PRINTED: 03/26/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345354	B. WING		C
	ROVIDER OR SUPPLIER OVE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284	02/15/2019
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENTS	3	F 00	00	
	A complaint investig from 2/13/19-2/15/19	ation survey was conducted			
	Immediate Jeopardy	was identified at:			
	CFR 483.25 at tag F (J).	689 at a scope and severity			
		726 at a scope and severity			
	The tag F689 constit Care.	uted Substandard Quality of			
	Immediate Jeopardy removed on 2/15/19.	began on 1/23/19 and was			
	A partial extended su	rvey was completed.			
E 656	corrections to the da jeopardy began and the immediate jeopal and not 1/23/19. The removed on 2/14/19	was amended to make tes when the immediate removed. The correct date of rdy beginning was 1/22/19 e immediate jeopardy was and not 2/15/19.	F 6:		2/45/40
SS=D	a== / : .ai a / / / /	·	F 6	00	3/15/19
	implement a compre care plan for each re resident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identi	cility must develop and hensive person-centered sident, consistent with the rth at §483.10(c)(2) and			
_ABORATORY	LECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Electronically Signed 03/11/2019

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345354	B. WING			C		
NAME OF D	ROVIDER OR SUPPLIER	34334	B: WING_	STREET ADDRESS, CITY, STATE, ZIP C		2/15/2019		
NAME OF T	NOVIDER OR 3011 EIER			728 PINEY GROVE ROAD	ODE			
PINEY GR	ROVE NURSING AND	REHABILITATION CENTER		KERNERSVILLE, NC 27284				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 656	describe the follow (i) The services the or maintain the rephysical, mental, required under §4 (ii) Any services the under §483.24, §4 provided due to the under §483.10, in treatment under §483.10,	wing - lat are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and hat would otherwise be required 183.25 or §483.40 but are not he resident's exercise of rights cluding the right to refuse 183.10(c)(6). He deservices or specialized hices the nursing facility will he of PASARR If a facility disagrees with the SARR, it must indicate its hident's medical record. with the resident and the hitative(s)- higoals for admission and higher facilities must document hent's desire to return to the hiesses and/or other appropriate higher facilities and the higher facility failed to develop a care higher facility failed to develop a care hed discharge goals and plans higher facility failed to develop a care hed discharge goals and plans higher facility failed to develop a care higher facility f	F	Piney Grove Nursing and F Center acknowledges recei Statement of Deficiencies a this Plan of Correction to th the summary of findings is a correct and in order to main compliance with applicable	ipt of the and proposes ne extent that factually ntain			

		(X3) DATE COMP	SURVEY LETED				
		345354	B. WING				C 15/2019
	ROVIDER OR SUPPLIER OVE NURSING AND RE	HABILITATION CENTER	-	72	TREET ADDRESS, CITY, STATE, ZIP CODE 28 PINEY GROVE ROAD ERNERSVILLE, NC 27284	<u> U21</u>	15/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	3/15/18 with diagnose hemiplegia following aphasia. A review of the quarte (MDS) assessment of Resident #2 was cogreview of the MDS as was an active dischar Resident #2 to return A review of the care puthere was no care plaplanning. On 2/13/19 at 10:23 a completed with Resident awaiting list for all	aritted to the facility on es that included, in part, cerebral infarction and early Minimum Data Set ated 12/29/18 revealed intively intact. Further esessment revealed there are plan in place for to the community. Dolan updated 1/3/19 revealed in that addressed discharge AM an interview was lent #2. She stated she was in apartment in the state program that assisted	F	656	provisions of quality of care of resident The Plan of Correction is submitted as written allegation of compliance. Piney Grove Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreeme with the statement of Deficiencies nor does it constitute an admission that an deficiency is accurate. Further, Piney Grove Nursing and Rehabilitation Cent reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding	a n nt y er	
	stated Resident #2's to an apartment in the #2 had applied to five communities and was Social Worker reporte interdisciplinary team planning with Reside in the comprehensive On 2/14/19 at 10:06 a completed with the M discharge plans and addressed on the comprehension of the complete with the M discharge plans and addressed on the comp	cility Social Worker. She discharge plan was to return e community and Resident e different housing s on their waiting lists. The ed that although the had addressed discharge nt #2 they had not included it e care plan.			On 2/29/19 the Social Worker updated care plan for Resident #2 to include discharge plan. On 2/15/19 the Minimum Data Set (MD Nurse audited the last 7 days of admissions to ensure the baseline care plans included discharge plans. Discharge baseline care plans were plain the four new residents care plans the were admitted in the last 7 days. On 2/26/19 the facility consultant audited 100% of care plans to ensure discharg plans are present on all care plans.	os) e ace at	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		l` ´com		SURVEY
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NAME OF PE	ROVIDER OR SUPPLIER	0.000.	<u> </u>	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	15/2019
	(0 / 1 <u>2 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1</u>				PINEY GROVE ROAD		
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER			RNERSVILLE, NC 27284		
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F 656	Continued From page	e 3	F 6	556			
	•	M an interview was dministrator. She stated she blans and goals be included			MDS Nurses were proactively in-service by the DON on 2/26/19 on care plan development, including discharge plans and inclusion on the baseline care plan On 2/27/19 the administrator proactive in-serviced the social worker in the care plan development, including discharge plans and the inclusion on the baseline care plan. This in-service was complet on 2/27/19. All newly hire MDS Nurse Social Worker will receive this in-service during orientation. The DON and/or designee will audit ne admission and readmission baseline caplans to ensure the discharge plans are included on care plans for 3 months. Toon and/or designee will audit 100% of all comprehensive care plans monthly amonths to ensure that discharge plans addressed on each care plan. The Administrator will be responsible for implementing this plan of correction to ensure any issues of developing and	s, n. ly e ted or ce ww are e he of x 3 are	
F 689	Free of Accident Haz	ards/Supervision/Devices	F 6		implementing a discharge baseline car plan will be addressed through addition root cause analysis, process correction training, and monitoring.	nal	3/15/19
SS=J	CFR(s): 483.25(d)(1)(1)(4)(4)(4)(1)(4)(4)(1)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)						5.15.15
	§483.25(d)(2)Each re	esident receives adequate					

