PRINTED: 08/25/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` '			(X3) DATE SURVEY COMPLETED		
		345039	B. WING				C 21/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	Z I/ZUZZ	
CUMMED	STONE HEALTH AND DE	HABILITATION CENTER		48	35 VETERANS WAY			
SUMMER	SIONE REALIR AND RE	HABILITATION CENTER		K	ERNERSVILLE, NC 27284			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	D/II L	
E 001 SS=F	Establishment of the CFR(s): 483.73	Emergency Program (EP)	E	001			8/18/22	
	-	418.113, §441.184, §460.84, 83.475, §484.102, §485.68, §485.920, §486.360,						
	must comply with all and local emergency The [facility, except for must establish and memergency prepared requirements of this s	or Transplant Programs] applicable Federal, State preparedness requirements. or Transplant Programs] aintain a [comprehensive] ness program that meets the section.* The emergency m must include, but not be ng elements:						
	the terms "facility" or refers to all provider a this appendix. This is lieu of the specific pro the regulations. For	ndicated, the general use of "facilities" in this Appendix and suppliers addressed in a generic moniker used in ovider or supplier noted in varying requirements, the that provider/supplier will be						
	comply with all applic local emergency prep. The hospital must de comprehensive emer program that meets the section, utilizing an all emergency prepared but not be limited to, *[For CAHs at §485.6]	gency preparedness he requirements of this ll-hazards approach. The ness program must include, the following elements:						
		deral, State, and local ness requirements. The						
ABOBATORY	DIDECTOR'S OR BROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATUR			TITI F		(X6) DATE	

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

08/14/2022

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

Electronically Signed

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
		345039	B. WING			07/	
NAME OF P	ROVIDER OR SUPPLIER	343003	5: ******		REET ADDRESS, CITY, STATE, ZIP CODE	07/2	21/2022
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER			5 VETERANS WAY ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE AT CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 001	emergency prepared but not be limited to, this REQUIREMENT by: Based on record revifacility failed to maintabergency Prepared failed to provide and the annual staff training failed to conduct an atthat was either communicatility based or a tab their EP plan. The findings included A review of the facility. A. No documentation of the EP plan. B. No evidence of an that was either communicatility-based exercise the last 12 months. On 7/21/22 at 9:28 Al was interviewed. He sworking at the facility training on the EP plan he knew there was so try to locate that infor	and maintain a gency preparedness all-hazards approach. The mess program must include, the following elements: is not met as evidenced few and staff interviews, the ain a comprehensive ness (EP) plan. The facility maintain documentation of ng of the (EP) plan and diditional full-scale exercise funity-based or individual, letop exercise as part of it is additional full-scale exercise funity-based or individual additional full-scale exercise funity-based or individual are or a tabletop exercise in in the Maintenance Director stated he just started and did not know if annual an was completed. He stated and type of drill and would mation.	E	001	The statements made in 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 tall or will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. E 001 1. Corrective action for resident(s) affected by the alleged deficient practic On 8/10/2022, the facility completed training on the facility semergency Preparedness Plan. The training also included an Emergency Evacuation training pertaining to the facility bigg risk, a tornado or potential high winds. The Emergency Preparedness Manual has been updated with the current train and educational information. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 8/10/22, the Administrator and Qua	I ken on ee: est ing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING			1	21/2022
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284			21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
E 001	because they could many people coming On 7/21/22 at 9:45 A burst sprinkler was p Director stated he conducted of training On 7/21/22 at 11:42 conducted with the A just started this mon should be conducted	but no training was done never set it up, there was too g in and out. AM, documentation of the provided. The Maintenance buld not locate any other	E	001	Assurance team reviewed the Emerger Preparedness Plan and training materi pertaining to a tornado/high winds to be included in the training program. The training material was accurate and up to date for the current year 2022. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficies practice: The Administrator conducted training to staff, including contractors on the Emergency Preparedness Plan. Training was also given on the Emergency Evacuation procedures for a tornado on high wind scenario. This training will be completed annually and discussed as profithe QAPI Meeting. 4. Monitoring Procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Administrator or designee will mone compliance utilizing the E001 Quality Assurance Tool weekly x 5 weeks them monthly x 2 months. The Administrator designee will monitor for compliance to validate the employees understanding the Emergency Preparedness training program. Reports will be presented to weekly Quality Assurance committee be the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing will reviewed at the weekly Quality Assurance validates the weekly Quality Assurance will reviewed at the weekly Quality Assurance will reviewed at the weekly Quality Assurance.	al e to to to the to to the to the	

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E 001	Continued From pag	e 3	ΕO	Meeting. The weekly QA Meeting attended by the Administrator, Di Nursing, MDS Coordinator, There Manager, Unit Support Nurses, Hinformation Manager, and the Di Manager.	irector of apy Health			
F 000	INITIAL COMMENTS	3	F 0	Date of Compliance: 8/18/22				
	survey was conducted 07/21/22. Event ID# Jeopardy wa identified CFR 483.10 at tag F8 (J). CFR 483.25 at tag F8							
	(J). CFR 483.45 at tag F ⁻ (J).	756 at a scope and severity						
	The tag F684 constit Care.	uted Substandard Quality of						
	07/13/22 for Residen 07/21/22.	for tag F684 began on t #46 and was removed on for tags F580 and F756 nd was removed on						
	An extended survey	was conducted.						
F 553 SS=D	38 of the 59 complain substantiated resultin Right to Participate in CFR(s): 483.10(c)(2)	ng in deficiencies. n Planning Care	F 5	53		8/11/22		

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F 553	development and imperson-centered platimited to: (i) The right to particincluding the right to be included in the plate revisions to the personal to the perso	ght to participate in the aplementation of his or her of care, including but not sipate in the planning process, identify individuals or roles to anning process, the right to ad the right to request con-centered plan of care. Sipate in establishing the outcomes of care, the type, and duration of care, and any to the effectiveness of the informed, in advance, of of care. Sive the services and/or items of care. The care plan, including the patient changes to the plan acility shall inform the resident pate in his or her treatment eresident in this right. The just-	F 55	<u>'</u>			
	resident representat (ii) Include an asses strengths and needs (iii) Incorporate the r cultural preferences This REQUIREMEN by: Based on record re interviews, the facilit intact residents to pa	sment of the resident's		The statements made on this F Correction are not an admissior not constitute an agreement wit alleged deficiencies. To remain	n to and do h the		

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NAME OF P	ROVIDER OR SUPPLIER	2.5555		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	21/2022
TO THE OT THE	TO VIDERY ON OUT FEILING				B5 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			ERNERSVILLE, NC 27284		
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F 553	Continued From page	e 5	F:	553			
	in care planning.) reviewed for participation			compliance with all Federal and State Regulations the facility has taken or wil take the actions set forth in this Plan of		
	The findings included	:			Correction. The Plan of Correction constitutes the facility sallegation of		
		admitted to the facility on			compliance such that all alleged		
	10/1/2019 with diagno				deficiencies cited have been or will be		
	hemiplegia, atrial fibri disease and abnorma	llation, atherosclerotic heart al posture.			corrected by the date or dates indicated	d.	
					F553 RIGHT TO PARTICIPATE IN		
	A review of the comprehensive annual minimum data set (MDS) dated 6/29/2022 revealed				PLANNING CARE		
	Resident #60 was cog making.	gnitively intact for decision			Corrective Action:		
	_				Resident #60: Care plan meeting		
		n meeting note dated			scheduled for August 18th, 2022.		
		ed a care plan meeting			Invitation hand delivered to resident an	d	
		t #60's family member was			invitation also mailed to resident□s		
		e family member to attend			representatives.		
	on 5/4/2022.				Resident #4: Care plan meeting	_	
					scheduled for August ¿¿¿¿¿ 18th, 2022		
		ducted with Resident #60 on			Invitation hand delivered to resident an	a	
		n. and she revealed she had Irticipate in a care plan			invitation also mailed to resident⊡s		
		not sure what a care plan			representatives.		
	meeting was at the sk				Identification of other residents who ma	a\/	
	meeting was at the sr	tilled fluiding facility.			be involved with this practice:	1 9	
	On 7/19/2022 at 4:35	p.m. an interview was			All current cognitively intact residents,		
		DS coordinator, and she			have the potential to be affected by the		
	revealed the facility p				alleged practice.		
		e the family of a resident via			.		
		dent on the day of the care			On 8/9/2022 through 8/10/2022 an aud	lit	
	plan meeting. She ad	ded that the meeting would			was completed by the Social Worker, N	∕lini	
		dining room and if the			Data Set Support nurse, to ensure that		
		of bed at the time of the care	current cognitively intact residents		current cognitively intact residents had		
		eting would take place	been invited to participate in the plan		ng		
		nd the individual members			of their care. Each current cognitively	ĺ	
	of the care plan meet meet with the Reside	ing would be expected to nt after the care plan			intact resident was asked if they were invited to participate in the planning of		

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				OIVID INC	<u>7. 0930-039 i</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345039	B. WING _			1	21/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
				48	85 VETERANS WAY		
SUMMER	SIONE HEALIH AND RE	EHABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 553	Continued From page	e 6	F 5	553			
		what had been discussed			their care. If the resident responded wi	th a	
	_	When asked to demonstrate			response of no, then the facility schedu		
		f the most recent care plan			a care plan meeting and invitation was		
		#60 a care plan signature			hand delivered and also mailed to		
	_	was provided that read:			resident □s representatives. Out of the	80	
		neeting was conducted on			current residents, 19 residents had not		
	5/4/2022 and care pla	an invitation was sent on			been invited to participate in the planni		
	4/20/2022 to the resid	dent representative. Those in			of the resident□s care plan. Each of th	e	
	attendance were liste	ed as: the social worker,			19 residents received an invitation of the		
		ment nurse, MDS nurse, and			scheduled care plan meeting which we		
		e Resident was not included			held by 8/18/2022. Each invitation was		
		nurse added that since			hand delivered to them, and also maile		
	· ·	meetings had not taken			to their resident representative. This wa	as	
	·	and she was not certain if			completed on 8/10/2022.		
	the individual membe				0 0		
	portions of the care p	eeting because nothing was			Systemic Changes:		
		ated a change to the current			On 8/10/2022 The Registered Nurse (F	5M)	
		stem should occur to include			Minimum Data Set (MDS) Coordinators		
	invitations being sent				MDS Support Nurse and any other	-,	
		plan meeting note that			Interdisciplinary team member that		
		ion of the invitation, the			participates in the MDS assessment		
		d any updates that need to			process was in serviced /educated by t	he	
		vas her expectation that all			Director of Nursing.		
		gnitively intact understand			The education focused on: The resider	nt	
	what the care plan m	eeting was and that it was			has the right to participate in the		
	their right to participa	ite.			development and implementation of his	s or	
					her person-centered plan of care,		
	2. Resident #4 was	originally admitted to the			including but not limited to: (i) The right	: to	
	facility on 12/5/18 and	d re-admitted on 8/9/21.			participate in the planning process,		
					including the right to identify individuals	or or	
		ım data set (MDS) dated			roles to be included in the planning		
		sident #4 was cognitively			process, the right to request meetings	and	
	intact.				the right to request revisions to the		
					person-centered plan of care. (ii) The r		
		y's records revealed an			to participate in establishing the expect	:ed	
		: #4's care plan meeting was			goals and outcomes of care, the type,	ĺ	
		t's responsible party on			amount, frequency, and duration of car	e,	
	5/25/22 for the meeting	ng date of 6/15/22. There			and any other factors related to the		

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		345039	B. WING _		_	C 07/21/2022	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STA	ATE, ZIP CODE	0172172022	
				485 VETERANS WAY			
SUMMERS	STONE HEALTH AND	REHABILITATION CENTER		KERNERSVILLE, NC 272	284		
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F 553	Continued From p	age 7	F 5	53			
	was no document	ation available indicating		effectiveness of the	plan of care. (iii) The		
		nvited to her care plan meeting.		right to be informed			
		1 3		1 -	of care. (iv) The right		
	The care plan sigr	nature form dated 6/15/22 did		to receive the service			
		esident #4's signature indicating		included in the plan	of care. (v) The right		
	the resident was r	not in attendance to her care		to see the care plan	n, including the right to		
	plan meeting.			sign after significant	t changes to the plan		
				of care. The facility			
		w on 7/18/22 at 11:48 a.m.,			to participate in his or	•	
		d that she was not aware of a		her treatment and s			
		to discuss her care. She		resident in this right		_	
		never been invited to any care		1 1	acilitate the inclusion o	of	
	plan meetings but	would like to have been invited.		the resident and/or			
	On 7/40/00 at 4:0/	Fig. 100 Alba MDC Nivina a state of		1	nclude an assessment		
		5 p.m., the MDS Nurse stated e invitations to the care plan			engths and needs. (iii)		
		e invitations to the care plan esidents' responsible			dent's personal and s in developing goals o	of .	
	_	2 weeks prior to the care plan		care.	s in developing goals o	"	
	•	e resident was not up and out		This in service was	completed by		
	_	of the meeting, the team would		08/11/2022. Any M			
		ng and then each participant) and member of the		
		lent's room individually to meet		1 .	, m who did not receive		
	_	She added that the resident		in-service training w			
	would be allowed	to give input and the resident's		work until training is	completed. This		
	signature obtained	d. She stated there was no			en integrated into the		
	signed medication	review or care plan review to		standard orientation	•		
		s covered with the resident.		1 -	refresher courses for		
		tweak to the system should			will be reviewed by the	:	
		ny resident that was their own			Process to verify that		
		with a cognition status greater		the change has bee	en sustained.		
		the resident understood what		Manitaria			
		d for and documentation of the		Monitoring:			
		des the resident's signature,		To oncure complian	on The Director of		
		ntation, and documentation of red in the meeting with the		To ensure complian Nursing and/or Assi			
	resident.	ca in the meeting with the			w 5 cognitively intact		
	TOSIUGITI.			1	that they have been		
				invited to participate	_		
				their care. This will			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	()	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284		<u> </u>	
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F 554 SS=D	CFR(s): 483.10(c)(7) §483.10(c)(7) The rig medications if the inte defined by §483.21(b this practice is clinica This REQUIREMENT by: Based on observatio interviews and record interdisciplinary team document the ability of self-administer medic (Resident #58) who w medications at bedsic	Meds-Clinically Approp ht to self-administer erdisciplinary team, as (2)(ii), has determined that lly appropriate. is not met as evidenced is not met as evidenced review, the facility's failed to assess and of a resident to ations for 1 of 1 resident was observed to have		basis for 4 weeks then monthly months. The results of this audit reviewed at the weekly QA Team Reports will be presented to the QA Committee by the Director of and/or Mini Data Set (MDS) Costo ensure corrective action initial appropriate. Any immediate conbe brought to the Director of Nur Administrator for appropriate action Compliance will be monitored at ongoing auditing program review Weekly Quality of Life Meeting. QA Committee meeting is attended Administrator, Director of Nursin Coordinator, Unit Manager, Sup Nurse, Therapy, HIM (Health Info Management), Dietary Manager Nurse. Date of Compliance: 8/11/2022 The statements made on this program review of the correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with all and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility allegations allegating the sallegation of constitutes the facility allegating al	t will be m Meeting weekly of Nursing or tion. Ind weekly ded by high MDS port formation. Wound formation of to and do he the lefederal has take in this orrection.	g rs ill ne	8/18/22
	medications at bedsic Findings included:	le.			orrection	1	

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F 554	Resident #58 was ad 6/20/22 with diagnost stage renal disease at The admission Minim dated 6/26/22 reveals cognitively intact. Physician (MD) order included an order dat (calcium carbonate a give three tablets by review of the medical assessments or orde self-administration of An observation and in with Resident #58 on plastic medication cutablets was observed on the overbed table. Resident #58, she stafter she had already since she was supposhe told MA #1 she was	mitted to the facility on es that included, in part, end and diabetes. The most assessment ed Resident #58 was The swere reviewed and the standard of the standard for the mouth with meals. Further are cord revealed no record revealed for the medications. The mouth with meals are completed for the medications. The mouth with meals are conducted 7/17/22 at 12:16 PM. A per that contained three Tums within the resident's reach During an interview with a medication Aide #1 (MA to her late in the morning reaten her breakfast and sed to take them with meals, would take them with her did not think she had been ity to self-administer		5554		ce: ent n for o n led	
	completed with MA # gave medications, sh resident swallow the the room. MA #1 rec medications to Resid when she attempted	1. She explained when she e typically watched the medication before she left alled she had administered ent #58 on 7/17/22 and said to give the resident the dent told her she wasn't			and Unit Support Nurse, initiated interviews with residents that were cognitively intact with BIMS of 13-15 regarding their desire to self-administer medication. Results: There were no residents who desired to self-administer their medications.	r	

