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 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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E 000	Initial Comments The survey team entered the facility on 01/06/25 to conduct a recertification survey. The survey team was onsite 01/06/25 through 01/09/25. Additional information was obtained offsite on 01/10/25. Therefore, the exit date was 01/10/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RHNI11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/06/25 to conduct a recertification survey and complaint investigation. The survey team was onsite 01/06/25 through 01/09/25. Additional information was obtained offsite on 01/10/25. Therefore, the exit date was 01/10/25. Event ID# RHNI11. The following intakes were investigated NC00221791, NC00218023, NC00218463, NC00225232, NC00217323, NC00212152, NC00211786, NC00225019, NC00223873, NC00222301, NC00225523, NC00224907, NC00222976, and NC00223874. 7 of the 51 complaint allegations were substantiated.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		2/4/25

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

Electronically Signed | 02/04/2025

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F 622	Continued From page 1	F 622		

because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

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F 622	Continued From page 2 medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Nurse Practitioner (NP), and the resident's	F 622	To remain in compliance with all federal and state regulations the facility has taken	

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F 622	Continued From page 3 representative, the facility failed to allow a resident with behaviors to remain in the facility and to provide written documentation which stated the reason the facility could not meet the resident's needs for 1 of 1 resident (Resident #205) reviewed for facility initiated discharge. Findings included: Resident #205 was admitted to the facility on 5/9/24 with the diagnosis of dementia and repeated falls. The admission Minimum Data Set (MDS) dated 5/24/24 for Resident #205 documented the resident had an intact cognition. The active diagnosis was dementia. Social Worker #1's note dated 9/24/24 at 3:59 pm documented she sent a referral for Resident #205's admission to a sister facility's memory care unit in another town for possible admission. The note indicated the Social Worker would continue to follow-up. Social Worker #1's note dated 9/24/24 at 5:09 pm documented an email was received from the sister facility for Resident #205's admission and they had no bed in the memory care unit at that time. The note indicated the Social Worker would continue to look for placement. Resident #205 had a significant change MDS dated 10/15/24 for cognitive decline and falls. Resident #205 had severe cognitive impairment. Resident #205 was coded with no behaviors, rejection of care, or wandering. The resident had 2 or more falls without injury since the previous MDS assessment.	F 622	or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F622 1. Corrective action for those residents allegedly affected by the deficient practice: On 12/19/24 resident # 205 was discharged from the facility without resident and or responsible party being involved in the discharge process including location to which resident would be transferred to or written notice of transfer/discharge. There is no corrective action for this resident due to discharge on 12/19/24. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. An audit of all residents discharged from the facility from 1/3/25-2/3/25 for written notice of transfer and or discharge due to behaviors was completed on 2/3/25 by the Nurse Consultant. The results revealed: 30 of 30 residents were not discharged due to behaviors and did not require a notice of transfer or discharge documentation. There was no corrective action due to no deficient practice. 3. Systemic changes: All Social Workers and Discharge	

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F 622	Continued From page 4 The NP documented in Resident #208's progress note dated 12/3/24 that he saw the resident for her monthly chronic conditions visit. The Resident's Representative had not conveyed any concerns. Nursing staff reported the resident had intermittent severe behavioral disturbance including exit seeking and was a fall risk. The resident was assessed and noted to have notable cognitive gaps (deficits). The plan for psychiatric conditions included major depressive disorder with psychotic episodes and the resident was restarted on Seroquel at bedtime. The NP will continue to collaborate with in-house psychiatry. The resident was clinically stable at the time of this encounter. Resident #205's discharge form documented she was transferred on 12/19/24 to a local nursing facility with a memory care unit. The form was signed by Nurse #4. The form was not signed by the resident's representative. There was no physician documentation in the medical record that indicated the specific resident needs the facility could not meet, the facility's efforts to meet those needs, or the services the receiving facility would provide to meet the needs of the resident which could be met at the current facility. On 1/9/25 at 8:46 am Nurse #4 was interviewed. Nurse #4 stated Resident #205's representative was not available (at the facility) at the time of discharge on 12/19/24 to sign the discahrge form. She was informed by Social Worker #1 that all paperwork had been completed. On 1/9/25 at 9:46 am a follow up interview was	F 622	Planners were educated on 2/3/25 on transfer notices. This education included: " Resident and representative have the right to participate in discharge planning " Written documentation of discharge must be sent to resident and representative " MD must provide documentation that resident does not meet level of care and requires discharge to another level of care. The facility will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 2/3/25. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Administrator or designee will begin on 2/10/25 monitoring 5 residents randomly using the QA Tool: Notice of Transfer Discharge, weekly x 4 weeks and then monthly for 3 months for compliance with the notice of transfer and discharge process. The Administrator or designee will report to the Quality Assurance Performance Improvement Committee any findings, identified trends,	

