PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345354 B. WING			l	C / 02/2016			
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1/	02/2010	
				7:	28 PINEY GROVE ROAD			
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER			ERNERSVILLE, NC 27284			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN		F	282			4/28/16	
	must be provided by	d or arranged by the facility qualified persons in resident's written plan of						
	by:	is not met as evidenced						
		ns, record reviews and staff			Piney Grove Nursing and Rehabilitatio			
	interviews the facility failed to follow the plan of				acknowledges receipt of the Statement	of		
	care for 1 of 3 sampled resident 's (Resident #1)				Deficiencies and proposes this Plan of			
	who was care planned for a geri-chair and a chair				Correction to the extent that the summa	•		
	alarm for risk for falls.				of findings is factually correct and in ord to maintain compliance with applicable	Jei		
	Findings included:				rules and provisions of quality of care o	of		
					residents. The Plan of Correction is			
	Resident #1 was adm	•			submitted as a written allegation of			
		nosis of left femur fracture,			compliance.			
	chronic obstructive pu							
		1 was discharged home on			Piney Grove Nursing and Rehabilitation			
	3/22/16.				response to this Statement of Deficience	cies		
	T	D. L. O. L (MDO)			does not denote agreement with the			
	The most recent Minimum Data Set (MDS) assessment with assessment reference date of				Statement of Deficiencies nor does it			
					constitute an admission that any			
		Resident #1 was severely			deficiency is accurate. Further, Piney Grove Nursing and Rehabilitation			
		and required extensive			reserves the right to refute any of the			
	include bed mobility a	ty of daily living (ADL's) to			deficiencies on this Statement of			
	Include bed inobility a	illu transiers.			Deficiencies through Informal Dispute			
	The care plan initiated	d on 3/1/16 with a focus on			Resolution, formal appeal procedure			
		t Resident #1 required			and/or any other administrative or legal			
		y related to left hip fracture			proceeding.			
		nat indicated dependent in			p. 55556mig.			
		3/1/16 for risk for falls			On 3/21/2016, Resident #1 was			
	related to impaired ba				immediately assessed by a nurse. After	r		
		resident in areas of high			the assessment, Resident #1's physicia		 	
		air and when family is not			was notified and neurological checks w			
ADODATODY	-	SUPPLIER REPRESENTATIVE'S SIGNATURI	-		TITLE		(X6) DATE	

