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 10/27/2022

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 from 10/26/22 through 10/27/22. Event ID# 2E8511 1 of the 1 complaint allegation(s) was not substantiated.	F 000		
F 689 SS=G	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 observation, record review, resident and staff interviews, nurse practitioner interview, the facility failed 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 ankle joint) of indeterminate age for 1 of 2 residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on 3/19/2014 with a diagnosis of Alzheimer's disease, and osteoarthritis.	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 11/09/2022

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 10/27/2022

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 1	F 689		

Resident #1's quarterly Minimum Data Set dated 8/15/22 coded Resident #1 as being severely cognitively impaired. The resident required extensive assistance of two persons for transfers.

Resident #1's care plan dated 9/2/22 documented she had an activities of daily living (ADLs) self-care performance deficit. Interventions included a full mechanical lift for all transfers with a medical sling. Resident #1 had a care plan focus area for inappropriate behaviors: kicking, cursing, refusing care, yelling at staff, and scratching staff was identified with interventions which included administering medications as ordered, anticipate resident's needs, when possible, approach in a calm manner and assess for underlying causes of frustration/behaviors such as: hunger, thirst, discomfort, toileting needs, pain, and intervene when possible.

A health status note written by the Unit Manager (UM) dated 10/10/22 read in part; resident yelling when right foot touched with noted discoloration and slight swelling after kicking staff member. Resident unable to describe incident and was in no immediate distress.

A health status note dated 10/10/22 read in part; resident yelling when right foot touched with noted discoloration and slight swelling after kicking staff member. Resident unable to describe incident and was in no immediate distress, on-call (Nurse Practitioner) to be (NP was in the facility) notified with continued monitoring.

Findings of Resident #1's right foot X-ray completed on 10/10/22 revealed prominent

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 10/27/2022

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 2	F 689		

osteopenia was present; hammertoe deformities were present and an old appearing fracture involving the distal tibial metaphysis (the area at the ankle end of the tibia). No displacement seen; soft tissue swelling was noted. No definite fractures or dislocations of the right foot could be identified.

A nurses note dated 10/11/22 written by the UM noted Nurse Practitioner (NP) in room and resident yelling when right lower leg is touched or moved. NP to evaluate and notify family.

A new X-ray was ordered on 10/11/22 of the right tibia/fibula (tibia is the shinbone, the large of the two bones in the lower leg & fibula is the smaller bone than the tibia and runs beside it, the lower end of the fibula forms the out part of the ankle joint) with the following results; 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 of indeterminate age.

A NP note written on 10/11/22 read in part; X-ray results for Resident #1 shows mildly displaced fracture of the distal diaphysis of the tibia and non-displaced fracture of the distal fibula of indeterminate age, bony structure is osteoporotic. Called residents daughter/responsible party (RP) and provided update. RP agreed to send to Emergency department for evaluation. Called facility back and provided update to unit manager.

A health status note written by the UM dated 10/11/22 revealed new orders from the NP to send to the Emergency Department (ED) for evaluation and treatment. NP to notify family.

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 10/27/2022

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 3	F 689		

A review of an ED report dated 10/11/22 read in part Resident #1 had entered with a right ankle X-ray taken of the right tibia fibula reveals 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 of indeterminate age.

A health status note dated 10/12/22 read in part; revealed Resident #1 returned to the facility on 10/12/22 from the hospital. Once in residents room Resident #1 was placed in bed using a mechanical lift without incident. Right leg with soft cast on and wrapped with gauze from base of right toes to knee. Toes are warm to touch. Will continue to monitor and observe of evident of pain.

A review of the statement written by NA #1 dated 10/10/22 read in part; "I was preparing to transfer Resident #1 to the bed. A I was preparing to transfer her I put the bed in the lowest position and locked and nothing around the area. I reached down to hold onto Resident #1 and told her to give me hug, as she likes giving hugs. I placed my foot between her legs and feet. As I placed her into bed, she started to kick which is normal for Resident #1 and yelled "my leg", "my foot". I was asking Resident #1 what was wrong but that is all she said, so I ran and got a nurse. Her Kardex says full mechanical lift not pivot. The reason I picked her up is I was just not thinking. I should have looked at her Kardex".

