STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 1/17/23 to conduct a complaint survey and COVID-19 Focused Infection Control Survey. The team exited on 1/19/23. Additional information was obtained on 1/20/23. The survey team returned to the facility on 2/1/23 to complete validation of F726 and exited on 2/2/23. Therefore, the exit date was changed to 2/2/23.. Event ID # 9H9911. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The following intakes were investigated: NC00193965; NC00194312; NC00194888; NC00196686; NC00196863; NC00197058 and NC00197274. Three (3) of the 7 complaint allegations were substantiated resulting in deficiencies. Intake NC00196686 resulted in Immediate Jeopardy. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) and CFR 483.35 at tag F726 at a scope and severity (J). Immediate Jeopardy began on 1/2/23 and was removed on 1/19/23. The tag F689 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		2/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 1 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 2	F 623		

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 3 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews, interview with the Ombudsman, and record review, the facility failed to notify the Ombudsman of a resident's transfer/discharge from the facility and failed to include the name and contact information of the Long Term Care Ombudsman on the transfer/discharge notice. Additionally, the facility failed to include with the transfer/discharge notice the information about requesting an appeal of the transfer/discharge for 1 of 2 residents reviewed for hospitalization (Resident #6). However, this practice had the potential to affect other residents. Findings included: Resident #6 was admitted to the facility on 8/1/22 with diagnoses that included, in part, seizure disorder and mood disorder. A significant change Minimum Data Set (MDS) assessment dated 11/30/22 indicated Resident #6 had severely impaired cognition.	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken 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. F623 The facility failed to notify the Ombudsman of a resident□s transfer/discharge from the facility and failed to include the name and contact information of the Long Term care Ombudsman on the transfer notice. Additionally, the facility failed to include the appeal information with the transfer notice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 4 A review of Resident #6's profile in the electronic health record revealed Resident #6 was his own responsible party. A nurse's note dated 12/4/22 indicated Resident #6 was sent to the emergency department due to a change in condition. During an interview with the Admissions Director on 1/17/23 at 1:44 PM, she confirmed Resident #6 remained at the hospital. On 1/17/23 at 3:00 PM an observation was made of a one page form titled, "Nursing Home Notice of Transfer/Discharge" which was located in a folder on the desk at the 100 hall/200 hall nurse's station. The form included a section titled, "Appeal Rights," which read, in part, " ...The request for an appeal (see attached form) must be received by the hearing officer no later than the 11th calendar day or your right to appeal is waived ...." There was no attached form in the folder that included information on a resident's appeal rights. Nurse #1 was interviewed on 1/17/23 at 3:05 PM. He explained when a resident was transferred to the hospital, the following paperwork was sent with the resident: interact transfer form, notice of transfer/discharge, history and physical and labwork results. During the interview, the notice of transfer/discharge form was reviewed with Nurse #1 who stated when he filled out the form he completed the date of the notice, the date of transfer/discharge, the reason for transfer/discharge and the location of transfer/discharge. Nurse #1 said he had not filled out the ombudsman section which included	F 623	1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/4/2022, resident #6 discharged from the facility and hasn□t returned. Resident #6 remains discharged, therefore no further corrective action could be completed. On 01/17/2022 and again on 01/20/2022, the Ombudsman received notice that resident #6 was discharged from the facility on 01/17/2023 via encrypted email. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 1/19/2023, the Administrator identified residents that were potentially impacted by this practice by completing an audit of the discharges in the last 14 days. This audit consisted of reviewing the transfer discharge residents who had not received proper discharge/transfer documentation and appeal information. Additionally, the facility reviewed all residents who had been transferred or discharged from the facility in the past 60 days to ensure the Ombudsman had been notified. On 01/17/2022 the Ombudsman was sent an encrypted email all the residents who had been transferred or discharged from the facility in November and December. Beginning 01/16/2023, Nurses were educated on the transfer discharge notification process. Beginning 01/20/2023, The facility Social Worker and Discharge planner was educated on Ombudsman notification, transfer/discharge and appeal notification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5 the name of the ombudsman, address and phone number. Additionally, Nurse #1 had no knowledge of where information about requesting an appeal was located. A phone interview was completed with Nurse #2 on 1/17/23 at 3:50 PM, during which she confirmed she was the nurse who sent Resident #6 to the hospital. She explained when she transferred a resident to the hospital she sent the following forms: facesheet, medication list, a medical transfer form, and a notice of transfer/discharge. She thought she had sent the transfer/discharge form in the packet with Emergency Medical Services when Resident #6 left the facility. Nurse #2 stated she did not recall writing any information on the transfer/discharge notice about the name or contact information of the Ombudsman. She added she was not aware of any form that had appeal information on it. On 1/18/23 at 3:30 PM an interview was conducted with the Unit Manager. She reported when a resident was transferred to the hospital, the facility sent the medication administration record, facesheet, bed hold policy form, and notice of transfer/discharge form. She said nursing staff completed part of the transfer/discharge form but had not added in the name of the Ombudsman to the form, nor was any appeal information sent along with the transfer/discharge notice. Interviews were completed with the Social Services Director (SSD) on 1/19/23 at 9:44 AM and 10:28 AM, during which she shared when a resident transferred to the hospital, the nurse completed the notice of transfer/discharge and some of the nurses gave a copy of the notice to	F 623	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 1/16/2023, the Staff Development Coordinator and Nurse consultant begin educating and re-educating the nurses, social worker and discharge planner on transfer discharge notices. Additionally, on 01/20/2023, the social worker and discharge planner was educated on notifying the Ombudsman of all facility transfers and discharges. This in-service was incorporated in the new employee facility orientation for the IDT members identified above. Any of the IDT members who does not receive scheduled in-service training will not be allowed to work until training has been completed by 01/20/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F623 Quality Assurance Tool. The tool will monitor transfers to the hospital and discharges home to ensure that each resident that is transferred or discharged receives notification of the reason the facility initiated the transfer or discharge as well as their appeal rights. This will be monitored weekly x 3 weeks then monthly x 2 months. Additionally, the administrator will monitor the monthly reporting to the Ombudsman to ensure he/she has received notification of all residents transferred or discharged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 6 the SSD. She added a copy of the notice went with the resident to the hospital. She further explained appeal information was provided by the facility's legal team when a 30 day notice of discharge was issued to a resident and acknowledged if the appeal information was not located at the nurse's desk as part of the notice of transfer/discharge, then the notice had incomplete information when it was sent with the resident to the hospital. The SSD reviewed her files and said she had not received a copy of the transfer/discharge notice the facility sent when Resident #6 transferred to the hospital. A review of electronic mail (e-mail) communication provided by the Ombudsman's office revealed their office received an email from the SSD dated 1/17/23 at 2:06PM that provided a list of discharges for November and December 2022. A phone interview was completed with the Ombudsman on 1/19/23 at 11:38 AM. She stated the facility e-mailed a list of discharged residents for November and December 2022 to her earlier in the week. She reviewed her files from July 2022-January 2023 and stated the facility had not sent a list of transfers/discharges to the Ombudsman office until 1/17/23 when they sent a list for November and December 2022. During a follow up interview with the SSD on 1/19/23 at 1:08 PM, she revealed a list of transfers/discharges was emailed to the Ombudsman if it was a 30 day notice issued by the facility. She verified she sent a list to the Ombudsman earlier in the week for residents who transferred/discharged from the facility in November and December 2022. She stated she	F 623	This audit will be performed monthly times 3 months. Reports will be presented to the monthly Quality Assurance (QA) committee by the Administrator or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality A Meeting or until no longer deemed necessary. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 7 hadn't sent the list for November and December 2022 until earlier in the week because the Ombudsman office was transitioning to a new Ombudsman and added she had not inquired at the Ombudsman office as to who else to send the notices to, but had waited until the new Ombudsman started. The Administrator was interviewed on 1/19/23 at 1:23 PM and explained the SSD was supposed to send the list of transfer/discharges to the Ombudsman on a monthly basis. She instructed the SSD earlier in the week to send the list for December 2022 to the Ombudsman. She said the Ombudsman had recently changed to a different staff member. The Administrator further stated the facility had sent appeal information when issuing a 30 day notice of discharge, but not when a resident was transferred to the hospital.	F 623		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and	F 626		2/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 8 (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on staff interviews, interviews with the hospital discharge planner and hospital psychiatrist, and record review, the facility failed to permit a resident to return to the facility following a facility-initiated transfer to the hospital for 1 of 2 residents (Resident #6) transferred to the hospital. Resident #6 was medically and psychiatrically stable for return on 1/6/23 when the facility refused to readmit the resident. Findings included: Resident #6 was admitted to the facility on 8/1/22 with diagnoses that included, in part, seizure disorder and mood disorder. A significant change Minimum Data Set (MDS)	F 626	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken 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. F626 The facility failed to permit a resident to return after a facility-initiated transfer/discharge.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 9 assessment dated 11/30/22 indicated Resident #6 had severely impaired cognition. He demonstrated physical and verbal behaviors four out of six days during the lookback period and refused care 1-3 days out of the seven day lookback period. The assessment revealed Resident #6's behaviors significantly interfered with the resident's care and put others at significant risk of physical injury. Additionally, he received antipsychotic and antidepressant medications for 7 of 7 days during the MDS lookback period. The care plan, updated 11/30/22, included focus areas of refusals of care and physical/verbal behaviors. Interventions included, "Psychiatric referral, administer medications as ordered, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later..." A review of Resident #6's profile in the electronic health record revealed Resident #6 was his own responsible party. A friend was listed as Resident #6's emergency contact. A nurse's note dated 12/4/22 stated, "Resident observed by the window of his room. The cover of the air conditioning unit was observed on the floor ...bowel movement observed all over the floor ...Resident was assisted back to bed by staff. Certified nursing assistant reports resident has been combative during this shift. Order obtained to send resident to emergency department (at Hospital #1). Awaiting call from behavioral health." On 1/17/23 at 2:08 PM, a phone interview was	F 626	1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/4/2022, resident #6 discharged from the facility and hasn't returned. On 01/13/2023, Administrator spoke to case management and shared that resident would need a guardian prior to returning to facility to satisfy readmission criteria as resident was without capacity. Resident would need signed consent to treat and Advanced Directives. Resident #6 did not have family or responsible party. Guardianship hearing held on 02/07/2023 and interim guardian in place. Facility is currently coordinating with hospital for readmission as always planned. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 1/17/2023, the Administrator identified residents that were potentially impacted by this practice by completing an audit of the discharges and readmissions from the last 14 days. This audit consisted of reviewing the discharges and readmissions to identify any residents who were denied readmission after a facility-initiated transfer/discharge. This audit was completed on: 1/17/2023. The results included: Three of three residents were readmitted from the facility. On 1/17/2023 the Administrator implemented corrective action for those residents which included: no corrective action needed. No areas of concern noted. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 10 complete with the Hospital Discharge Planner at Hospital #2. She explained Resident #6 was seen in another hospital's emergency department (Hospital #1) and then transferred 12/7/22 to her hospital (Hospital #2) for an inpatient behavioral health stay. Her first contact with the facility's Administrator was on 12/9/22 and at that time, she was informed by the Administrator that the facility would not accept the resident back "since he was hospitalized other than where he was sent." The Hospital Discharge Planner stated she spoke with the facility Admissions Director on 12/29/22 about the resident's return and was told the facility would re-admit Resident #6 on 12/30/22. The Hospital Discharge Planner then received a call back from the Admissions Director later in the day and was told a level two Pre-admission Screening and Resident Review (PASRR) needed to be completed prior to the resident's return to the facility (The purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid certified nursing facilities receive appropriate placement and services). She obtained the level two PASRR number on 1/6/23, which indicated Resident #6 was appropriate for skilled nursing level of care. When she called the facility and spoke with the Admissions Director, she was informed the Administrator would not re-admit the resident since he had been gone from the facility for more than 30 days. The Hospital Discharge Planner spoke again with the Admissions Director on 1/10/23, who stated she reviewed recent hospital notes (from Hospital #2) and read the resident had been combative with a nurse (grabbed the nurse's finger) over the previous weekend. Additionally, the Hospital Discharge Planner reported on 1/12/23 she and the Administrator spoke by telephone and the	F 626	Education: On 1/17/2023, the Regional Director of Operations (RDO) began in-servicing the following members of the interdisciplinary (IDT) to include: the Administrator and Director of Nursing. Training will include: • Admission/Readmission Policy This in-service was incorporated in the new employee facility orientation for the IDT members identified above. Any of the IDT members who does not receive scheduled in-service training will not be allowed to work until training has been completed by 01/17/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F626 Quality Assurance Tool. The tool will monitor discharges to the hospital to ensure that if the facility is able to meet the needs of the resident upon their hospital discharge as well as admission/readmission criteria that they are allowed readmission to the facility. This will be monitored weekly x 3 weeks then monthly x 2 months. Reports will be presented to the monthly Quality Assurance (QA) committee by the Administrator or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality A Meeting or until no longer deemed necessary. The QA Meeting is attended by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 11 Administrator said since Resident #6 was away from the facility more than 30 days he would be treated as a new admission and new admission paperwork would need to be completed. The Administrator informed the Hospital Discharge Planner since Resident #6 didn't comprehend what needed to be signed in the paperwork, he needed a legal guardian. The Hospital Discharge Planner said she spoke with the Administrator on 1/16/23 who said the facility required a legal guardian to sign the admission paperwork for the resident. She added Resident #6 was currently not having any negative behaviors, was stable and ready for discharge back to the facility. A hospital psychiatric note dated 1/16/23 revealed, " ...Patient was discussed in treatment team today and that he is stable for placement and we are waiting placement. We will continue current treatment plan. Patient's symptoms have improved since yesterday's assessment." During an interview with the Admissions Director on 1/17/23 at 1:44 PM, she explained when a resident was ready to return from the hospital, typically the hospital notified her. She said Resident #6 transferred to the hospital on 12/4/22 due to agitated behaviors. He initially went to the hospital near the facility (Hospital #1) and then transferred to another hospital (Hospital #2) for an inpatient psychiatric stay. She recalled the Hospital Discharge Planner called her on a Friday, (she thought it was about two weeks ago but was unsure of exact date), and said the hospital staff thought the resident might be ready to return to the facility; they wanted to see how he did over the weekend and planned to reach out to the Admissions Director after the weekend with an update. When the hospital called back after	F 626	Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 12	F 626		