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011141450	270NE HEALTH AND DE	WAR DIVITATION OF NITED		485 VETERAN	IS WAY			
SUMMER	SIONE HEALIH AND RE	HABILITATION CENTER		KERNERSVII	LLE, NC 27284			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 554	Continued From page	∋ 10	F 5	54				
F 334	going to take them at already eaten her bre the medication at the could take them later #58 was ready for the she was not suppose the bedside but thougand Resident #58 did it was okay to leave to later in the day. During an interview with Manager on 7/20/22 when a nurse or medications to a resident swallow the the room. She stated assessed as being all medications and the have left the Tums at The Corporate Nurse at 10:42 AM and stat self-administration as	em at that time since she had er breakfast. MA #1 said she left to the resident's bedside so she later in the day when Resident for them. MA #1 added she knew posed to leave medications at thought since it was "just Tums" 8 did not have a roommate, that have them for the resident to take are with the Long Term Care Unit 10/22 at 9:17 AM, she explained medication aide gave resident, they watched the the medications before they left tated Resident #58 had not been any able to self-administer the medication aide should not at the bedside. Iturse was interviewed on 7/20/22 a stated the facility had on assessments available if a led permission to self-administer		,				
				specific of and/or in requirem Monitorin F554 Qui Director monitor of self-admother me	of correcton is effective and the deficiency cited remains correct to compliance with regulatory ments. In a will be completed using the pality assurance tool. The of Nurses or designee will compliance of the medication ministration process and that not eds are at bedside if the reside the been assessed for	oted		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _				C 21/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS 485 VETERANS V KERNERSVILLI			21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BI I-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 554	Continued From page	÷ 11	F	self-admini- resident roc various day assure com self-admini- Monitoring weeks then resolved fo on self- adr process. Roweekly QA Nursing to initiated as be monitore program re Meeting. TI attended by Nursing, M Manager, F and the Die that are ide process wil facility Qua	stration. Monitoring of 6 cms will be completed on a so of the week and shifts to appliance with the stration of medication policy will be completed weekly x in monthly x 2 months or untile of compliance with facility policy in monthly x 2 months or untile of compliance with facility policy in monitoring the presented to the committee by the Director of the committee of	5 I licy he of	
F 558 SS=D	S483.10(e)(3) The rig services in the facility accommodation of repreferences except wendanger the health of their residents. This REQUIREMENT by: Based on observation	sident needs and when to do so would or safety of the resident or is not met as evidenced ns, resident and staff	F				8/18/22
		ns, resident and staff review, the facility failed to		F558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			1	C / 21/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 07	21/2022
					35 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			ERNERSVILLE, NC 27284		
				<u> </u>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page	F 5	558				
	for the resident to req needed for 2 of 5 resi	light within reach to allow uest staff assistance if dents (Resident #65 and ed for accommodation of			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.	do	
	Findings included:				To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this		
	1. Resident #65 was admitted to the facility on 7/3/18 with diagnoses that included, in part, chronic obstructive pulmonary disease and hypertension.				plan of correction. The plan of correction constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be	on	
	The annual Minimum				corrected by the dates indicated.		
	had moderately impa	B/22 revealed Resident #65 ired cognition. She required with bed mobility and was			Corrective action for resident(s) affected by the alleged deficient practic	ce:	
	totally dependent for	assistance with transfers.			On 08/10/2022, the Director of Nurses (DON) initiated an observation of		
	included a focused ar	eare plan, updated 7/18/22, rea of risk for falls. A care uded, "ensure that call light is			resident⊡s rooms. The call device was reach of resident #41.	s in	
	within reach."	·			On 08/10/2022, the DON initiated an observation of resident s rooms. The	call	
		The call light was on the			device was in reach of resident #65.		
	the cord was draped nightstand. During a	t of the resident's bed and over the side of the n interview with Resident 0 PM, she reported she was			Corrective action for residents with t potential to be affected by the alleged deficient practice.	ne	
	staff came into the ro	ble to reach the call light and stated when came into the room she told them to put the light cord within her reach.			All residents have the potential to be affected by this alleged deficient practi On 08/10/2022 the DON initiated walki rounds to audit 100% of all resident room	ng	
	at 4:18 PM, she was light was observed be underneath her pillow	n of Resident #65 on 7/18/22 awake and in bed. The call whind the resident and of Upon interview with 1/22 at 4:19 PM, she said			for reachable access to a call device. A residents who didn't have their call devin reach, had their call device placed within their reach.	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING				
		345039	B. WING		C 07/21/2022		
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE	0112112022		
				485 VETERANS WAY			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 558	Continued From page	e 13	F 558	3			
	she could not reach t	he call light since it was		3. Measures /Systemic changes to			
	behind her and under	neath her pillow.		prevent reoccurrence of alleged defici	ent		
				practice:			
	An interview was com	npleted with Nurse #13 on					
	7/21/22 at 2:12 PM, d	luring which she stated		On 08/18/2022, the DON initiated			
	Resident #65 used he	er call light and made her		observation rounds that will be comple	eted		
		She explained when she		by Nurse managers and department			
	•	she left a resident's room,		managers and include observation of			
		all light was within reach of		devices to ensure they are in reach of			
	the resident or clipped to the resident's bed or clothing.			residents for accommodation of needs	3.		
				0 00/40/0000 # 5014 104 #			
	, .			On 08/10/2022, the DON and Staff			
		vith the Interim Director of		Development Coordinator (SDC) bega			
	staff were educated the	21/22 at 2:56 PM, he stated		education of all full time, part time, PF licensed nurses (Registered Nurses a			
	supposed to be in rea	_		Licensed Practical Nurses), Medication			
	Supposed to be in rea	deri of the residents.		Aides, and Certified Nursing Assistant			
	2 Resident #41 was	admitted to the facility on		(CNA) including agency staff on facilit			
		s that included, in part,		policy of assuring that residents have	,		
	diabetes and hyperte			reachable access to a call device use	d to		
	,,			notify staff when they need assistance) .		
		ssessment dated 6/17/22					
		1 had severely impaired		This information has been integrated	nto		
		red extensive assistance		the standard orientation training and	.		
	· ·	was totally dependent for		agency orientation for all staff identifie			
	assistance with trans			above and will be reviewed by the Qu	ality		
	-	care plan, updated 6/3/22,		Assurance process to verify that the			
		rea of activities of daily living.		change has been sustained.			
	to use call light to call	on included, "encourage me		Any staff identified above who does n	ot		
	to use can ngin to can	า เดา ผิวอเอเตเเดษ.		receive scheduled in-service training			
	│ │On 7/17/22 at 12·46 □	PM, Resident #41 was		not be allowed to work until training ha			
		The call light cord was in		been completed by 08/18/2022.	-		
				22311 30111p13133 3 y 00/10/2022.			
	the nightstand drawer to the left of the resident's bed and the push button hung outside of the		4. Monitoring Procedure to ensure that	t the			
		1 attempted to reach the call		plan of correction is effective and that			
		out was unable to reach over		specific deficiency cited remains corre			
	far enough to push th			and/or in compliance with regulatory			
		•		requirements.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345039	B. WING _				C / 21/2022	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		48	TREET ADDRESS, CITY, STATE, ZIP CODE 35 VETERANS WAY ERNERSVILLE, NC 27284	<u> </u>	21/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 558	During an observation at 9:39 AM, she was simple conversation. draped over the night #41 demonstrated she call light. An interview was con 7/21/22 at 11:35 AM, Resident #41 used henceds known to staff responsibility of the might within reach of the finished providing call During an interview with 7/21/22 at 2:56 PM, he	in of Resident #41 on 7/19/22 in bed and engaged in The call light was observed distand drawer and Resident e was unable to reach the inpleted with Nurse #7 on during which she stated er call light and made her is She explained it was the urse aides to place the call he resident when they were re. with the Interim DON on he stated staff were hts were supposed to be in	F	558	Quality assurance audits will be completed by the Director of Nurses or designee to monitor the that residents able to access a reachable call device request staff assistance using the F558 Quality Assurance Tool. Monitoring of resident rooms will be completed on various days of the week and shifts to assure compliance with the call bell po Monitoring will be completed weekly x weeks then monthly x 2 months or untiresolved for compliance with facility po on call bell process. Reports will be presented to the weekly QA committee the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitor and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.	are to 3 6 licy. 5 I licy by		
F 561 SS=D	§483.10(f) Self-detern The resident has the promote and facilitate through support of re		F 5	561	Date of Compliance: 08/18/2022		8/18/22	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER STONE HEALTH AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 485 VETERANS WAY KERNERSVILLE, NC 27284	•	111111111111111111111111111111111111111		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN (((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 561	activities, schedules waking times), heal care services consists assessments, and papplicable provision §483.10(f)(2) The rechoices about aspet facility that are sign §483.10(f)(3) The rewith members of the community activities facility. §483.10(f)(8) The reparticipate in other religious, and comminterfere with the rigitality. This REQUIREMENT by: Based on record reinterviews, the facilic choice to receive a	his section. esident has a right to choose is (including sleeping and the care and providers of health istent with his or her interests, plan of care and other is of this part. esident has a right to make cots of his or her life in the ifficant to the resident. esident has a right to interact the community and participate in is both inside and outside the esident has a right to activities, including social, inunity activities that do not aphts of other residents in the interest in the i	F		n this plan of nission to and do ent with the remain in al and state s taken or will			
	Resident #35 was admitted to the facility on 6/3/22 with diagnoses of, in part, depression, pressure ulcer to sacral region and neuromuscular dysfunction of bladder. An admission Minimum Data Set assessment dated 6/8/22 revealed Resident #35 had intact			correction. The plan of co constitutes the facility so compliance such that all deficiencies cited have be corrected by the dates in F561	orrection allegation of alleged een or will be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						(С		
		345039	B. WING _			07/	/21/2022		
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE				
CUMMED	STONE HEALTH AND D	FUADU ITATION CENTED		48	35 VETERANS WAY				
SUMMERS	SIONE HEALIH AND RI	EHABILITATION CENTER		K	ERNERSVILLE, NC 27284				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY 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)		(X5) COMPLETION DATE		
F 561	Continued From pag	e 16	F 5	61					
1 001				ן י טכ					
		ed extensive assistance of 2			4				
	-	and minimum assistance for			Corrective action for resident(s)				
	bathing. Resident #3	5 was non-ambulatory.			affected by the alleged deficient praction	e:			
	A review of the care	plan dated 6/23/22 revealed			A corrective action was obtained when				
		of daily living self-care			resident #35 received a shower on				
		elated to deconditioning and			07/21/2022. On 08/13/2022, resident	was			
	interventions for help	with activities of daily living.			interviewed on his preferences for his				
					shower. Resident□s preferences were	;			
		er schedule for Resident #35			updated in the resident□s task.				
	revealed he was to receive a shower on Sunday								
	and Tuesday on 7PN	∕I-7AM shift.			Corrective action for residents with				
					the potential to be affected by the alleg	ed			
		AM, an interview was			deficient practice.				
		dent #35. He stated he had							
		ice he was admitted on			All residents have the potential to be				
		vas dirty and needed to be			affected by the alleged deficient praction	e.			
		ney tried to give hm one / dizzy when he sat up and			On 09/12/2022 the Registered Nurse				
		nto the bed. He stated he			On 08/13/2022 the Registered Nurse Supervisor (RN) completed resident				
		y using a shower stretcher or			interviews on 100% of all current				
		ailable. He stated he had			residents to identify if they have a				
	received bed baths.	allable. He stated he had			preference of when they wished to take	_			
	received bed batilis.				their shower. Any residents who	•			
	On 7/20/22 at 8:45 A	M an interview was			requested a preference of when they				
		ing Assistant (NA) #2. She			wished to be showered had their task				
		ith Resident #35 on 7/17/22			updated to reflect their preference. Th	is			
		a shower because the			was completed on 08/13/2022.	-			
	resident was unable								
		•			3. Measures /Systemic changes to				
	On 7/20/22 at 8:53 A	M, an interview was			prevent reoccurrence of alleged deficie	nt			
		3. She stated every room had			practice:				
		he facility did not have a			On 08/12/2022, the Quality Assurance				
	shower stretcher. NA#3 added there was at least one other resident that was unable to sit up and			Nurse Consultant educated the Director	r of				
				Nurses (DON) on residents right to					
	used a reclining whe	elchair to receive a shower.			choose when they wish to shower. This	3			
					education included how to update the				
	On 7/21/22 at 10:51	AM, the Director of Nursing			resident record to reflect their preferen	ce.]]		
	(DON) was interview	ed. He stated if a resident			On 07/25/2022, the DON and the Staff				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING				24/2022	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		485 VET	ADDRESS, CITY, STATE, ZIP CODE ERANS WAY RSVILLE, NC 27284	<u>ı 077.</u>	21/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY THE PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE				
F 561	sit up to receive a sh be notified so alterna residents can receive just because there w facility the reclined, of appropriate for Resid therapy might need to the appropriate chair	rn where they were unable to ower, management should tes could be put in place so e showers. He added that as another wheelchair in the	F	educeneed Reg Pracenurs agel inclustres inclustres inclustres above provential Qual the component of the provential Region of the province of the provential Region of the province of	relopment Coordinator (SDC) begandation of all full time, part time, as ded (PRN) licensed nurses, gistered Nurses (RN) and Licensed ctical Nurses (LPN) and certified sing assistants (CNA s), including ncy staff on self-determination auding resident preferences of when wish to shower and promoting dents rights. Inservice was incorporated in the endough employee facility orientation for the employee and also wided to agency staff working in the lity. This will be reviewed by the fallity Assurance process to verify the end of the employee facility orientation. It staff who does not receive schedule ervice training will not be allowed to be allowed to extend the employee facility and	e led by lat hat cted cour to		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING				0
NAME OF D	20//050 00 01/00/150	343033	B. WING		TREET ARRESTO OFFICE TIP CORE	07/	21/2022
	ROVIDER OR SUPPLIER STONE HEALTH AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	÷ 18	F	561	appropriate. Compliance will be monito and the ongoing auditing program reviewed at the weekly Quality Assuran Meeting. The weekly QA Meeting is attended by the Administrator, Director Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/18/2022	of	
F 580 SS=J	CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the reside consistent with his or representative(s) whee (A) An accident involveresults in injury and h physician intervention (B) A significant changemental, or psychosoc deterioration in health status in either life-thr clinical complications (C) A need to alter tre a need to discontinue treatment due to advectommence a new for (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent information	cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident on there is- ring the resident which as the potential for requiring i; ge in the resident's physical, ial status (that is, a i, mental, or psychosocial eatening conditions or i; atment significantly (that is, an existing form of erse consequences, or to m of treatment); or esfer or discharge the	F	580	Date of Compliance: 06/18/2022		7/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _		07/21/2022	
	ROVIDER OR SUPPLIER STONE HEALTH AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 485 VETERANS WAY KERNERSVILLE, NC 27284	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETI HE APPROPRIATE DATE	ON
F 580	resident and the resident and the resident there is- (A) A change in room as specified in §483 (B) A change in resistate law or regulat (e)(10) of this sectic (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a come that is a composite §483.5) must disclose its physical configur locations that compert, and must spectroom changes betwounder §483.15(c)(9). This REQUIREMENT by: Based on record repractitioner, and Metacility failed to notif laboratory results. It was critically low at on 07/14/22 and critically low at on 07/15/22 through lawere not acted on be continued, and no fid one. This deficier residents reviewed (Resident #46). Immediate jeopardy	t also promptly notify the sident representative, if any, m or roommate assignment 8.10(e)(6); or ident rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and e resident posite distinct part. A facility distinct part (as defined in see in its admission agreement ration, including the various rise the composite distinct bify the policies that apply to reen its different locations	F	The statements made on the correction are not an admissed not constitute an agreement alleged deficiencies. To remain in compliance with and state regulations the factor will take the actions set for plan of correction. The plan constitutes the facility sall compliance such that all alledeficiencies cited have bee corrected by the dates indictivated.	sion to and do t with the th all federal cility has taken orth in this of correction egation of eged n or will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING			C 07/21/2022		
NAME OF D	ROVIDER OR SUPPLIER	04000	1		FREET ADDRESS, CITY, STATE, ZIP CODE	1 077	21/2022	
NAME OF FI	NOVIDER OR SUFFLIER				, , ,			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			S VETERANS WAY			
				KI	ERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page	⊋ 20	F 5	580				
F 580	results resulting in the notification and was resulting in the facility provided a allegation of compliance at actual harm with pote harm that is not immer monitoring and all stars. The findings included Resident #46 was reary 12/22 with diagnost fracture and insulined He was prescribed in sugar checks during. A hospital discharge included an order for units daily (long-actin bloodstream in 2-4 hot time and can last up blood sugar test strip times daily as directe summary dated 7/12/draw a complete bloometabolic panel (BMI hormone (TSH) on 7/Resident #46's blood a critical low blood sumilligrams/deciliter (non/dl). Per laborator	e lack of physician removed on 7/21/22 when an acceptable credible rice. The facility will remain a scope and severity D (not ential for more than minimal ediate jeopardy) to ensure aff have been in-serviced. I: admitted to the facility on resincluding Covid, left hip rependent diabetes mellitus. Sulin with regular blood previous admission. summary dated 7/12/22 long-acting basal insulin 20 g means insulin enters ours from administration to 24 hours in the body) and as to check blood sugars four d. The hospital discharge (22 also included an order to red count (CBC), basic P), and thyroid stimulating (13/22). work dated 7/14/22 showed agar value of 37 mg/dl) (normal level 70-99	F 5	580	 Corrective action for resident(s) affected by the alleged deficient practic Resident #46 is deceased therefore no corrective action was required. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected. On 07/19/2022, the Nurse Consultant completed an audit of 100% of all curreresident slab values to identify if there were any alert lab values that were not communicated to the Nurse Practitione or Medical Provider for the last 60 days. The audit revealed eleven alert lab values were reviewed. Six alert lab values had provider notification upon receipt. The Director of Nurses and the Assistant Director of Nurses immediately notified the Medical Director and Individual providers on 07/20/2022 of the five required alert lab values that were not previously communicated at the time of the lab results. Measures/Systemic changes to previously communicated deficient practic Education: On 7/19/2022 the Director of Nurses and Assistant Director of Nurses began in 	he ent e er s. ues d		
	facility staff about this was released to the efaxed to the facility or	s critical value.This result electronic medical record and			Assistant Director of Nurses began in servicing of all licensed nurses (full tim part time, and prn including agency nurses) on Critical Labs and changes is condition including critical labs or signs/symptoms of hypoglycemia. Staf	n		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _				C 21/2022
NAME OF PI	ROVIDER OR SUPPLIER	<u>l</u>	1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 011	21/2022
					85 VETERANS WAY		
SUMMERS	STONE HEALTH AND RI	EHABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From pag	e 21	F 5	580			
	revealed there was r physician was notifie sugar on 7/14/22.	o documentation the d of the critically low blood			were educated on how critical labs are received, to promptly notify the physici and/or on call of all critical labs, documnotification in the electronic record, an	an nent	
	blood work was draw	#46's MAR showed that /n again on 7/15/22 and there on that it was done on			notify the resident and RP of changes condition including critical labs or signs/symptoms of hypoglycemia.		
	dated 7/15/22 showed of 25 mg/dl. Per repo- called Nurse #9 on 7 technician #1. This re	atory results for the BMP and a critical low blood sugar ort, this critical result was 1/15/22 at 5:02pm by lab result was released to the cord and faxed to the facility m.			This information has been integrated in the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quaranse process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training what has been allowed to work until training has been sustained.	d ality ot vill	
	revealed there was r physician was notifie sugar on 7/15/22. During an interview v 7/19/22 at 2:47 pm, I	al record for Resident #46 to documentation the d of the critically low blood with lab technician #1 on the stated that he was never member on 7/14/22 to relay			been completed by 07/22/2022. 4. Monitoring Procedure to ensure that plan of correction is effective and that specific deficiency cited remains corre and/or in compliance with regulatory requirements.	t the	
	7/15/22 and informed level of 25 (mg/dl), a of 37 (mg/dl) at that the was unable to reaper the laboratory poresults to the facility's would continue to tryphone. During an interview was 19:45 am, he stated the ever receiving a photograph of the property	but did reach Nurse #9 on d him of the current critical is well as the previous result ime. He also stated that, if inch a staff member by phone, licy, he would release the is system to be flagged and it to reach the facility by with Nurse #9 on 7/19/22 at inat he had no recollection of the call from the lab regarding Resident #46. When asked			Quality assurance audits will be completed by the Director of Nurses of designee to monitor that notification of changes is being completed for critical results using the F580 Quality Assurar Tool. Monitoring of 100% of the critical lab results will be completed weekly to assure compliance with notification of changes. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance with facility policy on notification of changes. Reports will be presented to weekly QA committee by the Director of	lab nce I e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			1	C 21/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	21/2022
					B5 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			ERNERSVILLE, NC 27284		
				K	ERNERSVILLE, NC 2/204		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 22	F 5	580			
F 380	about critical lab result contact the on-call promay be needed, and the results in the doct sign off on when they He again stated that any phone calls about 7/15/22. During an interview wo 7/19/22 at 3:35 pm, the fortical lab results of She stated that she would be be stated that she would be stated that she would levels for Reside phone number to contavailable 24 hours at with immediate verbated folder where the staff reports for her to revistacility. She also stated facility on 7/18/22 and in her folder for her to 100 During an interview wo 7/19/22 at 5:02 pm, the him of critical lab results of critical lab results of 15/22. He stated the him or whomever was 24 hours a day. He as immediate verbal not where the staff will pureports for him or his visit to the facility. The Administrator was jeopardy on 7/20/22 at 22/20/22 at 22/20/20 at 24/20/20 at 24/20/	alts, he stated he would ovider, get any orders that then place a printed copy of tor's folder for him/her to a come into the facility next. The did not recall receiving it any critical results on the state surveyor notified her from 7/14/22 and 7/15/22. The area not aware of any critical dent #46. She stated the stact the on call doctor was day. She also stated, along all notification, there was a will put any critical lab value ew upon next visit to the ed that she was in the did there were no critical levels or review. With the Medical Director on the state surveyor notified aults from 7/14/22 and the phone number to contact as on call for him is available also stated, along with a stated along with a state or review upon next was a folder at any critical lab value staff to review upon next staff to review up		580	Nursing to ensure corrective action is initiated as appropriate. Compliance we be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 07/22/2022	of ,	
		a credible allegation of emoval dated 7/20/2022.					

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 21/2022		
	ROVIDER OR SUPPLIER	HABILITATION CENTER		485 VE	ET ADDRESS, CITY, STATE, ZIP CODE ETERANS WAY IERSVILLE, NC 27284				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 580	Continued From page	e 23	F 5	80					
	Credible Allegation of removal:	f immediate jeopardy							
		nts who have suffered, or serious adverse outcome as mpliance.							
	is no longer a resider On 07/19/2022, the Nan audit of 100% of a values to identify if the that were not communicationer or Medical days. The audit reverse were reviewed. Six a notification upon receand the Assistant Direction of the Medical Exproviders on 07/20/20 lab values that were communicated at the	Jurse Consultant completed all current resident's lab ere were any alert lab values nicated to the Nurse al Provider for the last 60 aled eleven alert lab values lert lab values had provider eipt. The Director of Nurses ector of Nurses immediately Director and Individual 022 of the five required alert not previously time of the lab results.							
	process or system fa	ne entity will take to alter the ilure to prevent a serious on occurring or reoccurring will be completed.							
	all licensed nurses (findluding agency nursure educated on ho to promptly notify the all critical labs, docur	Nurses began in servicing of ull time, part time, and prn ses) on Critical Labs. Staff w critical labs are received, physician and/or on call of nent notification in the							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345039	B. WING			l	21/2022
NAME OF PR	ROVIDER OR SUPPLIER	3.0000		s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	21/2022
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			85 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	has not completed the 7/19/2022, will not be critical lab training is a in-service will be incomployee facility orient facility and agency lice the DON was notified ensure the critical lab incorporated into the orientation program for licensed staff by the COD Date of IJ removal 7/2. The credible allegation removal was verified onsite validation through the condition, and "Previous and "Previous and "Previous for contous validate in-service symptoms of hypogly notification regarding DON, assistant DON, corporate nurse met of assessed all current resigns and symptoms assessment, no current having any signs and The immediate jeopat 7/21/22.	that any licensed staff who e in-service training on allowed to work until the completed. The critical lab rporated into the new intation program for both ensed staff. On 7/19/2022, of the responsibility to in-service will be new employee facility or both facility and agency clinical Nurse Consultant. 21/2022 In of immediate jeopardy on 7/21/22 as evidenced by ugh record review, and staff of facility in-service materials ucation", "Changes in renting Errors on Admission" intent. Staff were interviewed completion on signs and cemia and physician critical lab results. The the floating DON, and the with all floor nurses and residents to identify any of hypoglycemia. Per their ent residents were identified symptoms of hypoglycemia. rdy was removed on		580			
F 584 SS=B	CFR(s): 483.10(i)(1)-6 §483.10(i) Safe Envir	onment.	F	584			8/18/22
	The resident has a rig	ght to a safe, clean,					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345039	B. WING		07/21/2022	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 584	but not limited to resupports for daily li The facility must pr §483.10(i)(1) A saf homelike environm use his or her pers possible. (i) This includes en receive care and se physical layout of t independence and (ii) The facility shal the protection of th or theft. §483.10(i)(2) Hous services necessary and comfortable in §483.10(i)(3) Clear in good condition; §483.10(i)(4) Priva resident room, as s §483.10(i)(5) Adeq levels in all areas;	comelike environment, including eceiving treatment and ving safely. covide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the he facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss ekeeping and maintenance of to maintain a sanitary, orderly,	F 584			
	1990 must maintain 81°F; and §483.10(i)(7) For the sound levels.	n a temperature range of 71 to ne maintenance of comfortable NT is not met as evidenced				

AND PLAN OF CORRECTION IDEN	TIFICATION NUMBER:	A. BUILDIN	NG	COMF	SURVEY PLETED
	345039	B. WING			C / 21/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07	12112022
			485 VETERANS WAY		
SUMMERSTONE HEALTH AND REHABILITA	ATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTICAL STATEMENT OF THE PREFIX O	PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		ILD BE	(X5) COMPLETION DATE
Based on observations and reinterviews, the facility failed to environment for 1 of 3 rooms and 300 hall (Room 321) and failed clean living environment for 2 (Resident #8 and Resident #5 environment. The findings included: 1. Resident #35 (Room 321) of facility on 6/3/22. On 7/17/21 at 12:16 PM, an of Resident #35's room revealed 1 walker, 1 oxygen concentrated linens were thrown over a chast the shelving area contained seitems that were placed there in the nightstand contained multion other items that did not appear. On 7/17/21 at 12:16 PM, during Resident #35, he agreed his reand was like that since he morroom. He added one wheelched did not use oxygen and did not oxygen concentrator was in his conducted with Housekeeper did not put items away in the resident was in the resident was sistants were responsed on 7/19/22 at 10:15 AM, an inconducted with NA #3 who states assistants should put the residence way on admission and remove	provide a homelike reviewed on the d to maintain a of 8 residents 8) reviewed for was admitted to the beservation of d two wheelchairs, for in the room. Bed in across the room, reveral personal person	F 5	The statements made on this plan correction are not an admission to not constitute an agreement with a alleged deficiencies. To remain in compliance with all fe and state regulations the facility hor will take the actions set forth in plan of correction. The plan of corconstitutes the facility allegation compliance such that all alleged deficiencies cited have been or with corrected by the dates indicated. F584 1. Corrective action for resident(s) affected by the alleged deficient pon 8/1/2022, the privacy curtains residents #8 and #58 were removered awith clean privacy curtain housekeeping staff. Also the room resident #35 was emptied of all its related to the resident scare. The was then cleaned to include sweet mopping of floor, cleaning of the nightstand, over bed lighting and windowsills. 2. Corrective action for residents were potential to be affected by the alledeficient practice: 100% audit of all rooms in the factor completed by the administrative seed 11/2022 to ensure that all rooms free of clutter and cleaned accord policy. Any rooms not cleaned prowere reported to Environmental Deficient practice.	and do ne deral s taken his ection of be actice: or d and s by the of ms not room bing and were ng to perly	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE COMP	SURVEY LETED
		345039	B. WING			C 07/21/2022	
NAME OF D	DOVIDED OD SLIDDLIED	343003	1	CTREET ADDRESS CITY STATE ZID CODE		07/	21/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY			
	-	-		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 584	Continued From page	e 27	F 5	84			
	2. Resident #8 was a 1/24/22. The quarter assessment dated 5/5 was cognitively intact. An observation of Re at 11:46 AM revealed bottom half of the privacy curtain half t	admitted to the facility on ly Minimum Data Set 5/22 indicated Resident #8 sident #8's room on 7/17/22 dark colored stains on the vacy curtain. with Resident #8 on 7/17/22 d she wasn't sure how long id been stained and added, enough."		3. Measures/Systemic change reoccurrence of alleged deficie Education: All housekeepers were re-educe Environmental Director by 8/1/cleaning rooms according to the Housekeeping Guidelines policy. The Environmental Director or will complete weekly audits using Housekeeping QA Audit Tool to that resident rooms are being according to policy. 4. Monitoring Procedure to ensiplan of correction is effective a specific deficiency cited remain and/or in compliance with regu	cated by 2022 on the General Cy. designed ing the colleaned cleaned cleaned corrections are that that the corrections are corrections.	ce: the al e	
	curtain. During an interview w 7/21/22 at 2:30 PM, s cleaned residents' roo of the privacy curtains soiled, she removed s laundry to be washed privacy curtains in the hung up if a resident's sent to the laundry de On 7/21/22 at 2:01 Pl Resident #8's privacy	oms she made observations and if they were stained or the curtain and sent it to the said there were extra a laundry room that could be curtain was stained and epartment.		requirements. This Housekeeping QA Audit T completed weekly reviewing 2 each hall to identify any rooms not been cleaned according to This above audit will be completimes 4 weeks then monthly tir months or until resolved by Qu Assurance (QA) Committee. R be presented to the monthly Q committee by the Administrato Environmental Services Direct corrective action was initiated appropriate. Compliance will be and ongoing auditing program the monthly QA Meeting. The incomplete in the complete i	rooms on that have policy. The policy policy policy policy policy and the policy polic	n re ekly ill ure red d at	
	interview with the Env Director on 7/21/22 a housekeeping staff w	vironmental Services		Meeting is attended by the Adr Director of Nursing, MDS Coor Support Nurses, Therapy, HIM Dietary Manager.	ministrato dinator,		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345039	B. WING _				C 21/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	L I/LVLL
				4	85 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	e 28	F 5	584			
F 584	cleaned residents' roo observed to be stained housekeeper remove the laundry to be was in the resident's room Services Director con- were present on the p #8's room and said si the curtain and sent in to be cleaned. An interview was con- Administrator on 7/21 privacy curtains should cleaned as needed. 3. Resident #58 was 6/20/22. The admiss assessment dated 6/2 #58 was cognitively in An observation of Ref 7/17/22 at 12:16 PM on the bottom half of During an interview was at 12:17 PM, she said that the privacy curtal since she was admitting	oms. If the curtain was ed or soiled, the d the curtain and sent it to shed and then hung back up in. The Environmental offirmed dark colored stains privacy curtain in Resident taff should have removed it to the laundry department in laundry department in the laundry department	F	584	Date of Compliance: 8/18/2022		
		22 at 2:10 PM revealed dark bottom half of the privacy					
	7/21/22 at 2:30 PM, s cleaned residents' ro	vith Housekeeper #2 on she shared when she oms she made observations s and if they were stained or					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING		C 07/21/2022	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	VII 11 2022	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 584	laundry to be washed privacy curtains in the	e 29 the curtain and sent it to the l. She said there were extra e laundry room that could be s curtain was stained and	F 58	34		
	on 7/21/22 at 2:10 Pl Resident #58's privace with the Environment an interview with the Director on 7/21/22 at housekeeping staff we observations of the procleaned residents' roo observed to be stained housekeeper removes the laundry to be was in the resident's room Services Director con were present on the process.	M an observation of cy curtain was completed al Services Director. During Environmental Services t 2:12 PM, he said ere responsible to make rivacy curtains when they oms. If the curtain was ed or soiled, the d the curtain and sent it to shed and then hung back up in. The Environmental firmed dark colored stains privacy curtain in Resident staff should have removed t to the laundry department				
F 641 SS=D	Administrator on 7/21 privacy curtains shou cleaned as needed. Accuracy of Assessm CFR(s): 483.20(g) \$483.20(g) Accuracy	./22 at 3:29 PM. He said ld be free of stains and nents	F 64	.1	8/11/22	
	resident's status. This REQUIREMENT by: Based on record revi	is not met as evidenced iew and staff interviews, the ately code the Minimum		The statements made on this Plan of Correction are not an admission to and	d do	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345039	B. WING _			C 07/21/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	21/2022
				4	85 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 641	1 Continued From page 30		F	641			
	Data Set (MDS) asses weight loss and medireviewed (Resident # The findings included 1. Resident #15 was 4/1/122 with diagnose congestive heart failure The Admission Nursing revealed Resident #1 was 272.4 pounds. A medical record revieweights for Resident # 4/9/22 271.6 6/10/22 236.8 A quarterly MDS date #15 had moderately independent with med 238 pounds. The MD loss.	ssment in the areas of cations for 2 of 33 residents 15 and Resident #24). : admitted to the facility on es of, in part, edema, re and dementia. Ing Assessment dated 4/1/22 5 's weight on admission ew revealed the following #15: ad 5/13/22 revealed Resident impaired cognition, was als after set up and weighed S was code "No" for weight		041	not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or witake the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date of dates indicated. F641 ACCURACY OF ASSESSMENTS Corrective Action: Resident # 15: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [5/13/2022] was modified. Resident # 24: Resident Minimum Data Set (MDS) assessment (Admission Assessment,) with Assessment /Reference Date (ARD) [5/27/2022] was modified.	f r S a	
	interviewed. She state	M, the MDS Nurse was ed she didn ' t code the she didn ' t think the weight			modified. Identification of other residents who may be involved with this practice: All current residents who have weight I of 5% or more in the last month or loss	oss	
	their intent was to ens was coded appropriat	irector of Nursing. He stated sure the MDS assessment			10% or more in last 6 months and all current residents who receive medicati administered subcutaneously during the Mini Data Set (MDS) 7 day look back for assessment reference date(s) have the potential to be affected by the alleged practice.	ons e or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245020	B. WING		C		
NAME OF B	201/1252 02 01 1251 155	345039	B. WING _		•	1/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS WAY			
				KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From page	e 31	F 6	641			
		tive diagnoses included t did not have a diagnosis of		On 8/10/2022 through 8/1 was completed by Mini Da Nurse Consultant to revie Data Set (MDS) assessm	ata Set (MDS) w all Minimum		
	revealed his medicat milligrams (mg) / 0.4 (a medication which rheumatoid arthritis) time a day every 14 of 5/24/22. A review of Medication Administratevealed the resident adalimumab on 5/24/medication order. The indicate the resident Resident #24 's administration or the resident resident resident #24 's administration or the resident	injected subcutaneously one days with a start date of Resident #24 's May 2022 ation Record (MAR) received one injection of 22 in accordance with the me May 2022 MAR did not received insulin.		months to ensure that all who have weight loss of 5 the last month or loss of 1 last 6 months were coded section K0300:Weight los Data Set (MDS) .Out of a assessments, 3 assessmendified to reflect accurat Section K0300 Weight los assessments were modificationaccuracy. On 8/10/2022 8/11/2022 an audit was composed months with the Minimum Data Set (MDS)	current residents 5% or more in 10% or more in I correctly in s of the Mini total of 94 ents were te data for ss. 3 MDS ed due to 2 through completed by the or review all assessments in		
	received one injection 7-day look back period Resident #24 received this 7-day look back An interview was con	reported the resident of any type during the od. The MDS also indicated of one insulin injection during period. Inducted on 7/19/22 at 3:07 of MDS Nurse. During the		the last 3 months to ensure residents receiving medic administered subcutaneous corrected in Section N035 Mini Data Set (MDS). 0 cassessment were modified inaccuracy. This was come 8/11/2022.	ations usly were coded 50:Insulin of the of MDS d due to		
	the Medication section admission MDS date both the resident 's Inurse stated, "It (the He did not receive instrument of the confirmed Resident indicated he received." An interview was confirmed section.	Jurse was asked to review on of Resident #24 's d 5/27/22. Upon review of MDS and his EMR, the MDS injection) was (adalimumab). Sulin." The MDS nurse #24 's MDS should not have an injection of insulin. Inducted on 7/21/22 at 3:00 Interim Director of Nursing		Systemic Changes: On 8/11/2022 The Registe Minimum Data Set (MDS) and MDS Support nurse a Interdisciplinary team mel participates in the MDS as process was in serviced // Director of Nursing. The education focused or	OCOORDINATOR OCOORDINATION OCOORDI		
	(DON). During the in	terview, the inaccuracy of t #24 's medication was		must ensure that each as accurately reflects the res	sessment		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _				21/2022	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	0772	21/2022	
TO WILL OF TH	TO VIDER OR GOLF EIER				/ETERANS WAY			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	F 641 Continued From page 32 discussed. When asked, the Interim DON stated, "It is our intent to ensure the MDS is coded		F 6	S	Section N: 0350 insulin. Insulin injection Record the number of days that insulin			
	discussed. When asked, the Interim DON stated,			Find de la	Record the number of days that insulin njections were received during the last days or since admission/entry or reentress than 7 days. Review the resident needication administration records for the days look-back period (or since admission/entry or reentry if less than a days). Determine if the resident receive nsulin injections during the look-back period. Count the number of days insulingections were received and/or insulingections were received and/or insulinged and the last nonth or loss of 5% or more in the last nonth or loss of 10% or more in last 6 months. 5% weight loss in 30 days; Stay with the resident weight closest to 30 days ago and multiply it by .95 (or 95%) The resulting figure represents a 5% lower than the resulting figure, the resident as lost more than 5% body weight. 10 weight loss in 180 days. Start with the resident weight closest to 180 days and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 90%). The resulting figure represents a 10% loss and multiply it by .90 (or 9	y if sne red in art 0). ss rent % ago		
				a n	Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receives.			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUC		(X3) DATE COMP	
		345039	B. WING			07/	21/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER	-1	485 VETERA	RESS, CITY, STATE, ZIP CODE ANS WAY VILLE, NC 27284	1 0111	L 1/2022
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F 641	Continued From page	e 33	F	work ur informated standal required all emp Quality the charman department of the content of the	ice training will not be allowed to ntil training is completed. This ation has been integrated into the rd orientation training and in the rd in-service refresher courses for loyees and will be reviewed by the Assurance Process to verify that ange has been sustained. Tring: The Director of grand/or Administrator will review at electronic medical records arm Data Set (MDS) assessment and be either one of the following sments Admission, Annual or refly Assessment to ensure that an N: 0350 Insulin and Section Weight Loss is coded accurately all be done on weekly basis for 4 then monthly for 3 months. The of this audit will be reviewed at a QA Team Meeting. Reports will ted to the weekly QA Committee ector of Nursing and/or Mini Data DS) Coordinators to ensure give action initiated as appropriate mediate concerns will be broughed at the Weekly Quality of Life go. Weekly QA Committee meeting and ongoing auditing programed at the Weekly Quality of Life go. Weekly QA Committee meeting and ongoing auditing programed at the Weekly Quality of Life go. Weekly QA Committee meeting and Management, Director of gramman and programment action. Compliance will red and ongoing auditing programment action. Unit Management, Director of gramman and programment action. Director of gramman action, Director of gramman action. Director of gramman action, Director of gramman action	e or the at v 5 y. the be by a e. at to r be im	