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NAME OF P	ROVIDER OR SUPPLIER	343394	B. WING	9	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	15/2019
		HABILITATION CENTER		7	28 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
040.15	CHMMADV CT	ATEMENT OF DEFICIENCIES	ID.		<u> </u>		(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page supervision and assist accidents. This REQUIREMENT by: Based on observation and physician intervision ensure repositioning a pulling him under his residents (Resident # to prevent accidents. reposition Resident # sustaining a large helf collection of blood), esevere bruising to his sent to the hospital or with hematoma of cheanemia. Resident #1 1/30/19. Immediate jeopardy brursing assistant (NA #1 up in his wheelchearms which resulted in Jeopardy was remove facility implemented as Immediate Jeopardy remains out of complications out of complications are the provinced in the	et 4 stance devices to prevent is not met as evidenced ans, record review and staff ews, the facility failed to techniques were followed resident in his wheelchair by arms for 1 of 3 sampled et) reviewed for supervision The failure to properly aresulted in Resident #1 matoma (an abnormal experiencing blood loss and achest. Resident #1 was an 1/26/19 and diagnosed est wall and acute blood loss areturned to the facility on the gan on 1/22/19 when all the propertion of the prop		689	On 1/30/19 resident #1 was re-admitted to the facility from acute care hospital aremains stable at this time. Residents that require assistance with ADL's including transferring have the potential to be affected. On 1/29/29 a 100% audit of Resident Care Guides for accuracy in guidance for transfer assistance of dependent residents was completed by the facility consultant. All resident care guides were accurate for guidance in care delivery. Beginning 1/29/19, the staff facilitator (initiated in-service for 100% of licensed nurses, nursing assistants, including agency staff, on appropriate transfers a gait belt use. In-service completed on 2/14/19. This in-service was added to new staff orientation including agency staff. Yearly proactive education for licensed nurses, and nursing assistants including agency staff, will occur starting in 2019 with this training and will be scheduled yearly thereafter. This in-service will ensure licensed nursing and certified nursing assistants, including agency, are aware of the expectations related to safe transfers and gait belt uses the saf	or I SF) I and s,	
		nitted to the facility on s's diagnosis included: entia and atrial fibrillation.			This will ensure staff are competent related to resident transfers. The Interdisciplinary Team (IDT) will		

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		345354	B. WING _				C 02/15/2019
	ROVIDER OR SUPPLIER OVE NURSING AND RE	EHABILITATION CENTER		72	TREET ADDRESS, CITY, STATE, ZIP CODE 28 PINEY GROVE ROAD ERNERSVILLE, NC 27284	<u>'</u>	02/10/2010
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F 689	12/19/18, revealed assistance of one perfunction of self-suffice one position to another the care plan goal with the necessary physis Interventions include two if fatigued. A Quarterly Minimur 1/1/19 indicated Resimpaired cognition as assistance with one transfers and utilized had limitation in rangleft sides. A review of a progred dated 1/23/19 reveat to bruise on left cheed described bruise on of him by nursing state elevated bruise of the noted a deep bruise right axilla had not consignificant elevated pectoralis major, was and non-fluctuant, wo fedema noted and within 24 hours since Doppler and stat lab. An interview with the at approximately 10.00 Resident #1 on 1/22	#1's care plan, updated on Resident #1 required erson to maintain maximum ciency for transferring from the related to: unsteady gait. It was for Resident #1 to receive cal assistance to transfer. It was istance of one person, and Data Set (MDS) dated sident #1 had moderately and required extensive person for bed mobility and day wheelchair. Resident #1 age of motion on his right and led, "Seen for acute visit due st and slight cough. Patient his chest to be result of a tug aff. Noted a large non the right axillary fossa. There is right axillary fossa, was soft the extensive amount the fact that it had developed eny initial evaluation of him,	F	689	review changes of Condition and incide during am IDT meeting. The review winclude appropriate investigation, interventions, notification of attending physician and responsible party. The results of the review will be shared wit the QAPI team on a monthly basis for months. The DON, and ADON will present the in-service comments, supervision observations, and audit trends to the I weekly as needed and monthly QAPI committee for three months. The IDT QAPI committee will focus on improvir staff competency, including with reside transfers. The results of the audits for Supervision for accidents utilizing the Incident aud tool will be shared with the QAPI team the DON or QI nurse on a monthly base for 3 months. Results of the on-going audits will be presented to the QAPI meeting x 3 months or until a time determined by the QAPI members for sustained compliance. The Administrator will be responsible of implementing this plan of correction to ensure any issues of staff competency be addressed through additional root cause analysis, process correction, training, and monitoring.	on it by sis	
	at approximately 10: Resident #1 on 1/22 and ordered a chest stated he did not see	30 AM revealed he examined /19 for increased confusion					