the weekend, they indicated Resident #6 was ready and indicated they would complete a new PASRR review. The Admissions Director shared she pulled the hospital notes and read the resident had aggressive behaviors towards a nurse at the hospital (grabbed the nurse's fingers and twisted them). She notified the Administrator of the notes. The PASRR was completed by the hospital and a PASRR number was approved on 1/5/23. The Admissions Director stated since that time, the Hospital Discharge Planner had been communicating with the Administrator regarding the resident's return.

The Administrator and Nurse Consultant were interviewed on 1/17/23 at 2:28 PM. The Administrator shared when a resident was at the hospital, typically the Admissions Coordinator stayed in touch with the case manager/discharge planner at the hospital. The facility had access to a resident's medical record in the hospital and discussed with case managers/discharge planners what the plan was for return to the facility. When a resident was ready to transfer back, the facility reviewed the hospital record and made sure they were able to meet the medical needs and take care of the resident. The Administrator reported Resident #6 was sent to the emergency department at the hospital near the facility (Hospital #1) in December 2022 due to aggressive behaviors; from the emergency department the resident was transferred to another hospital (Hospital #2) for an inpatient behavioral health stay. She explained when a resident transferred to the hospital, a transfer/discharge notice was sent with the resident as part of the paperwork given to emergency medical services. The Administrator stated the Hospital Discharge Planner from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 13	F 626		

Hospital #2 called on 1/13/23 and left a voicemail for her (the Administrator). When she returned the Hospital Discharge Planner's phone call on 1/16/23, she asked for an update on Resident #6. The Administrator was informed during the call that the resident "was stable and doing well." The Administrator recalled she spoke with the Hospital Discharge Planner the week before and informed the hospital that Resident #6 needed a guardian or someone who could sign his paperwork since he experienced a cognitive decline since he left the facility. She said while he was at the hospital, Resident #6 was newly diagnosed with dementia. The Administrator added Resident #6 initially signed his own admission paperwork when he was first admitted to the facility. She added the resident needed to have a guardian or a representative in order for him to return. She said from a clinical/behavioral standpoint the resident "was fine," but she hadn't pulled any updated notes.

On 1/17/23 at 3:15 PM, the Administrator provided a copy of a daily inpatient progress note from the hospital, authored by the Hospital Psychiatrist and dated 1/17/23. The note read, in part, " ...Patient continues to steadily improve and is awaiting placement ...needs discharged to safe environment ... Patient was reevaluated today in the day room and he has no complaints. Staff reported that patient took all his medications this morning. No concerning behaviors requiring any as needed medications were reported ...Facility will not take patient until he has a guardian ... Patient was discussed in treatment team today and will continue to work on guardianship ...". This note further indicated the following:

-"Disposition: continued psychiatric

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 14	F 626		

hospitalization justified due to continued danger to others and high probability of danger if discharged with imminent rehospitalization likely." -"Estimated date of discharge: indeterminate, pending stabilization."

During an interview with the Administrator on 1/17/23 at 3:20 PM, she indicated she thought the hospital note reflected the resident was not ready to return to the facility based on the comments under the disposition and estimated date of discharge headings.

A second phone interview was completed with the Hospital Discharge Planner on 1/17/23 at 3:35 PM and the daily inpatient progress note was reviewed with her. She explained the treating psychiatrist was required by the insurance company to daily justify a patient's need for ongoing treatment in an inpatient behavioral health setting, which is why the psychiatrist wrote that continued psychiatric hospitalization was needed. She added Resident #6 had been compliant with his medication regimen, had not exhibited aggressive behaviors and was stable for discharge back to the facility. She further stated if the hospital applied for guardianship and filed paperwork on 1/18/23, it "would probably be around the week of 2/6/23 before an interim guardian was appointed" who could sign admission paperwork at the facility. She reiterated, again, that Resident #6 remained stable and ready for discharge.