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 07/21/2022	
NAME OF PI	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE		V	
				485 VETERANS WAY			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		
F 641	Continued From page	e 34	F 64				
F 658 SS=E	Services Provided Me CFR(s): 483.21(b)(3)	eet Professional Standards (i)	F 6	Date of Compliance: 8/11/202 ²	1	8/18/22	
	as outlined by the commust- (i) Meet professional This REQUIREMENT by: Based on observation and facility record revaccurately transcribe for 1 of 6 residents (Formedications administ observations. The transpirint ablets instead period of 15 days. The findings included Resident #24 was ad 5/21/22 from a hospit diagnoses included a fractures. A review of the resides Summary included a This list included the Enteric Coated (EC) and to the content of the recommendation.	d or arranged by the facility, imprehensive care plan, standards of quality. Is not met as evidenced ins, staff interviews, hospital views, the facility failed to a medication order identified desident #24) reviewed for ered during the med pass anscription error resulted in the facility over a standard for the facility over a standard for the facility on		The statements made on this correction are not an admission not constitute an agreement walleged deficiencies. To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility sallegate deficiencies cited have been of corrected by the dates indicated. F658 1. Corrective action for reside affected by the alleged deficient A corrective action was obtained resident #24 on 07/20/2022, waspirin order was corrected. The Practitioner was made aware of alleged deficient practice by the Support Nurse on 07/20/2022. 2. Corrective action for reside	in to and of the correction ation of ed or will be ed. Int(s) int practice ed for when the her Nurse of the ed.	en n	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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	Continued From pag were dated 5/21/22. 81 mg EC aspirin tak mouth two times a dwith a start date of 5 (scheduled for admir 5:00 PM daily). The days or 6 weeks after order was also input Electronic Medical Rone - 81 mg EC aspir by mouth one time a start date of 7/3/22. The resident 's May Medication Administrated administered to from 5/22/22 to 6/22/2 discontinued on 6/22/2 order was input into Record (EMR) for 81 administered as one hours for antiplatelet of 6/22/22 and an enfor administration at The medication orde tablet to be administed ay for antiplatelet we re-ordered on 6/22/2/2 Resident #24 's Jun	e 35 These orders included one - plet to be administered by any for antiplatelet for 6 weeks (22/22 and end date of 7/3/22 inistration at 9:00 AM and end date of this order was 42 ar its start date. A second into the resident 's ecord (EMR) on 5/21/22 for rin tablet to be administered day for antiplatelet with a 2022 and June 2022 ration Records (MARs) and one - 81 mg EC aspirin by mouth two times a day (22. This order was 2/22 and a new medication his Electronic Medical mg (EC) aspirin to be tablet by mouth every 12 for 6 weeks with a start date and date of 8/3/22 (scheduled 8:00 AM and 8:00 PM daily). In for one - 81 mg EC aspirin ered by mouth one time a cith a start date of 7/3/22 was 2.	TAG	658	potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. On 08/01/2022, the Director of Nurses (DON), reviewed 100 % of all new admissions from July 19 August 1, 2 to identify that the orders had been transcribed accurately including orders accuchecks monitoring. There were no orders for accuchecks that required corrections. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficie practice: Education: On 07/25/2022, the DON and the Staff Development Coordinator (SDC) began education of all Full Time, Part Time, a as needed (PRN) Licensed Nurses; Registered Nurses (RN), Licensed Practical Nurses (LPNs) including ager staff on the admission orders process a medication transcription including havir one nurse to enter the admission order and a second nurse to verify the	o22 for nt nd ncy and ng s	
	81 mg EC aspirin ad 12 hours from 6/22/2 review (7/17/22). Ac received one - 81 mg mouth one time a da	t continued to receive one - ministered by mouth every 22 through the date of the Iditionally, Resident #24 g EC aspirin administered by y initiated on 7/3/22 and istration at 9:00 AM daily. on orders for the			admission orders including transcribing the orders correctly and not omitting ar new orders. Additionally, On 07/25/2022, the DON initiated education to the Nurse manag including the Minimum Data Set (MDS) Nurse, SDC, and Unit Support Nurses	ers	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345039	B. WING			l	21/2022
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		-
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	ran concurrently thro (7/17/22). Therefore total of 3 tablets of 8 through 7/17/22. A medication pass of 7/17/22 at 10:43 AM received two - 81 mg review of his medicat were two current ordorder initiated on 6/2 a start date of 7/3/22 An interview was cor AM with a corporate (DON) who served a from 2/16/22 - 5/23/2 float DON confirmed medication orders intablets to be given in mg aspirin tablet to b of 3 tablets daily). So the orders, the aspirinas one - 81 mg EC a twice daily for six we tablet given once dail also reported she revand consultation report	irin were active orders and ugh the date of the review, Resident #24 received a 1 mg EC aspirin from 7/3/22 deservation conducted on revealed Resident #24 tablets of aspirin. The cion orders revealed there ers for 81 mg aspirin (one 2/22 and a second order with 1). Inducted on 7/19/22 at 10:27 floating Director of Nursing is the facility 's Interim DON 2. During the interview, the Resident #24's current cluded two - 81 mg aspirin the morning and one - 81 e given each evening (a total ne reported upon review of a should have been initiated espirin tablet administered eks, then reduced to one by thereafter. The float DON riewed the resident 's EMR orts. She did not identify the orders or recommendations admission orders for the	F	658	the above education of admission orde process and medication transcription a on completion of a QA check to verify tall new admissions orders were enterecorrectly and not omitting any new orde. The QA check will be completed in the clinical meeting attended by the DON, SDC, MDS Nurse, and the Unit Supportures. This information has been integrated in the standard orientation training and in 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. Any staff who does not receive schedu in-service training will not be allowed to work until training has been completed 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F658 Quality Assurance Tool weekly x 5 weethen monthly x 2 months. The DON or designee will monitor for compliance will monitoring of transcribing new orders	nd hat d hat t t to the or led b by t hat eted	
	cared for Resident #2 error identified with the	24. During the interview, the ne resident's aspirin was eported the facility notified			from all sources including admissions a consult orders including any new order for aspirin. Reports will be presented to the weekly Quality Assurance committee.	s o	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	C	(X3) DATE SURVEY COMPLETED	
		345039	B. WING_			C 07/21/2022	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	DE I	0772172022	
OUMMEDO	TONE HEALTH AND DE	THARM ITATION CENTER		485 VETERANS WAY			
SUMMERS	SIONE HEALIH AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284			
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F 658	Continued From page	÷ 37	F 6	558			
	orders from orthopeditime frame for twice of No change in the order confirmed Resident # have included only or at this time. A telephone interview at 2:20 PM with Nurse identified as the nurse orders for Resident # 6/22/22. When asked	are there were no new ics to change the original laily dosing of his aspirin. ers were found. She 24 's current orders should he - 81 mg aspirin tablet daily		by the DON to ensure correct initiated as appropriate. Combe monitored and the ongoin program reviewed at the week Assurance Meeting. The week Meeting is attended by the ADirector of Nursing, MDS CoTherapy Manager, Unit Supp Health Information Manager, Dietary Manager. Date of Compliance: 08/18/2	pliance will g auditing ekly Quality ekly QA dministrator ordinator, oort Nurses, and the	,	
	PM with the facility 's interview, the DON recorders had been iden DON stated he would of aspirin orders for the a transcription error. ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A reside out activities of daily I services to maintain opersonal and oral hygometric transcriptions. This REQUIREMENT by: Based on observation family interviews the first recorders.	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced in, record review, staff and facility failed to provide	F 6	The statements made on thi correction are not an admiss	ion to and d	8/18/22 o	
	resident (Resident #2	g (ADL) assistance for a 2) that was dependent on wer and nail care in 1 of 5		not constitute an agreement alleged deficiencies. To rema compliance with all federal a	ain in		

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 _			1	C 21/2022
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>			STREET ADDRESS, CITY, STATE, ZIP CODE	1 011	21/2022
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SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			KERNERSVILLE, NC 27284		
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F 677	Continued From page	e 38	F		,		
	residents reviewed fo	r ADL care.			regulations the facility has taken or wil take the actions set forth in this plan o		
	The findings included	:			correction.		
		mitted to the facility on			The plan of correction constitutes the		
	1/5/2018 with diagnoses that included dementia,				facility □s allegation of compliance suc		
	cerebral infarction, ar	nd aphasia.			that all alleged deficiencies cited have		
					been or will be corrected by the dates		
		erly Minimum Data Set			indicated.		
	, ,	22 revealed Resident #22			F677		
	had severe cognitive impairment with no rejection of care and required total assistance of one staff				F677		
		al hygiene and bathing.			Corrective action for resident(s)		
	member with persona	arriygierie and batılıng.			affected by the alleged deficient practi	ce.	
	A review of Resident	#22's care plan dated			anodou by the anoged denoion practi	50.	
		focused area for ADL self			On 07/19/2022, a corrective action wa	S	
		icit with interventions that			obtained for resident #22 when she		
		2 required staff assistance			received a shower and nail care.		
	with bathing and pers	•					
					2. Corrective action for residents wit	h	
	An observation was o	conducted of Resident #22			the potential to be affected by the alleg	ged	
	on 7/17/2022 at 12:1	1 p.m. lying in bed with long			deficient practice.		
		ark brown debris under each					
		served to be greasy and			All residents have the potential to be		
	stuck to her head and	I uncombed.			affected by the alleged deficient practi	ce.	
	An interview was con	ducted with Resident #22's			On 08/13/2022 the Director of Nurses		
	responsible party (RF	P) on 7/17/2022 at 3:33 p.m.			(DON) initiated an audit of 100% of all		
	and she revealed whe	en she visits her mother in			current residents. This audit was		
	the evening, she freq	uently finds her mother with			completed to identify any residents wh	0	
		shed and she does not			had dirty nails that were not trimmed to)	
	believe her mother re				the desired length according to their		
		added the last shower she			preference. Any resident identified as		
		eater than two weeks ago			requiring nail care received nail care.	Γhis	
		one in over three months to			was completed on 08/13/2022.		
		stated the nursing assistants					
		bath instead of a shower			On 08/13/2022 the DON initiated an a		
	and could not wash h	er mother's hair in the bed.			of 100% of all current residents. This a was completed to identify any resident		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG	, , ,	(X3) DATE SURVEY COMPLETED		
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F 677	Continued From pag	ge 39	F 6	77			
	6:10 p.m. of Resider hair greasy and stuc appearance. Her nai with brown debris ur	conducted on 7/19/2022 at nt #22 lying in bed, with her k to her head, uncombed in ils were observed to be long nderneath each nail.		who had greasy hair and reshower. Any resident ident requiring a shower had arreceive a shower. This wa 08/13/2022. 3. Measures /Systemic common shows the shower is a shower.	ified as angements to s completed on		
	log revealed she had scheduled shower times on Tuesday and Friday, day shift with the following documented showers: Tuesdays:			prevent reoccurrence of all practice: On 07/25/2022, the DON a Development Coordinator education of all full time, pa	eged deficient and the Staff (SDC) began		
	7/5/2022 no shower	was documented as given.		needed (PRN) licensed nu Registered Nurses (RN) ar Practical Nurses (LPN) and nursing assistants (CNA agency staff on the right to and receive nail care in a n	nd Licensed d certified s), including be showered		
	Fridays: 7/8/2022 no shower	given.		requested, and necessary grooming. This in-service was incorported new employee facility orier	orated in the		
	p.m. with the Assista (ADON) present at F ADON stated the Re and dirty underneath She stated the Resid looked like it needed An interview was con 7/19/2022 at 6:54 p. not give Resident #2	nducted on 7/19/2022 at 6:46 ant Director of Nursing Resident #22 bedside and the esident's nails were too long and needed to be cleaned. It is determined by the washed. Inducted with NA #1 on m. and she revealed she did the charted in the electronic		above-mentioned employe provided to agency staff we facility. This will be review Quality Assurance process the change has been susta. Any staff who does not rec in-service training will not be work until training has been 08/18/2022. 4. Monitoring Procedure	es and also orking in the ed by the to verify that ained. eive scheduled be allowed to n completed by		
	medical chart was in error. She stated the	accurate and charted in documentation that revealed nower to the Resident on		the plan of correction is eff specific deficiency cited rel and/or in compliance with r requirements.	ective and that mains corrected		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUMENT A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345039	B. WING _			1	C 21/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		48	TREET ADDRESS, CITY, STATE, ZIP CODE 85 VETERANS WAY ERNERSVILLE, NC 27284	1 011	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	p.m. with the Director revealed it was his ex level of care be provi stated a root cause a It was his expectation nail and hair care as	ducted on 7/19/2022 at 7:16 of Nursing (DON) and he expectation that the highest ded to all Residents. He nalysis would need to occur. In that the Resident receive needed, a shower when that the documentation every	F	677	The DON or Designee will monitor compliance utilizing the F677 ADL Quarter Assurance Tool weekly x 5 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to include weekends assure that dependent residents are receiving showers and nail care as a port their ADL care. This will include audit 6 residents on various halls to ensure corrective action is initiated as appropriate. Compliance will be monitor and the ongoing auditing program reviewed at the weekly Quality Assurant Meeting. The weekly QA Meeting is attended by the Administrator, Director Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	to art ting ored nce	
F 684 SS=J	applies to all treatme facility residents. Bas assessment of a resident residents receive accordance with profipractice, the compressive plan, and the resident REQUIREMENT by: Based on record review Practitioner, and Medical Paractitioner, and Medical Resident Re	ndamental principle that int and care provided to led on the comprehensive dent, the facility must ensure treatment and care in lessional standards of lensive person-centered	F	684	The statements made on this plan of correction are not an admission to and not constitute an agreement with the	do	7/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE NG	(X3) DATE SURVEY COMPLETED		
			A. BUILDI				2
		345039	B. WING _			l	21/2022
NAME OF PROVIDER OF SUMMERSTONE HE		EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
resident (Resider acting in- blood su sugar wa (mg/dl) a (mg/dl) ti were not continue done. Th sampled assess, t treat an o lower leg pressure Immedia gave Re knowing removed acceptat jeopardy compliar harm wit that is no monitorir The facil of D for a The findi Resident 7/12/22 o Covid-19 mellitus. sugar ch	at #46). The sulin without gar. On 7/12 as critically load and, on 7/15/hrough labor acted on by d, and no fur is deficient presidents. Anotify the physical period acted on 5 and 10 for 1 of 4 resulters (Resulters (Resulters) and 10 for 1 of 4 resulters (Resulters) are acted to 1 for 1 of 4 resulters (Resulters) and 11 states are acted to 1 immediate and all states are acted to 1 immediate and 11 immediate and 11 immediate and 11 immediate and 11 immediate acted to 1 immediate acted to 1 immediate and 11 immedia	dependent diabetes facility administered long monitoring the resident's 4/22, Resident #46's blood ow at 37 milligrams/deciliter 22, it was critically low at 25 ratory work. These results the facility, daily insulin ther blood sugars were oractice occurred for 2 of 3 Also, the facility failed to rysician, and obtain orders to in the right lower leg and left residents reviewed for ident #15). Degan on 7/13/22 when staff its first insulin dose without blood sugar level and was when the facility provided an allegation of immediate the facility will remain out of the and severity D (not actual to more than minimal harm the property of the end of the end severity of the end severity aff have been in-serviced. Cited at a scope and severity Resident #15).	F	584	alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tal 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. F684 1. Corrective action for resident(s) affected by the alleged deficient practice. Resident #46 is deceased therefore no corrective action was required. On 07/19/2022, a corrective action was obtained for resident #15. The Nurse assessed the residents lower leg woun There was no signs of infection. The resident received a new order for the wound to his lower leg and treatment we completed. 2. Corrective action for residents with the potential to be affected by the alleg deficient practice. On 07/27/2022, the Director of Nurses completed a 100% audit of current residents to ensure that each resident receives treatment and care in accordance with professional standards practice. There were no corrective actions required. On 07/19/2022, the Nurse Consultant of the potential to be affected by the allegonations required.	ken on d. vas	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING				04/0000
NAME OF P	ROVIDER OR SUPPLIER	04000		S.	TREET ADDRESS, CITY, STATE, ZIP CODE	071	21/2022
IVAIVIL OF T	TOVIDER OR GOLF EIER				85 VETERANS WAY		
SUMMERS	STONE HEALTH AND F	REHABILITATION CENTER			ERNERSVILLE, NC 27284		
				- '	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	ge 42	F	684			
	included an order fo	or long-acting basal insulin 20			completed an audit of 100% of all curre	ent	
		ing means insulin enters			insulin dependent diabetic residents to		
	- , -	hours from administration			identify if they have orders for accuche	cks	
	time and can last up	o to 24 hours in the body) and			and if they had any critical glucose labs	S.	
	_	ips to check blood sugars four			This audit was completed on 07/19/202	22.	
		ted. The hospital discharge			The audit identified that 19 of 19 currer		
		2/22 also included an order to			insulin dependent diabetic residents ha	ıd	
		ood count, basic metabolic			orders for accuchecks. No corrective		
	panel, and thyrold s	timulating hormone on			actions were required. Additionally, 0 o	T U	
	1/13/22.				current insulin dependent diabetic residents had a critical glucose lab in the	20	
	The physician's ord	er dated 7/12/22 was insulin			last 60 days. No corrective actions wer		
		nilliliter-inject 20 units			required. All current insulin dependent		
		e time a day for diabetes			diabetic residents blood sugars are bei		
		re no orders for monitoring			monitored as ordered.	J	
	blood sugar levels.	-					
					On 07/19/2022, the Director of Nurses		
	_	with Nurse #8 on 7/19/22 at			and the nurse management team bega		
		ed she completed Resident			an audit of residents who were potentia	ally	
	-	on arrival. She stated she			affected by the noncompliance by		
		ischarge medication orders to			completing an audit of all new		
		hen hand-entered the same			admissions/readmissions for the month	1 01	
		puter system which the on-call motely and then the pharmacy			July 2022, to identify any new admissions/readmissions who are insu	lin	
	• •	e stated she was aware a			dependent diabetic residents to ensure		
		needed regular finger stick			orders for accuchecks on the discharge		
		but did not remember			summary were not entered at the time		
	_	entered that into the system			the admission. The audit was complete		
		ot of orders that day. She			on 07/19/2022. The audit identified 18		
		ave entered blood sugar test			total admissions. 2 of 18 admissions		
	•	t orders separate from the			were insulin dependent diabetics with		
	pharmacy order.				orders for accuchecks. The 2 admissio		
	Decident #401-	liantina naluninintustissa saasa			identified as insulin dependent diabetic		
		lication administration record			admission did have orders for accuche	CKS	
	, ,	17, 2022 showed no current blood checks. His MAR			with blood sugars that are being monitored as ordered. No corrective		
		ation that insulin was			actions were required.		
		tes with staff initials.			actions were required.		
	aariiiiiotoroa ori dal	can mado.			On 7/20/2022, the Director of Nursing a	and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345039	B. WING			C
NAME OF D	DOVIDED OD CLIDDLIED	343039	D. WING_	CTDEET ADDRESS	S, CITY, STATE, ZIP CODE	07/21/2022
NAME OF PI	ROVIDER OR SUPPLIER					
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		485 VETERANS \		
	-	-		KERNERSVILL	E, NC 27284	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684	Continued From page	e 43	F 6	34		
F 084	Resident #46's blood a critical low blood sumilligrams/deciliter (nmg/dl). Per laborator unsuccessful attempt facility staff about this Blood work was drawn on one documented Resident #46's blood a critical low blood suthis critical result was at 5:02pm by the technist critical result was at 5:02pm by the technist critical sugar results for the critical sugar results fo	work dated 7/14/22 showed ugar value of 37 ng/dl) (normal level 70-99 ry report, multiple, ts were made to contact the	F 6	Assistant E floor nurse residents to symptoms residents vand symptoms residents vand symptoms. Assistant E practice: On 7/25/20 Assistant E servicing of treatment a prn including Education identified was readmission wounds to receives the symptoms.	Director of Nurses met with a se and assessed all current or identify any signs and of hypoglycemia. No current were identified having any signs of hypoglycemia. No or were impacted. The systemic changes to occurrence of alleged deficiency of the control of th	nt gns ther ent nd ad ewly
	results to the system	licy, he would release the to be flagged and would ch the facility by phone.			022 the Director of Nurses a Director of Nurses began in	nd
	9:45 am, he stated the ever receiving a phorocritical lab results for	with Nurse #9 on 7/19/22 at the had no recollection of the call from the lab regarding Resident #46. He stated esident #46 was on insulin.		servicing a nursing ass and prn ind changes in	all licensed nurses and certifi sistants (full time, part time, cluding agency nurses) on a condition which includes mia and decreased meal into	
	are put on the reside administration record fingerstick blood suga since he was admitte stated Resident #46	d sugars are done then they nt's medication I. He did not recall doing any ar tests on Resident #46 ad on 7/12/22. He also ate "pretty good" while he d that he was not working on		signs and s assessmer glucose lev protocol fo physician o	ation also included identifying symptoms of hypoglycemia, int monitoring including blood vels, following the diabetic or hypoglycemia, notification of signs and symptoms and action of assessment and acti	d of