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	ROVIDER OR SUPPLIER OVE NURSING AND RE	HABILITATION CENTER		728 P	ET ADDRESS, CITY, STATE, ZIP CODE INEY GROVE ROAD NERSVILLE, NC 27284	1 02	13/2013	
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	examined him again large swollen area at Doppler study and a physician stated invable considered due to Resident #1's cardial dementia. An interview on 2/13, #1 who rounds with the physician saw Residincreased confusion. When the physician stated the applying ice to the area. She stated the applying ice to the area. She stated the applying ice to the area. A record review revedated 1/22/19 for a considered in the chest "interval development bibasilar infiltrates singly physician assistant, initiated for Augment for 10 days, probiotic days, mucinex 600 mebulizer treatments. A review of the Dopprevealed "fluid collections".	on 1/23/19 and observed the and bruising and ordered a complete blood count. The asive intervention would not to the risk for infection and a status and diagnosis of 1/19 at 10:40 AM with Nurse the physician stated the ent #1 on 1/22/19 for and there was no bruising. Saw Resident #1 on 1/23/19, and bruising to the right chest nurses were monitoring and rea. aled a physician's order thest x-ray. aled a physician's order coppler study and a complete of x ray results revealed at of right perihilar and the ent 1/22/2018" called to new orders received and in 875 milligrams by mouth and as needed. Other results done on 1/23/19 tion 9.65 x 5.71 x 5.46 tial included organizing	F	689				
	A review of the comp	plete blood count results						

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	ROVIDER OR SUPPLIER OVE NURSING AND REI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284	CODE	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE	
F 689	A review of a progress practitioner dated 1/2 Resident #1 for follow to right upper chest. The right upper chest extending from the st with some yellowing a dark echymotic area of The results of the cord Doppler ultrasound results of the Statement by nurse taken by the Director telephone revealed N care for Resident #1 tup in the chair. The supplied Resident #1 up under his arm. An interview on 2/13/revealed she was ass 1/22/19 on first shift (when she went into Find 1/22/19 in the mornin bed to the wheelchair side of the bed becaupivot. NA #1 stated the #1 from his bed to his assistance. She stated down in his wheelchair	s note by the nurse 4/19 revealed she saw y up on hematoma formation The progress note revealed had a raised, firm area, ernum to under the arm pit and light bruising to area. A on right rib cage was noted. Inpete blood count and esults were reviewed. aide (NA) #1 dated 1/25/19 of Nursing (DON) via A#1 had been assigned to on 1/22/19 and she asked on help her pull Resident #1	F	689			
		member if she pulled rhis arms to reposition him e recalled that she did not					

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		345354	B. WING _			C 02/1	5/2019	
	OVE NURSING AND	REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP C 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284	ODE	V 2.	<u> </u>	
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F 689	remember seeing Resident #1's bod! A review of a state 1/25/19 revealed sassist her to pull u wheelchair. She elobserved NA #1 puheelchair with he stated she instruct. An interview on 2/Restorative Aide #entered Resident help to pull Resident wheelchair and as his wheel chair. She toward the back of by the back of his would do the same resident, but when NA #1 pulling Resident #1. Record review revi	he stated she did not any swelling or bruising on	F	589				

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		345354	B. WING _			02/1) 15/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS,	, CITY, STATE, ZIP CODE	1 02/	13/2013
DINEY CD	OVE NUBSING AND DE	LIADU ITATION CENTED		728 PINEY GROVE	E ROAD		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		KERNERSVILLE	, NC 27284		
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F 689	Continued From page	e 9	F 6	889			
	hospital. She stated sexactly what happened	she couldn't remember ed or why she sent him to recalled he was in a lot of					
	Resident #1 was sen Department for pain a	ated 1/26/19 revealed t to the Emergency and increased swelling and at and right side per family					
	1/30/19 revealed Resemergency department to the chest wall that Resident #1 was in a of 150, complaining of shoulder pain. Hemogrom baseline on admitted the remained hemody received parenteral in supplement with follo Troponin is elevated ischemia and most like	trial fibrillation with heart rate of chest wall pain and globin was down 4 grams hission and stabilized at 8.9. In amically stable. He con and will discharge on iron w up as an outpatient. But not consistent with kely related to trauma.					
	AM with Physical The was very familiar with worked with him ofter Resident #1 going to had variable levels of days stand and pivot and other days requir assistance. PT #1 staresistant to getting output the start of the start o	the hospital on 1/26/19, he functioning and could some with stand by assistance, red more hands on ated Resident #1 could be					

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F 689		ne 10 nd needed to be encouraged on his back or left side. He	F	689		
	stated it was importated they were doing and process things as he	ant for staff to explain what give Resident #1 time to e did have impaired cognition. ould utilize gait belts to				
	10:45 AM revealed F back with eyes open observed to Residen bruising in various st Resident #1's chest on right side. The res	esident #1 on 2/13/19 at Resident #1 lying in bed on There was swelling at #1's right chest and tages of healing observed to at midline, toward axilla and sident was unable to state d swelling on his chest				
	director of nursing (E Administrator told he 1/25/19 and she beg interviewed NA #1 a was determined that	er about the bruising on lan an investigation. She nd Restorative Aide #1 and it the swelling and bruising on occurred from the improper				
	revealed she didn't r informed about the s stated it was never a resident by pulling th staff should have a g	with the DON on 2/14/19 emember when she was swelling and bruising. She acceptable to transfer a nem under their arms and all gait belt and use gait belts to operly to prevent injuries.				
	Administrator revealed swelling and bruising	n 2/13/19 at 1:40 PM with the ed she became aware of the g to Resident #1 on 1/25/19 per called her concerned				