The Hospital Psychiatrist was interviewed by telephone on 1/18/23 at 10:02 AM. She was Resident #6's primary psychiatrist while he was at the hospital. She stated the resident was stable and no longer required an inpatient hospital level

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 15 of care. She added he was not a danger to others but needed a safe living environment. She explained she wrote in her daily note that continued hospitalization due to danger to others was to justify an inpatient psychiatric stay for insurance until nursing home placement was arranged and he could return to the facility. She added he was stable and ready for discharge back to the skilled nursing facility.	F 626		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, Nurse Practitioner (NP) and hospital radiologist interviews, and record reviews, the facility failed to transfer a resident safely from her recliner to the bathroom toilet with the assist of one while using a sit-to-stand lift for 1 of 2 residents reviewed for accidents (Resident #4). Resident #4 experienced a fall when the nurse aide did not fasten the sling's chest support strap securely in accordance with the manufacturer's instructions and did not use the leg straps attached to the lift resulting in the resident falling from the lift to the floor. Resident #4 was sent out to the hospital for evaluation / treatment and was found to have a right acetabular roof/iliac bone fracture (the main weight-bearing area of the hip joint) and 3	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken 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. F689 The facility failed to safely transfer a resident from her recliner to the bathroom toilet with the assist of one while using a	2/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

lumbar vertebral fractures (two fractures on the 3rd lumbar vertebra or L3; and one fracture on the 4th lumbar vertebra or L4). The lumbar vertebrae are 5 bones located at the bottom section of the spine (lower back) and are identified as L1 to L5. Resident #4 reported her pain level after the fall as an "8 to more than 10" (with 0 indicative of no pain and 10 representative of the worst pain possible).

Immediate Jeopardy began on 1/2/23 when Resident #4 was transferred by a nurse aide with a sit-to-stand lift without either the chest support strap or leg straps being securely fastened, resulting in her falling to the floor and sustaining multiple fractures. Immediate Jeopardy was removed as of 1/19/23 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective.

The findings included:

A review of the manufacturer's "Instructions for Use" for the facility's sit-to-stand lift (dated October 2019) included directions for the safe use of the lift. The instructions read in part, "To fasten the [chest] support strap securely, press the buckles (if available) or hook and loop strap (if available) together. The strap shall be tight, but comfortable for the resident ....Remember to tighten the strap once the resident becomes raised from the chair ...The sling support strap will help to support the resident in the sling during sit- to-stand lift. Resident experienced a fall with injury.

1. Corrective action for resident(s) affected by the alleged deficient practice:
Resident #4 was sent to hospital for evaluation and treatment on 01/02/2023. Upon return from the hospital, therapy re-evaluated resident #4□s transfer status and it was determined that she was then appropriate for a total mechanical(Hoyer) lift. Resident #4 was educated on her new transfer status and her careplan/Kardex was updated to reflect the change as well.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 01/04/2023, the Administrator, Director of Nurses, Staff Development, Rehab Manager, MDS, Unit Manager and the Clinical Nurse Consultant began identification of residents that were potentially impacted by this practice. This audit was completed by reviewing current residents who were identified as requiring transfer utilizing of the sit to stand and hoyer lift on 100/200 halls and if the transfer device was appropriate. This audit was completed on 01/05/2023. The Director of Nurses and the Clinical Nurse Consultant began updating the care plan to ensure it included the required number of individuals to complete a safe transfer and the proper device that needed to be used. This care plan update was completed on 01/05/2023. Since 1/05/2023, the Director of Nurses, Rehab team and the nurse management team

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17 the raising procedure. The strap also retains the sling in the correct position around the resident." Additionally, the manufacturer's instructions included a boxed warning in bold print which read, "Warning: The sling chest support strap must always be applied and fastened when using the sling." The role of the lower leg straps attached to the lift were also described in the instructions as follows: "[The lower leg straps are an] Accessory used to ensure that the lower parts of the resident's legs stay close to the knee support. They pass around the knee supports, then around the resident's lower calves. To fasten, click the strap into it's socket as with a seatbelt. Ensure that the straps are firm but comfortable for the resident." Resident #4 was admitted to the facility on 2/1/18. Her cumulative diagnoses included a history of acute respiratory failure with hypoxia (low oxygen level in the blood). A review of Resident #4's Care Plan included the following area of focus, in part: -- I have an Activities of Daily Living (ADL) self-care performance deficit related to impaired balance (Date Initiated: 2/2/18; Revision on: 10/26/22). The 10/26/22 revision indicated a sit-to-stand lift with a large sling was required for transfers. Resident #4's Occupational Therapy Treatment Encounter Notes included a notation authored by the facility's Occupational Therapist (OT) on 11/2/22 at 1:50 PM. The note read in part: " ...Pt [Patient] educated regarding need to use knee strap during use of stand up (sit-to-stand) lift for toileting tasks, as pt has refused to allow staff to use same in past due to c/o [complaints of] pain.	F 689	have reviewed residents at the time of admission, quarterly and with significant changes to ensure that lift status and number of staff needed for transfer was documented on the care plan for the resident. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: 01/04/2023, the Director of Nurses and Staff development coordinator began in-servicing all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees) on Mechanical Lift Safety Education which included education on how to use the lift, how many caregivers are required to use the lift, and what to do if there is a problem with the lift. This was completed on 01/18/2023. After 01/18/2023, this in-servicing was incorporated into all new hire orientation for nurses, certified nursing assistants and agency staff that are allowed to use the lift. The training included both sit to stand and Hoyer lift manufactured by ARJO. Additionally, on 01/04/2022, the Director of Nurses began validation of competency of certified nursing assistants and nurses (agency and non-agency) on use of the lift. This was completed on 01/18/2023. Competency was continued during the orientation process for new hires and as a part of the agency training. Agency staff are not allowed to use lifts until they have received training. They received	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18 OT educated pt regarding allowing OT to pad strap to increase comfort and allow proper support. Pt agreeable to same. Pt educated regarding staff inability to use stand up machine (sit-to-stand lift) without proper strapping due to heightened fall risk." Resident #4's level of pain was documented in her electronic medical record (EMR) 0 to 4 times a day during the two week period prior to her fall using the numeric pain scale rating ranging from 0 to 10. From 12/18/22 to 1/1/23, there were the 34 documented reports of the resident's pain level which included: --On 12/19/22 at 9:23 PM, the resident's level of pain was documented as "3"; --On 12/26/22 at 8:23 PM, the resident's level of pain was documented as "2"; --On 12/27/22 at 10:27 PM, the resident's level of pain was documented as "3"; --On 12/28/22 at 8:10 PM, the resident's level of pain was documented as "3." Thirty (30) of the 34 reports of the resident's level of pain were documented as "0" from 12/18/22 and 1/1/23. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/30/22. The MDS reported Resident #4 had intact cognition. She was totally dependent on staff for transfers and required two plus (2+) persons physical assist. Resident #4's EMR included a Change in Condition report dated 1/1/23 at 8:16 PM which indicated the resident was sent out to the hospital Emergency Department (ED) for evaluation and treatment due to chest pain and shortness of breath.	F 689	education on this restriction at the beginning of their first shift in the facility. Once they are properly trained on lift use they are allowed to use lifts according to facility policy. Supervisory staff are notified when an agency staff member has been trained. The Director of Nurses has ensured that all licensed nurses and certified nursing assistants (full-time, part time, as needed and agency) employees who do not complete the in-service training will not be allowed to work until the training is completed. The Director of Nursing accomplished this by: making sure that the written agency orientation packet is provided to and reviewed with the agency staff prior to their first shift in the facility. All employees must complete general orientation prior to working with residents. This training is included in the orientation process. Completed 01/18/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On 01/16/2023, the Director of Nurses or a designee began weekly monitoring (which included facility staff and agency staff) to identify if training had been completed, on how to use the lift and if the correct number of caregivers were used to complete the transfer. The facility will review 2 sit to stand transfers and 5 staff knowledge checks with these audits. Audits will be performed weekly times 3 weeks, and then monthly times 2 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19 A Nursing Note dated 1/2/23 at 3:32 AM reported the resident returned to the facility on 1/2/23 at 3:00 AM with a diagnosis of a urinary tract infection (UTI) and fungal infection. The note reported an antibiotic and antifungal medication were prescribed. The resident was reported as "still complaining of difficulty breathing." Her oxygen saturation level (O2 sat) was 93% on 3 liters / minute of supplemental oxygen. A Fall Report dated 1/2/23 at 5:37 PM and authored by the facility's Director of Nursing included a description of an incident involving Resident #4 which read, "The resident was being transferred to the bathroom by two CNAs [Certified Nurse Aides] on the stand up [sit-to-stand] lift. The resident was holding on to the lift properly but suddenly she was observed falling, so the CNAs lowered her to the floor. The resident had a syncope episode [temporary loss of consciousness]. Resident stated that she had fainted." The Fall Report indicated the Immediate Action Taken as: "The nurse was noted by CNAs that the resident had been lowered to the floor after fainting. The nurse assessed the resident and she was lifted off the floor by [brand name of a total mechanical lift]. No injury noted but received orders to send to hospital for evaluation." The Fall Report indicated no injuries were observed at time of incident. The resident's level of pain was reported to be "0." An interview was conducted with Resident #4 on 1/17/23 at 12:00 PM as she recalled the incident of 1/2/23 when she had a fall in the bathroom. The resident reported the Nurse Aide (NA) who assisted her to the bathroom was new and this was her first day working at the facility. When	F 689	to ensure compliance with policy and procedure. Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

asked to detail what occurred on the day she fell, the resident again reported she had a new NA working with her on that day. She did not recall the NA's name. The resident stated she was being transferred from the recliner to the toilet in her bathroom. The resident then stated, "The girl didn't fasten the center strap" (referring to the chest support straps on the sling). She reported "I told her she didn't hook the cross-straps on me." Resident #4 reported "only the two long straps" that connected each side of the sling to the lift were used for the transfer. However, the "cross straps" which secured the sling to her (the resident's) chest were not used. Resident #4 stated during the transfer, she "slipped a little and felt weak, then fell to the ground." Resident #4 reported her back hurt and stated, "They had to call the fire truck to get me off of the floor." Upon further inquiry, the resident reported the sit-to-stand lift (not a total mechanical lift) was always used to transfer her but she reiterated the NA who transferred her did not use the straps like they were typically used. When specifically asked, the resident reported she did not actually faint or lose consciousness during the transfer on 1/2/23. Resident #4 reiterated she "just felt weak" when she fell in the bathroom.