BURATURY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/20/2016

Electronically Signed

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
						С	
		345354	B. WING _		•	4/02/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		728 PINEY GROVE ROAD			
				KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	Continued From page	e 1	F 2	82			
	with her and provide personal alarm: bed and chair. The resident care guide for nurse aide 's dated 3/1/16 for Resident#1 listed interventions of non-ambulatory, aide of 2 persons, keep resident in areas of high traffic when in geri-chair and family is not with her, assist with eating, falls, non-kid foot wear, keep personal items within reach, hi-low bed: return to lowest position when giving care, mat on floor beside of bed, toilet frequently, alarm: bed and chair, geri-chair, dentures(upper). Review of the incident note written by nurse #1 dated 3/21/16 at 7:50 AM revealed in part: the nurse aide observed resident #1 attempting to leave the dining room and tried to roll wheel chair out while sitting in it, the chair was locked and the chair flipped back. Resident #1 fell and hit her head, resident was assessed by a nurse and it was reported to nurse #1 that resident had a knot on the back of her head, nurse #1 assessed Resident #1 's head and noted the same finding, the medical doctor was informed and new order was received for neruo checks every 4 hours,			initiated with no negative findi 3/21/2016, Resident #1's resp party was notified. On 3/21/20 Resident #1 was sent to the h further evaluation. On 3/21/20 #1 returned from the hospital computerized tomography scabrain was completed revealing intracranial abnormality. On 3/22/2016, the director of nurse, and staff facilitator com 100% in-service with all nursir and nurses regarding following resident care plan and resident to include using the proper charesidents. On 4/4/2016, the director of nurse, and staff nurse comple audit to ensure all residents, in Resident #1, were with the apchair and/or safety alarms. The revealed all residents were in appropriate chair, as assigned resident care plan and on the care guide. Any alarms that were	consible con		
	· ·	temperature 98.9, pulse was eased to 98 and resident 's		properly placed on the resider bed were immediately placed			
	A physicians order w 10:03 AM to transfer further evaluation aft The computerized to without contrast date	as obtained on 3/21/16 at resident to the hospital for er hitting head with fall.		On 4/4/2016, the director of nurse, and staff nurse initiated in-service related to chair or being appropriately placed an properly with all nursing assis nurses. This was 100% comp 4/7/16.	d an ed alarms d functioning tants and olleted on		
				On 4/20/2016, the director of	nursing, QI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			Ι,	С	
		345354	B. WING				02/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	02/2010	
				72	28 PINEY GROVE ROAD			
PINEY GR	OVE NURSING AND F	REHABILITATION CENTER		K	ERNERSVILLE, NC 27284			
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		COMPLETION DATE	
F 282	Continued From pa	age 2	F:	282				
	An interview with n	urse #1 on 4/2/16 at 8:45 AM			nurse, MDS nurse, staff facilitator, and			
	revealed that she w	vas on duty on 3/21/16 and			staff nurse began auditing all resident			
		ining room and assessed			care guides to ensure bed and/or chair	•		
		she fell. She indicated that			alarms are properly noted on the resid			
	Resident #1 had tip	pped over her wheelchair.			care guide, resident care plan, and are			
	Nurse #1 further in			properly placed and working. This aud	lit			
	familiar with Reside			will be completed 5 days per week for	one			
	was suppose to be			week, then 3 days per week for 4 weel	ιs,			
	and was not aware			then 1 time weekly for 8 weeks.				
	place. Nurse # 1 st							
	care guide in the re			On 4/20/2016, the director of nursing,				
	know their care needs.				nurse, MDS nurse, staff facilitator, and			
					staff nurse began auditing nursing			
	An interview with n			assistants and nurses to ensure the				
	10:30 AM indicated that she was assigned to				nursing assistants and nurses are			
	Resident #1 on 3/2			following the care guide and care plan	to			
		room table, the wheel chair			include assisting the resident into the			
		e wheel chair tipped			correct assigned chair and with assign			
	backwards, she we			alarm. This audit will be documented o				
	but it was too late.			Resident Care Audit form. These audit	-			
	chair alarm in place			will be completed 5 days per week for				
	the geri-chair was r			week, then 3 days per week for 4 weel then 1 time weekly for 8 weeks.	ις,			
	be located for a fev			liter i time weekly for 8 weeks.				
	•	Ichair and there were no chair chair, the chair alarm was in						
	the geri-chair.	Shall, the chall alarm was in			On 4/20/2016, the director of nursing of	ır		
	the gen chair.				QI nurse will begin reporting the results			
	During a phone inte	erview with nurse aide #2 on			the audits to the monthly QI committee			
		revealed that she was in the			The monthly QI committee will review			
				results of the audits and make				
	dining room and observed Resident #1 push the wheelchair away from the table, the wheelchair				recommendations as needed for	ĺ		
	was locked and the wheelchair fell backwards.				continued compliance in this area, and	to		
	She indicated that			determine the need for and/or frequen				
	geri-chair and there			of continued QI committee monitoring.				
	An interview with th	ne director of nurses on 4/2/16						
	at 11:08 AM reveal	ed that she would expect				ĺ		
		n the safest device,				ĺ		
	Decident#1 was in	the process of being evaluated						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345354	B. WING		04/02/2016
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284	1 04/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 282		expects the staff to use the	F 28	32	
F 323 SS=D	changed. 483.25(h) FREE OF A HAZARDS/SUPERVI The facility must ensi- environment remains as is possible; and ea	SION/DEVICES ure that the resident as free of accident hazards	F 32	23	4/28/16
	by: Based on observation interviews the facility plan interventions for for 1 of 3 sampled resident #1). Findings included: Resident #1 was adm 2/19/16 with the diag chronic obstructive process.	is not met as evidenced ons, record reviews and staff failed to implement care a geri-chair and chair alarm sidents reviewed for falls nitted to the facility on nosis of left femur fracture, ulmonary disease and 1 was discharged home on		On 3/21/2016, Resident #1 was immediately assessed by a nurse the assessment, Resident #1's ph was notified and neurological che initiated with no negative findings 3/21/2016, Resident #1's respons party was notified. On 3/21/2016, Resident #1 was sent to the hosp further evaluation. On 3/21/2016 #1 returned from the hospital after computerized tomography scan of brain was completed revealing not intracranial abnormality.	nysician ccks were consible sital for Resident cr a
	assessment with ass 3/18/16 revealed that cognitively impaired a assistance with activitinclude bed mobility a	mum Data Set (MDS) essment reference date of Resident #1 was severely and required extensive ty of daily living (ADL's) to and transfers. Resident #1's ed to be not steady and only		On 3/22/16, the director of nursing nurse, and staff facilitator comple 100% in-service with all nursing a and nurses regarding following the resident care plan and resident cate include using the proper chair to	ted a assistants le are guide

