controlling infections seases for all residents, bors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; astandards, policies, and bogram, which must include, lance designed to identify ble diseases or can spread to other an possible incidents of se or infections should be asmission-based precautions ent spread of infections; blation should be used for a t not limited to:	F	880				

Facility ID: 923294

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	-	ND HUMAN SERVICES				FORM	D: 11/08/202 AAPPROVE D. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345039	B. WING				C 108/2021	
	ROVIDER OR SUPPLIER			48	TREET ADDRESS, CITY, STATE, ZIP CODE 85 VETERANS WAY ERNERSVILLE, NC 27284	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 880	circumstances. (v) The circumstance must prohibit employ disease or infected sl contact with residents contact will transmit t (vi)The hand hygiene by staff involved in di §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update the This REQUIREMENT by: Based on observatio record review, the fac approved disinfect an (glucometer) used for #1, #2, #3, #4, #5 and can be contaminated cleaned and disinfect approved disin the manufacturer of t	ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the ten by the facility. Ille, store, process, and s to prevent the spread of view. uct an annual review of its ir program, as necessary. T is not met as evidenced ons, staff interviews, and cility staff failed to use an t product and procedure to shared blood glucose meter r 6 of 6 residents (Resident d #6). Shared glucometers with blood and must be ted after each use with an d procedure. Failure to use	F	880	F880 Infection Control Plan of Corre- and Directed Plan of Correction The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all fede and state regulations the facility has to or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility □s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	d do ral caken s tion		

L

Facility ID: 923294

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/08/202 MAPPROVE D. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345039	B. WING			C / <b>08/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				485 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000						
F 880	Continued From page		F 880			
		began on 9/27/21 when		1. How corrective action will		
		nurse new to the facility)		accomplished for those resider		
		bod glucose testing for 6		have been affected by the defi	cient	
		gned hall using a shared		practice:		
	-	1 did not disinfect the				
		etween residents using an		On 09.28.2021, it was discove		
	-	fectant. In addition, Nurse		resident #1, #2, #3, 4#, 5# and		
		cility residents each had their neter stored in a plastic,		their blood sugar checked usin glucometer that had not been	•	
	•	his/her room. Immediate		with an approved EPA agent b		
		ed on 9/30/21 when the		residents. Once the facility wa		
		implemented an acceptable		the deficient practice, the Licer		
	credible allegation of			Practical Nurse Unit Support N		
	removal. The facility			promptly removed the glucome		
		r scope and severity level of		the cart. On 09.28.2021, the L		
	-	th a potential for minimal		Support Nurse checked each r		
		ediate Jeopardy) to ensure		cart to ensure there were no g		
		s are put in place and to		on the cart. No glucometers w		
	complete employee i	n-service training.		on the cart. Additionally, on 0	9.28.2021	
				the LPN verified that each resi	dent (#1,	
	The findings included	1:		#2, #3, #4, #5, #6) had their ov	vn	
				individual glucometer in their re	oom.	
	A review of the facility					
		nated January 2011; Last		The Director of Nurses (DON)		
	•	1) read, in part: "It is the		Medical Director of the deficier	-	
	policy of this facility to			on 09.28.2021. On 09.29.202		
	-	resident." The topic of		notified the Medical Director of		
		ytime the glucometer is		taken to correct the deficient p		
	-	N (as needed), it will be		including ensuring that each re		
		ted per Manufacturer's		their own individual glucomete		
	guidelines."			the nurses were educated on p		
	The menufactures is a	tructions for the alusemeter		to take for disinfecting the gluc		
		structions for the glucometer		On 09.29.2021, the Medical Di		
	-	structed the cleaning and		ordered vital sign monitoring for		
		e should be performed as		for resident #1, #2, #3, 4#, 5#	anu #0.	
		nimize the risk of transmitting		The DON notified the Ears the	County	
		ns. These instructions read hould be cleaned and		The DON notified the Forsyth Health Department of the defic		
		on each patient. The (Brand		practice on 09.29.2021. The H		
	usinected alter use				calli	