An observation of Resident #1 on 10/26/22 at 1:11 PM was completed. Resident #1 was in her room in bed with a cast on right foot. Resident was feeding herself and unable to answer any questions.

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 10/27/2022

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 4	F 689		

An interview was completed with the Unit Manager (UM) on 10/26/22 at 1:17 PM who was asked about Resident #1's injury to her leg. The UM stated that it was due to an "improper" transfer and explained that Nurse Aide (NA) #1 had transferred Resident #1 from her shower chair into her bed when Resident #1 kicked NA #1. The UM explained that Resident #1 was to be transferred by a mechanical lift. UM stated she was notified by the Nurse Aide (NA) #1 that Resident #1 was complaining of pain on her right lower extremity. UM stated the NP was in the facility and the UM and NP went to assess the resident and at that time they looked at Resident #1's foot and did not notice any abnormalities except the foot was a little red and the NP ordered an X-ray. The UM stated they asked Resident #1 if she was in pain, and she was not. Education was then completed with the nursing staff on proper transfers.

An interview was completed on 10/26/22 at 1:51 PM with the Interim Director of Nursing (DON) who recalled Resident #1's injury happened by a transfer where Resident #1 kicked her kicked her leg out but Resident #1 had not displayed any behaviors during the transfer. The DON stated she recalled that the NA who transferred Resident #1 had asked her to give NA #1 a hug (the DON stated the resident likes to give hugs) and had lifted Resident #1 up into bed and when doing so, the DON stated, "Resident #1 kicked out her leg and when doing so I think kicked NA #1 leg". The DON stated that Resident #1 should have been transferred by a mechanical lift and by 2 people. The DON explained that when something like this would happen, we had to complete an investigation to see what happened related to 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 10/27/2022

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 5	F 689		

resident's injury. The DON stated the SW had interviewed residents who were alert and oriented to see if they had any concerns related to staff hurting them or had treated them poorly and any concerns with safety. The SW interviews revealed no concerns. The DON stated that skin assessments had been completed on resident's who were not able to answer interview questions and skin assessments had not revealed any concerns. The DON stated that we had educated the NAs on the importance of using the Kardex (desktop file system that gives a brief overview of each patient) to find out specifically how to care for a resident as well as how to transfer residents. The DON stated that NA #1 was suspended while an investigation was completed. The DON stated that Resident #1's first X-ray which was completed on 10/10/22 revealed an old fracture but revealed there was no new fracture. The DON explained that on 10/11/22 there was a noticeable change in Resident #1's right leg and the swelling was more prominent on her lower right leg above her ankle. An X-ray was ordered, and it came back that she had a right fracture at the end of the tibia/fibula and was sent out to the hospital.

An interview was completed with Nurse Aide #2 on 10/26/22 at 2:15 PM who stated that when she would transfer Resident #1, she would use a mechanical lift and always two people. Nurse #2 stated that if Resident #1 was demonstrating behaviors we would try and soothe her and explain what we are doing for her.

An interview was completed with the SW on 10/26/22 at 2:31 PM who stated that regarding Resident #1 she had assisted with the investigation by interviewing residents who were cognitively intact and asked them if they felt safe,

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 10/27/2022

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 6	F 689		

if they had any concerns with staff, if they felt safe being transferred, was there always two people if using a mechanical lift. The SW stated there were no concerns from residents.