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	ROVIDER OR SUPPLIER OVE NURSING AND RE	EHABILITATION CENTER		728 F	PINEY GROVE ROAD ENERSVILLE, NC 27284	02	13/2019	
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F 689	about it. She stated member about the s investigation into hor interview with the Acrevealed she knew a because she made non that day and Resteam meeting. On 2/14/19 at 1:00 F and Corporate Nurse Immediate Jeopardy acceptable credible Jeopardy removal on The allegation of immediate Jeopardy removal on the deficient practice On 1/22/19 resident certified nursing ass belt, using resident's due to failure to follo result of knowledge On 1/22/19 resident facility for cough. On 1/23/19 abnormating interval development	she talked to the family welling and bruising and the w it occurred. A follow up diministrator on 2/14/19 about bruising on the 24th motes about it in her planner ident #1 was discussed in PM, the facility's Administrator e were informed of the r. The facility provided an allegation of Immediate in 2/15/19 at 11:06 AM. In will be accomplished for id to have been affected by expected by its and arms to assist ow transfer procedure as a deficit. # 1 received a chest x-ray in all chest x-ray results of int of right perihilar and	F	589				
	physician assistant, initiated for Augment Probiotic 1 cap daily PO and Neb treatme	ince 11/22/2018" called to new orders received and tin 875 mg x 10 days, x 21 days, Mucinex 600 mg ent ordered as needed.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	HABILITATION CENTER		728 P	INEY GROVE ROAD	1 021	10/2010	
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clinical team (DON, A Therapy) during morr for change in condition antibiotics. Physician the bruise not available. On 1/23/19 resident a medical director, in far abnormal chest x-ray resident to also have order received for ultrevitamin B-12, Vitamin for visit not received by the clinical team (DON, A Therapy) during morr for abnormal chest x-hematoma (bruise). It administrator instruct assistant director of restaff to determine cause on 1/24/19 director of director of nursing be interviews related to be interviews related to be certified nursing assistant of nursing, assistant of therapy manager regability. Discussion restations	ADON, MDS, administrator, and meeting (Cardinal IDT) on related to cough, and note from 1/23/19 indicating alle at time of review. # 1 was seen by physician, acility for follow-up to a Progress note reflected bruise on left chest. New reasound of chest area, CBC, and D, and BMP. Progress note by facility until 1/24/19. # 1 was discussed by the ADON, MDS, administrator, and meeting (Cardinal IDT) aray, diet downgrade, and During Cardinal IDT, and director of nursing and aursing to start interviewing use of hematoma (bruise). # nursing and assistant gan contacting staff for bruising on resident #1. # nursing and assistant tained statements from two stants that indicated resident director of nursing, and arding change in transfer sulted in a resident being	F	689				
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page clinical team (DON, A Therapy) during morr for change in conditionantibiotics. Physician the bruise not available of 1/23/19 resident abnormal chest x-ray resident to also have order received for ultrevitamin B-12, Vitamin for visit not received I On 1/24/19 resident actinical team (DON, A Therapy) during morr for abnormal chest x-hematoma (bruise). Description of the control of the c	ROVIDER OR SUPPLIER OVE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 clinical team (DON, ADON, MDS, administrator, Therapy) during morning meeting (Cardinal IDT) for change in condition related to cough, and antibiotics. Physician note from 1/23/19 indicating the bruise not available at time of review. 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On 1/25/19 director of nursing and assistant director of nursing assistants that indicated resident #1 was not transferred according to transfer	A BUILDII 345354 ROVIDER OR SUPPLIER OVE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 clinical team (DON, ADON, MDS, administrator, Therapy) during morning meeting (Cardinal IDT) for change in condition related to cough, and antibiotics. Physician note from 1/23/19 indicating the bruise not available at time of review. On 1/23/19 resident # 1 was seen by physician, medical director, in facility for follow-up to abnormal chest x-ray. Progress note reflected resident to also have bruise on left chest. New order received for ultrasound of chest area, CBC, Vitamin B-12, Vitamin D, and BMP. Progress note for visit not received by facility until 1/24/19. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KENNERSWILLE, NC 27284 SUMMAIN STATEMENT OF DEPICIENCIES (EACH DEPICIENCY WILL SE PRECEDED BY FILL REQUILATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 clinical team (DON, ADON, MDS, administrator, Therapy) during morning meeting (Cardinal IDT) for change in condition related to cough, and antibiotics. Physician note from 1/23/19 indicating the bruise not available at time of review. On 1/23/19 resident # 1 was seen by physician, medical director, in facility for follow-up to abnormal chest x-ray. Progress note reflected resident to also have bruise on left chest. New order received for ultrasound of chest area, CBC, Vitamin B-12, Vitamin D, and BMP, Progress note for visit not received by facility until 1/24/19. 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	C 02/15/2019