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 21/2022
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	21/2022
					85 VETERANS WAY		
SUMMERS	STONE HEALTH AND F	REHABILITATION CENTER			ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	ge 44	F 6	584			
		dent #46 was admitted and for entering his initial orders			taken in the medical record.		
	into the system. He was unsure who was assigned to him.				On 7/19/2022 the Director of Nurses at Assistant Director of Nurses began in servicing of all licensed nurses (full tim		
		ved a Nurse Aide #4 esident #46 was seen awake			part time, and prn including agency nurses) on Critical Labs. Staff were		
	and sipping on water	er and stated he was fine on			educated on how critical labs are		
	7/17/22 at 3:30 am	when she made rounds.			received, to promptly notify the physiciand/or on call of all critical labs, docum		
	Multiple attempts to	reach Nurse Aide #4 were			notification in the electronic record, and		
	unsuccessful.				notify the resident and RP of the critica labs. All critical lab results are currentl		
		o am, a review Resident #46's or 7/13/22-7/16/22 showed he			phoned to the nurse from a lab representative. If the lab is unable to		
	consumed 76-100%	of his meal one time and			reach the nurse at the facility, the lab		
	51-75% one time. A	All other meals were either <			representative will contact the on-call		
	25% or meal was re	efused.			nurse to report the critical lab result. T lab manager has been provided the	he	
	During an interview	with the floating Director of			phone number for the nurse on-call pho	one	
	Nursing on 7/19/22	at 3:10pm she stated you			number by the DON 7/19/2022. The la	b	
	_	nsulin without knowing what			representative facility contacts will be		
		ıgar level is. She added that			updated to include the nurse on-call		
		ered into the system and the			phone number by the DON on 7/19/20		
		lood sugars was something			The on-call nurse will then be responsi	ble	
		orking on and will be included			for following up to ensure the following		
	in their interdisciplin	lary meetings.			occurs: Physician and/or on call is notif		
	During an intensious	with the Nurse Prestitioner on			of the critical lab results, documentatio		
	•	with the Nurse Practitioner on the state surveyor notified her			the result in the electronic record, and notify the resident and RP of the critical		
		plood sugar checks. She			labs.	1	
		ce of finger stick sugar checks			1950.		
		nsulin and added that you			On 7/19/2022, the Director of Nursing a	and	
	-	ister insulin if you don't know			Assistant Director of Nurses also bega		
		gar level is. She stated that			servicing of all licensed nurses (full tim		
		of any critical blood levels for			part time, and prn including agency	•	
		stated he was newly admitted			nurses) on the admissions process and	d	
		d a chance to evaluate him			review to ensure one nurse enters the		
	yet. She also stated	d that she was in the facility			orders into the EMR and a second nurs	se	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		345039	B. WING _		07	//21/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	•		
0				485 VETERANS WAY			
SUMMER	STONE HEALTH AND	REHABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 004	0 1.5		_				
F 684	Continued From p	-	F6	584			
		and there were no critical levels er to review. She also stated		verifies the orders for accur nurses were also educated	•		
	that she expected	l all staff, including agency staff,		obtain blood glucose monite	oring orders for		
	to take care of the	e residents, for nurses to know		all insulin dependent diabet	ics and those		
	current sugar leve	els prior to administering insulin,		on diabetic medications. The	nis will be		
	and to be able to	recognize hypoglycemia signs.		reviewed for all new			
				admissions/readmissions a			
		w with the Medical Director on		new diagnosis or medicatio	n orders for		
		m, the state surveyor notified her		diabetes.			
		blood sugar checks. He stated					
there should be regular finger sticks with all residents who have insulin-dependent diabetes. This information has been integrated in the standard orientation training and							
		I	•				
		not aware of any critical blood		agency orientation for all st			
	-	stated that it was vital to be		above and will be reviewed Assurance process to verify			
		nt's blood sugar levels when		change has been sustained			
	administering ins	AIII1.		change has been sustained	1.		
	The Administrator	was notified of immediate		Any staff identified above w	ho does not		
	jeopardy on 7/20/	22 at 11:16am.		receive scheduled in-service			
				not be allowed to work until	training has		
		led a credible allegation of dy removal dated 7/20/2022 at		been completed by 07/22/2	022.		
	7:52pm.			4. Monitoring Procedure to	ensure that the		
				plan of correction is effective	e and that		
	Credible Allegation	n of immediate jeopardy		specific deficiency cited ren			
	removal:			and/or in compliance with requirements.	egulatory		
	Identify those rec	ipients who have suffered, or					
		, a serious adverse outcome as		Quality assurance audits w			
	a result of the nor	ncompliance.		completed by the Director of			
				designee to ensure that each			
		s deceased on 07/17/2022 and		receives treatment and care			
		ident of the facility.		accordance with profession			
		ne Nurse Consultant completed		practice and using the F68	•		
		of all current insulin dependent		Assurance Tool. Monitoring	•		
		to identify if they have orders		admissions of the critical la			
		nd if they had any critical sugar		be completed weekly to ass			
		as completed on 07/19/2022.		compliance. Monitoring will			
	THE AUGIL IGENTIFIE	ed that 19 of 19 current insulin		weekly x 5 weeks then mor	iu iiy X ∠	1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345039	B. WING _				C 21/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 077.	21/2022
				48	35 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		KI	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 46	F6	84			
	dependent diabetic re accuchecks. No corr required. Additionally dependent diabetic re lab in the last 60 days required. All current residents blood sugar ordered. On 07/19/2022, the Enurse management to residents who were proncompliance by condissions/readmission	esidents had orders for ective actions were , 0 of 0 current insulin esidents had a critical sugar s. No corrective actions were insulin dependent diabetic rs are being monitored as Director of Nurses and the eam began an audit of experimentally affected by the empleting an audit of all new ions for the month of July new ions who are insulin esidents to ensure no orders are discharge summary were see of the admission. The on 07/19/2022. The audit enissions. 2 of 18 admissions ent diabetics with orders for edmissions identified as abetics at admission did have so with blood sugars that are redered. No corrective di. Trector of Nursing and Nurses met with all floor all current residents to disymptoms of urrent residents were signs and symptoms of her residents were		004	months or until resolved for compliance Reports will be presented to the weekly QA committee by the Director of Nursir to ensure corrective action is initiated a appropriate. Compliance will be monitor and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 07/22/2022	y ng ns nred ne	
		ilure to prevent a serious					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		(X3	(X3) DATE SURVEY COMPLETED		
	3/5030	B WING			C		
			STREET ADDRESS, CITY, STATE, ZIP COD 485 VETERANS WAY KERNERSVILLE, NC 27284	E	07/21/2022		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE		
e outcome from the action 9/2022 the Diant Director of ed nurses and he, part time, and on also including of the content of th	m occurring or reoccurring will be completed. rector of Nurses and Nurses began in servicing all certified nursing assistants and prn including agency in condition which includes ecreased meal intake. The ded identifying signs and ycemia, assessment blood sugar levels, following for hypoglycemia, notification and symptoms and sessment and actions taken d. rector of Nurses and Nurses began in servicing of full time, part time, and prn reses) on Critical Labs. Staff ow critical labs are received, ephysician and/or on call of ment notification in the dot notify the resident and s. All critical lab results are the nurse from a lab e lab is unable to reach the the lab representative will urse to report the critical lab ager has been provided the enurse on-call phone 7/19/2022. The lab y contacts will be updated to -call phone number by the The on-call nurse will then be	F 6	984				
	SUMMARY S (EACH DEFICIENT REGULATORY OR URE From page se outcome from hen the action 19/2022 the Di ant Director of ed nurses and he, part time, a s) on changes lycemia and d tion also include oms of hypogli oring including betic protocol sician of signs hentation of as medical record 19/2022 the Di ant Director of nsed nurses (i) ant Director o	TION IDENTIFICATION NUMBER:	A BUILDIN 345039 OR SUPPLIER #EALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Used From page 47 See outcome from occurring or reoccurring on the action will be completed. 19/2022 the Director of Nurses and ant Director of Nurses began in servicing all ed nurses and certified nursing assistants one, part time, and prn including agency so on changes in condition which includes lycemia and decreased meal intake. The tion also included identifying signs and oms of hypoglycemia, assessment oring including blood sugar levels, following abetic protocol for hypoglycemia, notification sician of signs and symptoms and inentation of assessment and actions taken medical record. 19/2022 the Director of Nurses and ant Director of Nurses began in servicing of insed nurses (full time, part time, and prn ing agency nurses) on Critical Labs. Staff educated on how critical labs are received, and to notify the resident and the critical labs. All critical lab results are the facility, the lab representative will at the on-call nurse to report the critical lab. The lab manager has been provided the number for the nurse on-call phone for by the DON 7/19/2022. The lab entative facility contacts will be updated to be the nurse on-call phone number by the onto 17/19/2022. The on-call nurse will then be insible for following up to ensure the ing occurs: Physician and/or on call is	A BUILDING 345039 B. WING STREET ADDRESS, CITY, STATE, ZIP COD 485 VETERANS WAY KENNERSVILLE, NC 27284 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BUT PROVIDERS PLAN OF CO (EACH OPERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) WILL PROVIDERS PLAN OF CO (EACH OPERCENCE) TO THE BUT PROVIDERS PLAN OF CO (EACH OPERCENCE) ACTION CROSS-REFERENCED TO THE BUT PROVIDERS PLAN OF CO (EACH OPERCENCE) ACTION CROSS-REFERENCED TO THE BUT PROVIDERS PLAN OF CO (EACH OPERCENCE) F 684 F 684	A BUILDING 345039 BY STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL RESULATORY OR LS: IDENTIFYING INFORMATION) BY STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284 BY PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREEDLY TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 BY STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284 BY PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 BY STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284 BY PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 F 684 BY STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284 BY STATE ACTION (EACH CORRECTIVE ACTION) (EACH CORRECTION) (EACH CORRECTIVE ACTION) (EACH CORRECTION) (EACH CO		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 07/21	1/2022
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284			172022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 684	the resident and RP of On 7/19/2022, the Di Assistant Director of servicing of all licens time, and prn includir admissions process a nurse enters the ordesecond nurse verifies. The nurses were also obtain blood sugar minsulin dependent diamedications. This wind admissions/readmissions/readmissions/readmissions or medicat. The DON will ensure time, part time, and pwho does not completed. This in-service was in employee facility and licensed nurses (full including agency cernurses). Date of IJ removal 7/2.	ectronic record, and to notify of the critical labs. rector of Nursing and Nurses also began in ed nurses (full time, parting agency nurses) on the and review to ensure one ers into the EMR and a sethe orders for accuracy. The educated on the need to conitoring orders for all abetics and those on diabetic successed of the end o	F6	584			
	failure, edema and a The quarterly Minimu						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345039	B. WING _		0	C 7/ 21/2022	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 485 VETERANS WAY KERNERSVILLE, NC 27284		72172022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From pa	ge 49	F 6	584			
	extensive assistand people for his activi skin impairment.	paired cognition and required se to total dependence with 1-2 ties of daily living. He had no					
	incontinence with ri						
	A Weekly Skin Asservealed no new an	essment dated 7/16/22 eas.					
	made of Resident # bordered gauze dre drainage was obser hydrocolloid dressir lower leg with a dat	3 AM, an observation was 215 sitting in his wheelchair. A essing with visible dark eved to the left lower leg. A ng was observed to the right e of 7/14/22. Resident #15 did andages were on his legs.					
		ealed no documentation or to Resident #15 's right and					
	was made of Resid resident still had the the left lower leg an	AM, a second observation ent #15 's lower legs. The bordered gauze dressing to d the hydrocolloid dressing still in place to the right lower					
	't know anything al Resident #15 's low the dressing to the area was observed	AM, Nurse #7 stated she didn cout the areas or dressings to ver legs. Nurse #7 removed left lower leg and a small open with a small amount of e right lower leg also had a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345039	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER STONE HEALTH AND RI	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 485 VETERANS WAY KERNERSVILLE, NC 27284	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI	DATE
F 684	Nurse #7 read, "this BLE (bilateral lower of with normal saline are Physician notified an assess. Orders received A review of the physician notified and assess. Orders received A review of the physician point of the physician poi	d 7/19/22 at 8:25 AM by nurse noted open area to extremities). Area cleansed and dry dressing applied. d wound care requested to ved." Ician 's orders revealed an to clean right and left shin at dry with gauze, apply triple over with dry dressing, and be a day until healed. AM, an interview was birector of Nursing who stated belops a new area on their er that identifies the area in the medical record with the exphysician and family and rin place if needed. The revent/Heal Pressure Ulcer (i)(iii) The grity grity grity are ulcers. The results are to the season of a season of the s	F 6	884		8/18/22
	(ii) A resident with pronecessary treatment with professional sta	ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to vent infection and prevent				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345039	B. WING _			07/:	21/2022
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284		<u> </u>	172022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	by: Based on record revinterviews, the facility by the wound care pleasure ulcer reviewed for pressure. The findings included Resident #218 was a 1/22/20 with diagnos and dementia and ex 6/16/22. A progress note by the dated 4/27/22 includes antyl (a debriding as Resident #218 's samprep to the peri-wour. A review of the April Administration Record the wound was being ordered to he peri-woth treatment order to be a progress note by the dated 5/9/22 indicated deteriorated and was necrosis (devitalized included treatment or (a broad-spectrum and gentle to the skin) gas The treatment orders.	eloping. T is not met as evidenced riew and staff and physician y failed to implement orders hysician for a resident with a for 1 of 4 residents e ulcers (Resident #218). d: admitted to the facility on es of, in part, spinal stenosis spired in the facility on he wound care physician ed treatment orders to apply gent) and calcium alginate to cral wound and apply skin hd. 2022 Treatment rd revealed the treatment to y done but the skin prep bund was not listed as a e completed. he wound care physician	F	586	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 tall 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. F686 1. Corrective action for resident(s) affected by the alleged deficient practice. Resident #218 discharged from the facility, therefore no corrective action we required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 08/12/2022 the Director of Nurses (DON) began auditing 100% of the notes from the in house consultant wound MD for the last 4 weeks. This audit consisted of reviewing the wound notes to ensure that all orders and recommendations were carried out in it entirety. Any residents whose orders were not carried out in its entirety, will	l ken on ee: vas	

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			0-	C	
NAME OF D	ROVIDER OR SUPPLIER	04000		9-	TREET ADDRESS, CITY, STATE, ZIP CODE	0/	7/21/2022	
NAME OF T	TOVIDER OR SOLT FIER							
SUMMERS	STONE HEALTH AND R	EHABILITATION CENTER			B5 VETERANS WAY			
				K	ERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From pag	e 52	F	686				
	assessment dated 5. #218 had severely in required extensive to people with bed mob hygiene, bathing and at risk for pressure under and received pulcer and received pu	2022 Treatment rd revealed the treatment to being completed but skin nd was not listed as a e completed. AM, an interview was wound care physician. He amiliar with Resident #218 as sacral wound that continued condition. He stated when nds in the facility, a staff			have updated orders to reflect required. This audit was completed as of 08/12/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice: Beginning on 08/12/2022, the DON and the Staff Development Coordinator (St. began education of all full time, part times as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) including agency staff on treatment/services to prevent/heal/pressure ulcers. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive schedulin-service training will not be allowed to	ent d DC) ne, cy e		
	orders and the reside done as well. He sta wound dressing stick to help keep the area residents that have i primary dressing was but agreed the skin p	ent knows what is going to be ted the skin prep helps the k better and has alcohol in it a clean especially with noontinence. He stated the s the most important thing prep was also important and dered and being done as			work until training has been completed 08/18/2022. 4. Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The DON or Designee will monitor	by at nat		
	conducted with the D	AM, an interview was Director of Nursing. He stated nanent treatment nurse in the			compliance utilizing the F686 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months or until resolved.	ı		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345039	B. WING _			l	21/2022
	ROVIDER OR SUPPLIER	CHABILITATION 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)	PREFIX (EACH CORRECTIVE ACTION SHOULD B		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	6 Continued From page 53 facility and they were using agency staff to complete treatments and round weekly with the wound care physician. He stated the nurse that rounds with the wound care physician should have implemented all his orders.		F	5586	Audits will occur on various shifts and days of the week. This will include auditing 6 residents on various days an shifts to ensure corrective action is initiated as appropriate. Compliance wibe 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, Therapy Manager, Health Information Manager, and the Dietary Manager.	 	
F 689 SS=D	CFR(s): 483.25(d)(1)(1)(§483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents.		F	689			8/18/22
	Based on record revi the facility failed to re resident's bed after resident to sustain an reviewed for accident The findings included	other fall for 1 of 5 residents s (Resident #218). : dmitted to the facility on			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 tal 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	l ken	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
		345039	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 485 VETERANS WAY KERNERSVILLE, NC 27284	DE	V./21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	#218 had severely i required extensive a and total dependent Resident #218 was falls. A review of Resident 2/25/20 and revised on increased risk for a history of falls. Interest of a history of falls. Interest of a history of falls and the second increased risk for a history of falls. Interest of a history of falls and the second increased risk for a history of falls. Interest of a history of falls and the second increased risk for a history of falls. Interest of a history of falls and the second increase of the second in	in Data Set (MDS) 1/30/22 revealed Resident impaired cognition and assistance with bed mobility ice for transfers and toileting, non-ambulatory and had no it #218 's care plan dated on 3/30/22 included a focus if falls related to confusion and erventions included ress dated 3/11/22 and ted 3/14/22, hi-low bed dated is dated 3/14/22. ied 3/10/22 at 5:46 PM read, raying on back on floor beside isser. No injuries noted upon 3/10/22 revealed Resident laying on back on floor by dibed. Alert and verbal. No ted. The Fall Report indicated reviewed, care plan updated, in completed. Root cause was the air mattress and intervention in mattress. ubmitted on 3/11/20 at 10:00 in remove air mattress from	F 6	deficiencies cited have been corrected by the dates indicated. F689 1. Corrective action for result affected by the alleged deficition. Resident #218 is discharged facility, therefore no corrective required 2. Corrective action for result the potential to be affected be deficient practice. Beginning on 08/01/2022, the Nurses (DON), Staff Develop Coordinator (SDC), and United Nurse initiated an audit of the last 14 days from 07/19. This audit consisted of reviewensure the intervention was physically observing that the is in place if indicated. This completed on 08/01/2022. 3. Measures /Systemic chaprevent reoccurrence of allegoractice: On 07/25/2022, the DON and Nurse initiated Post fall educations and selections are reconsidered.	ior will be ated. sident(s) ient practice: I from the ve action is sidents with by the alleged e Director of pment Support e falls from 08/01/2022. wing falls to carried out by intervention audit was anges to ged deficient d the SDC cation to all d Nurses	
	Nurse #10 read, "at the room of resident	ed 3/13/22 at 7:17 PM by 3:10 PM, nurse was called to t by nursing assistant. Nurse face down on the right side of		(RNs), Licensed Practical Nu and Certified Nursing Assista full time, part time, and PRN including agency staff on the process.	ants (CNAs), staff	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345039	B. WING_			1	C 21/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	2 1/2022
	10115211 011 001 1 2.2.1				5 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			ERNERSVILLE, NC 27284		
				IX.			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 55	F 6	589			
	her bed. No injuries were noted to residents back, hips and lower extremities. Resident was log rolled onto a flat sheet to supine position and nurse noted a hematoma to right forehead and discoloration to right eye, skin tears to left hand and bruising to knees. On call physician gave order to send resident to emergency department. Air mattress was removed from bed and replaced with a regular mattress. A Fall Report dated 3/13/22 revealed resident was found on floor beside bed, slid off air mattress. Medical record and medications reviewed; care plan updated. Root cause was determined to be displaced air. Interventions were to place mats beside bed. A review of the Emergency Department record dated 3/13/22 indicated Resident #218 was brought in by emergency medical services for an unwitnessed fall at the facility. Has bruising and contusion to her right forehead. Vital signs within normal range. Computed tomography was completed of head and facial bones and spine with no acute fracture or dislocation and no acute intracranial abnormality found. X-rays to femur, tibia/fibia and pelvis showed no fracture. Resident #218 was not admitted to the hospital. Resident #218 expired in the facility on 6/16/22. On 7/20/22 at 2:22 PM, an interview was conducted with Nurse #12 who was the nurse that worked with Resident #218 on 3/10/22 when she fell out of the bed. She stated she could not recall Resident #218 at all and could not recall if the air mattress was removed from the bed on 3/10/22.				On 08/12/2022, the Quality Assurance Clinical Nurse Consultant educated the DON on the following topics using the Falls Review Nurse Manager Education. "Ensuring that fall interventions are entered into Kardex, task, or care plan timely if indicated. "Ensuring that the action of remove addition of falls interventions are put in place timely with observation if indicated. The DON will educate any nurse managers or nurse support staff who	n: al or to ed.	
					assist with the falls investigation procesusing the Falls Review Nurse Manager Education. This information has been integrated in the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quantum Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training who has been completed by 08/18/2022.	nto d llity t trill s	
					4. Monitoring Procedure to ensure that plan of correction is effective and that specific deficiency cited remains correct and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that fall intervention.	oted	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345039	B. WING			C 07/21/2022
	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 LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 689	conducted with Nurs Resident #218 fell of was still on the bed it. She stated Reside Nurse #10 didn't the for the air mattress to unaware of the previous the air mattress. On 7/21/22 at 8:48 Acconducted with the Fell who stated he could was removed from Fell the fall on 3/10/22. If the nurse's station and he picked those stated if it was some on top of that and the meeting and falls we work request was pure may not have gotter he did not work on the did not work on the wasn't at the fact #218's falls occurred daily stand-up meeting discussed and if an air mattress needed discussed. He could mattress was still on	PM, an interview was see #10. She stated when in 3/13/22, the air mattress because the resident slid offent #218 was very thin and ink she had enough weight to be effective. She was fous intervention to remove the state of the air mattress resident #218 's bed after the stated there was a box at that work orders were put in up 1-2 times a day. He stated the air mattress resident #218 's bed after the stated there was a box at that work orders were put in up 1-2 times a day. He stated to a fall, he was sere was a daily stand-up are discussed. He added if the put in on a Friday (3/11/22), he are to it until Monday because the weekends. AM, an interview was Director of Nursing. He stated sility in March when Resident and He stated there was a lang where falls have been intervention like removing an to be done, that would be not explain why the air the bed on 3/13/22 after the mat it should have been	F 68	are in place and carried out tin the F689 Quality Assurance To Monitoring of 6 residents with completed weekly to assure or with falls interventions. Monito completed weekly x 5 weeks the x 2 months or until resolved for compliance. Reports will be provided the weekly QA committee by the foliated as appropriate. Completed as appropriate. Completed and the ongoing program reviewed at the week Meeting. The weekly QA Meeting. The weekly QA Meeting and the Dietary Manager. Defit that are identified during the monitoress will be addressed through the facility Quality Assurance process.	pool. falls will be compliance oring will be then monthly resented to the Director exaction is liance will auditing ly QA ing is Director of the point or inguity the point of the point or inguity the point of the point or inguity the poi	8/18/22
	CFR(s): 483.25(g)(1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _		0:	C 7/ 21/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284		112 112022
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F 692	(Includes naso-gas both percutaneous percutaneous endo enteral fluids). Bas comprehensive assensure that a reside §483.25(g)(1) Main of nutritional status desirable body weigh balance, unless the demonstrates that the preferences indicat §483.25(g)(2) Is off maintain proper hydrogen based on observational supplementational supplementa	d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's essment, the facility must ent- tains acceptable parameters a such as usual body weight or ght range and electrolyte resident's clinical condition his is not possible or resident e otherwise; ered sufficient fluid intake to dration and health; ered a therapeutic diet when I problem and the health care erapeutic diet. NT is not met as evidenced ions, record review and istered Dietician (RD), and ed to implement a high calorie ent, as recommended by the ith a stage 4 pressure ulcer weight on admission. The to lose weight the following ed in severe weight loss that for 1 of 6 residents reviewed ent #35). ed: admitted to the facility on es including pressure ulcer of	F 6	The statements made on this correction are not an admission not constitute an agreement will alleged deficiencies. To remain in compliance with a and state regulations the facilit or will take the actions set forth plan of correction. The plan of constitutes the facility sallegar compliance such that all alleged deficiencies cited have been of corrected by the dates indicated.	n to and do ith the all federal y has taken n in this correction ation of r will be	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345039	B. WING _		1 ,	07/21/2022
NAME OF PR	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C		
				485 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER		KERNERSVILLE, NC 27284		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLÉTION DATE
F 692	Continued From page	e 58	F 6	92		
	3			The plan of correcting the s	enecific	
	Resident #35 was ord	dered a regular diet on		deficiency. The plan should		
	6/3/22.	aoroa a rogalar alot on		processes that lead to the		
	0/0/==:			cited:		
	A dietary assessmen	t dated 6/7/22 revealed				
		mitted on a regular diet with		Corrective action for re	esident(s)	
	thin liquids. The curre	ent by mouth oral intake was		affected by the alleged defi	cient practice:	
	noted as adequate at	50-75%. The resident had				
	multiple wounds.			For resident #35, a correcti		
				obtained and completed on	n 07/17/2022.	
		ım Data Set assessment		The Registered Dietitians		
	dated 6/8/22 revealed			recommendations were rev	-	
		ependent with meals, was 74		physician on 07/17/2022 ar	• •	
		ed 136 pounds, did not have		The Staff Development Co		
		ders, and had not lost ent did not indicate any		(SDC) entered the approve from the Registered Dietitia		
		s were in place. Resident		recommendation into the re		
		essure ulcer that was		electronic medical record (I		
	present on admission			Clockering medical record (i		
				Corrective action for re	esidents with	
	A note by the Registe	ered Dietician (RD) dated		the potential to be affected	by the alleged	
	, ,	ead, in part, "underweight		deficient practice.	,	
	BMI (body mass inde	x). Tolerates regular diet, fair				
	intake. Patient declin	ed RD recommended tube		All residents have the poter	ntial to be	
		assist to improve high		affected by the alleged defi	cient practice.	
		nmend provide nutrition				
		nutrition needs. Start Med		On 08/11/2022, the Directo		
		rie, high protein nutritional		(DON) completed an audit		
		ters by mouth three times a		recommendations for July 2		
		ditional 540 kilocalories and		received from the Registere		
	23 grams of protein".			This audit consisted of revi nutritional recommendation	•	
	The Medication Admi	nistration Record (MAR) for		provider has reviewed then		
	June 2022 revealed t			orders were written into the		
		a day was not on the MAR.		approved by the provider.	, ,	
		,		findings were found at the t		
	Review of Resident #	435 's weights documented		audit.	-	
	in the electronic heal	-				
	136.2 pounds on 6/12	2/22 and 127.4 pounds on		3. Measures /Systemic cl	hanges to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		` IDENTIFICATION NI IMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 t. BOILBING			С	
		345039	B. WING		0.7	7/21/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		72 172022	
				485 VETERANS WAY			
SUMMERS	STONE HEALTH AND RI	EHABILITATION CENTER		KERNERSVILLE, NC 27284			
(V4) ID	STIMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	APPECTION .	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE	
F 692	F 692 Continued From page 59		F 69	02			
	7/11/22.			prevent reoccurrence of alleg	ed deficient		
				practice:	,		
	A note by the RD dat	ed 7/15/22 at 8:02 PM read,		'			
	in part, 6.6 percent w			On 08/12/2022 in-service edu	ucation was		
		nutrition supplement to		initiated by the Quality Assura	ance Nurse		
		. Start Med Pass 2.0 90		Consultant to the DON. Topic			
	milliliters by mouth th			·			
	-			" The Registered Dietician	ı will		
	A review of the July 2	2022 physician ' s orders		Complete Nutritional assessn	ments for		
	revealed the order fo	r Med Pass 2.0 90 milliliters		residents to identify nutritional	al risk		
	three times a day wa	s entered on 7/17/22.		(significant weight change, w	ounds,		
				enteral feedings, dialysis resi	dents, etc.),		
	On 7/17/22 at 11:52	AM, Resident #35 was		nutritional declines, and oppo	ortunities to		
	interviewed. He state	ed he was a chef at a nice		improve nutritional status. Re	egistered		
		od in the facility was terrible		Dietician nutritional recomme	endations are		
		s ago. He stated no one had		to be reviewed and approved			
	ever asked him abou	t food likes/dislikes.		services. If nutritional recomn			
				are approved orders must be			
		AM, an interview was		DON or designee will review			
		Dietary Manager. She stated		recommendations for complia			
		ork at the facility on 7/3/22		" The Registered Dietitian			
	_	7/6/22 due to a change in		nutritional recommendations			
		e stated she had not spoken		compliance at her monthly re	view.		
		ut food preferences, and she		The Dietem Meneger Minima	Data Cat		
		eferences were maintained.		The Dietary Manager, Minimu			
		I find no record of food dent #35. She stated he got		Support Nurse, and nurse ma	-		
	·	s placed on his breakfast		time, part time, and as neede required to complete this edu			
		oose what he wanted to eat		required to complete this edu	icalion.		
	the following day.	loose what he wanted to eat		This information has been int	egrated into		
	the following day.			the standard orientation train	-		
	On 7/20/22 at 10·17	AM, the RD was interviewed.		agency orientation for all staf	-		
		d Resident #35 on 6/14/22		above and will be reviewed b			
		high risk because of		Assurance process to verify t			
		nd wounds. She added the		change has been sustained.			
		creased nutritional needs.		and a second design of the second sec			
		e made recommendations,		Any staff identified above who	o does not		
		the Administrator, the		receive scheduled in-service			
		nd the Dietary Manager. She		not be allowed to work until tr	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		K2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			1	C	
NAME OF DE	ROVIDER OR SUPPLIER	343033	B: Wille _	27	FREET ADDRESS, CITY, STATE, ZIP CODE	07/	/21/2022	
NAME OF T	TOVIDER OR SOLT LIER				, , ,			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER	485 VETERANS WAY		ERNERSVILLE, NC 27284			
240.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES		<u> </u>			0(5)	
(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 692	Continued From page	e 60	F 6	92				
		ow why the Med Pass didn ' t une, but she added there			been completed by 08/18/2022.			
	was some turnover in Administrator, Directo	the facility including the or of Nursing, and the			4. Monitoring Procedure to ensure that plan of correction is effective and that	the		
	Dietary Manager, all i	n the last couple of months.			specific deficiency cited remains correct	cted		
	noticed the Med Pass	ent #35 again in July, she s 2.0 wasn ' t ordered and			and/or in compliance with regulatory requirements.			
	recommended it agai	n.			Quality assurance audits will be			
	On 7/20/22 at 11:16 A	AM, an observation was			completed by the Director of Nurses or			
		to Resident #35 ' s sacral			designee to monitor that nutritional			
	wound. The wound w	as large and covered the			recommendations have been complete			
	entire sacral area and	l beyond.			using the F692 Quality Assurance Tool			
	O:- 7/04/00 -+ 44:40 /	ANA Ale a Director of Normalia a			Monitoring of 6 residents with nutritional	al		
		AM, the Director of Nursing stated recommendations			recommendations will be completed weekly to assure compliance with			
	from the dietician sho				nutritional recommendations. Monitorin	na		
	mom the distribution of	and so par into place.			will be completed weekly x 5 weeks the	•		
					monthly x 2 months or until resolved fo			
					compliance. Reports will be presented			
					the weekly QA committee by the Direct			
					of Nursing to ensure corrective action i initiated as appropriate. Compliance wi			
					be monitored and the ongoing auditing			
					program reviewed at the weekly QA			
					Meeting. The weekly QA Meeting is			
					attended by the Administrator, Director	of		
					Nursing, MDS Coordinator, Therapy			
					Manager, Health Information Manager,			
					and the Dietary Manager. Deficiencies that are identified during the monitoring			
					process will be addressed through the	ł		
					facility Quality Assurance process.			
F 756	Drug Regimen Revies	w, Report Irregular, Act On	F 7	756	Date of Compliance: 08/18/2022		8/18/22	
SS=J							5, 15,22	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345039	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER STONE HEALTH AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284		0172172022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 756	Continued From page 8483 45(a) Drug Bo	-	F 7	56		
		lrug regimen of each resident t least once a month by a				
	§483.45(c)(2) This rof the resident's me	review must include a review dical chart.				
	irregularities to the a facility's medical dir and these reports m (i) Irregularities including that meets the (d) of this section for (ii) Any irregularities during this review m separate, written reattending physician director and director minimum, the reside and the irregularity (iii) The attending physician tirregularity has been action has been tak be no change in the physician should do the resident's medical transportation.	criteria set forth in paragraph or an unnecessary drug. In the pharmacist must be documented on a port that is sent to the and the facility's medical or of nursing and lists, at a cent's name, the relevant drug, the pharmacist identified. The hysician must document in the decord that the identified on reviewed and what, if any, cen to address it. If there is to be medication, the attending occument his or her rationale in cal record.				
	maintain policies an drug regimen review limited to, time fram the process and ste when he or she ider requires urgent action	acility must develop and ad procedures for the monthly we that include, but are not uses for the different steps in ups the pharmacist must take notifies an irregularity that on to protect the resident.				