A telephone interview was conducted on 1/17/23 at 4:02 PM with NA #1. NA #1 was identified as the agency (temporary staff) nurse aide who was assigned to care for Resident #4 on first shift of 1/2/23 from 7:00 AM to 7:00 PM. During the interview, the NA reported 1/2/23 was the first and only shift she worked at the facility. NA #1 reported, "No one gave me rounds ....I did not know anything about the resident." The NA stated she did not have access to the residents' electronic Kardex (an electronic record which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

provided details of the type of care a resident required) or any other information typically available via the electronic Kiosk (a computer terminal) until the end of her shift. NA #1 reported she had to ask residents and other staff for information about resident care. NA #1 stated right before dinner, Resident #4 needed to use the bathroom. The NA reported she understood the resident usually kept a sit-to-stand lift inside her bathroom but it was not there so she had to go to another hall to get a lift for the transfer. NA #1 recalled the leg straps on the lift were attached to the lift but they were "in knots" and "tied up to the machine." The NA stated she was able to use the strap of the sling "under the arms only" but did not provide additional details about whether or not the chest support strap was secured. The NA then reported she began to transfer Resident #4 from her recliner to the bathroom. NA #1 stated, "She was hanging on fine." Then the NA noticed the resident appeared to be getting weak so she grabbed her from behind and slid her down to the floor. She stated the resident did not faint or lose consciousness. NA #1 reported another NA (NA #2) had been in and out of the resident's room during the transfer and reported that NA was in the room just as the resident fell to the floor. NA #1 then stated, "When this lady fell, I caught her and put her on the floor." The NA recalled Resident #4 complained of pain so she put a pillow behind her legs and back and had the resident lean on her leg for support. When EMS arrived, the Emergency Medical Technicians (EMTs) transferred the resident off of the floor and onto the stretcher.

A telephone interview was conducted on 1/18/23 at 9:27 AM with NA #2. NA #2 was identified as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

an agency (temporary staff) nurse aide who worked on the first shift of 1/2/23 from 7:00 AM to 7:00 PM. During the interview, the NA reported 1/2/23 was the first and only time she worked at the facility. NA #2 reported her assignment was to provide showers for the residents. When asked about the incident involving Resident #4, the NA reported a nurse had told her the resident needed to use the bathroom and asked her to go in and check on her. NA #2 stated she went into the room and the resident confirmed she wanted to use the bathroom so the NA went and told NA #1 the resident needed assistance. NA #2 also went into the room to help with the transfer but recalled before lifting the resident up, she noticed the resident was on supplemental oxygen. However, the oxygen tubing was not long enough to reach the bathroom. She told NA #1 to wait while she found a longer oxygen tube. When NA #2 returned to the resident's room, she observed that NA #1 had already hooked the resident up to the sit-to-stand lift and began the transfer to the bathroom. NA #2 reported she observed NA #1 trying to lower Resident #4 to the toilet but she was not close enough (the legs on the base of the sit-to-stand lift were not open) and she was not able to transfer her successfully. NA #2 also observed the resident did not have the harness (sling) fastened and her legs had not been secured with the leg straps on the lift. NA #2 stated she tried to help slide the resident down while attempting to hold on to the harness. The NA explained the resident was "losing the harness" (sling) because it had not been fastened. The resident was still holding on to the lift's metal bars as she fell. She did not observe Resident #4 to lose consciousness. After the resident reached the floor, the harness (sling) was disconnected from the lift. NA #2 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

while NA #1 tried to stabilize the resident with her leg, she saw the NA's knee was "into the resident's back." After the fall, NA #1 went out of the room to get help while NA #2 hooked up the resident's supplemental oxygen. NA #2 reported Resident #4 complained of pain in her back, legs, and feet. The resident rated her pain as "more than 10." When EMS arrived, NA #2 resumed her other duties.

An interview was conducted on 1/17/23 at 3:30 PM with Nurse #1. Nurse #1 was identified as having worked on 1st shift (7:00 AM to 7:00 PM) on 1/2/23 at the time of Resident #4's fall. When asked to recall the details of his involvement with Resident #4 on 1/2/23 (the date of her fall from the lift), Nurse #1 reported he was not in the room at the time of the fall and was actually in the process of sending another resident out to hospital. After Resident #4's fall, he reported both he and the Unit Manager went into Resident #4's room. He observed the resident sitting on the bathroom floor with an NA still holding on to her and the resident was still holding onto the sit-to-stand bars. He could not recall noticing which lift or sling straps were fastened at that time because his focus was on the resident. Nurse #1 recalled the resident was complaining of back pain and he reported the Unit Manager told him to go ahead and get her ready to be sent out to the hospital. He called EMS and accompanied them down to Resident #4's room when they arrived. The EMS team transferred the resident off of the floor and onto the stretcher for transport to the hospital.

An Interdisciplinary Team (IDT) progress note authored by Nurse Practitioner (NP) #1 and dated 1/2/23 at 8:33 PM reported the resident was sent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24	F 689		

to the hospital ED "for pulsating sensation in abdomen as reported by nursing." The note reported this feeling was not new however prior workup had been unremarkable. The NP also wrote, "Of note, staff report that patient had a witnessed fall during transfer with lift, no notable injuries, no acute reports of pain ... however reports that it felt like 'she swallowed her heart.' Sent to ER [Emergency Room] at request of patient. This writer spoke with MD [Doctor] at [name of hospital] who states that patient is still being worked up."

Resident #4's hospital records included the following:
- An ED Provider Note dated 1/2/23 at 7:23 PM. The note indicated Resident #4 presented to the ED for evaluation of injuries sustained in a fall. The note reported, "She had a witnessed ground-level fall in the restroom at her skilled nursing facility earlier today. The patient states that she felt generally weak and then fell to the ground. There was not a loss of consciousness. She states that she hit her head and back against the ground and is complaining of diffuse pain, but mostly headache and back pain. EMS [Emergency Medical Services] was called, patient was subsequently transported to our emergency department for further evaluation."

- On 1/2/23 at 8:30 PM, computerized tomography (CT) of the resident's thoracic (12 vertebrae located in the upper and middle part of the back) and lumbar spine was performed with a comparison to a CT of the resident's abdomen and pelvis conducted on 11/22/21. The findings were reported by Radiologist #1. The radiology report noted the presence of a fracture cleft (a possible indication of a compression fracture)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

through the superior (upper) aspect of the 3rd lumbar (L3) vertebral body, a left L3 transverse process (a wing-shaped protrusion on the vertebra) fracture, and a minor superior endplate (a transitional area where the vertebral body and disc between the vertebrae come together) compression fracture deformity of the L4. A chronic healed L2 compression fracture deformity was also included in the findings. On 1/2/23 at 8:27 PM, a CT of Resident #4's chest, abdomen and pelvis was completed. The radiology findings reported the resident had an acute nondisplaced fracture through the right acetabular roof / iliac bone. Additional radiology tests conducted of the resident's lower extremities noted the resident had osteopenia.

- Resident #4's hospital Discharge Summary dated 1/4/23 at 12:11 PM reported the resident was admitted to the Trauma Service for further management and monitoring. The hospital records reported Orthopedic Trauma was consulted for her right acetabular roof and iliac bone fracture with the fracture managed non-operatively. Neurosurgery was consulted for the lumbar spine fractures, which were also managed without surgical intervention. Resident #4 was fitted in a Thoracic-Lumbar-Sacral Orthosis (TLSO) brace used to limit motion of the thoracic, lumbar and sacral regions of the spine and upright imaging was obtained. The resident's spine was cleared for mobility while wearing the TLSO brace. The resident's hospital Discharge Summary also reported the resident was discharged back to the facility on 1/4/23 after receiving treatment for her injuries present on admission. These injuries were noted on the Discharge Summary to include an acute nondisplaced fracture of the right acetabular roof

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26	F 689		

/ iliac bone fracture and fractures of the L3 vertebral body, left L3 transverse process and L4 superior endplate. The resident's discharge medications included 325 milligrams (mg) acetaminophen to be given as two tablets by mouth every 8 hours as needed (PRN) for pain, headache, or fever; and 50 mg tramadol (an opioid pain medication) to be given as one tablet by mouth twice daily as needed.