Facility ID: 923294

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DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					D: 11/08/2021
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		E SURVEY PLETED
		345039	B. WING _			10	C / <b>08/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER			35 VETERANS WAY ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
		,			DEFICIENCY)		
E 000		- 40					
F 880	Continued From page		F 8	880			
	, ,	lucose Monitoring System			Department was also made aware of		
		testing multiple patients			interventions that facility put into place		
	when standard preca				include ensuring that each resident ha		
		ection procedures are			their own individual glucometer and th		
	followed." The Clear	ning and Disinfection			the nurses were educated on proper s	steps	
	instructions read, "Th	e cleaning procedure is			to take for disinfecting the glucometer	S.	
	needed to clean dirt,	blood and other bodily fluids			The Forsyth County Health Departme	nt	
	off the exterior of the	meter before performing the			recommended review of the medical		
	disinfection procedur				diagnosis of resident #1, #2, #3, 4#, 5	#	
	-	to prevent the transmission			and #6 to identify any resident who ha		
	-	gens. A variety of the most			any diagnosis related to a Blood Born		
		-registered wipes have been			Pathogen (BBP). There were no		
	-	for cleaning and disinfecting			residents who were identified to have	anv	
	of the (Brand Name)				BBP diseases. The DON initiated and	•	
		The instructions provided a			completed this review on 10.08.2021.		
		-			-		
		bes which were shown to be			Additionally, the Forsyth County Heal		
		glucometer. This list did not			Department reviewed education with		
	include alcohol wipes	5.			facility via a phone call on 10.08.2021		
					The DON and Administrator attended	the	
		stration observation was			education.		
		t 6:23 AM with Nurse #1.					
		ed as an Agency nurse					
	(temporary staff) who	was assigned to care for					
	residents on the 200	Hall from 7:00 PM on			2. How the facility will identify other		
	9/27/21 to 7:00 AM o	n 9/28/21. The nurse			residents having the potential to be		
	reported she was nev	w to the facility. Nurse #1			affected by the same deficient practic	e:	
	•	8/21 at 6:34 AM as she					
		ter stored on top of the			All residents who have orders for		
	medication cart and c	•			accuchecks have the potential to be		
		cose check for Resident #1.			affected. On 09.28.2021 the DON		
		ed gloves and entered			identified 100% of all residents with o	rders	
		with the testing equipment.			for accuchecks. The LPN reviewed 1		
		sident's blood glucose,			of all residents identified as having or		
		the medication cart and was			for accuchecks to ensure that each		
		d an alcohol wipe to wipe off			resident had their own individual		
		placed the glucometer back			glucometer. The review was completed	ed	
	-				on 09.28.2021. Results: all residents		
	-	ion cart. Nurse #1 was				nau	
		pleted the medication pass.			their own individual glucometer.	0024	
	when asked, Nurse #	#1 stated she had completed			Additionally, on 09.28.2021	.021,	

Facility ID: 923294

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		MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
			A. BUILDING	3	C	
		345039	B. WING			, )8/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		0/2021
				485 VETERANS WAY		
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 880	Continued From page	<b>-</b> 19	F 88	30		
		glucose checks scheduled	100	the DON or designee of	ompleted daily	
		Upon further inquiry, the		audits to check the med		
	-	ther blood glucose checks		ensure there were no g		
		pleted earlier that morning.		cart. Results: No gluco		
		ed Resident #2, Resident #3,		on the cart.		
		nt #5, and Resident #6. As				
		rse #1 continued, the nurse		3. Address what mea		
		ometer observed to be used		place or systematic cha	0	
		a shared meter used for all		ensure that the deficien	it practice will not	
		ed residents. Nurse #1 tated she "assumed" the		reoccur:		
	-	glucometer for residents		On 09.28.2021, the DO	N and the Quality	
		nly glucometer she had		Assurance Nurse Cons	-	
		nquiry, the nurse was asked		glucometer policy. The		
		he meter between the		revisions to the policy revisions		
	residents. Nurse #1	reported she used an				
	-	previously observed to clean		LTC Infection Control S		
		er between residents. Nurse		On 10.21.2021, the LTC		
		there were any disinfectant		Assessment was comp		
	· ·	e medication cart specifically		Infection Preventionist,		
		d disinfect a glucometer.		of Nurses (ADON), LPN		
		ot know. Upon request, /ed as she opened the		Nurse, Regional Clinica the Contracted Consult		
	bottom drawers of the			Infection Self-Assessme		
		ectant wipes were observed		discussed with and sen		
	to be stored on the m	-		Director for review on 1		
		ducted on 9/28/21 at 6:47		Root Cause Analysis: C		
		night shift nurse supervisor.		Director of Nurses, Ass		
		s regarding the use of a		Nurses, Administrator,	0	
	-	nd failure to disinfect the		of Operations, Quality A Consultant, LPN Unit S		
	disinfectant were disc	residents with an approved		conducted a root cause		
		shared glucometer would		determined that the roo		
		d using (Brand Name)		deficient practice was the		
		lowever, she reported each		didn⊡t notify the facility		
		idual glucometer and she		the agency nurse would		
		ut where the glucometer		the required agency ori		
		ach of the residents' rooms.		need to be completed.		