OLIVILIY	O I OIT MEDIO/ITE G	WEDIO/ ND CEITTIGEC				CIVID IV	3. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 5 6.125				С
		345039	B. WING				/21/2022
NAME OF P	ROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		-
				48	35 VETERANS WAY		
SUMMERS	STONE HEALTH AND RI	EHABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 756	Continued From pag	e 62		756			
				, 50	The statements made on this plan of		
	Nurse Practitioner ar	view, consultant pharmacists,			The statements made on this plan of correction are not an admission to and	do	
		y failed to complete an			not constitute an agreement with the	uo	
		nt #46's medication regimen			alleged deficiencies.		
	that identified the ne				To remain in compliance with all federa	al	
		ident #46's initial medication			and state regulations the facility has ta		
		not identify the inadequate			or will take the actions set forth in this		
	•	administration. Resident #46			plan of correction. The plan of correction	on	
		without blood sugar testing			constitutes the facility s allegation of		
	and experienced criti	ically low blood sugars			compliance such that all alleged		
	identified through blo	oodwork. This was for 1 of 3			deficiencies cited have been or will be		
	residents reviewed for	or pharmacy services. Also,			corrected by the dates indicated.		
	the facility failed to re						
	·	s, recommendations, and the resident's medical			F756		
	record or within the fa	acility so the records were			 Corrective action for resident(s) 		
	· ·	6 of 13 residents whose			affected by the alleged deficient practic	ce:	
		viewed (Resident #24, #15,					
	1	218). And the facility failed to			Resident #46 is deceased therefore no)	
	act on the Pharmacy				corrective action was required.		
		complete an abnormal					
	_	nt (AIMS) assessment for 1			Resident #168 is deceased therefore n	10	
	1	ent #22) reviewed for			corrective action was required.		
	unnecessary medica	uoris.			Resident #218 is deceased therefore n	10	
	Immediate jeonardy	began on 7/14/22 when			corrective action was required.	10	
		st #1 reviewed Resident			corrective action was required.		
		nd failed to recognize there			On 08/14/2022, a corrective action was	s	
		ders for blood sugar testing			obtained for resident #4. The most red		
	with the administration				pharmacy recommendation from July		
		when the facility provided an			2022 was reviewed with the provider a	nd	
		allegation of compliance.			approved. New order from the July 202		
		in out of compliance at a			pharmacy recommendation was written		
	scope and severity E	(not actual harm with			resident #4□s Electronic Medical Reco	rd.	
	·	an minimal harm that is not					
		to ensure monitoring and all			On 08/12/2022, a corrective action was	3	
	staff have been in-se	erviced.			obtained for resident #65. The most		
					recent pharmacy recommendation from		
	The facility was also	cited at a scope and severity			July 2022 was reviewed with the providence of th	der	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345039	B. WING			07/	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077.	21/2022
TO THE OT TH	TO VIDER OR GOLF EIER				B5 VETERANS WAY		
SUMMERS	STONE HEALTH AND F	REHABILITATION CENTER			ERNERSVILLE, NC 27284		
(X4) ID	SLIMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 756	Continued From page	ge 63	F	756			
	of E for example #2	(Resident #24, #15, #4, #65,			and approved. New order from the July	,	
	-	d for example #3 (Resident			2022 pharmacy recommendation was		
	#22).				written in resident #65□s EMR.		
	The findings include	ed:			On 08/01/2022, a corrective action was	;	
					obtained for resident #15. The most		
		eadmitted to the facility on			recent pharmacy recommendation from		
		ses including Covid, left hip			July 2022 was reviewed with the provid		
		dependent diabetes mellitus.			and approved. New order from the July	'	
		vith regular blood sugar			2022 pharmacy recommendation was		
	died in the facility or	ous admission. Resident #46 n 7/17/22.			written in resident #15□s EMR.		
	A boonital disabaras	a summary dated 7/12/22			On 08/12/2022, a corrective action was obtained for resident #24. The most	5	
		e summary dated 7/12/22 or long-acting basal insulin 20			recent pharmacy recommendation from	,	
		ing means insulin enters			July 2022 was reviewed with the providence of th		
		hours from administration			and approved. Assessment for AlM □s	161	
		to 24 hours in the body) and			recommended from the July 2022		
		ps to check blood sugars four			pharmacy recommendation was		
	times daily as direct	ted. The hospital discharge 2/22 also included an order to			completed in resident #24□s EMR.		
		ood count, basic metabolic			On 08/12/2022, a corrective action was	;	
	panel, and thyroid s	timulating hormone on			obtained for resident #22. The most		
	7/13/22.				recent pharmacy recommendation from	n	
					July 2022 was reviewed with the provid	ler	
		dated 7/12/22 was insulin			and approved. New order from the July	<i>'</i>	
	degludec (long-actir				2022 pharmacy recommendation was		
		0 units subcutaneously one			written in resident #22□s EMR.		
	-	tes mellitus. There were no			Additionally, on 07/20/2022, an		
	orders for monitoring	g blood sugar levels.			assessment for AIM□s from a previous	•	
	The 5-90 ()				pharmacy recommendation was		
	•	y review dated 7/14/22,			completed in resident #22□s EMR.		
		ultant pharmacist #1 showed			2 Corrective estimates and an action to with		
		es with Resident #46's current			Corrective action for residents with the potential to be affected by the alleg		
	the insulin.	review did not acknowledge			the potential to be affected by the alleg	eu	
	uie irisuiin.				deficient practice.		
	Consultant pharmacinterviewed.	cist #1 was unable to be			On 07/20/2022, the Pharmacy Director completed an audit of 18 residents who		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345039	B. WING			C 7/21/2022
NAME OF P	ROVIDER OR SUPPLIER	1 0.000		STREET ADDRESS, CITY, STATE, ZIP COD		112112022
	101.52.1.01.100.1.2.2.1			485 VETERANS WAY	-	
SUMMERS	STONE HEALTH AND RI	EHABILITATION CENTER	KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 756	Continued From pag	e 64	F 75	56		
				were potentially affected by the	ne	
	During an interview o	on 7/19/22 at 3:20 pm,		noncompliance by completing		
	_	st #2 stated that consultant		comprehensive review of all r		
	•	eted the initial medication		admissions/readmissions for		
		admissions to the facility. She		July 2022. The audit consiste		
		ot receive fingerstick blood		review of insulin dependent d		
		only receive medication		ensure orders for diabetic mo		
	orders and that is wh	at they review and base their		in place. The pharmacy cons	sultant also	
	recommendations or	. She stated that the facility		reviewed current lab results.		
	-	ordering and keeping up with		Recommendations based on		
		/hen asked if blood sugars		were sent to the physician by		
		would monitor during their		supervisor on 7/20/2022. The		
		he stated no, she probably		recommendations may includ		
	was based on medic	se. She stated the review		labs, order changes, or additi monitoring. There were no or		
	was pased on medic	ation orders only.		residents impacted.	uici	
	During an interview v	vith the Nurse Practitioner on		residents impacted.		
	_	she stated that she was not		On 08/12/2022, the Director of	of Nurses	
		#46 was not receiving any		(DON) completed an audit to		
		cks. She stated he was		of the pharmacy recommenda		
	newly admitted and s	she had not had a chance to		July 2022 □ August 2022. Th	nis audit	
	evaluate him yet. Sh	e also relayed the		consisted of reviewing the ph		
		stick sugar checks in the		recommendations to ensure t		
	•	nd she would expect finger		has reviewed them and that of		
	_	ults to be on the resident's		written into the (EMR) if appro	-	
		ation record for review. She		provider. All recommendation		
	_	d not administer insulin if		required orders will have orde		
		the current sugar level is justed based on the daily		the EMR no later than 08/18/	2022.	
	blood sugar results.	justed based off the daily		3. Measures /Systemic cha	naes to	
	biood sagai results.			prevent reoccurrence of alleg		
	The Administrator wa	as notified of immediate		practice:	,	
	jeopardy on 7/20/22			'		
	, , ,	•		As of 07/20/2022, the nurse of	consultant	
	The facility provided	a credible allegation of		educated the pharmacy direc		
		removal dated 7/21/2022.		need for all pharmacist consu		
				review new admissions and r		
		nts who have suffered, or		to conduct comprehensive re		
	are likely to suffer, a	serious adverse outcome as		includes reviewing discharge	summaries	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245020	B. WING			С	
		345039	B. WING			07/21/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, O	CITY, STATE, ZIP CODE		
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER		485 VETERANS WA	ιY		
COMMEN	TONE HEALITIAND IN	ENABLEMATION SERVER		KERNERSVILLE,	NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 756	Continued From page	e 65	F 75	66			
	a result of the nonco				ng pre-hospital admission		
	a rocalt or the fields	mphanos.			nitoring with readmission		
	Resident # 46 was de	eceased on 07/17/2022 and			onitoring and blood work		
	is no longer a resider				ensuring that the facility is		
		Pharmacy Director completed			mprehensive services for		
		nts who were potentially		1 '	nts with diabetic needs. In		
		ompliance by completing a			gularities identified, the		
	comprehensive revie			consultant ph	harmacist will notify facility	,	
	admissions/readmiss	sions for the month of July		clinical leade	ership for immediate follow	-up	
	2022. The audit con-	sisted of a review of insulin		to the medica	al provider.		
	dependent diabetics	to ensure orders for diabetic					
	monitoring are in place				22 all current pharmacy		
		wed current lab results.			who service the facility wer		
		ased on this review were			the need for all pharmacis		
		by the nurse supervisor on			to review new admissions		
		commendations may			s to conduct comprehensiv		
		bs, order changes, or			ncludes reviewing discharg	-	
		onitoring. There were no			and comparing pre-hospita	I	
	other residents impa	cted.			abetic monitoring with		
	0				orders for monitoring and	_	
		ne entity will take to alter the illure to prevent a serious			orders and ensuring that the	е	
	•	•			viding comprehensive those residents with diabet	tio	
	and when the action	m occurring or reoccurring		1	ses of irregularities identifi		
	and when the action	will be completed.			nt pharmacist will notify fac	l l	
	As of 07/20/2022 the	e nurse consultant educated			ership for immediate follow	-	
	the pharmacy director			to the medica	•	-up	
		nts to review new admissions		to the medica	ai providor.		
	•	conduct comprehensive		On 07/29/202	22, the Pharmacy director		
	review that includes	· · · · · · · · · · · · · · · · · · ·			nitoring of the pharmacy		
	summaries and comp				y a different pharmacy		
		nonitoring with readmission			ho didn⊡t complete the		
		and blood work orders and			sure there is a		
	ensuring that the faci			1	ive review that includes		
		ces for those residents with		· ·	scharge summaries and		
	diabetic needs. In ca				re-hospital admission diab	etic	
		tant pharmacist will notify			ith readmission orders for		
		ship for immediate follow-up			nd blood work orders and		
	to the medical provid				t the facility is providing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(c
		345039	B. WING _			07/	21/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMMED	STONE HEALTH AND E	DELIA DIL ITATIONI CENTED		48	85 VETERANS WAY		
SUMMERS	SIONE REALIR AND R	REHABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 756	Continued From pag	ge 66	F 7	756			
					comprehensive services for those		
	Pharmacy consultar	nts will review all discharge			residents with diabetic needs. In cases	of	
	summaries for new				irregularities identified, the consultant		
		e event the pharmacy review			pharmacist will notify facility clinical		
		dependent diabetics, the			leadership for immediate follow-up to the	ne	
	-	iew all orders to ensure			medical provider.		
	orders for diabetic n	nonitoring are in place.			1		
		armacist consultant will review			The pharmacy director will ensure that		
	_	ke recommendations to the			any new consultant pharmacists who d	oes	
	physician if order ch	anges, additional labs or			not complete the in-service training will		
	additional diabetic monitoring is required. This				not be allowed to review charts for the		
	will be completed at	the time of the initial review			facility until the training is completed.	his	
	to ensure residents	with diabetes are receiving a			in-service was incorporated into the ne	W	
	comprehensive revi	ew with the necessary care			pharmacy employee orientation for the		
	and services, monitor	oring for their diabetes.			above identified staff.		
					Any staff identified above who does no		
		egional Director of Operations			receive scheduled in-service training w		
		with the pharmacy director			not be allowed to work until training has	5	
		s for ongoing monitoring for			been completed by 08/18/2022.		
		diabetic needs, specifically			0 00/40/0000 # 0 ## 4		
	_	chart information for new			On 08/12/2022, the Quality Assurance		
		dmissions, to include			Clinical Nurse Consultant (QANC)		
		es practices for providing care			educated the DON on the following top	ICS	
		ous pharmacy audits did not ood work or orders for insulin			using the Procedures for Handling the initial pharmacy review reports as well	36	
						a 5	
	dependent diabetics	.			the regular monthly pharmacy review reports. This education also included t	hat	
	The Pharmacy Dire	ctor will in-service all			once the Note to Attending Physician	iat	
	•	are assigned reviews for the			Prescriber is completed with the provid	ere	
		2. The Pharmacy Director will			response; the DON will ensure a copy		
		ed in service packet the			scanned into the resident s record and		
		ensure the training has been			then the DON will file a copy in the bind		
	completed and for re				titled pharmacy initial or monthly review		
	The pharmacy direc	tor will ensure that any			The DON will educate any nurse		
	•	ists who does not complete			managers or nurse support staff which		
		ng will not be allowed to review			includes the Staff Development		
	charts for the facility				Coordinator (SDC), Minimum Data Set		
	completed. This in-	service was incorporated into			Nurse (MDS), Unit Support Nurse, and		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345039	B. WING _				C 21/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	. 017	LIIZUZZ
					85 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 67	F	756			
		nployee orientation for the including the agency staff			Registered Nurse (RN) Supervisor, wh assists with handling the initial pharma review reports as well as the regular monthly pharmacy review reports.		
	IJ Removal 7/21/2022	2			On 08/18/2022, the Pharmacy Consult	ant	
	removal was verified onsite validation throu interviews. The facilit the consulting pharm an audit of current diamet to discuss the ne summaries for any m readmissions. The plab work and make re on results. The facility	on of immediate jeopardy on 7/21/22 as evidenced by ugh record review, and staff y nurse consultant met with acist on 7/20/22 to complete abetic residents. They also red for reviewing discharge onitoring orders for new and harmacist will also review ecommendations depending y immediate jeopardy d to be completed as of			was contacted to add other facility tear members to receive the pharmacy reviewed including the MDS Nurse and the SDC Nurse. The team will discuss and observe completion of the pharmacy reviews in their clinical meeting to ensurompliance. This information has been integrated in the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Qual Assurance process to verify that the change has been sustained.	n ew ne i i ure	
	12/31/19 with re-entry cumulative diagnoses hypertension, chronic disease, Alzheimer 's behavioral disturbance disorder and anxiety The resident 's electric included monthly MR consultant pharmacist following, in part:On 7/6/21, an MRR pharmacist included read: "repeat."On 8/10/21, an MRI pharmacist included in the second	s included diabetes, c obstructive pulmonary s disease, dementia with te, major depressive disorder. ronic medical record (EMR) Rs completed by the tt. The MRRs included the conducted by the recommendations which			Any staff identified above who does no receive scheduled in-service training w not be allowed to work until training has been completed by 08/18/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective a that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that pharmacy review reports have been completed using the F756 Pharmacy Review Quales Assurance Tool. Monitoring of 6 reside with pharmacy reviews completed to	ill s e nd	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		345039	B. WING _			07	/21/2022
	ROVIDER OR SUPPLIER STONE HEALTH AND RE	EHABILITATION CENTER		48	TREET ADDRESS, CITY, STATE, ZIP CODE S5 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	read: "f/u (follow-up)On 10/12/21, an MF pharmacist included read: "AIMS, docum No additional informathe consultant pharma Resident #168 ' s ' s pharmacist conducte 10/25/21. The pharm read: "Initial pharma review completed. Re report." No additional related to the consult recommendations. The resident ' s EMR completed by the cor MRRs included the formation of the consult read: "AIMS, documed and the completed by the cor MRRs included the formation of the consult read: "AIMS, documed and the completed by the cor MRRs included the formation of the consult read: "AIMS, documed and the completed by the cor MRRs included the formation of the consult read: "AIMS, documed and the complete by the cor MRRs included the formation of the consult read: "AIMS, documed and the complete by the cor MRRs included the formation of the consult read: "AIMS, documed and the complete by the cor MRRs included the formation of the complete by the cor MRRs included the formation of the complete by the cor MRRs included the formation of the corp. -On 1/18/22, an MRI pharmacist included the complete by the corp. -On 4/20/22, an MRI pharmacist included the complete by the corp. -On 5/17/22, an MRI pharmacist included the complete by the corp. -On 5/17/22, an MRI pharmacist included the complete by the corp. -On 5/17/22, an MRI pharmacist included the complete by the corp.	I dose reduction)." conducted by the recommendations which , AIMS." RR conducted by the recommendations which entation." ation was provided related to acist 's recommendations. EMR revealed a consultant d an initial MRR on nacist 's note from the MRR cist medication regimen ecommendations made, see al information was provided ant pharmacist 's included monthly MRRs resultant pharmacist. The following, in part: R conducted by the recommendations which entation." R conducted by the recommendations which or."	F	756	assure compliance with procedure for handling pharmacy review reports. Quality assurance audits will be completed by the Consultant pharmaci to ensure that a comprehensive pharmacy review was completed. Monitoring will be completed weekly x weeks then monthly x 2 months or unti resolved. Reports will be presented to weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/18/2022	5 I the of ill	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER STONE HEALTH AND	REHABILITATION CENTER	4	TREET ADDRESS, CITY, STATE, ZIP CODE 85 VETERANS WAY ERNERSVILLE, NC 27284			
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F 756	Continued From pa		F 756				
	pharmacist for Respharmacist note remedication regimer Recommendations additional informaticonsultant pharmacist consultant pharmacist consultant pharmacist recommendations additional informaticonsultant pharmacist consultant pharmacist consultant pharmacist review of Responsible to the resiprovide details from dated 7/6/21, 8/10/1/18/22, 2/15/22, 36/9/22, or 6/14/22. documentation in Frecord to indicate the findings / recommeresponse was recesponse was recesponse was recesponse was recesponsed in the resident so diseased depression. The resident selection in Frecord to indicate the findings of the recommeresponse was recesponse was recesponsed in the resident selection. The resident selection in Frecord to indicate the findings of the resident selection. The resident selection in Frecord to indicate the findings of the recommendation in Frecord to indicate the findings of the recommendation in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate the findings of the resident selection in Frecord to indicate	completed by a consultant ident #168 on 6/9/22. The ad, "Initial pharmacist in review completed. made, see report." No on was provided related to the cist 's recommendations. thly MRR was conducted by macist. The pharmacist read: "documentation." No on was provided related to the cist 's recommendations. desident #168 's EMR revealed macy Consultation Reports dent 's medical record to in the MRR recommendations 21, 9/7/21, 10/12/21, 10/25/21, 1/18/22, 4/20/22, 5/17/22, Additionally, there was no desident #168 's medical ne consultant pharmacist 's indations were reviewed or a lived from the provider. It was admitted to the facility on allative diagnoses included see, osteoporosis, and ctronic medical record (EMR) IRRs completed by the cist. The MRRs included the drecommendations which all dose reduction."					

	ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRU	(X3) DATE SURVEY COMPLETED			
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2-c) Resident #4 wa 12/5/18. Her cumular diabetes, renal insufficial disorder with mixed at the resident 's electric included monthly MR consultant pharmacist following, in part:On 7/7/21, an MRR pharmacist included read: "repeat, documerad: "repeat, documerad: "repeat, documerad: "documentationOn 8/10/21, an MRR pharmacist included read: "documentationOn 12/8/21, an MRR pharmacist included read: "lab."On 1/18/22, an MRR pharmacist included read: "lab."On 2/16/22, an MRR pharmacist included read: "GDR, repeat." No additional information the consultant pharmacist included read: "GDR, repeat." No additional information and the consultant pharmacist included insultant pharmacist included in pharmac	s admitted to the facility on tive diagnoses included ciency, and an adjustment nxiety and depressed mood. Tonic medical record (EMR) Rs completed by the t. The MRRs included the recommendations which entation." R conducted by the recommendations which on." R conducted by the recommendations which recommen	F 78	56		
pharmacist included r	ecommendations which				
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR LETTER CONTINUED FOR INTERPRETATION OF ITERACT	ROVIDER OR SUPPLIER STONE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 71 2-c) Resident #4 was admitted to the facility on 12/5/18. Her cumulative diagnoses included diabetes, renal insufficiency, and an adjustment disorder with mixed anxiety and depressed mood. The resident 's electronic medical record (EMR) included monthly MRRs completed by the consultant pharmacist. The MRRs included the following, in part:On 7/7/21, an MRR conducted by the pharmacist included recommendations which read: "repeat, documentation."On 8/10/21, an MRR conducted by the pharmacist included recommendations which read: "documentation."On 12/8/21, an MRR conducted by the pharmacist included recommendations which read: "lab."On 1/18/22, an MRR conducted by the pharmacist included recommendations which read: "lab."On 2/16/22, an MRR conducted by the pharmacist included recommendations which read: "lab."On 2/16/22, an MRR conducted by the pharmacist included recommendations which read: "GDR, repeat." No additional information was provided related to the consultant pharmacist 's recommendations. Resident #4 's most recent Minimum Data Set (MDS) was a quarterly assessment revealed she had cognitively intact skills for daily decision making. The MDS reported the resident 's medications included insulin injection and antidepressant medication on 7 out of 7 days during the look	ROVIDER OR SUPPLIER STONE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 71 2-c) Resident #4 was admitted to the facility on 12/5/18. Her cumulative diagnoses included diabetes, renal insufficiency, and an adjustment disorder with mixed anxiety and depressed mood. The resident 's electronic medical record (EMR) included monthly MRRs completed by the consultant pharmacist. The MRRs included the following, in part: -On 7/7/21, an MRR conducted by the pharmacist included recommendations which read: "repeat, documentation." -On 8/10/21, an MRR conducted by the pharmacist included recommendations which read: "lab." -On 12/8/21, an MRR conducted by the pharmacist included recommendations which read: "lab." -On 2/16/22, an MRR conducted by the pharmacist included recommendations which read: "lab." -On 2/16/22, an MRR conducted by the pharmacist included recommendations which read: "lab." No additional information was provided related to the consultant pharmacist's recommendations. Resident #4's most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/18/22. The MDS assessment revealed she had cognitively intact skills for daily decision making. The MDS reported the resident's medications included insulin injection and antidepressant medication on 7 out of 7 days during the look back period. On 7/17/22, a monthly MRR conducted by the pharmacist included recommendations which	ROWIDER OR SUPPLIER STONE HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOUL). REGULATORY OR LSC DENTFYMOS INFORMATION) Continued From page 71 2-c) Resident #4 was admitted to the facility on 12/5/18. Her cumulative diagnoses included diabetes, renal insufficiency, and an adjustment disorder with mixed anxiety and depressed mood. The resident's electronic medical record (EMR) included monthly MRRs completed by the consultant pharmacist included recommendations which read: "lab." On 8/10/21, an MRR conducted by the pharmacist included recommendations which read: "lab." On 1/18/22, an MRR conducted by the pharmacist included recommendations which read: "lab." On 1/18/22, an MRR conducted by the pharmacist included recommendations which read: "lab." On 1/18/22, an MRR conducted by the pharmacist included recommendations which read: "GDR, repeat." No additional information was provided related to the consultant pharmacist's recommendations. Resident #4 's most recent Minimum Data Set (MDS) was a quarterly assessment revealed she had cognitively intact skills for daily decision making. The MDS reported the resident's medications included insulin injection and antidepressant medication on 7 out of 7 days during the look back period.	A BUILDING