An interview was completed with the Senior Quality Assurance Nurse Consultant (NC) on 10/26/22 at 3:13 PM who stated that the NA#1 was performing a transfer and the resident's leg kicked out during the transfer and Resident #1 said "ouch". NA #1 notified her nurse, and the NP was in the building who responded and looked at Resident #1's leg. The NC stated, "that from our investigation there was nothing unusual about the transfer and could not say that it was an improper transfer". The NC stated that they had NA #1 complete a reenactment in the room and had it set up as when Resident #1 was transferred. The NC stated that NA #1 did transfer Resident #1 as a one person transfer and did not follow Resident #1's care plan but nothing significant happened during the transfer that would cause the resident's leg to kick out and there were no behaviors exhibited by Resident #1. The NC stated that she could not say that if a mechanical lift was used would her leg still have kicked out. The NC stated a full investigation was completed including skin assessments, interviews, and education. The CC stated that the facility completed a plan of correction and were in there third week of monitoring per the plan of correction.

An interview was conducted on 10/26/22 with NA #1 at 3:42 PM. NA #1 stated that on 10/10/22 she was transferring Resident #1 from her shower chair to the bed. NA #1 stated that Resident #1 likes to give me hugs as it helps her relax and I had given her a hug and transferred her at 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 10/27/2022

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 7	F 689		

same time. NA #1 stated that it was her fault. Resident #1 stated that her bed was in the lowest position and locked but during the transfer was kicking both feet, there was nothing around her that she could have kicked and did not feel her connect with something like her leg hitting something. NA #1 stated she laid her on the bed and afterwards Resident #1 said "her leg". NA #1 stated she immediately got a nurse. NA #1 stated that she had worked with Resident #1 before but had never transferred her and did not know she was a mechanical lift and did not look at the Kardex. NA #1 stated Resident #1 was very light, but it was inappropriate for me not to use a mechanical lift and did not ask anyone if she was a mechanical lift. NA #1 stated Resident #1 was not exhibiting any behaviors during the transfer.

An interview was completed with Nurse #1 on 10/26/22 at 6:31 PM who stated that she was working the night Resident #1 went to the hospital and spoke to EMS. Nurse #1 stated that she informed EMS that she had a negative X-ray on 10/10/22 and 10/11/22.

A telephone interview was completed with a former NA #3 on 10/27/22 at 11:04 AM who stated that she had given Resident #1 a shower on 10/10/22 and when she was bringing Resident #1 back to her room NA #1 offered to assist Resident #1 putting her back to bed. NA #3 stated NA #1 told NA #3 when she transferred Resident #1, she used a stand to pivot transfer instead of a mechanical lift. NA #3 stated she was not in the room during the transfer. NA #3 stated that when she had given Resident #1 a shower, she had not observed anything unusual (such as bruising, falls, bumping into walls) with Resident #1 and explained she was fine during

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 10/27/2022

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 8	F 689		

her shower, her mood was fine and there were no behaviors present.

A telephone interview was completed with the former NP on 10/27/22 at 12:04 PM who treated Resident #1 regarding her leg injury. NP stated that she based her treatment plan off the X-ray and that is all the information she had. NP stated that it would be speculation on her part but would say that her osteopenia could have been a contributing factor to her injury.

The facility provided the following corrective action plan with a completion date of 10/17/22.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
Resident was assessed by the NP. Pain was assessed and managed. Care plan was reviewed, and the plan of care was accurate according to the resident's care status. Care plan was updated with new changes. Therapy assessed the resident for any new recommendations.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 10/10/2022, 100% of current residents that were able to be interviewed, were asked if transfers were completed according to their plan of care. This was completed by the Unit Support Nurse. Results included: All residents who had

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 10/27/2022

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 9	F 689		

been transferred according to their plan of care. Additionally, skin observations were completed on current residents on the aid's assignment that were not interviewed. These residents were assessed to identify any edema or signs/symptoms of pain related to transfers according to the plan of care. Results included: No residents were identified as having transfers that were not completed according to the plan of care. On 10/10/2022 the DON implemented corrective action for those residents which includes: No corrective action was needed. On 10/13/2022 the Director of Nursing completed 5 random observations of transfers with and without the lift from 10/13/2022 - 10/17/2022. There were no concerns with any of the transfers.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 10/10/2022, the Director of Nursing in-serviced all Licensed Nurses (RN's & LPN's) and CNA's Full time, Part time, and PRN staff (including agency) on Safe Transfers. This training will include all current staff including agency. This training included:
" Safe Transfers
" Utilizing the Kardex
" When to utilize the Kardex
" Abuse training.