Resident #4 was readmitted to the facility on 1/4/23. A review of the resident's medications orders dated 1/4/23 included 325 mg acetaminophen to be given as two tablets by mouth every 8 hours as needed for pain, headache, or fever; and 50 mg tramadol to be given as one tablet by mouth twice daily as needed.

A review of Resident #4's January 2023 Medication Administration Record (MAR) revealed the resident received one dose of acetaminophen on 1/5/22 at 4:34 AM for a documented level of pain rated as "6" on a scale of 0 to 10 (with 0 indicative of no pain and 10 representative of the worst pain possible). Resident #4 also received PRN tramadol in accordance with the physician's orders on 1/5/23 at 10:03 AM for a pain level of 7. The medication was reported to have been effective.

The resident's EMR included a Comprehensive Encounter notation dated 1/5/23 and authored by NP #2. The NP reported Resident #4 was seen on this date for a post hospitalization visit due to a witnessed fall. The notation read, in part: " ...Patient seen today for post hospitalization for a witnessed fall resulting in closed nondisplaced dome fracture of right acetabulum and iliac bone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27	F 689		

fracture with recommendations of non-surgical conservative treatment, WBAT [weight bearing as tolerated] to BLE [bilateral lower extremities], and lumbar spine fractures. Patient fitted for a TLSO for L3 vertebral body fx [fracture], L3 transverse process fracture, and L4 superior end plate fx ..."

Further review of Resident #4's January 2023 MAR revealed the resident received PRN medication on each of the following dates / times:
--1/8/23 at 9:20 AM for a pain level of 8. The medication was reported to have been effective.
--1/9/23 at 9:24 AM for a pain level of 4 and at 9:12 PM for a pain level of 10. The medication was reported to have been effective on both occasions.
--1/10/23 at 10:21 AM for a pain level of 9. The medication was reported to have been effective.
--1/11/23 at 5:28 PM for a pain level of 9. The medication was reported to have been effective.

A notation made in Resident #4's EMR indicated the resident was seen by NP #1 on 1/12/23 at 11:49 AM. The note read, in part: "Patient returned from [hospital] stay on 1/4/23 following a fall and found to have lower back compression fx and fx to sacral [the portion of the spine between the lower back and tailbone]. Has prn order for tramadol q12h [every 12 hours as needed], using occasionally. Pain to lower back controlled, patient is not routinely using recommended back brace bc [because] she is spending majority of time in bed ...patient states that she is doing fair without acute concerns ..."

A follow-up interview was conducted with Resident #4 on 1/18/23 at 10:57 AM. When asked how she was doing, the resident responded by stating she was "not doing good."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28	F 689		

The resident reported she was receiving therapy and with their help, she sat of on the side of the bed. Upon further inquiry, the resident stated she was glad to sit up for a short time but reported it was painful. During the interview, the resident was asked to rate her level of pain. She reported having pain "all the time" and rated the level of pain as an "8 to more than 10." The resident reported the pain medications prescribed for her were helpful in reducing the pain. When asked, the resident confirmed during the 1/2/23 transfer (when she fell from the lift) her sling was loose, the "cross straps" were not secured, and no leg straps were fastened on her legs. Resident #4 added, "I told the lady it usually takes two [staff] but she didn't say nothing."

An interview was conducted on 1/18/23 at 2:50 PM with the facility's Maintenance Director. During the interview, the Maintenance Director reported safety checks were done on all lifts once weekly on Fridays. He stated he inspected all mechanical lifts on 1/3/23 (after Resident #4's fall). When asked, the Director reported on 1/3/23 he noticed the leg straps on one of the sit-to-stand lifts were tied up in knots so he replaced those straps.

An interview was conducted on 1/18/23 at 10:10 AM with NP #1. During the interview, the NP recalled she had given the order to send Resident #4 to the hospital on 1/2/23. She reported that initially when she gave the okay to send her out, she understood it was due to breathing issues. NP #1 stated the resident did have chronic pain. The NP also acknowledged she conducted a visit with the resident on 1/12/23. The hospital radiology reports were discussed during the interview and included the finding of osteopenia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

When asked, the NP reported both osteopenia (reduced bone mass, but less severe than osteoporosis) and osteoporosis place a resident at an increased risk of sustaining any type of fracture as compared to someone else with normal bone density.

A telephone interview was conducted on 1/18/23 at 12:49 PM with NP #2. During the interview, the NP reported she saw Resident #4 on 1/5/23 after the resident returned to the facility. The NP stated during her visit, the resident did not have a lot of pain while lying in bed. The NP thought unless the resident was moving, her pain should be controlled. Upon inquiry, NP #2 reported Resident #4's fractures could possibly take 8-10 weeks to mend. In the meantime, unless therapy was working with the resident it was best for her to lay in bed. When asked, the NP reported even a "hard sit" could potentially cause fractures for someone with osteopenia or osteoporosis.

An interview was conducted on 1/19/23 at 7:45 AM with the facility's Director of Nursing (DON). When asked, the DON reported as long as she had been working at the facility, the facility's policy was for two staff members to be present for all transfers using a sit-to-stand or total mechanical lift.

On 1/19/23 at 9:45 AM, the Administrator requested an observation be conducted as she and two facility staff members attempted to "re-enact" Resident #4's 1/2/23 fall from the sit-to-stand lift. The Administrator stated the re-enactment was based on information provided by Resident #4. She reported Resident #4 stated the cross-straps (chest support straps) of the sling itself were not fastened during the transfer,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30	F 689		

the leg straps were not used, and only the two straps (one on each side) of the sling were fastened to the lift . Based on the re-enactment conducted and observed on 1/19/23 at 9:45 AM, the Administrator questioned whether the resident would have been able to fall from the sit-to-stand lift. However, when asked, the Administrator confirmed neither of the NAs who worked with the resident on 1/2/23 (the time of the fall) had participated in a re-enactment of the transfer. She reported one NA said she would come in and do the re-enactment but she did not. The other NA declined to participate. When the Administrator was asked if there was question about the resident having experienced a fall from the lift and sustaining fractures, the Administrator responded by saying she was not certain the resident actually sustained her fractures from the 1/2/23 incident.

An interview was conducted on 1/19/23 at 11:07 AM with the facility's Occupational Therapist (OT). This OT was identified as having worked with Resident #4 in November and December 2022 to determine the safety of lifts used to transfer the resident. During the interview, the OT was asked about her work with Resident #4. The OT reported the resident basically got agitated when staff used the knee (leg) strap for her when using the sit-to-stand lift. The OT reported she educated the resident that the leg straps were used for her safety. She stated Therapy provided the resident with sheepskin to use on the back of the lift's leg straps so they would be more comfortable. During the interview with the OT, inquiry was made as to why it was important for the sit-to-stand leg straps to be utilized during a transfer. The OT responded by saying that if the resident was not able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31	F 689		

maintain her grasp for any reason (such as a weak spell), she could slide down and out of the machine without the leg straps. She stated the leg straps would be an extra measure for her safety. When asked what the OT's thoughts were with regards to a resident being transferred with a sit-to-stand lift without using leg straps and with the chest support strap either loose or not being used at all, the OT responded, "Oh no, it's not safe."

The hospital radiologist was interviewed by telephone on 1/20/23 at 2:59 PM. During the interview, the radiologist confirmed he reviewed Resident #4's thoracic / lumbar films. The radiologist reported the resident's L3 and L4 lumbar vertebral fractures were "unhealed" and likely "acute fractures." He stated, "a fracture of this nature was likely something recent." At that time, Resident #4's fall on 1/2/23 was described to the radiologist. When asked if the resident's lumbar fractures could be the result of her fall on 1/2/23, the radiologist stated, "they certainly could be."

Upon request, the facility provided documentation of a "Review to Ensure Quality" (initiated on 1/4/23) for review on 1/17/23 at 2:00 PM. This review indicated the facility began an investigation of Resident #4's fall on 1/4/23. The initial report indicated an investigation was needed because "Resident complained of feeling weak and her legs gave way during transfer in sit to stand lift." Immediate education that was being initiated included "Mechanical lift education; Agency orientation checklist; and Nursing admin (administrative) staff on agency orientation checklist being completed before agency staff can work in facility." The Root Cause Analysis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32	F 689		

statement read: "The resident was being transferred when she had an emergent situation where she went unconscious causing her to have decreased alertness and compromising her mobility." The plan for correcting the specific area of concern identified and process that led to the concern included a 4-point plan that addressed: 1) Corrective action for resident involved; 2) Corrective action for potentially impacted residents; 3) Systemic changes; and 4) Quality Assurance. The date of completion for the systemic changes involving the in-service training of nursing staff was 1/18/23.

The Administrator was notified of immediate jeopardy on 1/18/23 at 1:40 PM. The facility provided an acceptable credible allegation on 1/18/23.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 01/02/2023 Resident #4 received injury during a lift transfer resulting in injury.

On 01/04/2023, the Administrator, Director of Nurses, Staff Development, Rehab Manager, MDS, Unit Manager and the Clinical Nurse Consultant began identification of residents that were potentially impacted by this practice. This audit was completed by reviewing current residents who were identified as requiring transfer utilizing of the sit to stand and hoyer lift on 100/200 halls and if the transfer device was appropriate. This audit was completed on 01/05/2023. The Director of Nurses and the Clinical Nurse Consultant began updating the care plan to ensure it included the required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		

number of individuals to complete a safe transfer and the proper device that needed to be used. This care plan update was completed on 01/05/2023. Since 1/05/2023, the Director of Nurses, Rehab team and the nurse management team have reviewed residents at the time of admission, quarterly and with significant changes to ensure that lift status and number of staff needed for transfer was documented on the care plan for the resident.

Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

On 01/04/2023, the Director of Nurses and Staff development coordinator began in-servicing all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees) on Mechanical Lift Safety Education which included education on how to use the lift, how many caregivers are required to use the lift, and what to do if there is a problem with the lift. This was completed on 01/18/2023. After 01/18/2023, this in-servicing was incorporated into all new hire orientation for nurses, certified nursing assistants and agency staff that are allowed to use the lift. The training included both sit to stand and mechanical lift manufactured.

Additionally, on 01/04/2022, the Director of Nurses began validation of competency of certified nursing assistants and nurses (agency and non-agency) on use of the lift. This was completed on 01/18/2023. Competency was continued during the orientation process for new hires and as a part of the agency training. Agency staff are not allowed to use lifts until they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34	F 689		

have received training. They received education on this restriction at the beginning of their first shift in the facility. Once they are properly trained on lift use they are allowed to use lifts according to facility policy. Supervisory staff are notified when an agency staff member has been trained.

On 01/16/2023, the Director of Nurses or a designee began weekly monitoring (which included facility staff and agency staff) to identify if training had been completed, on how to use the lift and if the correct number of caregivers were used to complete the transfer. These audits included actual observation of staff (including agency) carrying out transfers. There were no concerns identified from any of the audits that were completed.

The Director of Nurses has ensured that all licensed nurses and certified nursing assistants (full-time, part time, as needed and agency) employees who do not complete the in-service training will not be allowed to work until the training is completed. The Director of Nursing accomplished this by: making sure that the written agency orientation packet is provided to the agency staff prior to their first shift in the facility. The facility leaves the packets near the time clock and will follow up by phone when needed to ensure that the packet is reviewed. All employees must complete general orientation prior to working with residents. This training is included in the orientation process. Completed 01/18/2023.

This in-service was incorporated into the new employee facility orientation for all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees). This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 began on 1/16/2023 and will continue. Completed 01/18/2023 Date of IJ removal-01/19/2023 The facility's credible allegation of Immediate Jeopardy removal was validated on 1/19/23. The validation was evidenced by observation of lift transfers using a sit-to-stand lift and by interview with the Director of Nursing and nursing staff members regarding the system put into place to ensure nursing staff were provided the necessary in-service education prior to working their shift. Multiple interviews with both licensed nursing staff and non-licensed nursing staff (NAs) working on each of the halls at the facility were conducted. The nursing staff consistently reported they received in-service education on the use of both the sit-to-stand and total mechanical lifts. Staff were able to verbalize key measures necessary to ensure a resident's safety during the lift transfers, including ensuring the lift and sling straps were securely attached and two staff members were used for a lift transfer. Immediate Jeopardy was removed on 1/19/23.	F 689		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 726		2/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 36 accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to provide agency Nurse Aides (NA #1 and NA #2) with orientation and training to meet individual residents' care needs, including education and verification of the NA's competency on the safe use of the facility's mechanical sit-to-stand lift. One (1) of 2 residents reviewed for accidents (Resident #4) experienced a fall when the nurse aide did not fasten the sling's chest support strap in accordance with the manufacturer's instructions and did not use the leg straps attached to the lift. The resident fell from the lift to the floor. The resident was sent out to the hospital for evaluation / treatment and was found to have a right acetabular roof/iliac bone fracture (the main weight-bearing area of the hip joint) and 3 lumbar	F 726	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken 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. F726 The facility failed to provide agency orientation and training to meet the individual residents□ care needs including education and verification of the NA□s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 37 vertebral fractures (vertebrae located in the lower back). Immediate Jeopardy began on 1/2/23 when two new agency NAs (NA #1 and NA #2) began working at the facility without receiving orientation, training, and verification of their competency to transfer a resident safely with a sit-to-stand lift, resulting in her falling to the floor and sustaining multiple fractures. Immediate Jeopardy was removed as of 1/19/23 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective. The findings included: A review of the manufacturer's "Instructions for Use" for the facility's sit-to-stand lift included directions for the safe use of the lift. The instructions read in part, "To fasten the [chest] support strap securely, press the buckles (if available) or hook and loop strap (if available) together. The strap shall be tight, but comfortable for the resident ....Remember to tighten the strap once the resident becomes raised from the chair ...The sling support strap will help to support the resident in the sling during the raising procedure. The strap also retains the sling in the correct position around the resident." Additionally, the manufacturer's instructions included a boxed warning in bold print which read, "Warning: The sling chest support strap must always be applied and fastened when using	F 726	competency on the safe use of the facility□s mechanical sit-to-stand lift. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 01/04/2023, upon return from the hospital, therapy re-evaluated resident #4□s transfer status and it was determined that she was then appropriate for a total mechanical(Hoyer) lift. Resident #4 was educated on her new transfer status and her careplan/Kardex was updated to reflect the change as well. Additionally, beginning on 01/04/2023, all nurses and nursing assistants were educated and re-educated on mechanical lift safety. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 01/04/2023, the Administrator, Director of Nurses, Staff Development, Rehab Manager, MDS, Unit Manager and the Clinical Nurse Consultant began identification of residents that were potentially impacted by this practice. This audit was completed by reviewing current residents who were identified as requiring transfer utilizing of the sit to stand and hoyer lift on 100/200 halls and if the transfer device was appropriate. This audit was completed on 01/05/2023. The Director of Nurses and the Clinical Nurse Consultant began updating the care plan to ensure it included the required number of individuals to complete a safe transfer and the proper device that needed to be used. This care plan update was completed on 01/05/2023. Since	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 38 the sling." The role of the lower leg straps attached to the lift were also described in the instructions as follows: "[The lower leg straps are an] Accessory used to ensure that the lower parts of the resident's legs stay close to the knee support. They pass around the knee supports, then around the resident's lower calves. To fasten, click the strap into it's socket as with a seatbelt. Ensure that the straps are firm but comfortable for the resident." Resident #4 was admitted to the facility on 2/1/18. Her cumulative diagnoses included a history of acute respiratory failure with hypoxia (low oxygen level in the blood). A review of the resident's Care Plan included the following area of focus, in part: -- I have an Activities of Daily Living (ADL) self-care performance deficit related to impaired balance (Date Initiated: 2/2/18; Revision on: 10/26/22). The 10/26/22 revision indicated a sit-to-stand lift with a large sling was required for transfers. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/30/22. The MDS reported Resident #4 had intact cognition. She was totally dependent on staff for transfers and required two plus (2+) persons physical assist. A Fall Report dated 1/2/23 at 5:37 PM and authored by the facility's Director of Nursing included a description of an incident involving Resident #4 which read, "The resident was being transferred to the bathroom by two CNAs [Certified Nurse Aides] on the stand up [sit-to-stand] lift. The resident was holding on to	F 726	1/05/2023, the Director of Nurses, Rehab team and the nurse management team have reviewed residents at the time of admission, quarterly and with significant changes to ensure that lift status and number of staff needed for transfer was documented on the care plan for the resident. Additionally, beginning on 01/04/2023, all nurses and nursing assistants were educated and re-educated on mechanical lift safety. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: 01/04/2023, the Director of Nurses and Staff development coordinator began in-servicing all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees) on Mechanical Lift Safety Education which included education on how to use the lift, how many caregivers are required to use the lift, and what to do if there is a problem with the lift. This was completed on 01/18/2023. After 01/18/2023, this in-servicing was incorporated into all new hire orientation for nurses, certified nursing assistants and agency staff that are allowed to use the lift. The training included both sit to stand and Hoyer lift manufactured by ARJO. Additionally, on 01/04/2023, the Director of Nurses began validation of competency of certified nursing assistants and nurses (agency and non-agency) on use of the lift. This was completed on 01/18/2023. Competency was continued during the orientation process for new hires and as a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 39 the lift properly but suddenly she was observed falling, so the CNAs lowered her to the floor. The resident had a syncope episode [temporary loss of consciousness]. Resident stated that she had fainted." The Fall Report indicated the Immediate Action Taken as: "The nurse was noted by CNAs that the resident had been lowered to the floor after fainting. The nurse assessed the resident and she was lifted off the floor by [brand name of a total mechanical lift]. No injury noted but received orders to send to hospital for evaluation." The Fall Report indicated no injuries were observed at time of incident. The resident's level of pain was reported to be "0." Resident #4's hospital Discharge Summary dated 1/4/23 at 12:11 PM reported the resident was discharged back to the facility on 1/4/23 after receiving treatment for her injuries present on admission. These injuries were noted on the Discharge Summary to include an acute nondisplaced fracture of the right acetabular roof / iliac bone fracture and fractures of the L3 vertebral body, left L3 transverse process and L4 superior endplate. Resident #4 was readmitted to the facility on 1/4/23. An interview was conducted with Resident #4 on 1/17/23 at 12:00 PM as she recalled the incident of 1/2/23 when she had a fall in the bathroom. When asked to detail what occurred on the day she fell, the resident reported she had a new NA working with her on that day. She did not recall the NA's name. The resident stated she was being transferred from the recliner to the toilet in her bathroom. The resident then stated, "The girl didn't fasten the center strap" (referring to the	F 726	part of the agency training. Agency staff are not allowed to use lifts until they have received training. They received education on this restriction at the beginning of their first shift in the facility. Once they are properly trained on lift use they are allowed to use lifts according to facility policy. Supervisory staff are notified when an agency staff member has been trained. The Director of Nurses has ensured that all licensed nurses and certified nursing assistants (full-time, part time, as needed and agency) employees who do not complete the in-service training will not be allowed to work until the training is completed. The Director of Nursing accomplished this by: making sure that the written agency orientation packet is provided to and reviewed with the agency staff prior to their first shift in the facility. All employees must complete general orientation prior to working with residents. This training is included in the orientation process. Completed 01/18/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On 01/16/2023, the Director of Nurses or a designee began weekly monitoring (which included facility staff and agency staff) to identify if training had been completed, on how to use the lift and if the correct number of caregivers were used to complete the transfer. The facility will review 2 sit to stand transfers and 5 staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 40 chest support straps on the sling). She reported "I told her she didn't hook the cross-straps on me." Resident #4 reported "only the two long straps" that connected each side of the sling to the lift were used for the transfer. However, the "cross straps" which secured the sling to the resident's chest were not used. Resident #4 stated during the transfer, she "slipped a little and felt weak, then fell to the ground." When specifically asked, the resident reported she did not actually faint or lose consciousness during the transfer on 1/2/23. Resident #4 reiterated she "just felt weak" when she fell in the bathroom. A follow-up interview was conducted with Resident #4 on 1/18/23 at 10:57 AM. When asked, the resident confirmed during the 1/2/23 transfer (when she fell from the lift) her sling was loose, the "cross straps" were not secured, and no leg straps were fastened on her legs. Resident #4 added, "I told the lady it usually takes two [staff] but she didn't say nothing." A telephone interview was conducted on 1/17/23 at 4:02 PM with NA #1. NA #1 was identified as the agency (temporary staff) nurse aide who was assigned to care for Resident #4 on first shift of 1/2/23 from 7:00 AM to 7:00 PM. During the interview, the NA reported 1/2/23 was the first and only shift she worked at the facility. NA #1 reported, "No one gave me rounds ....I did not know anything about the resident." The NA stated she did not have access to the residents' electronic Kardex (an electronic record which provided details of the type of care a resident required) or any other information typically available via the electronic Kiosk (a computer terminal) until the end of her shift. NA #1 reported she had to ask residents and other staff for information about resident care. Attempts	F 726	knowledge checks with these audits. Audits will be performed weekly times 3 weeks, and then monthly times 2 months to ensure staff competence compliance with policy and procedure. Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 41	F 726		