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F 622	Continued From page 5 conducted with Nurse #4. Nurse #4 stated Resident #205 was discharged on 12/19/24 to a local nursing facility with a memory care unit. Social Worker #1 completed the paperwork. Nurse #4 stated she did not know why the Resident's Representative was not present at the time of discharge. The Resident's Representative normally signed the discharge paperwork. Nurse #4 stated Social Worker #1 informed her that the discharge paperwork was completed. Nurse #4 stated, "I understood that the Resident's Representative knew about the discharge to a memory care unit." Nurse #4 indicated Social Worker #1 reported to her that the Resident's Representative had not wanted the resident discharged to the facility after the discharge had taken place. Nurse #4 stated the resident had declined quickly from dementia. She was combative, confused, and was frequently wandering and falling. The resident required increased supervision, including one on one, and was not safe without supervision. The NP was aware. On 1/9/25 at 12:05 pm an interview was conducted with Resident #205's Resident's Representative. The representative stated that she was notified by Social Worker #1 back in August 2024 that the resident would require a higher level of care with a memory care unit. The Resident's Representative was provided with 3 facilities that had a memory care unit. The Resident's Representative stated the 3 facilities had a 1-star rating (nursing home rating from 1 to 5 with 1 being the lowest), she observed the facilities, and declined the choices. The Resident's Representative stated that the facility discussed on multiple occasions that the resident needed a higher level of care, and that care could	F 622	or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 2/4/25	

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F 622	Continued From page 6	F 622		

not be safely provided at this facility. Resident #205's Representative stated she provided one facility name in Clemmons to Social Worker #1 that she would agree to discharge the resident. The Resident's Representative stated in November 2024 she was approached about the discharge to a higher level of care/memory care unit again by Social Worker #1 and she (the Resident's Representative) asked for the resident to remain at the facility. In December 2024 she received a call from Social Worker #1 that the resident had been discharged to one of the three facilities the Resident's Representative was provided back in August 2024. The Resident's Representative stated she was not advised prior to the day of discharge that Resident #205 was being discharged to another facility with a memory care unit. She was notified on the day of discharge. When the Resident's Representative informed Social Worker #1 that she had refused this facility, the Social Worker denied being told that. Resident #205's Representative stated the resident remained at the new facility for a week and was discharged to and currently at hospice.

On 01/08/25 at 12:36 pm the Nurse Practitioner (NP) was interviewed. The NP stated due to Resident #205's decline from dementia and frequent falls, the facility could not meet the needs of the resident. The resident required and was provided one on one supervision for wandering and behaviors. The Resident's Representative agreed that the resident required a higher level of care. The resident was discharged to a facility with a memory care unit for increased supervision.

The Director of Nursing (DON) was interviewed on 1/9/25 at 10:10 am. The DON stated she

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F 622	Continued From page 7	F 622		

remembered Resident #205's discharge was agreed upon with the Resident's Representative and Social Worker #1 and was not facility initiated for a higher level of care. She was discharged to another facility with a memory care unit. The DON stated all discharge paperwork would be in Resident #205's record. The DON had no other documentation, and Social Worker #1 was no longer employed at the facility and her phone number was disconnected. The DON believed there was a verbal consent by the Resident's Representative for discharge to a facility with a memory care unit.

On 1/19/25 an interview was attempted with Social Worker #1 who was no longer with the facility. The phone number was disconnected.

On 1/19/25 at 2:41 pm an interview was conducted with the Business Office Manager. The Business Office Manager stated Resident #205 was discharged to another facility in agreement with the Resident's Representative. Social Worker #1 would have completed the paperwork. She further stated that this discharge not a facility-initiated discharge.

On 1/9/25 at 3:51 pm an interview was conducted with the Discharge Planner. The Discharge Planner stated she was aware that Resident #205's Resident's Representative spoke with Social Worker #1 about the planned discharge to another facility with a memory care unit to meet the resident's needs. The Discharge Planner stated the Resident's Representative agreed with the discharge to another facility with a memory care unit if it was in close proximity to her so she was able to visit the resident. The Discharge Planner stated she thought the Resident's