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 On 1/25/19 resident #1's care plan was updated to reflect change in transfer technique to 2 person mechanical lift by the minimum data set nurse. Residents care plan includes the care guide (ICSP) which communicates to nursing staff including certified nursing assistants and agency staff a resident's transfer technique. On 1/26/19 resident # 1 was sent to emergency	
room for evaluation of increased size of bruising, swelling and pain on left side of chest. On 1/29/19 certified nursing assistant # 1 was provided in-service training by assistant director of nursing on transfers and gait belt use which included residents in a chair and poor position, return demonstration of resident transfer completed. Nursing assistant # 1 was provided with gait belt. Extra gait belts are available at nurse's stations and staff facilitator office. On 1/30/19 resident #1 was re-admitted to facility from acute care hospital. On 1/31/19 resident was evaluated and added to caseload for physical, speech, and occupational therapy for treatment as appropriate, including change in transfer ability. As a result of the therapy evaluation resident was picked up by therapy services for physical, occupational, and speech services on 1/31/19. Therapy goals include resident will be 1 person assistance with bed mobility, transfer stand- pivot, resident will have a tolerable pain level with range of movement. On 1/29/19 the interdisciplinary team (DON, ADON, administrator, and therapy) utilized	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER	1 0.000		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	15/2015	
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER			PINEY GROVE ROAD RNERSVILLE, NC 27284			
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F 689	Continued From page	e 14	F	689				
	root cause of the resi	"5 whys" to determine the ident injury was staff failure elated transfers due to						
		dentify other residents having fected by the same deficient						
	assistant director of r an audit of resident of currently in facility for based on each reside guides were correct of	tor of nursing (DON) and nursing (ADON) completed care guides for all residents or proper transfer status ent's current status. All care with no negative findings as documented on a census.						
	transfer observations the facility to ensure completed per care g noted. This audit was	and ADON completed s of all residents currently in transfer observed was guide. No negative findings is documented on a census.						
	100% of licensed nur including agency staf assistant #1, on appr without gait belt, incluresidents using arms gait belt not appropriagait belt use. This instaff orientation, inclu 100% complete with licensed nurses, and ensure in-service is ethe DON, and/or ADO audits of 5 resident tr	rses, and nursing assistants, ff and certified nursing ropriate transfers with and uding not repositioning as of draw sheet when ate and resident in bed, and service was added to new uding agency staff. In-service all nursing staff (CNAs, agency staff) on 2/14/19. To effective beginning 2/13/19 ON will complete random ransfers 5 times weekly, to hifts, and agency staff, for						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OVE NURSING AND RE	HABILITATION CENTER		72	TREET ADDRESS, CITY, STATE, ZIP CODE 28 PINEY GROVE ROAD EERNERSVILLE, NC 27284	1 02/	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	technique is correct by plan and facility processof gait belt when gait	e 15 sfer and ensuring transfer based on the resident care edure including correct use belt use is appropriate. The inted on the transfer audit	F	689			
	On 1/29/19 the interd any other resident ind related to resident tra issues noted.	isciplinary team discussed cidents or occurrences insfer technique. No other be put into place or systemic sure the deficient practice					
	will not occur: On 1/29/19, the ADON initiated in-service for 100% of licensed nurses, and nursing assistants, including agency staff and certified nursing assistant #1, on appropriate transfers with and without gait belt, including not repositioning residents using arms, use of draw sheet when gait belt not appropriate, and gait belt use. This in-service was added to new staff orientation, including agency staff. In-service was 100% complete with all nursing staff (CNAs, licensed nurses, and agency staff) on 2/14/19. To ensure in-service is effective beginning 2/13/19 the DON, and/or ADON will complete random audits of 5 resident transfers 5 times weekly, to include all halls, all shifts, and agency staff, for transfer observation. The audit will be completed by observing the transfer and ensuring transfer technique is correct based on the resident care plan and facility procedure including use of gait belt when appropriate. The audit will be documented on the transfer audit tool.						
		ed to nursing staff during					