made to conduct a follow-up telephone interview with NA #1 were unsuccessful.

A telephone interview was conducted on 1/18/23 at 9:27 AM with NA #2. NA #2 was identified as an agency (temporary staff) nurse aide who worked on the first shift of 1/2/23 from 7:00 AM to 7:00 PM. During the interview, the NA reported 1/2/23 was the first and only time she worked at the facility. When asked, NA #2 reported the orientation she received at the facility consisted of a "walk-through" of the facility conducted at the start of her shift. She stated other new NAs were included in this walk-through to let them know where everything was. The NA reported she did not receive an orientation packet. NA #2 also stated that although she had asked for access to the residents' Kardex and other information available from the Kiosk so she could do her charting, she did not receive access to these records "until late in the shift."

An interview was conducted on 1/18/23 at 11:09 AM with the facility's Staff Development Coordinator (SDC). The SDC reported she was new to the facility with a start date of 12/29/22. Upon inquiry, the SDC reported the facility had a structured orientation process for new employees and agency staff conducted by the Human Resources (HR) staff member. This orientation process was already in place when the SDC started in her position.

An interview was conducted on 1/18/23 at 1:00 PM with the HR staff member who was identified as being responsible for the facility's orientation of new staff (both employees and agency). During the interview, the HR staff member reported the orientation process for new NAs was a two-day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 42	F 726		

orientation. Day 1 of the education included general information about the company and facility. Day 2 of the education was provided for nurses and NAs covering more clinical information. Upon inquiry, the HR staff member reiterated both new facility staff employees and new agency staff attended this orientation prior to working their first shift. She also reported there was a Skills Checklist that was typically signed off on by either the facility's Director of Nursing (DON) or SDC. A review of Day 2's printed orientation packet included information on the use of lifts. This information included the following statement in bold print which read, "Before you lift: Must have a spotter before lifting a resident with either lift. Total or stand aide [sit to stand lift]." Additional written information provided indicated a skills check off and return demonstration on the use of lifts. A notation on the skills checklist indicated this form was required to be completed within 10 days of hire.

An interview was conducted on 1/18/23 at 5:00 PM with the facility's DON. During the interview, the DON was asked about the orientation provided to agency NAs. The DON clarified that only agency staff coming from one specific agency (not the agency employing NA #1 or NA #2) went through the 2-day orientation previously discussed with the HR staff member. She reported the Unit Manager typically stayed in the facility and provided a more condensed orientation and information on "The [Company] Way" for new agency staff coming from the other agencies (such as NA #1 and NA #2). She reported, "Agency staff can't start working at the facility without the orientation."

Upon request, the orientation and training

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 43	F 726		

material for NA #1 and NA #2 was provided for review on 1/18/23 at 4:07 PM by the facility's Unit Manager. The packet of information was entitled, "Agency Nurse Aide Orientation." This packet included the following, in part:
--An outline of the topics covered in the information packet included "Falls" and the "Content" read: "In each resident's Kardex under Safety, will be listed fall prevention information. You are responsible for knowing what these are. Residents should be rounded on frequently."
--Another topic in the outline was entitled, "Lists and how residents transfer" and noted the following: "We have lifts stored in clean utility. Lift pads are kept in the storage closet on the floor. Residents who require a lift for transfers will be noted in the resident's Kardex." It also read in bold print: "Agency aides must not operate a mechanical lift. If you are assigned to a resident that needs a lift, the facility aide will operate the lift and the agency aide will assist as a spotter. Remember: It is your responsibility to know what lift is required to transfer a resident. You will know this by checking the Kardex as seen below [referring to a sample diagram]. You can access a residents Kardex on the [computer terminal] by logging into the resident's chart ..."
--A skills checklist for a sit-to-stand lift was also included in the orientation packet. Nothing was checked as completed. The checklist was signed only by the Unit Manager and dated 1/2/23.
--A "Mechanical Lift Transfer Safety and Change in Condition Education Packet" for nurses and NAs noted in bold print, **Prior to performing a transfer, it is important that you always completed the following:" One bullet point listed read, "When using any lift, 2 caregivers [in bold print] must be present during the lift. One operating the lift and the other acting as a spotter. This is important to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 44	F 726		

protect the resident from potential injury such as hitting their leg on the lift mast, etc."
All of the training material in both NA #1 and NA #2's training / orientation packet was signed by the Unit Manager and dated 1/2/23. However, neither NA #1 or NA #2 signed any of the orientation training information or checklists included in her orientation / training packet.

An interview was conducted on 1/18/23 at 5:10 PM with the facility's Unit Manager. The Unit Manager reported, "That day [1/2/23] was hectic with several people being oriented." The Unit Manager recalled she did provide an orientation to the building and walked around with the new agency staff on 1/2/23. The Unit Manager also stated she asked the orientees to sign the forms in their orientation packet. NA #1 and NA #2 did not sign any documents in their orientation packets before they left their shift on that date. It was noted NA #1 and NA #2's lift checklists were not completed. The Unit Manager reported she would normally try to orient the new agency staff before the start of their shift but 1/2/23 was a very busy day with a lot going on so she had to get the NAs on the floor as soon as possible.

A follow-up interview was conducted on 1/19/23 at 12:50 PM with the Unit Manager. The Unit Manager reported each of the NAs were supposed to come to her to complete the orientation packets at some point during their shift, but NA #1 and NA #2 did not come back to do so on 1/2/23. During a second follow-up interview conducted on 1/19/23 at 2:33 PM with the Unit Manager, she reported, "We verbalized the orientation materials but did not do the lift checklist as a return demonstration."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 45	F 726		

An interview was conducted on 1/19/23 at 7:45 AM with the facility's Director of Nursing (DON). During the interview, the orientation and training of agency NAs were discussed. The concern identified with the facility's failure to provide and/or document orientation, training and competencies provided for the two agency NAs (NA #1 and NA #2) working when Resident #4 fell to the floor was discussed. The DON stated she understood the concern. The DON reported she should have followed-up with the new SDC at the facility to ensure a process for the orientation of the new agency NAs was in place.

Upon request, the facility provided documentation of a "Review to Ensure Quality" (initiated on 1/4/23) for review on 1/17/23 at 2:00 PM. This review indicated the facility began an investigation of Resident #4's fall on 1/4/23.
Immediate education that was being initiated included "Mechanical lift education; Agency orientation checklist; and Nursing admin [administrative] staff on agency orientation checklist being completed before agency staff can work in facility." The plan for correcting the specific area of concern identified and process that led to the concern included a 4-point plan that addressed: 1) Corrective action for resident involved; 2) Corrective action for potentially impacted residents; 3) Systemic changes; and 4) Quality Assurance. The date of completion for the systemic changes involving the in-service training of nursing staff was 1/18/23.