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F 756	recommendations. Further review of Re there were no Pharm included in the reside provide details from dated 7/7/21, 8/10/2 or 7/17/22. Addition documentation in Re to indicate the consurecommendations where was received from the 2-d) Resident #65 who 7/3/18. Her cumulated anemia, hypertension obstructive pulmonal disorder and depressional transportation of the consultant pharmacist included monthly MF consultant pharmacist included read: "prn (as neededed: "prn (as neededed: "f/u (follow-up)On 10/11/21, an MR pharmacist included read: "f/u (follow-up)On 10/11/21, an MR pharmacist included read: "repeat."On 12/8/21, an MR pharmacist included read: "lab, documer)On 1/18/22, an MR pharmacist included read: "lab, documer)On 1/18/22, an MR	sident #4 's EMR revealed hacy Consultation Reports ent 's medical record to the MRR recommendations 1, 12/8/21, 1/18/22, 2/16/22 ally, there was no sident #4 's medical record Itant pharmacist 's findings / ere reviewed or a response re provider. as admitted to the facility on ive diagnoses included in, renal insufficiency, chronic ry disease (COPD), anxiety sion. Bronic medical record (EMR) RRs completed by the st. The MRRs included the recommendations which italians which R conducted by the recommendations which tation."	F 7	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 756	On 2/16/22, an MF pharmacist included read: "repeat."On 3/19/22, an MF pharmacist included read: "documentatirOn 4/20/22, an MF pharmacist included read: "clinical doc (No additional inform the consultant pharmacist included read: "clinical doc (No additional inform the consultant pharmacist yield in the maximum to the maximum	RR conducted by the I recommendations which RR conducted by the I recommendations which on." RR conducted by the I recommendations which documentation)." Ration was provided related to macist 's recommendations. st recent Minimum Data Set al assessment dated 7/8/22. Ent revealed she had docognitive skills for daily the MDS reported the resident anded an antidepressant, domedication on 7 out of 7 on 1 out of 7 days during the	F 756			

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F 756	Continued From page	ge 74	F 75	56			
	4/1/22. His cumula	vas admitted to the facility on tive diagnoses included a pertension, heart failure, and					
	(MDS) was a quarte 5/13/22. The MDS moderately impaired decision making. T 's medications inclu	est recent Minimum Data Set erly assessment dated assessment revealed he had d cognitive skills for daily he MDS reported the resident aded an antidepressant, diuretic medication on 7 out of ok back period.					
	included monthly M consultant pharmac following, in part:On 5/16/22, an MF pharmacist included read: "documentaticOn 6/13/22, an MF pharmacist included read: "lab, repeat."On 7/17/22, an MF pharmacist included read: "repeat." No additional inform	etronic medical record (EMR) RRs completed by the ist. The MRRs included the RR conducted by the if recommendations which in." RR conducted by the if recommendations which RR conducted by the if recommendations which it recommendations which it recommendations which ination was provided related to macist 's recommendations.					
	there were no Phari included in the resic provide details from dated 5/16/22, 6/13 there was no docun medical record to in	esident #15 's EMR revealed macy Consultation Reports dent 's medical record to the MRR recommendations /22 or 7/17/22. Additionally, nentation in Resident #15 's dicate the consultant as / recommendations were					

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F 756	provider. 2-f) Resident #24 wa 5/21/22. His cumulat history of multiple fra unspecified dementia disturbance. The resident 's elect revealed a consultan initial pharmacist med (MRR) on 5/23/22. The MRR included do "Initial pharmacist med completed. Recommon Resident #24 's adma (MDS) dated 5/27/22 impaired cognitive sk The resident 's MDS medications included on 4 out of 7 days and days during the look The resident 's EMR monthly MRRs compon pharmacist: On 6/13/22, an MRI pharmacist included read: "documentatio Involuntary MovemerOn 7/17/22, an MRI pharmacist included read: "repeat, AIMS. Further review of Resthere were no Pharm	se was received from the s admitted to the facility on tive diagnoses included a ctures, hypertension and the with behavioral ronic medical record (EMR) the pharmacist conducted an dication regimen review the pharmacist 's note from cumentation which read: edication regimen review endations made, see report." ission Minimum Data Set revealed he had moderately ills for daily decision making. assessment indicated his an antipsychotic medication d a diuretic on 5 out of 7 back period. included the following leted by the consultant R conducted by the recommendations which n, AIMS (Abnormal at Scale)." R conducted by the recommendations which	F7	756			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
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F 756	Continued From pag provide details from dated 5/23/22, 6/13/3 there was no docum medical record to incompharmacist 's finding reviewed or a responsive form 2/16/22 - 5/23/2 float DON was asked recommendations, comprovider response form 2/16/22 - 5/23/2 float DON was asked recommendations, comprovider response form 2/18, Resident #4, From the facility of the following a following a following a following pharmacist MRR country and the resident elsewhere in the facility. An interview was con AM with the facility. During the interview, describe the process sharing the MRR moderate in the MRR moderate was not as the facility.	the MRR recommendations 22, or 7/17/22. Additionally, entation in Resident #24 's licate the consultant gs / recommendations were use was received from the additionally inducted on 7/19/22 at 10:27 the floating Director of Nursing is the facility 's Interim DON 22. During the interview, the diff the consultant pharmacist consultation reports and resident #168, Resident #25, are available for review. The terview conducted with the ported only one "Note to Prescriber" originating from a all did be located. She stated no recommendations were is 'medical records or	F 7	DEFICIENC			
	she would write a prosper selection of the selection of t	ogress note in each resident ' nether or not she had ndations. She reported some ere intended for nursing staff into a "Nursing Note." Other ndations were intended for narmacist reported she would					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 756	recommendations via Regional Nurse Cons "important or urgent" stated it was up to the distribute/delegate the pharmacist reported upload the pharmacy responses from the pEMR. When asked, reiterated she would recommendations with to be scanned into ear medical record. A telephone interview at 2:00 PM with the factory or them. She reported she would be recommendations, rethem. She reported she recommendations her book. The NP state recommendations be done, and gave the NP reported the DON changes into the resi was the NP's under give these reports to scanned in to the resi and interview was con PM with the facility's interview, the DON reconcern regarding the recommendations and being available for rewould expect the reg	a email to the DON and sultant and would flag issues. The pharmacist e DON to print and e Nursing Notes. The she has asked the facility to recommendations with provider into each resident 's the consultant pharmacist expect the pharmacy that the provider 's response ach resident 's electronic are was conducted on 7/20/22 facility 's Nurse Practitioner erview, the NP described the preceiving the pharmacist's eviewing, and responding to she received the pharmacist when the DON put them in lated she typically reviewed so, noted what she wanted to see back to the DON. The lawould enter any order dent 's EMR. After that, it is standing that the DON would medical records to be ident's EMR.	F	756			

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F 756	1/5/2018 with diagnor infarction, Parkinson dementia, and anxie A review of the quark (MDS) dated 5/25/20 had severe cognitive disorganized thinking directed towards oth documented she recand an antidepressal lookback period. The routine basis only. A review of the elect Resident #22 reveal was completed on the A review for 12/6/2021 Consultant #1 for Rean antipsychotic mental A review of the Pharman review for 1/17/2022 Consultant #1 for Rean antipsychotic mental for an AIMS A review of the Pharman review for 2/15/2022 Consultant #1 for Rean antipsychotic mental for an AIMS A review of the Pharman review for 2/15/2022 Consultant #1 for Rean antipsychotic mental for an AIMS A review of the Pharman review for 2/15/2022 Consultant #1 for Rean antipsychotic mental for an AIMS A review of the elect Resident #22 reveal assessment was consultant was cons	pses that included a cerebral also disease, depression, and ty. Iterly Minimum Data Set also disease, depression, and ty. Iterly Minimum Data Set also disease, depression, and ty. Iterly Minimum Data Set also disease, depression, and ty. Iterly Minimum Data Set also disease, and ty. Iterly Minimum Dat	F7	756		

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					VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			RNERSVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 79	F 7	756			
	Consultant #1 for Res	written by the Pharmacy sident #22 requested an ident continuing to receive ication.					
	review for 7/16/2022 Consultant #1 for Res request for an AIMS f	nacy medication regimen written by the Pharmacy sident #22 repeated the for the Resident due to her an antipsychotic medication.					
	conducted with the U revealed she received consultant with the nuregimen review record also stated when to consust assessment. She revealed she seems assessment. She revealed she seems assessment assessment of Nursing be AIMS assessments with the seems assessment of Nursing be AIMS assessments with the seems assessment of Nursing be AIMS assessments with the seems assessment of Nursing be AIMS assessments with the seems assessment of Nursing be AIMS assessments with the seems of Nursing be AIMS assessments with the Nursing be AIMS assessments	d emails from the pharmacy ursing monthly medication inmendation and request that onduct an AIMS ealed she was not sure if it were due every three is and would need to ask her ecause she completed the when she received in the emails from the and Minimum Data Set in reviewed the chart for realed she was able to see consultant documented the con 12/6/2021, 1/17/2022, it is again on 6/13/2022 and it is dishe had been out of work une, 2022 and was not sure been emailed to but the eted in June 2022 as alled in December 2021 and tent Director of Nursing bloyed and the emails were					
		OON. The nursing quested from the Pharmacy n to be sent to the Unit					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 07/21/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	0112112022
(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)	5.475
F 759 SS=E	the follow up. She add not completed until Mean to completed until Mean to completed until Mean to complete until Mean to complete until Mean to complete until Mean to consultant recomment to be expedited as question to the situation and mean to be expedited as question to the situation and mean to be expedited as question and the situation and mean to be expedited as question and the situation and mean to be expedited as question and the situation and mean to be expedited as question and the situation and the	to the DON to improve on ded the second AIMS was larch of 2022. ducted with the interim DON revealed the facility protocol ent was to be conducted every 6 months. He stated follow up on Pharmacy ndations was for the request eickly as possible based on lication. He added a request e an AIMS, the goal was for kly as possible, and this before the pharmacist month. The Errors are not 5 The is not met as evidenced The instance of the second of the	F 759		:

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 07/21/2022
NAME OF PI	ROVIDER OR SUPPLIER	I .		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0112112022
				485 VETERANS WAY	
SUMMERS	STONE HEALTH AND RI	EHABILITATION CENTER		KERNERSVILLE, NC 27284	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
F 759	Continued From pag	e 81	F 759	9	
	history of multiple fra	actures and hypertension.		indicated.	
	Aide) #1 was observ	AM, Medication Aide (Med ed as she checked Resident		F759	
	_	is vital signs included a blood		Corrective action for resident(s)	
		nd pulse of 69 beats per		affected by the alleged deficient practice.	
	,	the resident 's vital signs		On 08/11/2022 the Director of Nurse	
		aide was observed as she		assessed resident #24, there were r	10
	• •	dications for administration to		findings of harm to resident #24.	
		nedications pulled for		Additionally, the MD was notified of	
	administration included one tablet of 100 medication errors for resident #24 milligrams (mg) metoprolol succinate (an 07/19/2022 and there were no new		n		
	extended release for	•	07/19/2022 and there were no new orders. Medication aide #1 has not		
		edication). The med aide was		worked since the facility was notified	Lof
	observed as she crus			the alleged deficient practice.	
	succinate tablet alon			the aneged denoterit practice.	
		ed aide stirred the crushed		2. Corrective action for residents wi	th the
		udding as she prepared to		potential to be affected by the deficie	
	administer them to R			practice:	
				All resident receiving medications ha	ave
	On 7/17/22 at 10:32	AM, Med Aide #1 was asked		potential to be affected.	
	to stop before going	into Resident #24 ' s room			
	with the medications	prepared for administration.		On 07/20/2022 and 07/21/2022, the	
	When she was inforr	med the metoprolol succinate		Pharmacy Consultant completed rar	ndom
	tablet could not be ci			medication administration observation	ons
		e #1 came to the med cart to		with licensed nurses and medication	aides
		At that time, Nurse #1 told		to validate staff competency with	
		ull the medications for		medication administration.	
		structed her not to crush the			
	T	tablet. The med aide was		On 08/11/2022 the DON began audi	ting
		he prepared the resident 's		100% of resident medication	.:41-
		inistration. She placed the		administration records of residents v	vitn
		tablet (whole) into a med		active orders for metoprolol with	with
		led Aide #1 administered the Resident #24 on 7/17/22 at		parameters and hydrochlorothiazide	
	10:43 AM.	\esiueiii #∠4 Uii // //∠∠ äl		parameters to identify any administr	
	10.43 AW.			of medications outside of the param or residents who receive their medic	
	According to Lavi Ca	omp, a comprehensive		crushed and have orders for enteric	alions
		n database, metoprolol		coated aspirin which should not be	
		i database, illetopiolei	1	Todatod dopinin willon onload fill be	1

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345039	B. WING _				21/2022
NAME OF PR	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	077	21/2022
					5 VETERANS WAY		
SUMMERS	TONE HEALTH AND RE	EHABILITATION CENTER			ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	Continued From page	e 82	F 7	759			
F 759	succinate tablets shochewed. A review of Resident conducted on 7/18/2: received on 6/7/22 for succinate to be giventime a day for hypertimicluded instructions systolic blood pressurate less than 60 bpm the maximum pressurate less than 60 bpm the	#24 's medication orders 2 revealed an order was or 100 mg metoprolol as one tablet by mouth one ension. The order also to hold this medication for a re less than 120 and a heart a. Systolic blood pressure is re the heart exerts while sented by the top number of ding. aducted with Med Aide #1 on At that time, the Med Aide s on Resident #24's July ministration Record (MAR) at the time of the medication vation on 7/17/22. When she ital sign results, and der for Resident #24 's , Med Aide #1 stated she inistered this medication to aducted on 7/19/22 at 10:47 s Interim Director of Nursing nterview, the observations dication administration pass en asked about crushing a tablet, the DON stated, "If		759	crushed. The results of the audit were shared with the physician. There were new orders received. Corrections were made to add supplemental information the order to aid in monitoring of the parameters. Medication error reports v completed for resident #24. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice: On 07/25/2022 the SDC Nurse began educating all full time, part time, and pr licensed nurses Registered Nurses (RN and Licensed Practical Nurses (LPN), a medication aides including agency staff the following topics: " Prevention of medication errors " Following Medication orders for parameters " Following the 6 rights of medication administration Beginning 08/11/2022, the SDC will validate competency of following parameters and crushing medications. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive schedulin-service training will not be allowed to work until training has been completed 08/18/2022.	e in vas vas nt n N) and fon	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
	345039	B. WING _		_	07/:	21/2022
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STA	TE, ZIP CODE	1 0	
			485 VETERANS WAY			
SUMMERSTONE HEALTH AND REHA	ABILITATION CENTER		KERNERSVILLE, NC 272	284		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 759 Continued From page 8	3	F 7	59			
DON stated he would exfollow the guideline as it When asked if the medical administered to Resider his vital signs taken, the according to the way the When asked, the DON sonursing staff, "To follow order) specifies." When should have been admingiven the results of his vital stated, "Not according to written." 2) Resident #24 was ad 5/21/22. His cumulative history of multiple fracture of 115/65 and pulse of 60 (bpm). After the resider taken, the med aide was prepared 10 oral medical Resident #24. The medical administration included milligrams (mg) hydroch Med Aide #1 administer hydrochlorothiazide (alo medications) to Resident #2 conducted on 7/18/22 received on 6/7/22 for 2	expect nursing staff, "To to the order) specifies." cation should have been in #24 given the results of the DON stated, "Not the order was written." stated he would expect the guideline as it (the asked if these meds instered to Resident #24 wital signs taken, the DON to the way the order was the way the order was the diagnoses included a tres and hypertension. If, Med Aide #1 was the dealth was the dealth was the dealth was the diagnoses included a tres and hypertension. If, Med Aide #1 was the diagnoses included a blood pressure to be beats per minute that 's vital signs were is observed as she attorns for administration to dications pulled for one tablet of 25 inforothiazide (a diuretic), and the way the other oral and #24 on 7/17/22 at 10:43	F 7	1. Monitoring Proceed the plan of correction specific deficiency of and/or in compliance requirements. The DON or Designate compliance utilizing Observation Tool we monthly x 2 months Audits will occur on days of the week to assure that we are freerror rates less than include monitoring in employees RN□s, Laides on various shift ensure corrective accurate appropriate. Compliand the ongoing audited to reviewed at the week Meeting. The weekly attended by the Adm Nursing, MDS Coord Manager, Health Informand the Dietary Manager of Compliances.	in is effective and the ited remains correcte with regulatory the F759 Medication eekly x 5 weeks the or until resolved. Various shifts and include weekends free of medication pass of LPN s, or medication pass of LPN s, or medication is initiated as ance will be monitoditing program ekly Quality Assurary QA Meeting is ministrator, Director dinator, Therapy formation Manager, mager.	on en to ill 4 on et to ored once	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345039	B. WING			C 07/21/2022	
	DER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 485 VETERANS WAY KERNERSVILLE, NC 27284		7112112022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
ins blockers may an	sod pressure less is than 60 bpm. So eximum pressure discrepresented by the sesure reading. Interview was considered a service of the order of th	this medication for a systolic than 120 and a heart rate ystolic blood pressure is the the heart exerts while beating by the top number of a blood anducted with Med Aide #1 on At that time, the Med Aide #1 on At that time, the Med Aide #1 on At the time of the medication rotation on 7/17/22. When she wital sign results, and roter for Resident #24's and roter for Resident #24's yellow and the wital sign results, and roter for Resident #24's yellow and heart wital sign results, and roter for Resident #24's yellow and heart wital sign results in the ministered this medication to had action administration pass had discussing the vital sign ructions provided in the hydrochlorothiazide, the lad expect nursing staff, "To as it (the order) specifies." hedication should have been ident #24 given the results of the DON stated, "Not yethe order was written."	F 75	9			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345039	B. WING		,	C 17/21/2022	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 485 VETERANS WAY KERNERSVILLE, NC 27284		772172022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 759	pulled for administrof 81 milligrams (maspirin. The med a crushed the EC aspectations. The medications. The medications into a padminister them to the medication when the medication into pulsassist the medication structure as the EC aspirin for the then crushed two clother oral medications into pulsassist the medications into pulsassist the medications where or the medications in the pulsassist the medication in the medication in the pulsassist the medication in the medic	esident #24. The medications ation included two (2) tablets g) Enteric Coated (EC) ide was observed as she birin tablets with 7 other oral med aide stirred the crushed budding as she prepared to Resident #24. 2 AM, Med Aide #1 was asked g into Resident #24 's room s prepared for administration.	F 75	59			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345039	B. WING _				C 21/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	21/2022
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			85 VETERANS WAY ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 759	Continued From page	e 86	F7	759			
		e given by mouth one time a of 7/3/22 (scheduled for 9:00					
F 760 SS=D	AM with the facility 's (DON). During the in made during the med were discussed. Who aspirin tablets, the DO listed as one medicat doctor specifies shou staff) should follow th	ducted on 7/19/22 at 10:47 Interim Director of Nursing terview, the observations ication administration pass en asked about crushing EC ON stated, "If those are ion the manufacturer and Id not be crushed, (nursing ose guidelines." If Significant Med Errors	F	760			8/18/22
	The facility must ensu §483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on observation pharmacist, and Nursinterviews and record hold the administration medications when a releast rate were outside indicated by his physifor 1 of 6 residents (Finedications administrations observations. The findings included Resident #24 was ad 5/21/22. His cumulations	is not met as evidenced is, staff, consultant is Practitioner (NP) review, the facility failed to in of antihypertensive resident 's blood pressure / de of the parameters ician orders. This occurred resident #24) reviewed for rered during the med pass			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 correctic constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 1. Corrective action for resident(s)	al ken	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345039	B. WING _			07/	21/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CHMMED	STONE HEALTH AND DE	HABILITATION CENTER		4	85 VETERANS WAY			
SUMMERS	STONE REALIR AND RE	HABILITATION CENTER		K	KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 760	F 760 Continued From page 87		F 7	760				
F 760	Resident #24 's admincluded the following25 milligrams (mg) hidiuretic) to be given a daily for hypertension100 mg metoprolol selease formulation of medication) to be given once daily for hypertension of medication of medication and the following once daily for hypertension on the following once daily for hypertension on th	ission orders dated 5/21/22 I, in part: hydrochlorothiazide (a list one tablet by mouth once of; succinate (an extended of an anti-hypertensive en as one tablet by mouth ension. Ission Minimum Data Set revealed he had moderately ills for daily decision making. I extensive assistance for g, eating, and personal eally dependent on staff for g. Resident #24 's MDS tory of fall(s) 2 to 6 months d a fracture related to a fall to his admission to the 's MDS assessment also d two or more falls without esion to the facility. Plan included an area of eave had actual falls with risk ted: 5/26/22; Revision on d interventions included, in the Initiated: 5/29/22; and Medication Adjustment exp. In 's order was received to and heart rate parameters for	F 7	760	affected by the alleged deficient practic On 08/11/2022 the Director of Nurses (DON) assessed resident #24, there we no findings of harm to resident #24. Additionally, the MD was notified of medication errors for resident #24 on 07/19/2022 and there were no new orders. Medication aide #1 has not worked since the facility was notified of the alleged deficient practice. 2. Corrective action for residents with potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. On 07/20/2022 and 07/21/2022, the Pharmacy Consultant completed randomedication administration observations with licensed nurses and medication aid to validate staff competency with medication administration. On 08/11/2022 the DON began auditing 100% of resident medication administration records of residents with active orders for metoprolol with parameters and hydrochlorothiazide with parameters to identify any administration of medications outside of the parameter or residents who receive their medicatic crushed and have orders for enteric coated aspirin which should not be crushed. The results of the audit were	ere f the des g th on ers ons		
	the new order was 6/2 25 mg hydrochlorotl	8/22. The order included: niazide to be given as one daily for hypertension; Hold			shared with the physician. There were new orders received. Corrections were made to add supplemental information)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING			C	
NAME OF D	DOMBED OF OURDINED	343039	B. WING _	0.TDEET ADDRESS SITV STATE 71D SI	•	/21/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
SUMMERS	STONE HEALTH AND	REHABILITATION CENTER		485 VETERANS WAY			
		-		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From page 88			60			
F 760	for Systolic Blood pressure the hear represented by the pressure reading) (HR) less than 60 scheduled to be a 9:00 AM each day100 mg metoprotablet by mouth of for SBP less than Metoprolol succinal administered to the Resident #24 's JAdministration Remark documented succinate and hydrochlorothiazid been administeredOn 6/16/22, the HR was 65; both hydrochlorothiazid been administeredOn 6/20/22, the HR was 88; both hydrochlorothiazid been administeredOn 6/21/22, the HR was 80; both hydrochlorothiazid been administeredOn 6/29/22, the HR was 62; both hydrochlorothiazid been administeredOn 6/29/22, the HR was 62; both hydrochlorothiazid been administeredOn 6/29/22, the HR was 62; both hydrochlorothiazid been administeredOn 6/29/22, the HR was 62; both hydrochlorothiazid	Pressure (SBP is the maximum t exerts while beating and is e top number of a blood less than 120 and Heart Rate. Hydrochlorothiazide was dministered to the resident at v. lol succinate to be given as one nee daily for hypertension. Hold 120 and HR less than 60. ate was also scheduled to be e resident at 9:00 AM each day. une 2022 Medication cord (MAR) was reviewed. The lather resident 's metoprolol drochlorothiazide were given on ing dates when the SBP / HR parameter indicated by the resident 's SBP was 118 and metoprolol succinate and de were documented as having dato the resident by Nurse #2. resident 's SBP was 118 and metoprolol succinate and de were documented as having dato the resident by Nurse #3. resident 's SBP was 104 and metoprolol succinate and de were documented as having dato the resident by Nurse #4. resident 's SBP was 112 and metoprolol succinate and de were documented as having dato the resident by Nurse #4. resident 's SBP was 112 and metoprolol succinate and de were documented as having dato the resident by Nurse #4. resident 's SBP was 112 and metoprolol succinate and de were documented as having dato the resident by Nurse #4.	F 7	the order to aid in monitorin parameters. Medication err completed for resident #24. " Preventing medication " Validating competency medication parameters " 6 rights of medication a " Following medication s " Following medication s a " Following medication characters: Education: On 07/25/2022 the SDC Nu educating all full time, part to licensed nurses Registered and Licensed Practical Nurse medication aides including a the following topics: " Prevention of medication of parameters " Following Medication of parameters " Following the 6 rights of administration Beginning 08/11/2022, the Solution of the preventing medication error Time, Part Time, and (PRN) LPNs, and Medication Aides	errors following administration afety practices ages to eged deficient rse began ime, and prn Nurses (RN) ses (LPN), and agency staff on on errors rders for of medication SDC will education on s to all Full Nurses; RNs, s.		
	A telephone interv	d to the resident by Nurse #5. riew was conducted on 7/20/22 urse #2. Nurse #2 was		This in-service was incorport new employee facility orient above-mentioned employee provided to agency staff wo	ation for the es and also		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
						С
		345039	B. WING _			07/21/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	
				485 VETERANS WA	AY	
SUMMER	STONE HEALTH AND	REHABILITATION CENTER		KERNERSVILLE,	, NC 27284	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 760	Continued From p	age 89 Jency (temporary) nurse who	F7	60 facility. This	s will be reviewed by the	
	_	e MAR that Resident #24 ' s			urance process to verify that	t l
	metoprolol succina	ate and hydrochlorothiazide I on 6/16/22 when his SBP / HR			has been sustained.	
	parameters indica	ted the medications should		Any staff wh	no does not receive schedul	ed
		During the interview, the			aining will not be allowed to	
		gns and physician 's order			aining has been completed	by
		The nurse reported she typically		08/18/2022.		
		ne medications under these d coded the MAR to indicate		4 Monitorin	ng Procedure to ensure that	
		not given. Nurse #2 stated that			orrection is effective and th	
		lent 's blood pressure was			ciency cited remains correc	
		dications were administered.			mpliance with regulatory	
		ry, the nurse would not		requirements		
	elaborate on this o	-				
					Designee will monitor	
		iew was conducted on 7/20/22			utilizing the F760 Medication	
		urse #3. Nurse #3 was			Tool weekly x 5 weeks the	n
		jency nurse who documented			months or until resolved.	
		Resident #24 ' s metoprolol rochlorothiazide were			ccur on various shifts and	
	,	rochlorothlazide were /20/22 when his SBP / HR			week to include weekends t we are free of significant	.0
		ted the medications should			errors. This will include	
	·	When asked, the nurse reported			nedication pass of 4	
		s not given, he would check a			RN□s, LPN□s, or medicatio	on
		nic MAR to indicate the med			rious shifts, halls, and days	
	was not given "pei	parameters." He reported a			ective action is initiated as	
	check mark with h	is initials would indicate the		appropriate.	Compliance will be monitor	red
	medication(s) was	administered.			oing auditing program	
					the weekly Quality Assuran	ce
		conducted on 7/20/22 at 2:49			e weekly QA Meeting is	_
		Nurse #4 was identified as an			the Administrator, Director	of
	, ,	documented on Resident #24 '		J	OS Coordinator, Therapy	
		etoprolol succinate and le were administered on 6/21/22			ealth Information Manager, tary Manager.	
	•	R parameters indicated the		and the Diet	.ary iviariayer.	
		d have been held. During the				
		at #24 's June MAR was				
		nurse. The MAR included the		ate of Comp	oliance: 08/18/2022	