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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F 689	stations, and staff do On 2/14/19 the DON reviewing all progres resident (all resident shifts, all halls) x 12 areas, including bruion and investigated documented on the ensure any bruising when appropriate. On 2/14/19 the DON will review POC skir all shifts, all halls) x alerts, including bruion and investigated documented on the ensure any bruising when appropriate. The performance im discussed and approperformance improve 1/28/19. The medicate the plan on 1/28/19 to make sure solution. Beginning 1/28/19, to communication in the communication to nearly interdisciplinary.	also available at nursing evelopment. I, and/or ADON began as notes entered for any also so notes entered for any also available at the facility increased. I, ADON, and/or MDS nurse allowed up allowed for any allowed up allowed up allowed up allowed up allowed up allowed up allowed in allowed to allowed up allowed by the quality assurance and director was made aware of and is in agreement with plan. Is to monitor its performance and allowed increased allowed the facility increased.	F6	89				
	provides residents v accidents by providi	vith supervision to prevent ng safe transfers. The IDT, I continue to monitor the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 689	Continued From pag	ge 17	F 6	689			
	facility to identify oth failure to supervise t	er factors contributing to o prevent accidents.					
	present the in-service observations, and at as needed and more months. The IDT are on improving resident of accidents, including the administrator are recommendations of QAPI committee to the for additional recommendations of the administrator with implementing this place property to ensure a supervision to prever addressed through a process correction, the supervision to the supervision to prever addressed through a process correction, the supervision to the supervision to prever addressed through a process correction, the supervision to prever addressed through a process correction, the supervision to prever addressed through a process correction, the supervision to prever addressed through a process correction, the supervision to prever addressed through a process correction, the supervision to prever addressed through a process correction, the supervision to prever addressed through a process correction, the supervision to prever a process correction and the supervision to prever a process correction.	Il be responsible for an of removal of immediate any issues of failure to provide at accidents will be additional root cause analysis, training, and monitoring.					
	Jeopardy removal w 1:30 PM. The valida interviews with both nursing staff on gait where to locate then and using draw shee of on-going inservice and non-licensed state belt use and when not them not positioning sheet when appropring updated care plan a	e allegation of Immediate as validated on 2/15/19 at tion was evidenced by licensed and non-licensed belt use and when not to use, in not positioning under arms et when appropriate. Review e records revealing licensed aff were in-serviced on gait ot to use, where to locate under arms and using draw liate. Review of Resident #1's and care guide reflecting tatus. Review of on-going					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 689	Continued From page audits, documented r residents to ensure c transfer status correc Competent Nursing S	eview of audit of all are guides correct and t.	F 6			3/15/19		
SS=J	CFR(s): 483.35(a)(3) §483.35 Nursing Sent The facility must have the appropriate comp provide nursing and resident safety and a practicable physical, well-being of each resident assessments and considering the resident assessments and considering the rediagnoses of the faciliaccordance with the fact sates of the faciliaccordance with the fac	vices e sufficient nursing staff with eletencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in facility assessment required cility must ensure that the specific competencies ary to care for residents' nrough resident escribed in the plan of care. In g care includes but is not evaluating, planning and at care plans and responding ey of nurse aides. ure that nurse aides are able etency in skills and y to care for residents'						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345354	B. WING				15/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DINEY OF	OVE NURSING AND DE	HARWITATION OFNITER		72	28 PINEY GROVE ROAD		
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		K	ERNERSVILLE, NC 27284		
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IAG	REGULTION ON		IAG		DEFICIENCY)		
F 726	Continued From page	e 19	F	726			
		on, record review and staff			On 1/30/19 resident #1 was readmitte	d to	
	and physician interview	ews, the facility failed to			the facility from an acute care hospital	and	
		rsing assistant was trained			currently remains in the facility in stable	Э	
	-	e allowing the nursing			condition.		
		1 of 3 (NA #1) agency					
		viewed. The failure to ensure			Resident that require assistance with		
		nd competent resulted in an			ADL's including transferring have the		
1		d repositioning of Resident			potential to be affected. On 1/29/19 a	_	
	#1 when NA #1 lifted			100% audit of Resident care guides for			
		nt #1 in his wheelchair,			accuracy in guidance for transfer		
		esident #1 sustained a large			assistance of dependent residents was completed by the facility consultant. A		
	hematoma (an abnormal collection of blood), experiencing blood loss and severe bruising to				residents care guides were accurate for		
		1 was sent to the hospital on			guidance in care delivery.	'1	
		ed with hematoma and acute			gardance in care delivery.		
	_	Resident #1 returned to the			On 1/29/19, the Assistant Director of		
	facility on 1/30/19.				Nursing (ADON) initiated proactive		
					in-service for 100% of licensed nurse,		
	Immediate jeopardy t	began on 1/22/19 when			nursing assistants, and certified nursin	g	
	nursing assistant (NA	A) #1 repositioned Resident			assistant #1, on appropriate transfers,	not	
	#1 up in his wheelcha	air by pulling him under his			repositioning residents using arms, and	t	
	arms which resulted i	in injury. Immediate			gait belt use. In-service was complete	d	
		ed on 2/14/19 when the			on 2/14/19. This in-service was added		
		an acceptable allegation of			new staff orientation, including agency		
	Immediate Jeopardy				staff. Return demonstration competen	-	
	remains out of compl				will be accomplished through observat	ion	
		no actual harm with potential			audits by the DON and/or ADON.		
		al harm that is not Immediate			D-ninnin - 4/00/40	OE\	
		ility to ensure monitoring			Beginning 1/29/19, the staff facilitator (
	systems put into plac	e are effective.			Initiated in-service for 100% of licensed	ג	
	Findings included:				nurses, nursing assistants, including	and	
	Findings included:				agency staff, on appropriate transfers a gait belt use. In-service completed on	ailu	
	Resident #1 was adn	nitted to the facility on			2/14/19. This in-service was added to		
		ncluded: cerebral infarct,			new staff orientation, including agency		
					staff. Yearly proactive education for		
	hemiplegia, dementia and atrial fibrillation.				licensed nurses, and nursing assistant	S.	
	Review of Resident #	#1's care plan, updated on			including agency staff, will occur starting		
		1 required assistance of one			2019 with this training and will be	3	