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		ND HUMAN SERVICES MEDICAID SERVICES				I	NTED: 11/08/20 FORM APPROVI B NO. 0938-03
TATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _				C 10/08/2021
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER			VETERANS WAY RNERSVILLE, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 880	glucometers were the calibrated once a we A review of each resi record revealed the f In addition to the bl to be checked by Nu 9/28/21, Resident #1 documented as chece at 9:19 PM. Resident #2 did not glucose results docu Nurse #1. In addition to the b the morning of 9/28/2 blood glucose docum #1 on 9/27/21 at 10:5 Resident #4 did no glucose results docu Nurse #1. In addition to the b the morning of 9/28/2 blood glucose docum #1 on 9/27/21 at 11:1 In addition to the b the morning of 9/28/2 blood glucose docum #1 on 9/27/21 at 11:1 In addition to the b the morning of 9/28/2 blood glucose docum #1 on 9/27/21 at 11:0	r reported all individual broughly disinfected and ek. dents' electronic medical following information: ood glucose level observed rse #1 on the morning of also had her blood glucose eked by Nurse #1 on 9/27/21 thave any additional blood mented as checked by lood glucose level checked 21, Resident #3 also had her nented as checked by Nurse 56 PM. thave any additional blood mented as checked by lood glucose level checked 21, Resident #5 also had her nented as checked by Nurse 12 PM. lood glucose level checked 21, Resident #6 also had her nented as checked by Nurse 12 PM. lood glucose level checked 21, Resident #6 also had her nented as checked by Nurse 12 PM. lood glucose level checked 21, Resident #6 also had her nented as checked by Nurse 17 PM.	F 8		Nurse#1 was not aware that each had their own individual glucomer the facility glucometer disinfecting procedure. On 09.29.2021, the O Assurance and Process Improver Committee met to discuss and re cause analysis. On 10.21.2021, contracted Nurse Consultant revi root cause analysis. This root cau analysis was incorporated into the correction/intervention plan. Contacted Consultant: Facility ha contracted with a Consultant who completed specialized training in Prevention and Control effective 10.21.2021 for a duration 6 mon assist in 1) in-services specific to issues cited if needed 2) assist w cause analysis 3) assist with dev of the plan of correction 4) assist development/review of the facility Control assessment 5) routine vis assist with monitoring infection prevention/control practices 6) wr report with findings, recommenda any will be provided following eac Education: On 09.28.2021, the E Nurses (ADON) began reeducatil licensed nurses and medication a	ter or of g Quality ment eview root the ewed the use e plan of s o has Infection date ths to the ith root elopment with / Infection sits to ritten ations if ch visit. Director of ector of ng all aides full	
	9/28/21 at 1:55 PM. infection control cond failure to use residen glucometers and her disinfectant on the sh	(A) Clinical Consultant on During the interview, the cerns related to Nurse #1's its' individually assigned failure to use an approved mared glucometer used for 6 ssed. The DON reported			time, part time, and PRN includin staff on the glucometer policy to i the following topics: "Residents must have their ov individual glucometer. "Glucometers must be cleane disinfected per Manufacturer s	include wn	

