

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/07/2026 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER Summerstone Health and Rehabilitation Center | STREET ADDRESS, CITY, STATE, ZIP CODE 485 Veterans Way , Kernersville, North Carolina, 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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|-------|---|-------|--|--|
| F0000 | <p>INITIAL COMMENTS</p> <p>The survey team entered the facility on 5/5/26 to conduct an unannounced complaint investigation and follow up. Additional information was obtained offsite on 5/7/26. Tags F677, F688 and F791 were corrected as of 5/7/26. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.</p> | F0000 | | |
|-------|---|-------|--|--|

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

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