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 08/09/2021

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 A complaint investigation survey was conducted on 8/9/21. Event ID# 7QIJ11. 2 of the 3 complaint allegations were substantiated and one resulted 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 and staff interviews, the facility failed to follow physician's orders for insulin sliding scale coverage for 1 of 3 (Resident #1) residents reviewed for diabetes. Findings include: Resident #1 was admitted to the facility 12/5/18 with diagnosis of diabetes mellitus, insulin dependent. Minimum Data Set (MDS) dated 7/23/21 revealed that Resident #1 was minimally confused and required supervision only for transfers, dressing and all activities of daily living. Resident #1 also used a rolling walker to ambulate and received insulin shots 7 days a week. A review of the physician's orders dated 3/2/2021 revealed that Resident #1 was ordered NovoLOG FlexPen Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 250 = 0; 251 - 350 = 2; 351 - 450 = 3; 451 - 550 =	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 07.29.2021, the Assistant Director of Nurses contacted the Endocrinologist to clarify the orders for this resident. The Endocrinologist didn't return the call to the	8/21/21

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

Electronically Signed | 08/21/2021

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F 658	Continued From page 1 4; 551 - 600 = 5, subcutaneously before meals for diabetes. A review of Resident #1's July medication administration record (MAR) showed that the sliding scale order was discontinued on 7/27/2021 and a new sliding scale order was placed on 7/30/2021 with the same instructions. A review of a physician's order for Resident #1 dated 7/27/21 stated "Make the following insulin changes-Novolog 6 units with breakfast, 4 units with lunch, 5 units with dinner; Lantus 30 units daily". The Assistant Director of Nursing (ADON) was interviewed on 8/9/2021 at 11:22 am. She stated that Resident #1 returned from a visit with her endocrinologist on 7/27/21 with new insulin orders. She stated that the endocrinologist did not address the current sliding scale order, so the receiving nurse discontinued the order. She stated that the nurse should have reached out to verify whether the physician intended to continue the sliding scale order and that she should have not just discontinued the current order. She stated that Resident #1's responsible party brought it to their attention and a new sliding scale order was obtained on 7/30/21. The ADON stated that they are in the process of reeducating staff and doing audits on their diabetic patient's orders to prevent this from happening again in the future.	F 658	facility until 7.30.2021. Resident #1 did not have any observed adverse effects as a result of the deficient practice. The physician was notified of the deficient practice. The medication order was clarified with the physician on 07.30.2021 and a new order was written. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Root Cause Analysis: The Director of Nurses (DON), Assistant Director of Nurses (ADON), and the staff nurse involved reviewed the incident and determined the root cause to be not following processes and utilizing resources. On 08.09.2021, the ADON initiated and completed an audit of 100% of all insulin orders from 08.09.2021 for the previous 14 days to identify any instances where the physician orders were not followed. The audit did not identify any concerns of not following orders for insulin orders. On 08.18.2021, the DON initiated an audit of all current and discharged residents' who had order for insulin and diabetic medication changes from 07.16.2021 through 08.16.2021 to ensure that all medication orders were transcribed as written or ordered following the physician's order. The audit revealed that	

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F 658	Continued From page 2	F 658	there were no other concerns where the physician's order wasn't followed. This audit was completed on 08.21.2021. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 08.16.2021, the DON and the Clinical Consultant Nurse reviewed the policy for Consults and determined that there was no change in the policy required. On 08.16.2021, the DON and ADON began reeducation of all Full Time, Part Time, and as needed (PRN) Nurses; Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) on the following: • Transcribing orders as written to ensure that the physician's order is followed • Ensuring that you have followed all instructions in the order. • Utilizing resources for assistance if there is any difficulty in understanding the order. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08.21.2021.	

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F 658	Continued From page 3	F 658	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 Nursing or designee will monitor compliance utilizing the F658 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with adequate monitoring of physician's ordered medication to ensure the physician order has been followed. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 08.21.2021	