The DON or designee will complete skills check and observation of lift transfers monthly and report any concerns to the QA list.
As of 10/17/2022, the Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 10/17/2022 will not be allowed to work until 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 10/27/2022

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 10 training is completed. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The DON or designee will monitor safe transfers weekly for 5 weeks and monthly for 2 months to ensure safe transfers are being completed. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Diet Manager. 5. Root Cause(s) of the event. Circle all that apply and describe below. Regulation, Care plan and other Root Cause Analysis statement (summarize investigation results regarding why it occurred). Consider using 5 whys process: Unintentional incident during resident transfer with factors related to severe osteopenia, osteoarthritis, and bony structures are osteoporotic. Resident disposition of being fragile and high risk for spontaneous fractures from September 11,2022. Root cause was reviewed 10/10/22 - 10/13/ 022. Presented to QA on 10/13/22. Date of compliance as of 10/17/22 and ongoing The plan of correction was reviewed and validated 10/27/2022 by interviews with the Senior Quality Assurance Nurse Consultant (NC), Director of Nursing, Unit Manager, Social Worker,	F 689		

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 10/27/2022

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 11	F 689		

nursing staff, including Nurse #1, Nurse Aide #1, Nurse Aide #2, and Nurse Aide #3. Included in the validation was a review of the plan of correction, educational in-services. The educational in-services included a power point titled 'Resident Transfer Safety Education Packet' which included a visual power point instruction on how to access the Kardex system and to review the instructions for each resident to assist with transfers. A review of the monitoring and audits was review which included a total mechanical lift competency checklist which was given to staff as part of the monitoring process.

An interview was completed with Nurse Aide #2 on 10/26/22 at 2:15 PM who stated that we need to check the Kardex system to see how a resident is to be transferred if we are not familiar with the transfer.

An observation of a transfer was completed on 10/26/22 at 5:46 PM with NA #1 and NA #4 in room 106 bed A of a resident who was a mechanical lift. The resident was transferred by two people who had used a sling from the resident's bed to her wheelchair. There were no concerns with the transfer. NA #4 was asked how she knew how to transfer a resident and she stated that "we are to check the Kardex system for each resident on how a resident was to be transferred and with how many people and the type of sling used in a mechanical lift.

An interview was conducted on 10/26/22 with NA #5 at 6:06 PM who stated that he would always check the Kardex and the instructions regarding the transfer status for each resident.

An interview was completed Nurse #2 at 6:08 PM

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 10/27/2022

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 12	F 689		

who stated that had monitor transfers to ensure the resident was being transferred the correct way.

An interview was conducted with two alert and oriented residents on 10/26/22 at 6:15 PM to 6:23 PM. There were no concerns with how they were being transferred using a mechanical lift.

An interview was completed with the DON on 10/26/22 at 6:22 PM who stated that part of her monitoring process for observing mechanical lifts includes waiting outside the hallway to ensure a second person was always present for the mechanical lift. If a staff member did not have two people, I would tell them they cannot transfer that person. The DON stated there had been no concerns with staff not utilizing two persons during a mechanical lift.

A phone interview was completed with Nurse #1 on 10/26/22 at 6:31 PM who stated that she has had training on transfers and will monitor staff transferring utilizing a two person lift and would assist staff if necessary if a NA needed additional help.

During an interview with the NC and the Administrator on 10/26/22 at 6:45 PM there had been no further incidents of staff failing to utilize the correct transfer for a resident after the compliance date on 10/17/22.

Based on the corrective action plan the facility was in compliance for F689 as of 10/17/22.