The Administrator was notified by telephone of immediate jeopardy on 1/26/23 at 5:35 PM. The facility provided an acceptable credible allegation on 1/27/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 46	F 726		

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 01/02/2023 Resident #4 received injury during a lift transfer resulting in injury.

On 01/04/2023, the Director of Nurses, Rehab Manager, and the Clinical Nurse Consultant began identification of residents that were potentially impacted by the alleged deficient practice. The alleged deficient practice includes: agency nurse aides who did not have proper orientation and training to meet the care needs of residents and verification of competency which would include safe use of the facility's mechanical lift. This audit was completed by reviewing current residents on 100/200 hall who were identified as requiring transfers utilizing a lift. This audit was completed on 01/05/2023. The Director of Nurses and the Clinical Nurse Consultant began updating the care plan to ensure it included the required number of individuals to complete a safe transfer and the proper device to be used. This care plan update was completed on 01/05/2023. Since 1/05/2023, the Director of Nursing and assessment nurses and therapy have reviewed residents on admission, quarterly and with significant changes to ensure that care plans include the use of lift and number of nursing assistants that should assist with transfers. This information is also included on all care guides

Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

On 01/04/2023, the Director of Nurses and Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 47	F 726		

development coordinator began in-servicing all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees) on Mechanical Lift Safety Education which included education on how to use the lift, how many caregivers are required to use the lift, and what to do if there is a problem with the lift. This was completed on 01/18/2023. After 01/18/2023, this in-servicing was incorporated into all new hire orientation for nurses, certified nursing assistants and agency staff that are allowed to use the lift. The training included both sit to stand and total mechanical lifts. All facility lifts are by the same manufacturer

Additionally, on 01/04/2023, the Director of Nurses began validation of competency of certified nursing assistants and nurses (agency and non-agency) on use of the lift. This was completed on 01/18/2023. Competency was continued during the orientation process for new hires and as a part of the agency training. Facility and Agency staff are not allowed to use lifts until they have received training and have validated competency. Competency is validated by noting the NA identifying the proper transfer technique and the proper device needed for the resident, the use of the transfer device and ensuring that all safety mechanisms related to the device are used properly, as well as return demonstration. Transfer status is located on the Kardex for each resident and is found in PCC. Every employee including agency receives a login with PCC access at the start of their shift. They receive education on this restriction at the beginning of their first shift in the facility. Once the staff member is properly trained on lift use, they are allowed to use lifts according to facility policy. Supervisory staff are notified when an agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 48	F 726		

staff member has been trained. The facility Scheduler and Educator keeps a record of all trained staff and ensures the staff member on the schedule has been trained. If a schedule modification is made, the Educator and Supervisor on Duty are notified by the scheduler and the Educator or designee completes the staff member's training and competency before the start of their shift. The current education is that an agency NA can use the lift with any other NA if both are properly trained. A list of all trained staff, including agency, is kept by the scheduler and the Educator and is updated as new staff are educated.

On 01/16/2023, the Director of Nurses or a designee began weekly monitoring (which included facility staff and agency staff) to identify if training had been completed on how to use the lift, and if the correct number of caregivers were used to complete the transfer. These audits included actual observation of staff (including agency) carrying out transfers, as well as Sit to Stand Staff Knowledge checks. The facility will perform 2 transfer observations per week for three weeks and then monthly times 2 months. There were no concerns identified from any of the audits that were completed.

The Director of Nurses has ensured that all licensed nurses and certified nursing assistants (full-time, part time, as needed and agency) employees who do not complete the in-service training will not be allowed to work until the training is completed. The Director of Nursing, nurse managers, Educator and Scheduler accomplished this by: making sure that the written agency orientation packet is provided to the agency staff prior to their first shift in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 49	F 726		

facility. The facility leaves orientation packets near the time clocks for the Supervisor and will follow up by phone, as needed, to notify the Supervisor that a new agency employee requires education that needs to be completed before they can begin the shift. The Supervisor will ensure that the packet is reviewed. This process of notifying the on shift Supervisor is performed by the Scheduler, Educator and Director of Nursing or designee prior to the start of the employees (agency employee) first shift. All employees must complete general orientation prior to working with residents. Transfer status is located on the Kardex for each resident and is found in PCC. Every employee including agency receives a login for PCC access at the start of their shift. This training is included in the orientation process. Completed 01/18/2023.

This in-service was incorporated into the new employee facility orientation for all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees). This began on 1/16/2023 and will continue. Completed 01/18/2023

Date of IJ removal-01/19/2023

The facility's credible allegation of immediate jeopardy removal was validated on 2/2/23. The validation was evidenced by review of facility and agency licensed nursing staff and nurse aides' (NAs) training and education files regarding both initial education and re-education of proper use of all mechanical lifts in the facility, demonstration of mechanical lifts used, re-demonstration of mechanical lift use and a written quiz related to use of mechanical lifts. Both facility and agency licensed nursing staff and NAs on all units were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 50 interviewed and were able to verbalize the mechanical lift education they received prior to returning to work or prior to beginning to work at the facility. Immediate Jeopardy was removed on 1/19/23.	F 726		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		2/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 51 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy,	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 52 resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 53 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee after each of the following surveys with a citation that was recited on the current complaint survey of 1/20/23: 1) The annual recertification / complaint investigation survey of 5/27/21. This was evident for one recited deficiency in the area of Free of Accident Hazards / Supervision / Devices (F689); 2) The annual recertification / complaint investigation survey of 7/21/22. This was for a recited deficiency in the area of Free of Accident Hazards / Supervision / Devices (F689); and 3) A complaint investigation survey of 10/27/22. This was also for one recited deficiency in the area of Free of Accident Hazards / Supervision / Devices (F689). The continued failure of the facility during four federal surveys of record within the last 3 years show a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F689: Based on resident and staff interviews, Nurse Practitioner (NP) and hospital radiologist interviews, and record reviews, the facility failed to transfer a resident safely from her recliner to the bathroom toilet with the assist of one while using a sit-to-stand lift for 1 of 2 residents reviewed for accidents (Resident #4). Resident #4 experienced a fall when the nurse aide did not fasten the sling's chest support strap securely in	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken 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. F867 The facility□s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions put in place to prevent Accidents after receiving previous citation(s). 1. Corrective action for resident(s) affected by the alleged deficient practice: On 1/20/2023, the Administrator educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Accidents (F689). This deficiency was cited again on the complaint survey completed on 1/19/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 54 accordance with the manufacturer's instructions and did not use the leg straps attached to the lift resulting in the resident falling from the lift to the floor. Resident #4 was sent out to the hospital for evaluation / treatment and was found to have a right acetabular roof/iliac bone fracture (the main weight-bearing area of the hip joint) and 3 lumbar vertebral fractures (two fractures on the 3rd lumbar vertebra or L3; and one fracture on the 4th lumbar vertebra or L4). The lumbar vertebrae are 5 bones located at the bottom section of the spine (lower back) and are identified as L1 to L5. Resident #4 reported her pain level after the fall as an "8 to more than 10" (with 0 indicative of no pain and 10 representative of the worst pain possible). During the recertification / complaint investigation survey of 5/27/21, the facility was cited for failing to implement fall safety interventions developed and care planned by its interdisciplinary team (IDT) for 1 of 4 residents reviewed for accidents. During the recertification / complaint investigation survey of 7/21/22, the facility was cited for failing to remove an air mattress from a resident's bed after a fall which caused a resident to sustain another fall for 1 of 5 residents reviewed for accidents. During the complaint investigation survey of 10/27/22, the facility was cited for failing to safely transfer a resident utilizing a mechanical lift. Resident #1 sustained a mildly displaced fracture of the distal diaphysis of the tibia (a fracture occurring at the ankle end of the tibia) and a nondisplaced fracture of the distal fibula (the smaller bone than the tibia and runs beside it, the lower end of the fibula forms the out part of the	F 867	Accidents (F689.) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 1/20/2023 to review the deficiencies from the January 17- January 19, 2023 complaint survey and reviewed the citations. On 1/20/2023, the RDO in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functions of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the area of Accidents (F689). 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 1/20/2023 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functions of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies in the areas of Accidents (F689). This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any QAPI committee team member who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 55 ankle joint) of indeterminate age for 1 of 2 residents reviewed for accidents. An interview was conducted on 1/19/23 at 1:57 PM with the facility's Administrator. During the interview, the Administrator reported she was fairly new to the facility (with a start date of 10/24/22). She confirmed her responsibilities included taking the lead for the facility's QAA committee. The Administrator reported all of the leadership team participated in the QAA monthly meetings. This leadership team consisted of the managers from each department, including: the Director of Nursing (DON), Medical Director, Business Office Manager, Admissions, Staff Development Coordinator, Environmental Services, Maintenance, and the Dietary Department. The Administrator reported the QAA committee's role would include a review of any survey results. The committee would discuss what happened, identify any concerns in the current process, develop and review a plan of correction, and identify the people who need to be involved in monitoring the area of concern going forward.	F 867	does not receive scheduled in-service training will not be allowed to work until training has been completed by 02/08/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the accident process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	