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING_				C 21/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		485 VETE	DDRESS, CITY, STATE, ZIP CODE RANS WAY SVILLE, NC 27284	<u>1 011</u>	21/2022
(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 760	resident 's SBP / HR nurse 's initials to ind given on this date. Wand documentation on urse stated she did she made an error in administering the mewhen she should not. Nurse #5 could not be interview. Nurse #5 wurse who documente that his metoprolol surbydrochlorothiazide when his SBP / HR pmedications should have his signs prior to a medications. The results a blood pressure of 1 Med Aide #1 was observed to mydrochlorothiazide to 10:43 AM. An interview was con 7/18/22 at 1:40 PM. Awas shown the orders and the vital sign results, and paramete #24 's metoprolol surbydrochlorothiazide, for the medication admin 7/17/22. Upon review results, and paramete #24 's metoprolol surbydrochlorothiazide, for the metal was documentation admin 7/17/22. Upon review results, and paramete #24 's metoprolol surbydrochlorothiazide, for the medication admin 7/17/22 was shown the orders and the vital sign results, and paramete #24 's metoprolol surbydrochlorothiazide, for the medication admin 7/17/22 was shown the orders and the vital sign results, and parameter #24 's metoprolol surbydrochlorothiazide, for the medication admin 7/17/22 was shown the orders and the vital sign results, and parameter #24 's metoprolol surbydrochlorothiazide, for the medication admin 7/17/22 was shown the orders and the vital sign results, and parameter #24 's metoprolol surbydrochlorothiazide, for the medication admin 7/17/22 was shown the orders and the vital sign results, and parameter #24 's metoprolol surbydrochlorothiazide, for the medication admin 7/17/22 was shown the orders and the vital sign results, and parameter #24 's metoprolol surbydrochlorothiazide, for the medication admin 7/17/22 was shown the orders and the vital sign results was shown the orders and the vital sign results was shown the orders and the vital sign results was shown the orders and the vital sign results was shown the orders and the vital sign results was shown the orders and the vital sign results was shown the orders and the vital sign results was shown the orders a	and a check mark with the licate the medications were then shown the information in Resident #24 's MAR, the not know for sure whether charting or an error in dications to the resident have. The reached for a telephone was identified as an Agency ed on Resident #24 's MAR occinate and the very administered on 6/29/22 arameters indicated the lave been held. The reached for a telephone was identified as an Agency ed on Resident #24 's MAR occinate and the lave been held. The reached for a telephone was identified as an Agency ed on Resident #24 's MAR occinate and the lave been held. The reached for a telephone was identified as an Agency ed on Resident #24 's MAR occinate and 25 mg or Resident #24 on 7/17/22 at lave was she administered on the late of the late of late with Med Aide #1 on the late of late with Med Aide #1 on the late of late with Med Aide #1 on late of late with Med Aide #1 on late of late with Med Aide #1 on late of	F	760			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 07/2	1/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	I ZIP CODE	0112	1/2022	
				485 VETERANS WAY				
SUMMER	STONE HEALTH AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		I	(X5) COMPLETION DATE	
F 760	at 3:56 PM with the N cared for Resident #2 NP stated, "If there a order), they should be reported the reason per the anti-hypertensive because it was though falling due to orthosta added, "The paramet to be on the safe side stated the orders give and hydrochlorothiaz if only one or the other met, the medication of AM with the facility's During the interview, metoprolol succinate were reviewed, along	was conducted on 7/19/22 Jurse Practitioner (NP) who 24. During the interview, the re parameters there (on the e followed." The NP parameters were added to medication orders was th Resident #24 may be etic hypotension. She ers were implemented just e." When asked, the provider en for metoprolol succinate ide would have indicated that er of the parameters was	F7	760				
	documented instance 6/21/22 and 6/29/22 and 6/29/22 and the resident 's SBP / the medications should discussed. When as regarding the metoprhydrochlorothiazide b #24 's SBP was less stated, "They should further inquiry, the collist could be pretty sig (metoprolol succinate An interview was continuous medical states).	es of 6/16/22, 6/20/22, and the observation of these iministered on 7/17/22 when HR parameters indicated and have been held were also ked what her thoughts were colol succinate and being given when Resident than 120, the pharmacist of the been given." Upon insultant pharmacist stated, inficant with both of them and hydrochlorothiazide)." ducted on 7/19/22 at 10:47 is Interim Director of Nursing						

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345039	B. WING				21/ 2022
	OVIDER OR SUPPLIER TONE HEALTH AND RE	EHABILITATION CENTER	•	STREET ADDRESS, CIT 485 VETERANS WAY KERNERSVILLE, N			-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761 SS=E	medication orders for hydrochlorothiazide a were discussed. The expect nursing staff, (the order) specifies.' medications should h Resident #24 given the taken, the DON state the order was written Label/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling or Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In according Federal laws, the facilities biologicals in locked temperature controls personnel to have acceptable storage of controlled the Comprehensive Econtrol Act of 1976 a abuse, except when the package drug distributions.	uctions provided in the Resident #24 's and metoprolol succinate DON stated he would "To follow the guideline as it 'When asked if these have been administered to the results of his vital signs d, "Not according to the way " and Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be the with currently accepted these, and include the they and cautionary the expiration date when of Drugs and Biologicals ordance with State and tility must store all drugs and compartments under proper the and permit only authorized		760			8/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED	
						С	
		345039	B. WING		07	7/21/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
CUMMED	OTONE HEALTH AND	DELIA DIL ITATIONI CENTED		485 VETERANS WAY			
SUMMER	STONE HEALTH AND	REHABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 761	Continued From p	page 93	F 76	31			
	1	ENT is not met as evidenced					
	by:	_ivi is not met as evidenced					
	'	ations and staff interviews, the		The statements made on t	his plan of		
) Label medications with the		correction are not an admis	•		
		tion required, including the		not constitute an agreemer			
		ent, on 2 of 2 medication carts		alleged deficiencies.			
		Hall Med Cart and the 100 Hall		To remain in compliance wi	ith all federal		
	Med Cart); 2) Dise	card expired medications on 2		and state regulations the fa			
		arts observed (the 300 Hall Med		or will take the actions set f			
	Cart and the 100	Hall Med Cart); and 3) Label		plan of correction. The plar	of correction		
		the date they were opened on 1		constitutes the facility□s all			
	of 2 medication carts (the 100 Hall Med Cart) and			compliance such that all all	•		
		on storage rooms (the 100/200		deficiencies cited have bee			
		m) observed to allow its		corrected by the dates indi	cated.		
	shortened expirat	ion date to be determined.					
	The finalines in al.	ما م ما ر		F761			
	The findings inclu	ded.		1 Corrective estion for rea	vidant(a)		
	1 a) An observat	ion was conducted on 7/17/22 at		Corrective action for res affected by the alleged defi	` '		
	l '	00 Hall medication cart in the		Resident #40, the Atrovent			
		e #6. The observation revealed		was removed and discarde			
	·	nir FlexTouch insulin pen was		on 07/17/2022 by Nurse #7			
	1	d cart. There was no label on			•		
		indicate the resident's name,		Resident #370, the Nitrogly	cerin was		
		or date opened. Nurse #6		removed and discarded on			
		ulin pen had been opened and		Nurse #6.	·		
	had no identifying	information on it. She stated,					
	"It shouldn't be or	there" and reported the pen		The identified expired over	the counter		
	needed to be disc	carded.		medications were discarde 07/17/2022 by the Nurse #			
	1-b) An observation	on was conducted on 7/17/22 at					
		0 Hall medication cart in the		Corrective action for res			
	1 *	e #6. The observation revealed		potential to be affected by t	the alleged		
		Lispro Kwikpen was stored on		deficient practice.			
		rt. There was no label on the		All residents in the facility v			
	1	cate the resident's name,		medications have the poter	ntial to be		
		or date opened. Nurse #6		affected.			
		ulin pen had been opened and		B : : 07/00/0555	TI D:		
	nad no identifying	information on it. She stated,		Beginning on 07/22/2022,	i ne Director of		

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 / 21/2022	
NAME OF P	ROVIDER OR SUPPLIER	0.000		STREET ADDRESS, CITY, STATE, ZIP		12112022	
TO WILL OF T	NOVIDEN ON OUT FIEN			485 VETERANS WAY	0002		
SUMMERS	STONE HEALTH AND	REHABILITATION CENTER		KERNERSVILLE, NC 27284			
	I			· ·			
(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 C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 761	Continued From p	page 94	F 7	761			
		there" and reported the pen		Nurses, Staff Developme	nt Coordinator		
	needed to be disc	·		(SDC), Registered Nurse			
				the Unit Support Nurses	= -		
	1-c) An observation	on was conducted on 7/17/22 at		medication carts, treatme			
		0 Hall medication cart in the		medication rooms two tim			
	presence of Nurse	e #6. The observation revealed		identify any expired or un	dated		
		containing 36 unidentified, white		medications. Corrections			
1		tored on the med cart. The vial		immediately where indica			
		rith any printed or hand-written		completed on 08/12/2022	·		
		refore, the vial of tablets did not		No manida at usan fassa da	ha affaataal hu		
		minimum required labeling ding the name of the drug or the		No resident was found to the deficient practice.	be allected by		
		ent the tablets were dispensed		the delicient practice.			
	for.	ent the tablets were dispensed		3. Measures/Systemic ch	nanges to		
				prevent reoccurrence of a			
	1-d) An observation	on was conducted on 7/17/22 at		practice:	Ū		
	3:10 PM of the 10	0 Hall medication cart in the		Education:			
	·	e #7. The observation revealed		On 07/25/2022, the DON	•		
		inhalers (MDI) were stored in		educating all full time, pa			
		nanufacturer's box labeled for		Licensed Nurses, Registe			
		ncg) / actuation Atrovent HFA).		(RNs), Licensed Practica	. ,		
		n inhaled medication used to		and Medication Aides inc			
		ructive pulmonary disease the inhalers stored in the box		staff on the following topic	JS.		
		HFA metered dose inhaler		" Checking medication	s for expiration		
		sed for Resident #40. The		date prior to administering	•		
		an albuterol inhaler. Albuterol is		" Labeling medications	•		
		ation used to treat asthma and		with date open as indicate			
	COPD. There was	s no labeling on the albuterol		" McNeill⊡s Pharmacy			
	inhaler to indicate	the name of the resident this		storage for selected items			
		nsed for. When asked, Nurse		This in-service was incorp			
		uld need to discard the albuterol		new employee facility orie			
		was not labeled with a		above-mentioned employ			
	resident's name.			provided to agency staff v			
	A rovious of Desi-	ont #40'o July 2022 ordere and		facility. This will be review	•		
		ent #40's July 2022 orders and		Quality Assurance proces the change has been sus			
		istration Record (MAR) lent had a current order for the		the change has been sus	la⊪tu.		
		actuation Atrovent HFA inhaler.		Any staff who does not re	eceive scheduled		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
						С	
		345039	B. WING _		07	//21/2022	
NAME OF F	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
01111115	OTONE HEALTH AND D	SUADU ITATION OFNITED		485 VETERANS WAY			
SUMMER	SIONE HEALIH AND K	EHABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 761 Continued From pag		e 95	F 7	61			
	However, she did no albuterol metered do	t have a current order for an se inhaler.		in-service training will not be work until training has been 08/18/2022.			
	AM with the facility's (DON). During the ir meds should have at reported that anythin both the administrate person receiving it. want the nurse to dis appropriately accord 2-a) An observation 2:52 PM of the 300 h presence of Nurse # a medication vial corbottle of 0.4 milligram medication used to resublingual (under the on the med cart. The medication vial indication vial indication vial indication were dispensed by a Resident #370. The the bottle of the nitro medication 's expiral Upon review, the nurnitroglycerin sublingual A review of Resident Medication Administrate and the residential mitroglycerin sublingually evangina (chest pain). medication included tongue and to let it did a doses in 15 minutes.	was conducted on 7/17/22 at dall medication cart in the 6. The observation revealed ntaining a manufacturer 's ins (mg) nitroglycerin (a elieve angina or chest pain) at tongue) tablets was stored a pharmacy label on the ated the nitroglycerin tablets in outside pharmacy for manufacturer's labeling on glycerin tablets indicated the tion date was October 2018. The confirmed the bottle of the paint tablets was expired. #370's July 2022 orders and the tation Record (MAR) at the date was one very 5 minutes as needed for		4. Monitoring Procedure to the plan of correction is effe specific deficiency cited remand/or in compliance with rerequirements. The Director of Nursing or demonitor compliance utilizing Quality Assurance Tool weethen monthly x 2 months. The designee will monitor for confabeling medications with a copened and ensuring the metreatment carts and the medis free of expired medication will be presented to the week Assurance committee by the ensure corrective action is in appropriate. Compliance will and the ongoing auditing proceeding. The weekly Qual Meeting. The weekly Qual Meeting. The weekly QA Meattended by the Administrate Nursing, MDS Coordinator, Manager, Unit Support Nursinformation Manager, and the Manager. Date of Compliance: 08/18/2	esignee will the F761 kly x 5 weeks he DON or mpliance with date when edication and dication room hs. Reports kly Quality e DON to nitiated as I be monitored ogram lity Assurance beting is or, Director of Therapy he Dietary		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345039	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 485 VETERANS WAY KERNERSVILLE, NC 27284	<u>'</u>	OTTE WEDEL
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 761	2-b) An observation 3:10 PM of the 100 presence of Nurse one stock bottle of tablets (an over-the originally containing approximately 50 to the med cart. The printed on the bottle review, the nurse of docusate tablets where the tablets where ta	on was conducted on 7/17/22 at a Hall medication cart in the #7. The observation revealed 100 milligram (mg) docusate e-counter stool softener) g 100 tablets with ablets remaining was stored on manufacturer's expiration date e was June 2022. Upon onfirmed the stock bottle of as expired. In onducted on 7/19/22 at 11:07 is Interim Director of Nursing the findings of the medication in the person receiving the expired all medications stored ould be within date. In was conducted on 7/17/22 at 11:07 is Hall medication cart in the material m	F 7	61		
	However, the manu pharmacy auxiliary medication needed opened/used. The	een placed on the med cart. ufacturer labeling and a sticker indicated the to be refrigerated until pharmacy auxiliary sticker d in 35 days after date				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345039	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZI 485 VETERANS WAY KERNERSVILLE, NC 27284	IP CODE	V//21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	DATE
F 761	Continued From pag		F 7	761		
	electronic medicatio bottle of calcitonin n under refrigeration a to 46 o F. After ope	omp, a comprehensive in database, an unopened asal spray should be stored at 36 degrees Fahrenheit (o F) ning, the bottle may be stored room temperature of 59 o F				
		t #63's medical record urrent order for 200 units / nasal spray.				
	8:45 AM of the 100/2	was conducted on 7/18/22 at 200 Med Storage Room in the ity 's Long Term Care (LTC)				
	vial of Tuberculin PF (used for skin testing tuberculosis) was storefrigerator. The via it had been opened. Manager reported storal of the Tuberculin	ealed an opened multi-dose PD injectable medication g in the diagnosis of ored in the med room all was not labeled as to when When asked, the Unit he would need to discard the a PPD injectable medication when the vial had been				
	multi-dose vial of Tu medication indicated product should be di An interview was co AM with the facility's (DON) to discuss the	storage instructions for a berculin PPD injectable I that once opened the iscarded after 30 days. Inducted on 7/19/22 at 11:07 Interim Director of Nursing e findings of the medication is. During the interview, the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
	345039	B. WING _			C 07/21/2022
NAME OF PROVIDER OR SUPPLIER SUMMERSTONE HEALTH AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 485 VETERANS WAY KERNERSVILLE, NC 27284	ODE	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIAT	
opened so the medi could be determined	eled with the date it was cation 's expiration date	F 7			8/14/22
SS=E CFR(s): 483.60(d)(4) §483.60(d) Food an Each resident received for soft, bite size moist meats. S483.60(d)(4) Food allergies, intoleranced food that is initially stated for soft food that is initially stated f	d drink ves and the facility provides- that accommodates resident es, and preferences; aling options of similar idents who choose not to eat erved or who request a e; T is not met as evidenced ons, record reviews, nterviews, the facility failed to sidents' food preferences for sidents #4, #55, #58)		The statements made on to correction are not an admiss not constitute an agreemer alleged deficiencies. To remain in compliance we and state regulations the factor will take the actions set plan of correction. The plan constitutes the facility set all compliance such that all all deficiencies cited have been corrected by the dates indicated	ession to and on the with the with all federal acility has tak forth in this of correction (legation of leged en or will be cated.	do en n

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		345039	B. WING			07/	21/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHMMED	STONE HEALTH AND D	EHABILITATION CENTER		4	85 VETERANS WAY		
SUMMERS	SIONE HEALIH AND R	ENABILITATION CENTER		۲	KERNERSVILLE, NC 27284		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 806	Continued From pag	je 99	F	806			
	intact and received a	a therapeutic/ mechanically			#4 was served mashed potatoes after		
	altered diet.				updating their food preference to not		
					include mashed potatoes; during interv	iew	
	A review of the clinic	al records indicated there			resident revealed she was served masl		
	was no food preferei	nces documentation			potatoes or rice at every lunch and dinr	ner	
	maintained for Resid	lent #4 prior to 7/18/22.			meal. During interview resident #55 sta	ted	
					she never received the ability to select		
	_	on 7/18/22 at 11:33 a.m.			menu items and often received items s		
		hat she was "tired" of			preferred not to receive. During intervie	:WS	
	receiving cooked rice and mashed potatoes				resident #58 stated she wanted items		
	everyday during lunch and supper. She revealed she was not allowed to choose food items she				inconsistent with diet and requested a	diet	
				change which the facility failed to act			
	preferred. She was u			upon.			
		. She revealed someone from er that morning (7/18/22)			On 7/18/2022 the dietary manager visit	ad	
	about her food likes	- ·			Resident #4 to update food preference:		
	about her lood likes	and distincts.			Speech last diet review for Resident #4		
	On 7/19/22 a.m. at	10:00 a.m. the Dietary			was on 7/17/2022; diet continues as		
		aled the facility changed its'			recommended by speech. On 8/6/2022		
		and the menus on 7/6/22.			Resident #55 visited and food preferen		
	She indicated the pro-	evious food service caterer			updated. Resident #58 completed a die		
		residents' food preference			waiver and diet was modified to Regula		
		he had not received any			diet and food preferences updated.		
	complaints from the	residents concerning food			Resident added to menu selection		
	choices. The DM sta	ited that only residents			program.		
	receiving regular die	ts would receive the select					
	choice menu allowin	g the resident to choose			2. Corrective action for residents with		
		she would like served the			the potential to be affected by the alleg	ed	
	next day for lunch ar	nd supper.			deficient practice.		
					All residents have the potential to be		
		on on 7/20/22 at 1:03 p.m.			affected by the alleged deficient practic	e.	
		ing on the side of her bed			All dietary staff in-serviced 7/18/2022	_	
		meal tray on the overbed			regarding accuracy of meals served an		
		e plated meal consisted of a			diet consistency policies. All dietary sta		
		hini, and mashed potatoes.			are to have competencies evaluated. A	.11	
		ed she did not want the meal shed potatoes" again. She			current entries in Traycard will be		
		equest anything else, instead			reviewed for accuracy and modified as needed by 8/14/2022. Menu selection		
		rs from a restaurant outing			program modified to ensure all resident	s	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 07/21/2022	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	21/2022
	101.52.1 0.1 00.1 2.2.1				85 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER			ERNERSVILLE, NC 27284		
	OLIMANA DV. OT	ATEMENT OF REFIGIENCIES			<u> </u>		217
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 806	F 806 Continued From page 100		F 8	306			
	with her family memb	er, the day before.			cognitively appropriate receive menu selections and are assisted as needed		
	6/3/22 with diagnosis	admitted to the facility on which included hypertensive ney disease with heart			with program. All residents will be interviewed to update food preferences 8/14/2022. 3. Systemic changes	s by	
	The physician's order	dated 6/3/22 revealed daliberalized renal diet of			In-service education was provided to a full time, part time, and as needed staff the Dietary Services Director on 7/18/2022. Topics included:		
	6/7/22 only included t regular consistency w	Preference Sheet dated he resident's renal diet of vith thin fluids. The resident's food dislikes were not			 ¿ Tray Accuracy Education ¿ Diet Consistency and Accuracy Policies ¿ Meal Service Policies ¿ Meal Selection Program Process This information has been integrated in 		
	indicated Resident #5 received a therapeuti				the standard orientation training and in required in-service refresher courses for all staff and will be reviewed by the Quassurance process to verify that the change has been sustained.	or	
	Resident #55 stated t	n 7/18/22 at 9:01a.m. that since her admission to be been able to choose the red on the renal diet.			Traycard to be reviewed and modified admissions, quarterly, and as needed be Dietary Service Director.		
	food service caterer a She indicated the pre	ed the facility changed its' and the menus on 7/6/22. vious food service caterer			Menus to be reviewed daily and modifice per diet preferences as needed by Diet Service Director.		
	sheets. She stated sh complaints from the r choices. The DM stat receiving regular diets choice menu allowing	esidents' food preference he had not received any esidents concerning food ed that only residents s would receive the select the resident to choose she would like served the d supper.			4. Quality Assurance monitoring procedure. The Dietary Services Director will moni accuracy of completed trays served to residents per Dietary Meal QA Audit weekly x4 and then monthly x 2. Trayc will be audited monthly and test trays completed monthly per policy by the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345039	B. WING		C 07/21/2022
NAME OF P	ROVIDER OR SUPPLIER	0.000	1	STREET ADDRESS, CITY, STATE, ZIP	•
TO THE OT T	NOVIBER OR GOLLER			485 VETERANS WAY	0052
SUMMER	STONE HEALTH AND	REHABILITATION CENTER		KERNERSVILLE, NC 27284	
	T				
(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 X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 806	a.m., Resident #5 liberalized renal d aware there were the renal diet and registered dieticia items she could a prepare renal diet she was not giver select/choice mer She also stated not her food preference. On 7/21/22 at 9:4 with the Registere she was covering Dietician assigned resident's food prehonored within the stated the resident the dialysis center the consequences. She indicated dial about residents resident #58 w 6/20/22 with diagristage renal diseas. The admission Midated 6/26/22 revice cognitively intact.	nterview on 7/21/22 at 9:01 5 indicated she received a iet. She stated that she was different menu options within had been educated by the n at the dialysis center on food and could not eat and on how to menus. Resident #55 stated a the option of the facility's are as were the other residents. To one from the facility discussed ces with her. 9 a.m., the telephone interview and Dietician (RD#1) revealed remotely for the Registered at to the facility. RD#1 stated the deferences should have been are renal diet restrictions. She at was seen weekly by the RD at the was seen weekly by the RD at the resident on a sof not following the renal diet. The system of the facility on noses that included, in part, end	F	Dietary Service Director. To dietitian will complete qual orders. Reports will be presented by Quality Assurance the Dietary Service Director Dietitian. Compliance will the Ambassador Program reviewed at the weekly Quality Meeting. The QA Meeting the Administrator, Director MDS Coordinator, Therap Information Manager, and Services Director. Compliance date: 08/14/26	The consultant really diet resented to the committee by or and/or one monitored by daily and reality Assurance is attended by of Nursing, y, Health the Dietary
		stated, "receiving therapeutic aluate and make diet change as needed."			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		(X3) DATE SI COMPLE	
		345039	B. WING _			C 07/2	1/2022
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY	Y, STATE, ZIP CODE	0112	1/2022
				485 VETERANS WAY			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		KERNERSVILLE, NO	27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		I	(X5) COMPLETION DATE
F 806	Continued From page	e 102	F 8	06			
		er dated 7/18/22 revealed receive a liberalized renal					
	7/17/22 at 12:16 PM During the interview, on a renal diet and re reported the facility h what she could eat at or approved list of su therapeutic diet to se requested it. She sai menu, the staff replie diet and had not give the past she had requispaghetti or lasagna her because of the diexplained she understhat were not consiste increased her phosph She said she wanted not all the time and fe honored and she was choices in what she a facility had not educate but she had received.	ad not given her a choice in nd had not provided a menu					
	On 7/19/22 at 9:27 A completed with the D explained all resident exception of resident lunch and dinner cho completed during bre menu was returned to breakfast trays and c	M an interview was ietary Manager. She is on regular diets, with the s on renal diets, received a ice menu that they akfast. The completed					

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345039	B. WING _				C 21/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		485 VE	T ADDRESS, CITY, STATE, ZIP CODE TERANS WAY ERSVILLE, NC 27284	1 01.	2172022
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 806	• - · · · · · · · · · · · · · · · · · ·		F 8	306			
	were not permitted to potassium and theref choice menu. The D had met with Resider tomato products but sher until the RD or M record. During an interview was	ore, had not received the etary Manager recalled she at #58, who requested stated she can't give them to D reviewed her medical					
	permanent RD and we completed nutrition at seen Resident #58 in her medical record. Suprovider was typically renal diet and when Filiberalizing her diet, the denied the resident's resident was provider and requested foods not consistent with the resident should be prefood and stated it was choose. RD #1 further consulted on changing indicated there was resident was resident should be prefood and stated it was choose. RD #1 further consulted on changing indicated there was resident was resident.	r inflexible with liberalizing a Resident #58 asked about the dialysis center's provider request. The RD added if a dieducation about their diet from the kitchen that were exprescribed diet, the ovided with the requested as the resident's right to ear stated she had not been g Resident #58's diet and					
F 812 SS=F	7/20/22 at 10:42 AM be asking residents for then provide education Food Procurement,S		F 8	312			8/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345039	B. WING_		0.7	C 7/ 21/2022	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 485 VETERANS WAY KERNERSVILLE, NC 27284		72172022	
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 812	state or local authorii (i) This may include if from local producers and local laws or reg (ii) This provision doe facilities from using p gardens, subject to o safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accord standards for food se This REQUIREMEN by: Based on observatio facility failed to maint kitchen and nourishn ensuring dishware w proper temperatures by not dating and lab and by not ensuring clean and free from o to ensure food items were dated, labeled o room number when s snack/nourishment re	re food from sources red satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ance with professional ervice safety. T is not met as evidenced ens and staff interviews, the ain sanitary conditions in the enent refrigerators by not ere washed and rinsed at in the dishwashing machine; eling resealed food items; ood service equipment were lebris. The facility also failed not provided by the facility with the resident's name and	F8	The statements made on thi correction are not an admiss not constitute an agreement alleged deficiencies. To remain in compliance with and state regulations the fac or will take the actions set fo plan of correction. The plan of constitutes the facility salle compliance such that all alleged deficiencies cited have been corrected by the dates indicated.	ion to and do with the all federal ility has taken rth in this of correction gation of ged or will be		
	Findings included:	and the literary 1910		For dietary services, a c action was obtained on 7/17/ Output to initial walls the work of the services and the services are actions. Output to the services of the services are actions.	/2022.		
		our of the kitchen with the 1) on 7/17/22 at 10:07 a.m.,		During initial walk through of was noted dietary services h			