Facility ID: 923023

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 _			C 02/15/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				728	PINEY GROVE ROAD		
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER		KE	RNERSVILLE, NC 27284		
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F 726	Continued From page	e 20	F 7	'26			
		nsferring from one position			scheduled yearly thereafter.		
		unsteady gait, hemiparesis. as for Resident #1 to receive			The in-service will ensure licensed nurs and certified nursing assistants, includi		
		al assistance to transfer.			agency, are aware of the expectations	9	
		d: assistance of one person,			related to safe transfers and gait belt us	se.	
	two if fatigued.				This will ensure staff are competent related to resident transfers.		
		Data Set (MDS) dated					
		dent #1 had moderately			On 1/2/9/19 the DON, and/or ADON		
	impaired cognition an				began random observation audits of resident transfers 5 times weekly x 4		
	assistance with one person for bed mobility and transfers and utilized a wheelchair. Resident #1				weeks and then weekly x 8 weeks. The	۵	
		e of motion on his right and			audit will be completed by observing th		
	left sides.				transfer and ensure transfer technique		
					correct based on the resident care plan		
	A review of a progres	s note by the physician			and facility procedure. This will ensure		
		for acute visit due to bruise			staff is competent in transfer procedure	÷.	
		nt cough. Patient described			The audit will be documented on the		
		be result of a tug of him by			transfer audit tool. The results of the		
	•	large non elevated bruise			audits will be shared with the QAPI		
	_	ssa. There is noted a deep			committee monthly for three months.		
		e bruise in right axilla had r there was a significant			Results of the observation audits will be	_	
	_	ver the entire right pectoralis			brought to stand down meeting on-goin		
	major, was a bleeding	- ·			for discussion with the Interdisciplinary	·9	
		the extensive amount of			Team members (IDT) and to the month	ly	
	edema noted and the	fact that it had developed			QAPI meeting. Results of the on-going	•	
	within 24 hours since	my initial evaluation of him,			audits will be presented to the QAPI		
	Doppler and stat labs	ordered."			Meeting x 3 months or until a time		
					determined by the QAPI members for		
		ler results done on 1/23/19			sustained compliance.		
		ion 9.65 x 5.71 x 5.46			The IDT members are recorded to	h a	
		ial included organizing			The IDT members are responsible for t Plan of Correction and the Administrate		
	hematoma, cyst or at	J30533 .			responsible for sustained compliance.	פו וע	
	A statement by nurse	aide (NA) #1 dated 1/25/19			responsible for sustained compilance.		
	taken by the Director				The Administrator will be responsible fo	or	
		IA#1 had been assigned to			implementing this plan of correction to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345354	B. WING_			C 02/15/2019		
NAME OF PE	ROVIDER OR SUPPLIER	0.000	-1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	15/2019	
	10115211 011 001 1 2.2.1				28 PINEY GROVE ROAD			
PINEY GR	OVE NURSING AND REI	HABILITATION CENTER			ERNERSVILLE, NC 27284			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 726	Continued From page	e 21	F 7	726				
	Resident #1 on 1/22/ and she asked Resto pull Resident #1 up ir revealed Restorative	19 on the 7AM - 3 PM shift rative Aide #1 to help her in the chair. The statement Aide #1 came to assist her sident #1 up by pulling him			ensure any issues of staff competency be addressed through additional root cause analysis, process correction, training, and monitoring.	will		
	revealed she was ass 1/22/19 on first shift (when she went into F 1/22/19 in the mornin bed to the wheelchair side of the bed becaupivot. NA #1 stated th #1 from his bed to his assistance. She state down in his wheelcha Aide #1 to assist her stated she couldn't re Resident #1 up under in his wheelchair. She have a gait belt. She	g to transfer him from the r, she got him to sit on the use he was able to stand and use the transferred Resident without any and Resident #1 was sliding uir so she asked Restorative to reposition him. She emember if she pulled r his arms to reposition him arms to reposition him are recalled that she did not						
	1/25/19 revealed she assist her to pull up F wheelchair. She ente observed NA #1 pullii wheelchair with her a stated she instructed An interview on 2/13. Restorative Aide #1.3 entered Resident #1.5	/19 at 1:30 PM with She stated on 1/22/19, she s room after NA #1 asked for #1 up in his wheelchair. She						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345354	B. WING				C 15/2019	
	ROVIDER OR SUPPLIER OVE NURSING AND RE	HABILITATION CENTER		72	REET ADDRESS, CITY, STATE, ZIP CODE 8 PINEY GROVE ROAD ERNERSVILLE, NC 27284	1 02/	10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 726	his wheel chair. She toward the back of Reby the back of his par would do the same the resident, but when she NA #1 pulling Reside She told NA #1 that where supposed to lift She did not observe a Resident #1. A physicians order da Resident #1 was sendent #1 was sender be partment for pain a bruising on right chest request. A review of the hospit 1/30/19 revealed Resemergency department days ago. Resident #1 heart rate of 150, contained swelling to the days ago. Resident #1 heart rate of 150, contained shoulder pain. He transporting oxygen if 13.5 - 17.5) was down admission and stabilithemodynamically station and will discharge follow up as an outpation and unstable consistent with ischemost likely related to An interview on 2/14/4/	ted NA #1 to pull him up in stated she got to the left side esident #1 and pulled him up ints. She assumed NA #1 ining on the other side of the ite looked up, she observed int #1 up under his arms. It was wrong and they were it residents under their arms. It was welling or bruising on and increased swelling and it and right side per family it all discharge summary dated sident #1 "presented to the ent after a family member chest wall that occurred 3 if was in atrial fibrillation with inplaining of chest wall pain emoglobin (responsible for in the blood; normal range in 4 grams from baseline on ized at 8.9. He remained ble. He received parenteral e on iron supplement with itient. Troponin level (a grentiate between myocardial le angina) is elevated but not mia (reduced blood flow) and	F	726				
	_	ts to transfer residents to						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345354	B. WING			C 02/15/2019		
	ROVIDER OR SUPPLIER OVE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284		12/13/2019		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 726	prevent injury. An observation of Ref 10:45 AM revealed Resident back with eyes open observed to Resident bruising in various states and right side. The reshow the bruising and occurred. An interview on 2/14/Development Coordinew hires included a lifting. It included info belts for transfers and member should receive and have it with them She stated there was staff as well with a chreview of the safe resmovement policy whimovement and handlinterventions/proceduindividually determine admission/re-entry as "use approved reside belts, in accordance training". An interview on 2/14/revealed the only ories started working a on the time clock. She a video about transfer.	sident #1 on 2/13/19 at esident #1 lying in bed on There was swelling the #1's right chest and ages of healing observed to at midline, toward axilla and ident was unable to state swelling on his chest 19 at 8:50 AM with the Staff nator revealed orientation for video about transfers and rmation about using gait dishe stated every staff ve one during orientation at all times when working. If an orientation for agency teck list that included a sident handling and chistated "staff will follow the ing safety ures for each resident as ed through the dmission process", including, and thandling aids, i.e. gait with instructions and 19 at 10:02 AM with NA #1 entation she received when at the facility was orientation e stated she never watched	F7	726				

