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 01/22/2021

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

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted from 1/20/2020 through 1/22/2020. Event ID # DCSK11 1 of the 3 complaint allegations was/were substantiated resulting in deficiencies. 1 of the 3 allegations was/were substantiated but did not result in a deficiency.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, responsible party, staff and physician interviews, the facility failed to carry out two physician orders on 1 of 3 residents (Resident #2), by not completing two Occult stool tests as ordered. Findings included: Resident #2 was admitted to the facility on 11/1/2018 with multiple medical diagnosis that included anemia, dementia, Bifascicular block and unsteadiness of feet with long term use of aspirin. Resident #2 had a documented family history of colon and stomach cancer. A review of the electronic medical record for Resident #2 revealed the physician was treating the resident for acute on chronic anemia due to a decrease in lab results for hemoglobin (HBG) and hematocrit (HCT) during July 2020. The	F 658	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. F658 1. Corrective action for resident(s) affected by the alleged deficient practice: On 01/21/2021, the Medical Director was notified of the order written in July 2020	2/19/21

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

Electronically Signed | 02/14/2021

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F 658	Continued From page 1 documentation revealed new orders for Vitamin B12 with a follow up in one month and two occult stool test dated July 17 and July 21, 2020. A review of the Medication Administration Record (MAR) for Resident #2 in the month of July 2020 revealed the two occult stool orders had been entered into the electronic system but had not been documented as completed. A review of all physician progress notes from July 2020 through January of 2021 revealed the physician team had documented Resident #2 had responded positively to the medication interventions to improve the HGB and HCT lab results and had repeated lab test, CBC, to review results. The progress notes indicated the resident had responded with increased HGB and HCT back to her baseline of greater than or equal to 10.0 HGB. There was no follow up documentation for the review of occult stool test. An interview was conducted with the Responsible party (RP) for Resident #2 on 1/20/2021. He revealed he had discovered the resident's toilet, in her private room on the COVID unit, to contain feces and blood on the date of 1/5/2021. He stated he called for assistance and was told by staff that the resident had been incontinent all day and staff had changed her briefs with no signs of bleeding and that the toilet had been out of order since 1/4/2021. He said he called the Director of nursing (DON) and the Unit Manager (UM) to request an assessment. He stated he made the decision to call 911. He said the hospital documented the resident was positive for blood in the stool and several days later a test was conducted to discover the origin of the bleeding and the resident was diagnosed with an	F 658	for fecal occult blood test not being completed. On 01/05/2021 Resident #2 was discharged from the facility, therefore no further corrective action could be completed for this resident. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who have orders for fecal occult blood tests have the potential to be affected by the alleged deficient practice. On 02/10/2021 a corrective action was initiated by the Director of Nurses who completed a 100 % audit of all orders from July 2020 until the present time to review any orders written for fecal occult blood test. The audit was completed on 02/12/2021 and revealed a total of 18 orders for fecal occult blood test with 8 orders carried out as ordered. The MD was notified of the results of the audit by the Director of Nurses on 02/12/2021. Any issues that were identified during this audit were corrected immediately by the Director of Nurses. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 02/12/2021, the Director of Nurses and the Unit Manager initiated education of all licensed nurses (RN□s & LPN□s) staff full-time, part-time, PRN staff and agency staff on the process for entering orders for Fecal Occult Blood Tests listed below: " The nurses will use the newly created	

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F 658	Continued From page 2 inoperable 6 cm ulcerated mass in the colon. An interview was conducted with Unit Manager #1 on 1/21/2021 2:32 p.m. and revealed the unit manager expected all physician orders to be completed as ordered by the physician and if a nurse had a concern with an order, to call and seek clarification from the MD. She stated the previous medical director had ordered the occult stool test for Resident #2 in July and had been replaced with the new medical director shortly after the dates of the ordered lab test. She stated she did not find documentation of the occult stool test completion in the medical record. An interview was conducted with the DON on 1/21/2021 and she revealed that it was her expectation that physician orders be completed as ordered. She stated she did not see documentation of the completion of the occult stool test ordered in July 2020. An interview was conducted with the medical director of the facility on 1/22/2021 and she revealed that the MD on call office was notified on the date of 1/5/2021 of Resident #2 being transferred to the hospital for an emergency evaluation. She stated if she had received the notification prior to the son calling 911, she would have had discussions with the family regarding goals of care and then ordered the resident to be assessed at a hospital based on the conversation. She revealed it was documented in her progress notes that the RP did not desire extreme measures and Resident #2 had do not resuscitate orders in place. She stated that it was her expectation that physician orders be completed as ordered. She stated she did not assess a need to order occult stools during her	F 658	order templates for Fecal Occult Blood Test in PCC " The new order template will have two parts. One part will fire to every shift for 3 days for collection of stools for testing. The second part will end with nurse signing off that stool occults were completed and MD notified of collective results " The nurses will also be educated on how to perform the Fecal Occult Blood Tests As of 02/19/2021 at 5pm, any licensed nurse who has not received the Guaiac Process education will not be allowed to work until the training has been completed. This includes full time, part time, agency staff, and PRN staff. The in-service will be incorporated into the new employee facility orientation. In addition to the training & education above, on 02/12/2021, the Director of Nurse initiated education for the Nurse Managers including the Unit Manager, Minimum Data Set Nurses, and any Nurse Managers who participate in the daily clinical meeting on the Orders Quality Review. The Orders Quality Review is a policy within the Orders Management Polity and Procedure that provides another method to ensure that orders have been carried out properly. As of 02/19/2021, any Nurse Manager that has not received this education will not be allowed to work until the training has been completed.	

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F 658	Continued From page 3 visits with Resident #2.	F 658	A Root Cause Analysis was initiated on 02/10/2021 that resulted in the corrective action implemented in this plan of correction. The Root Cause Analysis was completed to determine the best course of action to determine an effective Plan of Correction. The team members participating in the Root Cause Analysis included staff members from the Nursing Department, Environmental services, Administration staff, & Corporate staff which are members of the facility Quality Assurance and Performance committee. 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 Director of Nurses/Unit Managers will complete an audit of all orders written for Fecal Occult Blood Test and Hemoccult Test weekly Monday □ Friday to ensure that these orders are carried out as ordered. The audit will be completed by using the Guaiac Process Audit Tool for compliance. These audits will be completed weekly for a period of 4 weeks and then monthly for a period of 3 months or until resolved by the QA committee. Reports will be presented to the monthly 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.	

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F 658	Continued From page 4	F 658	Date of Compliance: 02/19/2021	