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IN	0. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		ONSTRUCTION		E SURVEY IPLETED
							С
		345039	B. WING _			07	7/21/2022
NAME OF PI	ROVIDER OR SUPPLIER	1		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				485 \	VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	EHABILITATION CENTER		KER	RNERSVILLE, NC 27284		
()(1) ID	CLIMMADV CT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE
F 812	Continued From page	e 105	F8	12			
		cycles were observed			dentify improper dish machine		
		of the high temperature			emperatures, reseal open container	of	
		peratures of each cycle read			grapes in walk-in fridge, date/label	,,	
		reading was 168 degrees			multiple items in the walk in freezer (*	bag	
		nal rinse reading was 140			of breadsticks, 1 box pulled chicken,	•	
		2nd wash reading was 160			pox of omelets), and date/label multip		
	_	and the final rinse reading			tems in dry storage (1 bag resealed j		
	was 140 degrees Fal			1 container apple pie filling, and bag			
	reading was 169 deg			couscous). During the tour food resid			
	rinse reading was 13		a	and stains were found around 1 doub	le		
	When questioned on		5	sealed container in dry storage,			
	requirements of the d	lishwasher, Dietary Staff #1		r	microwave, ingredient bins, and fry w	re	
		perature should read 165		k	paskets on top of fryer.		
	_	and the final rinse cycle					
		rees Fahrenheit. She stated			During observation of nourishments		
	1	eratures were checked for			rooms and dining room 1 of 2		
		second prewash cycle,			nourishment refrigerator/freezer and t		
		e placed in the machine.			main dining room refrigerator/freezer		
		the DM did not look at the			noted to have items without labels an		
	temperature gauges				dates (med pass containers, containe		
	throughout the three				Ensure, 1 opened box icy snacks, 5 1		
	final rinse cycles were	hree observations of the			diet sodas, 1 box pastries, and 1 gallo	Ж	
		egrees Fahrenheit. This		'	ce-cream).		
		e dietary staff member and		1	On 7/17/2022 Dietary Service Directo	r	
	· ·	tes of tray lid covers and			discarded any improper closed food a		
		e to be rewashed and rinsed			non-labeled/dated food items in the		
	-	I rinse temperatures. The			kitchen and nourishment fridges. Ven	dor	
		immediately notify the			contacted for dish machine repair and		
		or repair and until repaired,			dish machine 7/17/2022. Cleaning lis		
		e washed in the dishwasher			established to clean items cited; clear		
	then rinsed and sanit				complete 7/18/2022.	J	
	three-compartment s	ink.			•		
	·			2	2. Corrective action for residents wi	th	
				t	he potential to be affected by the alle	ged	
		20 a.m. observations of the		0	deficient practice.		
	food storage areas in	the kitchen revealed					
	resealed and opened	I food items that were not		/	All residents have the potential to be		
	dated and labeled an	d/or left uncovered. There	1	.	affected by the alleged deficient pract	ice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
						С	
		345039	B. WING _		07	//21/2022	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 812	pan of unidentifiable was not labeled or darefrigerator. One serve 6-inch deep pan of procellophane in the servalk-in refrigerator or grapes. The walk-in fbag of breadsticks not box of pulled chicken of omelets. In the dry 1-resealed bag of jell 1-(18 pound) contain filling not dated and wasubstance around the	coan covered with cellophane cooked, chopped meat that ated in the reach-in ving scoop was placed in a cureed bread covered with ving line refrigerator. The contained 1-open box of red creezer contained 1-resealed of dated/labeled; 1-opened not dated; and 1-open box of storage room there was o mix not dated apple pie	FE	On 7/17/2022, the Dietary Service Director completed a kitchen an nourishment walk through to ensemble food items were within their date dated properly. The maintenance complete a walk through of the lacked all equipment was in work and meeting manufacture reconstruction temperatures. 3. Systemic changes In-service education was providefull time, part time, and as needed Topics included:	d sure all es and ee director kitchen to king order nmended		
	10:22 a.m, the inside revealed yellow food Assistant Dietary Marmicrowave was last uwere food stains on t food warmer. The lide the table top sugar bigrainy particles. Ther containing large pieco of the deep fryer. The revealed the deep fry and the staff should have the containing large pieco of the deep fryer. The revealed the deep fryer and the staff should have the staff should have the containing large pieco of the deep fryer. The revealed the deep fryer and the staff should have the staff should have the containing large pieco of the deep fryer.	utilized 1-2 days prior. There the inside and outside of the s of the large sugar bin and in were covered with white we were 2-wire baskets es of fried food items on top e Assistant Dietary Manager wer was used the night before have cleaned it. 3 p.m. the in 1 of 2 nourishment rooms		" Storage and dating policies regulations. " Proper cleaning and sanital regulations. " Temperature regulations. " Procedures for alerting PIC equipment out of working order. " Inspections on shifts to obs food are within their dates and to out of date. This information has been integer the standard orientation training required in-service refresher could all staff and will be reviewed by Assurance process to verify that change has been sustained.	when erve all ossed if rated into and in the urses for the Quality t the		
	resealed food items t	g room was observed with hat were not dated, labeled e and room number, and		Quality Assurance monitoring procedure.	ng		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 7/24/2022	
NAME OF PE	ROVIDER OR SUPPLIER	04000	1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	7/21/2022	
TO THE OT THE	TO VIDERY OIL OOF TELETY			485 VETERANS WAY			
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 812	outdated, resealed ite nourishment room's regression 2-(32 ounce) resealed (nutrition drink) with a the directions on the drinks were to be used. There was also 1(8 of Ensure (nutrition drink) or date opened. In the box of multiple single resident's name. The defigerator/freezer countries of diet sodas to labeled with a resider contained: 1-box of palabeled with a resider resealed ice cream not some contained in the contained i	ems. The 100/200 hall efrigerator/freezer contained d containers of med plus 1.7 esticker date of 5/31/22, but containers indicated the d within 3 days of opening. unce) resealed container of (x) without a resident's name efreezer there was 1-open serve icy treats without a dining room's ensisted of 5(16 ounce)	F8	The Dietary Service Director or of will monitor procedures for proper storage weekly x 2 weeks then red 3 months using the Dietary QA A which will include inspections on and PM shifts to observe that all labeled, dated, and within proper Reports will be presented to the Quality Assurance committee by Administrator to ensure corrective initiated as appropriate. Compliate be monitored and ongoing auditic program reviewed at the weekly Assurance Meeting. The weekly Meeting is attended by the Administrator of Nursing, MDS Coording Therapy, Health Information Mar	er food monthly x Audit a both AM food is r dates. weekly the ve action ance will ing Quality QA nistrator, inator,		
F 880 SS=F	Dietary Manager state was responsible for m 2-nourishment rooms which were checked of and 1:30 p.m. She may responsible for the reand she was unaware maintained the dining Infection Prevention & CFR(s): 483.80(a)(1)(1)(1)(2)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	on the residents' halls everyday between 1:00 p.m. evealed dietary was not frigerator in the dining room e of which department room refrigerator. & Control (2)(4)(e)(f) Introl blish and maintain an and control program asafe, sanitary and lient and to help prevent the asmission of communicable	F 8	and the Dietary Manager Compliance date: 08/14/2022		8/18/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345039	B. WING _			C 7/21/2022	
	ROVIDER OR SUPPLIER STONE HEALTH AND RI	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 485 VETERANS WAY KERNERSVILLE, NC 27284		772 172022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 880	program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visit providing services unarrangement based unconducted according accepted national states §483.80(a)(2) Written procedures for the procedure for the procedure for the procedure in the facility (ii) When and to who communicable diseare ported; (iii) Standard and trait to be followed to previously for the procedure for the	prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, and controlling infections iseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to §483.70(e) and following andards; In standards, policies, and rogram, which must include, it is illance designed to identify ble diseases or y can spread to other to the contractions should be used for a ut not limited to:	F8				
	circumstances. (v) The circumstance	es under which the facility ees with a communicable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345039	B. WING_		C 07/21/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07/21/2022	
				485 VETERANS WAY		
SUMMERS	STONE HEALTH AND RE	HABILITATION CENTER		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 SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 880	Continued From page	e 109	F 88	30		
	disease or infected sk contact with residents contact will transmit the (vi)The hand hygiene by staff involved in directly §483.80(a)(4) A systet identified under the factorrective actions take §483.80(e) Linens. Personnel must hand	cin lesions from direct s or their food, if direct the disease; and procedures to be followed rect resident contact. The for recording incidents facility's IPCP and the fine by the facility. The facility of the facility of the facility of the facility.				
	The facility will condul PCP and update their This REQUIREMENT by: Based on record revifacility failed to impler program. This had the residents who resided The findings included A review of the facility Preparedness and Intrevealed the facility hasfety management from 7/21/22 at 3:01 Pl conducted with the M stated the previous at	ct an annual review of its r program, as necessary. is not met as evidenced ew and staff interviews, the ment a Legionella prevention e potential to affect all 74 d in the facility. : ' 's Emergency fection Control Programs ad not implemented water or Legionella. M, an interview was aintenance Director. He dministrator called him into		The statements made on this plan of correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all fed and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of correctionstitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880	eral taken is ction	
	training video about the stated the facility didr	t week and they had a ne water safety program. He ı ' t know about it and had ing about it. He stated they		 How corrective action will be accomplished for those residents for have been affected by the deficient practice: 	und to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		345039	B. WING				21/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	21/2022
CUMMED	STONE HEALTH AND DE	EHABILITATION CENTER		48	B5 VETERANS WAY		
SUMMER	SIONE HEALIH AND RE	ENABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page		F	880			
	, •	but no action has been taken.			On 7/13/2022 the Infection Control Policand Procedure-Water Safety Policy was updated by the Corporate Chief Nursin Officer to address identification and treatment for Legionella within the facility water system. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 08/11/2022, The Corporate Regional Maintenance Director completed a Water Management Risk Assessment for the facility to identify any risk areas. 3. Address what measures will be purplace or systematic changes made to ensure that the deficient practice will not reoccur: Education: The Director of Nursing (DON) and Star Development Coordinator (SDC) beganded action with all staff including all facing Registered nurses, Licensed practical nurses, medication aides, nursing aiden nonclinical staff, department heads, therapy department, environmental services, maintenance and dietary stafform 08/11/2022 on the facility water management program, which includes Legionella and the steps taken to reduct the risk of growth and spread of Legionella.	s g g ity : al ter t in ot lity s,	
					On 08/11/2022, the DON and SDC		

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				24/2022
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F 880	Continued From page	e 111	F8	initiated validation water program. 08/18/2022. 4. Monitoring the plan of correspecific deficien and/or in compli requirements: On 7/6/2022 the designee will obtous water safety using F880 Water Safety weeks then more that facility infect Legionella is in the weekly Quality Assurance (QA) in the weekly Quality Assurance meet or Director of Nuthat the correction ongoing concern appropriate for correquirements. That attended by Adminishing, Medical Control Nurse, Markegistered Nurse, Registered Nurse, Services Director, Dietary Information Market Director, Mainte Director, Report weekly Quality Assurance meet on the control Nurse, Market Services Director, Dietary Information Market Director, Mainte Director, Report weekly Quality Assurance are supposed initiated as approbe monitored are specific water than the control of the control	on of competency of the This will be completed by Procedure to ensure the ection is effective and the cy cited remains corrections are with regulatory and Administrator or eserve and monitor facing QA screening tool for ety- Legionella weekly and the year and the preservality of Life/Quality thing by the Administrator compliance. Quality and Process are accompliance with regular the weekly QA meeting ministrator, Director of all Director, Infection Minimum Data Set see, Environmental or, Social Services of Manager, and Activities and Activities and Activities and Activities and Compliance with the ongoing auditing and the ongoing auditing and the weekly Quality and the ongoing auditing and at the weekly Quality and the weekly	that that cted lity or x 5 ure ed ated or ure tory is	

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F 880	Continued From pag	e 112	F 88	Assurance Meeting. The weekly Queeting is attended by the Administ Director of Nursing, Minimum Data Nurse, Therapy Manager, Unit Sup Nurses, Health Information Manage the Dietary Manager. Compliance Date: 08/18/2022 Directed Plan of Correction Complit Date: 08/18/2022 Root Cause Analysis: A root cause analysis was completed 08/11/2022 by the: Infection Preve who is certified in infection control, and the Quality Assurance Nurse Consultant and was reviewed by the Performance Improvement (QAPI) committee on 08/12/2022. A safety meeting was held on 08/12/2022 to discuss ongoing implementation of water management program. This I Cause Analysis will be a part of our ongoing Performance Improvemen Process. The root cause analysis wincorporated into the plan of correction/intervention plan. On 08/11/2022, the DON and SDC initiated validation of competency of water program. This will be completed a validation Statement I attest that I have completed a coulnfection Control. I am the Director	etrator, Set port port er, and ance ed on ntionist DON, e / the Root - t vas	

PRINTED: 08/25/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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F 880	Continued From page	à 113	F	Nurse comp from educa Progr for F8 Reha Topic " [Progr Sprea Education included Augu This is to 8/18 Those in-set provided Progr in all Regist Pract Nursi aides thera	es/an Infection Preventionist havir pleted a course on Infection Control NC SPICE. I have provided ation on Legionella Prevention ram as described in the Plan of Ca 880 at Summerstone Health and abilitation Center. Es included: Developing a Water Management ram to reduce Legionella Growth and in Buildings. ation sessions were completed by staff member utilizing the PPE ation. In-service dates and times de: 1st 11, 2022 02:00 pm 9:00 pm 1st 12, 2022 09:00 am 3:30 pm 1st 12, 2022 and and 3:30 pm 1st 12, 2022 and 3:30 pm	and and and and and and	

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	Continued From page	tion	F 8	full time, part time, and PR including agency staff. The be incorporated into the ne facility orientation. Printed Name: Mariolyn Clarillo Credentials: NC Spice Cer Date: 08/12/2022	e in-service wi ew employee arillo, RN o, RN	8/18/22
SS=D	§483.80(d) (3) COVII LTC facility must deviand procedures to er (i) When COVID-19 vacility, each resident is offered the COVID immunization is mediresident or staff memiresident or staff memires are provided regarding the benefit effects associated wi (iii) Before offering Corresident or the resident receives education registes and potential side the COVID-19 vaccina (iv) In situations when requires multiple dos resident representation provided with current additional doses, included benefits or risks and associated with the COVID-19 vaccina transfer of the covided with current additional doses, included with the COVID-19 vaccina transfer of the covided with current additional doses, included with the COVID-19 vaccina transfer of the covided with the COVID-19 vaccina transfer of the covided with current additional doses, included with the COVID-19 vaccina transfer of the covided with the COVID-19 vaccina transfer of the covided with current additional doses, included with the COVID-19 vaccina transfer of the covided with the COVID-19 vaccina transfer of the covided with current additional doses, included with the COVID-19 vaccina transfer of the covided with current additional doses with the COVID-19 vaccina transfer of the covided with current additional doses with the COVID-19 vaccina transfer of the covided with the	D-19 immunizations. The elop and implement policies is are all the following: faccine is available to the and staff member 19 vaccine unless the cally contraindicated or the ber has already been DVID-19 vaccine, all staff id with education is and risks and potential side the the vaccine; DVID-19 vaccine, each intrepresentative egarding the benefits and de effects associated with ee; the COVID-19 vaccination ees, the resident, we, or staff member is information regarding those uding any changes in the				

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F 887	the opportunity to a vaccine, and chang Note: States that ar Final Rule - 6 [CMS requirements of 483 under IFC-5 [CMS-3 and (vi) The resident's indocumentation that the following: (A) That the resider was provided educate benefits and potentic COVID-19 vaccine; (B) Each dose of Coto the resident; or (C) If the resident distribution vaccine due to medic contraindications or (vii) The facility mainto staff COVID-19 vincludes at a minimin (A) That staff were information on obtain (C) The COVID-19 related information on obtain (C) The COVID-19 related information Disease Control and Healthcare Safety North This REQUIREMENTS Based on record refacility failed to docc Covid-19 vaccination	resident representative, has ccept or refuse a COVID-19 e their decision; e not subject to the Interim is 3415-IFC], must comply with 3.80(d)(3)(v) that apply to staff 3414-IFC] medical record includes indicates, at a minimum, at or resident representative ation regarding the ital risks associated with and OVID-19 vaccine administered it not receive the COVID-19 ical refusal; and intains documentation related accination that um, the following: provided education regarding tential risks VID-19 vaccine; ed the COVID-19 vaccine; ed the COVID-19 vaccine; and vaccine status of staff and as indicated by the Centers for de Prevention's National	F	The statements made on this pl correction are not an admission not constitute an agreement with alleged deficiencies.	to and do	

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F 887	Continued From pag	e 116	F 8	87			
	(Resident #55) reviev	wed for vaccination history.		-	To remain in compliance with all federa	al	
	The findings included				and state regulations the facility has tal or will take the actions set forth in this	ken	
	Resident #55 was ad 6/3/2022.	lmitted to the facility on			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	n	
	from the hospital, dather immunization his Pfizer dose 1 on 5/12 dose 2 on 6/1/2021. A review of Resident record at the facility, documented the secon history as 6/1/2022 raindicated on the hospital Resident #55's electrical and second sec	#55's discharge summary ted 6/3/2022, documented tory to include COVID-19 2/2021 and COVID-19 Pfizer #55's electronic medical under the immunization tab and dose of COVID-19 ather than 6/1/2021 as a poital discharge summary. Fronic medical record positive for COVID-19 on			corrected by the dates indicated. F887 The plan of correcting the specific deficiency. The plan should address th processes that lead to the deficiency cited: 1. Corrective action for resident(s) affected by the alleged deficient practic A corrective action was obtained for Resident #55 on 08/11/2022 when the residents immunization record was updated to reflect the accurate date of 2nd COVID Vaccine. On 08/12/2022, t	ce: his	
	p.m. with the Assista facility infection preve Resident #55's electr stated her vaccinatio COVID-19 was on 6/ hospital discharge su documented date wa entered into the elect facility appeared to b added that a booster been offered to the R	inducted on 7/21/2022 at 2:17 int Director of Nursing, the centionist, and she reviewed ronic medical record and in date of the second dose of 2/2022. She reviewed the immary and stated the is 6/1/2021 and that the date tronic medical record at the e a data entry error. She dose of COVID-19 had not desident due to the data entry ster dose had not appeared.			Registered Nurse Supervisor offered the resident her additional booster. 2. Corrective action for residents with the potential to be affected by the alleg deficient practice. On 08/10/2022 the Staff Development Coordinator who is the Infection Preventionist and the Unit Support Nur initiated an audit of 100% of the current residents vaccination records comparing the vaccination card with the informatic in the Electronic Medical Records. The facility has scheduled a date for an upcoming vaccine clinic. This was	ne ned see t t ng	

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F 887	Continued From page	117	F 88	completed on 08/11/2022. On 08/10/2022, Any records that updating were updated and residmeet criteria for a dose were offe vaccine. This will be completed of 08/18/2022. 3. Measures /Systemic change prevent reoccurrence of alleged of practice: On 08/11/2022 the Quality Assura Nurse Consultant began education the Director of Nurses (DON), SE Support Nurse, Registered Nurse Supervisor, and the Minimum Dar (MDS) Nurse on COVID Vaccine for residents. This in-service was incorporated new employee facility orientation above-mentioned employees and provided to agency staff working facility. This will be reviewed by the Quality Assurance process to ver the change has been sustained. Any staff who does not receive so in-service training will not be allow work until training has been compos/18/2022. 4. Monitoring Procedure to ensithe plan of correction is effective specific deficiency cited remains and/or in compliance with regulat requirements. Quality assurance audits will be	ents who red the on sto deficient ance on with oc, Unit esta Set Policy in the for the lalso in the eithe ify that cheduled wed to oleted by ure that and that corrected	

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F 887	CFR(s): 483.95(g)(1)- §483.95(g) Required aides. In-service training mu §483.95(g)(1) Be suff continuing competend be no less than 12 ho §483.95(g)(2) Include	Training for Nurse Aides (4) in-service training for nurse st- icient to ensure the se of nurse aides, but must	FS	completed by the Director of Nur designee to monitor that COVID information is accurately recorde the F887 Quality Assurance Tool Monitoring of 6 residents to ensur compliance with procedure for recovID Vaccine Data. Monitoring completed weekly x 5 weeks the x 2 months or until resolved. Repute be presented to the weekly QA country by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be and the ongoing auditing program reviewed at the weekly QA Meeting weekly QA Meeting is attended and Administrator, Director of Nursing Coordinator, Therapy Manager, Information Manager, and the Dimensional Manager. Deficiencies that are induring the monitoring process will addressed through the facility Quantity Assurance process.	Vaccine d using . re coording g will be n monthl borts will ommitted ure monitore m ing. The by the g, MDS Health etary dentified ll be	ly e	

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F 947	Continued From page	e 119	F 9	47			
	determined in nurse a and facility assessment address the special indetermined by the factorial special special indetermined by the factorial special special indetermined by the factorial special sp	rse aides providing services gnitive impairments, also ne cognitively impaired. is not met as evidenced riews and record review, the		The statements made on this paymention are not an administrative			
	training and abuse pr	lete required dementia care revention training for 3 of 3 (Nursing Assistants #3, #4,		correction are not an admissior not constitute an agreement wi alleged deficiencies.	th the		
	2/15/21. A review of records and transcrip online training progra	(NA) #3's date of hire was the facility's inservice it report from the facility's im revealed NA #3 had not ntia care training or abuse the past 12 months.		To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility sallega compliance such that all allege deficiencies cited have been or corrected by the dates indicate	y has taken in this correction ition of d r will be		
	she shared that deme prevention training we facility's online training computer system aut employee to complete the corporate office in courses and sent em needed to be complete been notified by the complete	DON) on 7/21/22 at 9:19 AM, entia care training and abuse ere completed through the ig academy. She said the		1. Corrective action for resident affected by the alleged deficient On 07/25/2022, in-services were scheduled to notify staff of the requirement to complete requirementia care training and abur prevention training annually. 2. Corrective action for resident potential to be affected by the adeficient practice:	nt practice: re red use ts with the		

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F 947	Continued From page 120			947				
	Center for Medicare and Medicaid Services (CMS) waiver for education that had been in effect for the public health emergency had expired. The Interim DON was interviewed on 7/21/22 at 2:56 PM and stated the clinical team encouraged				100% audit of the training records were reviewed to identify certified nursing assistants who had not met the requirement to complete the required dementia care training and abuse prevention training. Any staff who hadn □t			
	staff members to complete the required education and trainings and meet the deadlines. 2. NA #4's date of hire was 12/28/20. A review of the facility's inservice records and transcript report from the facility's online training program revealed NA #4 had not completed any dementia care training or abuse prevention training in the past 12 months.				completed the required training were notified of the staff requirement to complete the training. This will be completed by 08/18/2022.			
					 Measures/Systemic changes to preview reoccurrence of alleged deficient practi Education: 			
	In an interview with Director of Nursing she shared that den prevention training varieties facility's online trainicomputer system at employee to complet the corporate office courses and sent er needed to be completen notified by the trainings needed to Center for Medicare (CMS) waiver for exercise effect for the public expired.	the Corporate Floating (DON) on 7/21/22 at 9:19 AM, nentia care training and abuse were completed through the ing academy. She said the uto populated for the ete the training. She added monitored the completion of mails to staff when trainings eted. She said NA #4 had corporate office that the be completed since the e and Medicaid Services ducation that had been in health emergency had			On 07/25/2022, the Director of Nurses (DON) and the Staff Development Coordinator (SDC) began education of full time, part time, and prn certified nursing assistants that in-service training must 483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 house per year. 483.95(g)(2) Include dementing management training and resident abuse prevention training. 483.95(g)(3) Address of weakness as determined in nurse aides' performance reviews and facility assessment at 483.70(e) and maddress the special needs of residents determined by the facility staff. 483.95(4) For nurse aides providing services individuals with cognitive impairments, also address the sare of the cognitively	ng ire rs a se ess ay as (g)		
	2:56 PM and stated	the clinical team encouraged mplete the required education			also address the care of the cognitively impaired. Annual training is required armust be completed. This in-service was incorporated in the new employee facility orientation for the	nd		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 947	Continued From page	FS	947					
F 947	Continued From page 121 3. NA #5's date of hire was 9/12/19. A review of the facility's inservice records and transcript report from the facility's online training program revealed NA #5 had not completed any dementia care training or abuse prevention training in the past 12 months. In an interview with the Corporate Floating Director of Nursing (DON) on 7/21/22 at 9:19 AM, she shared that dementia care training and abuse prevention training were completed through the facility's online training academy. She said the computer system auto populated for the employee to complete the training. She added the corporate office monitored the completion of courses and sent emails to staff when trainings needed to be completed. She said NA #5 had been notified by the corporate office that the trainings needed to be completed since the Center for Medicare and Medicaid Services (CMS) waiver for education that had been in effect for the public health emergency had expired. The Interim DON was interviewed on 7/21/22 at 2:56 PM and stated the clinical team encouraged staff members to complete the required education and trainings and meet the deadlines.			above-mentioned employees. The reviewed by the Quality Assurance process to verify that the change been sustained. Any staff who does not receive so in-service training will not be allowed work until training has been compos/18/2022. 4. Monitoring Procedure to ensure plan of correction is effective and specific deficiency cited remains and/or in compliance with regulate requirements. The DON or Designee will monitor compliance utilizing the F947 Queleasurance Tool weekly x 2 weeks monthly x 3 months or until resolve the QAPI Committee. Audits will assure required nurse aid training completed. This will include audies well weekly completed. Compliance will be mand the ongoing auditing programe reviewed at the weekly Quality Assurance to ensure training attended by the Administrator, Dien Nursing, MDS Coordinator, There Manager, Health Information Manand the Dietary Manager. Date of Compliance: 08/18/2022		led by the cted / to l00 een eed nce		