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			C 02/15/2	2040
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	I , ZIP CODE	02/15/2	2019
				728 PINEY GROVE ROAD			
PINEY GR	OVE NURSING AND RE	HABILITATION CENTER		KERNERSVILLE, NC 27284			
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	(X5) DMPLETION DATE	
F 726 Continued From page		e 24	F7	726			
F 726	orientation checklist of stated she called NA and completed the or Positioning/reposition On 2/14/19 at 1:00 Pland Corporate Nurse Immediate Jeopardy. acceptable credible a Jeopardy removal on immediate jeopardy removal on immediate jeopardy removal on immediate jeopardy removal on those residents found the deficient practice. On 1/22/19 resident acertified nursing assist belt, using resident's due to failure to follow On 1/23/19 resident and on left chest. On 1/26/19 resident are room for evaluation of swelling and pain on On 1/26/19 resident acare hospital from em On 1/26/19 resident acare hospital from em On 1/26/19 resident acare hospital from em diagnosis of atrial fibri	wasn't completed. She #1 on the phone on 2/14/19 ientation checklist. ing wasn't completed. M, the facility's Administrator were informed of the The facility provided an illegation of Immediate 2/14/19. The allegation of emoval was as follows: In will be accomplished for It to have been affected by It is a transferred by stant #1 without use of gait chest and arms to assist or procedure. If I was noted to have bruise I was sent to emergency of increased size of bruising, left side of chest. If I was admitted to acute mergency room. It is a director	F7	726			
	hematoma of chest w On 1/30/19 resident # from acute care hosp On 1/29/19 the interd ADON, administrator	vall. #1 was re-admitted to facility ital. isciplinary team (DON,					

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			C 02/15/2019			
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		DATE			
F 726		e 25 dent injury was staff failure	F7	'26					
	to follow procedure re knowledge deficit.	elated to transfers due to							
	_	entify other residents having ected by the same deficient							
	100% of licensed nur including agency staf assistant #1, on appropositioning resident use. In-service was addedincluding agency staf	N initiated in-service for ses, and nursing assistants, f and certified nursing opriate transfers, not ts using arms, and gait belt ompleted on 2/14/19. This to new staff orientation, f. Return demonstration ecomplished through audits							
	complete random aud times weekly x 12 we completed by observi transfer technique is resident care plan an audit will ensure staff	ng the transfer and ensure							
	any other resident inc	isciplinary team discussed cidents or occurrences insfer technique. No other							
		e put into place or systemic sure the deficient practice							
	On 1/29/19, the staff	facilitator (SF) initiated							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345354	B. WING			C	
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284	•	02/15/2019	
(X4) ID PREFIX TAG			ID PREFII TAG	X (EACH CORRECTIVE ACTION	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 726	in-service for 100% of assistants, including transfers and gait belon 2/14/19. This in-set staff orientation, incluproactive education for nursing assistants, in occur starting in 2015 scheduled yearly the This in-service will ercertified nursing assistants aware of the expectat transfers and gait belare competent related. The performance improved 1/28/19. The medical the plan on 1/28/19 at How the facility plans to make sure solution Beginning 1/28/19, the communication in the	f licensed nurses, nursing agency staff, on appropriate tuse. In-service completed ervice was added to new iding agency staff. Yearly or licensed nurses, and cluding agency staff, will with this training and will be reafter. Issure licensed nurses and stants, including agency, are tions related to safe tuse. This will ensure staff do to resident transfers. Incovement plan was wed by the quality assurance ement (QAPI) committee on director was made aware of and is in agreement with plan. It to monitor its performance as are sustained. It is a proposed to form of: verbal	F	726			
	the DON, ADON, and interdisciplinary team education, and audit provides residents will accidents by providin QAPI committee will facility to identify othe competency including Beginning 1/28/19, the present the in-service observations, and au as needed and month.	service to nursing staff by d/or staff facilitator and daily (IDT) meetings, written forms to ensure the facility th supervision to prevent g safe transfers. The IDT, continue to monitor the er factors contributing staff g with resident transfers. le DON, and ADON will e comments, supervision dit trends to the IDT weekly hly QAPI committee for six d QAPI committee will focus					

F 726 Continued From page 27 F 726 on improving staff competency, including with resident transfers. The administrator and/or DON will present the recommendations of the daily IDT and monthly	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER PINEY GROVE NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 726 Continued From page 27 on improving staff competency, including with resident transfers. The administrator and/or DON will present the recommendations of the daily IDT and monthly STREET ADDRESS, CITY, STATE, ZIP CODE 728 PINEY GROVE ROAD KERNERSVILLE, NC 27284 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 726 Continued From page 27 on improving staff competency, including with resident transfers. The administrator and/or DON will present the recommendations of the daily IDT and monthly	02/13/2019		
on improving staff competency, including with resident transfers. The administrator and/or DON will present the recommendations of the daily IDT and monthly	(X5) COMPLETION DATE		
OAPI committee to the quarterly OAPI committee for additional recommendations for monitoring and continued compliance. The administrator will be responsible for implementing this plan of immediate jeopardy removal to ensure any issues of staff competency will be addressed through additional root cause analysis, process correction, training, and monitoring. Piney Grove Nursing and Rehabilitation alleges removal of IJ as of 2/14/19. The facility's credible allegation of Immediate Jeopardy removal was validated on 2/15/19 at 1:30 PM. The validation was evidenced by interviews with both licensed and non-licensed nursing staff on gait belt use and when not to use, where to locate them not positioning under arms and using draw sheet when appropriate. Review of on-going in-service records revealing licensed and non-licensed staff were in-serviced on gait belt use and when not to use, when not positioning under arms and using draw sheet when appropriate. Review of engage of the properties of the properties of the properties of them not positioning under arms and using draw sheet when appropriate. Review of nesdent #1's updated care plan and care guide reflecting change in transfer status. Review of no-going audits, documented review of audit of all residents to ensure care guides correct and transfer status correct.			