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	S FOR MEDICARE &				OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345039	B. WING		C
	ROVIDER OR SUPPLIER	340000		TREET ADDRESS, CITY, STATE, ZIP CODE	10/08/2021
	ROVIDER OR SOFFLIER				
SUMMERS	STONE HEALTH AND R	EHABILITATION CENTER		85 VETERANS WAY KERNERSVILLE, NC 27284	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	OULD BE COMPLETI
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE DATE
F 880	Continued From pag	le 21	F 880		
	-	viced after the infection		recommendations when visibly s	oiled and
		re identified the morning of		PRN. The cleaning procedure is	
		e need to use each resident '		to clean dirt, blood and other boo	
		ed glucometer and use of an		off the exterior of the meter befor	
		nt to clean/disinfectant a		performing the disinfection proce	dure.
	glucometer.			The disinfection procedure is needed	
	5			prevent the transmission of blood	
	An interview was cor	nducted on 9/30/21 at 11:00		pathogens.	
	AM with the facility's	Assistant Director of Nursing		" The sanitizing wipes for clea	aning and
	-	interview, the ADON		disinfecting are located in the un	
	reported only nurses	and facility staff medication		medication rooms and the supply	y room.
	aides conducted blo	od glucose monitoring for		" Sanitized and cleaned gluco	ometers
		reported an audit of the		are located in the unit medication	
		carts was conducted after the		or the supply room.	
	-	cerns were identified on		" The glucometer orientation I	material is
	9/28/21. This audit r	revealed the 200 Hall med		included in the agency orientatio	n
		oserved to be used by Nurse ot contain an EPA-approved		education packet.	
	disinfectant product			On 09.29.2021, the DON and AE	DON
	glucometers.			completed return demonstration	
	0			of licensed nurses and medication	
	A follow-up interview	was conducted on 9/30/21		to ensure they were aware of the	
	· ·	facility's DON. During the		procedure to clean and disinfect	
		eported she would expect all		glucometers. As of 09.29.2021,	
		dents ' blood glucose levels		all nurses and medication aides	
	in accordance with p	hysician's orders and to		completed return demonstrations	s. There
	follow "proper protoc	cols." She reported a		were no issues identified with the	e return
		t in each resident's room with		demonstrations.	
		used only for that resident.			
		d each glucometer needed to		The DON will ensure that any of	
		fected as needed. If any		above identified staff who do not	
	staff member had questions with regards to blood			the in-service training by 09.29.2	
		or the use of a glucometer,		not be allowed to work until the t	raining is
	he/she needed to rea ADON, or the DON f	ach out to a Unit Manager,		completed.	
		or guidanoc.		This in-service was incorporated	into the
	On 9/29/21 at 1.30 E	PM, the facility's Regional		new employee facility orientation	
		Clinical Consultant, and		above identified staff.	
	Director of Nursing v	Jimodi Oonsultant, anu		above lucitance stall.	

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) [	NO. 0938-039 DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	C	OMPLETED
		345039	B. WING			С
	ROVIDER OR SUPPLIER	545059		STREET ADDRESS, CITY, STATE, ZIP CO		10/08/2021
NAME OF F	ROVIDER OR SUFFLIER			485 VETERANS WAY	DE	
SUMMER	STONE HEALTH AND RE	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH	ON SHOULD BE	(X5) COMPLETION DATE
IAG				DEFICIENCY		
F 880	Continued From page	e 22	F 8	80		
		5 22				
	immediate jeopardy.			4. Monitoring Procedure	to ensure that	
	The facility provided	a credible allegation of		the plan of correction is effe		
		removal on 9/29/21 at 7:50		specific deficiency cited rem		
		of immediate jeopardy		and/or in compliance with re		
	removal indicated:			requirements:	5	
	-	f Immediate Jeopardy		The Director of Nursing or d	•	
	Removal:			monitor for compliance by o		
				blood sugar checks to ensu		
		se an approved disinfectant		the resident⊡s individual glu		
		re to clean and disinfect a		that the glucometers are cle		
		sed for 6 residents required		according to manufacturer g		
	-	ucose checked (Resident		Director of Nursing or desig		
		d #6). Nurse #1 (an Agency		observations of blood sugar		
		d the blood glucose testing		week x 4 weeks and then 5		
		/ residents each had their		of blood sugar checks per n		
		glucose meter stored in a		months. Results will be door		
	•	ainer in his/her room. Nurse		the F880 Quality Assurance		
		ed on how to disinfect a		will be presented to the wee		
		ccording to manufacturer's		Assurance committee by the		
		ed for multiple residents.		ensure corrective action is in appropriate. Compliance wil		
	Component 1: Identi	fy those recipients who have		and the ongoing auditing pro		
		to suffer, a serious adverse		reviewed at the weekly Qua		
		of the noncompliance; and		Meeting or until resolved by	the QA	
	On 9/28/21 it was die	scovered that resident #1,		Committee. The weekly QA attended by the Administrate	-	
		b had their blood sugar		Nursing, MDS Nurse, Thera		
		me glucometer that had not		Unit Support Nurses, Health		
	-	an approved EPA agent		Manager, and the Dietary M		
		Once the facility was notified				
		ce, the Licensed Practical		Directed Plan of Correction	Compliance	
	Nurse Unit Support N			Date: 10.22.2021		
		eter from the cart. On		Compliance Date: 10.22.202	21	
	-	t Support Nurse checked				
		to ensure there were no				
		art. No glucometers were				
		dditionally, on 9/28/21 the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/08/2021 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345039	B. WING					C 108/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	E	•	
				4	85 VETERANS WAY			
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		ĸ	ERNERSVILLE, NC 27284			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CO	RRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION	SHOULD B		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAC	3	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIA	ΛTE	DATE
					DEFICIENCE)			
F 880	Continued From page	23	F	880				
	LPN verified that each	n resident (#1, #2, #3, #4,						
	#5, #6) had their own	individual glucometer in						
	their room.							
	The Director of Nurse	s interviewed the nurses						
	and there were no oth	ner residents who were						
	identified as being im	pacted by the deficient						
	practice.							
	Component 2: Specit	fy the action the entity will						
		ess or system failure to						
	prevent a serious adv							
	-	, and when the action will be						
	complete.							
	complete.							
	On 9/29/21, the Direc	tor Nurses Assistant						
	Director of Nurses, Ad							
		s, Quality Assurance Nurse						
		Support Nurse, conducted a						
		nd determined that the root						
	cause of the deficient							
		the facility on call nurse						
		would be working and						
		itation to be completed and						
		re that each resident had						
	their own individual gl	ucometer or of the facility						
		ng procedure. On 9/29/21,						
	-	met to discuss and review						
	root cause of analysis	<ol> <li>The Medical Director and</li> </ol>						
	the Forsyth County H	ealth Department were						
		ficient practice and the						
		eficient practice on 9/29/21.						
		ledical Director and the						
		both informed on 9/29/21						
		at facility had put into place						
	-	at each resident had their						
	-	neter and that the nurses						
	were educated on pro							
	disinfecting the glucor	meters. There were no						