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345354	B. WING		C 04/02/2016	
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/02/2010	
				728 PINEY GROVE ROAD		
PINEY GR	OVE NURSING AND R	EHABILITATION CENTER	I	KERNERSVILLE, NC 27284		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
F 323	Continued From pa	-	F 323	3		
	able to stabilize with risk for falls.	n staff assistance and a high		residents.		
				On 4/4/2016, the director of nursing,		
		ted on 3/1/16 with a focus on		nurse, and staff nurse completed a 10		
		at Resident #1 required		audit to ensure all residents, including		
	assistance for mobility related to left hip fracture			Resident #1, were with the appropriate chair and/or safety alarms. The audit		
	with an intervention that indicated dependent in geri-chair. A focus on 3/1/16 for risk for falls			revealed all residents were in the		
	related to impaired balance revealed			appropriate chair, as assigned in the		
		p resident in areas of high		resident care plan and on the residen	t	
		chair and when family is not		care guide. Any alarms that were not		
		e personal alarm: bed and		properly placed on the resident's chai		
	chair.			bed were immediately placed correctl	y.	
	_	uide for nurse aide 's dated		On 4/4/2016, the director of nursing, (QI .	
		#1 listed interventions of		nurse, and staff nurse initiated an		
		le of 2 persons, keep resident		in-service with all nursing assistants a		
		fic when in geri-chair and		nurses related to chair/bed alarms be	•	
	_	r, assist with eating, falls, eep personal items within		properly placed and operating. This w 100% completed on 4/7/16.	las	
		eturn to lowest position when		100 % completed on 4/1/10.		
		floor beside of bed, toilet		On 4/20/2016, the administrator,the		
		ed and chair, geri-chair,		director of nursing, QI nurse, MDS nu	rse.	
	dentures(upper).			staff facilitator, and staff nurse began		
	Deview of the incide	ant note written by pures #1		auditing using the Hazard/Supervision/Devices audit too	al to	
		ent note written by nurse #1 50 AM revealed in part: the		monitor residents in dining room,	יו נט	
		d resident #1 attempting to		activities, hallways, shower rooms an	d	
		and tried to roll wheel chair		resident rooms to ensure the resident		
	_	, the chair was locked and the		environment remains as free of accident		
		Resident #1 fell and hit her		hazards as is possible; and each resi		
		assessed by a nurse and it		receives adequate supervision and		
	was reported to nurse #1 that resident had a knot			assistance devices to prevent accider	nts.	
	on the back of her h	nead, nurse #1 assessed				
	Resident #1 's head	d and noted the same finding,		On 4/20/2016, the director of nursing,		
		was informed and new order		nurse, MDS nurse, staff facilitator, an		
		ruo checks every 4 hours,		staff nurse began auditing all resident		
		od pressure- 132/88, pulse		care guides to ensure bed and/or cha		
	120, respirations 16	i, temperature 98.9, pulse was		alarms are properly noted on the residual	dent	

Facility ID: 923023

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				D. WING			С
		345354	B. WING			04	/02/2016
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DINEY OF	OVE NUDOING AND DE	IADU ITATION CENTED		72	28 PINEY GROVE ROAD		
PINET GR	OVE NURSING AND REI	ABILITATION CENTER		K	ERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	÷ 5	F:	323			
	daughter was notified A physicians order wa	as obtained on 3/21/16 at			care guide, resident care plan, and are properly placed and working. This Hazards/Supervision/Devices audit too will be completed 5 days per week for	ol one	
	10:03 AM to transfer further evaluation after			week, then 3 days per week for 4 week then 1 time weekly for 8 weeks.	KS,		
	The computerized tomography (CT) scan of brain without contrast dated 3/21/16 revealed impression of no acute intracranial abnormality.				On 4/20/2016, the director of nursing of QI nurse will begin reporting the result the audits to the monthly QI committee. The monthly QI committee will review	s of e.	
	revealed that she was was called to the dining Resident #1 when sh	se #1 on 4/2/16 at 8:45 AM s on duty on 3/21/16 and ng room and assessed e fell. She indicated that			results of the audits and make recommendations as needed for continued compliance in this area, and determine the need for and/or frequen	l to	
	Nurse #1 further indic familiar with Resident was suppose to be in and was not aware if	ed over her wheelchair. Eated that she was not E #1 and did not know if she E a wheelchair or a geri-chair E a chair alarm should be in E ed the nurse aides have a			of continued QI committee monitoring.		
	care guide in the residence know their care needs	dent 's closet to let them s.					
	10:30 AM indicated the Resident #1 on 3/21/2 #1 push the dining rowas locked and the was locked and the geri-chair was not be located for a few of placed in the wheelch	se aide #1 on 4/2/16 at hat she was assigned to 16 and observed Resident om table, the wheel chair wheel chair tipped towards her to stop the fall e wheel chair did not have a Nurse aide #1 revealed that in her room and could not lays and Resident #1 was hair and there were no chair air, the chair alarm was in					
		riew with nurse aide #2 on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345354	B. WING			C 04/02/2016
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		14/02/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	4/2/16 at 10:40 AM redining room and obsewheelchair away from was locked and the wide She indicated that Regeri-chair and there with the at 11:08 AM revealed Resident #1 to be in the Resident #1 was in the for a wheelchair but etc.	evealed that she was in the erved Resident #1 push the in the table, the wheelchair wheelchair fell backwards. esident #1 was not in a evere no chair alarm in place. director of nurses on 4/2/16 that she would expect	F	323		