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	FORM	APPROVED							
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED			
		345039				C 10/08/2021			
NAME OF PI	ROVIDER OR SUPPLIER			B. WING			10/08/2021		
					485 VETERANS WAY				
SUMMERS	JMMERSTONE HEALTH AND REHABILITATION CENTER			1	KERNERSVILLE, NC 27284				
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE		
		,			DEFICIENCY)				
F 880	further recommendations from the Health		F	880					
		edical Director. The facility							
	for next 72 hours for	obtain vital sign monitoring							
	On 9/28/21, the Dired	ctor of Nurses (DON) and							
		Nurses (ADON) began							
	l i	nurses and medication							
		me, and PRN including							
	the following:	lucometer policy to include							
	· Residents m	nust have their own individual							
	glucometer.								
	Glucometers must be cleaned and								
	disinfected per Manufacturer 's recommendations when visibly soiled and PRN.								
		-							
	"The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the								
	meter before performing the disinfection								
	procedure. The disinfection procedure is needed								
	to prevent the transm	ission of blood-borne							
	pathogens."	ng wipes for cleaning and							
		ed in the unit medication							
	rooms and the supply								
		id cleaned glucometers are							
	located in the unit me	dication rooms or the supply							
	room.								
		ion material is included in the							
	agency orientation ed	iucation packet.							
	On 9/29/21, the DON	and ADON completed QA							
		each medication cart to							
		glucometers on the cart							
		could complete a return							
		/ to clean and disinfect the							
	-	/29/21, 100% of all nurses have completed return							

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DEPARTI CENTER	FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 10/08/2021	
		345039	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
					485 VETERANS WAY		
SUMMERS	IMERSTONE 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 PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 880	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 demonstrations. There were no issues identified with the return demonstrations. As of 9/29/21 3pm, any employee who has not received this training will not be allowed to work until the training has been completed. This includes full time, part time, and agency staff. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Component 3: Date of completion 9/30/21 On 9/30/21 from 8:02 AM through 12:15 PM, observations and/or interviews were conducted with staff and Agency nurses assigned to each of the 4 halls within the facility with regards to required infection control practices using glucometers for blood glucose checks. All nurses were aware of the facility's policy to use individually assigned glucometers for each resident requiring blood glucose monitoring and to store the individual glucometer in each resident's room. The location of EPA-approved disinfectant wipes for the cleaning and disinfection of glucometers (as needed) was also observed and discussed with each nurse. Each hall nurse was able to demonstrate and/or verbalize the instructions provided through the in-servicing received on 9/29/21 regarding these infection control practices and the glucometer's manufacturer recommendations for cleaning and disinfection. Based on the observations, staff		F	880			
	the credible allegation	ew of the facility's records, n was validated and the vas removed on 9/30/21.					

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DEPART CENTER	FOR	D: 11/08/2021 MAPPROVED O. 0938-0391					
CENTERS FOR MEDICARE & 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 10/08/2021	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	CROSS-REFERENCED TO THE APPR CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION		

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