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F 622	Continued From page 8 Representative changed her mind on which facility after the discharge reported by the Social Worker. She was aware the Resident's Representative reported her disapproval.	F 622		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and family interviews, the facility failed to ensure a safe and orderly discharge when a resident was discharged home without a referral for home health services for 1 of 2 residents reviewed for discharge (Resident #356). The findings included: Resident #356 was admitted to the facility on 10/4/24 with diagnoses including stroke. A review of the physical therapy discharge summary dated 10/10/24 indicated Resident #356 was ambulatory and able to walk 150 feet with supervision, able to climb 12 steps with supervision, and independent in mobility. The discharge recommendation was for home health services to continue physical therapy at home. A review of occupational therapy discharge	F 624	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F624 1. How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice: On 10/11/24 resident # 356 failed to have safe and orderly discharge needs met when he was discharged home without home health, PT/OT as ordered by provider. There is no corrective action for this resident as resident was discharged	2/4/25

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F 624	Continued From page 9 summary dated 10/10/24 indicated Resident #356 was independent in toileting hygiene, toileting transfer, and required supervision with bathing and dressing. The discharge recommendation for home health services to continue occupational therapy at home. A review of physician order dated 10/11/24 revealed a discharge order for Resident #356 to discharge home with family with home physical therapy and occupational therapy services. Review of the discharge summary dated 10/11/24 indicated that Resident #356 was discharged from the facility on 10/11/24. The discharge summary was signed by Social Worker #2. The discharge summary indicated no home services were requested. An interview was conducted with Resident #356's family member on 1/17/25 3:26 pm. She indicated Resident #356 was discharged home on 10/11/24 with no home health orders from the facility and she felt the discharge was not a safe discharge. An interview was conducted with the Director of Rehabilitation services on 1/9/25 at 9:45 am. She indicated she met with Resident #356 to discuss his discharge planning needs prior to discharge. Resident #356 was cognitively intact and voiced that he wanted to be discharged. The Director of Rehabilitation further indicated she and Resident #356 agreed to move forward with the discharge plan to return home with family and to continue therapy at home. The Director of Rehabilitation revealed she made the Discharge Planner and additional interdisciplinary team members aware of the recommendation for home physical and	F 624	from the facility on 10/11/24. A follow up call was made to resident # 356 on 10/15/24 by the discharge planner, and he indicated his needs had been met and there were no further concerns. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: An audit of all residents discharged in the last 7 days to ensure their needs were met upon discharge and the discharge planning process was followed by the discharge planner was completed on 2/5/25 by the Nurse Consultant. Results: 4 of 11 residents were discharged to the hospital related to an acute medical change of condition, 1 of 11 residents expired in the facility, 6 of 11 were planned and had a safe and orderly discharge according to follow up phone call by discharge planner as documented on the post discharge user defined assessment in Point Click Care. There is no corrective action due to no deficient practice identified. 3. Systemic changes: All social workers and discharge planners were educated on 2/3/25 on the interdisciplinary process. This education included: " providing and documenting preparation and orientation to residents to ensure safe and orderly transfers. Orientation must be explained and written	

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F 624	Continued From page 10 occupational therapy. An interview was conducted with Social Worker #2 on 1/9/25 at 9:10 am. She indicated she was aware of the physician's discharge order on 10/11/24 which ordered home physical and occupational therapy. She further revealed that she did not follow through with the order as she thought the discharge order was standard for all residents and that the family had indicated they were planning to move and unsure of the new address. An interview was conducted with the Nurse Practitioner on 1/9/25 at 2:19 pm. He indicated he wrote the order to discharge Resident #356 home with home health physical and occupational therapy services and the Social Worker should have made the referral as ordered. An interview was conducted with the Administrator on 1/10/25 at 2:08 pm. She indicated the Social Worker should have followed the physician's discharge order to refer Resident #356 for home health services.	F 624	so the resident or responsible party can understand. " Documentation must be in the medical record to support education. The facility will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 2/3/25. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Administrator or designee will monitor the discharge process beginning 2/10/25 using the QA Tool: Discharge Planning Process weekly for 4 weeks and then monthly for 3 months for compliance with the discharge planning process. The Administrator will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary	

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F 624	Continued From page 11	F 624	Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 2/4/25	
F 689 SS=D	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 record review and interviews with staff, Nurse Practitioner, and the resident, the facility failed to provide care in a safe manner when a dependent resident rolled off her bed onto the floor during incontinence care. The resident was not injured. The deficient practice affected 1 of 7 residents reviewed for accidents (Resident #18). Findings included: Resident #18 was admitted to the facility on 8/17/24 with the diagnosis of osteoarthritis. Resident #18 had a significant change Minimum Data Set dated 11/15/24 for mobility decline, pressure ulcer, and a fall. The resident required extensive assistance with bed mobility and was always incontinent of bowel and bladder. The care plan for Resident #18 dated 11/26/24	F 689	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/29/24 Resident # 18 was assessed by the floor nurse on duty. The medical provider was notified and new orders were received to send to the local hospital for evaluation. Resident #18 returned from the hospital with no new orders. Resident #18□s Kardex and care plan were	2/4/25

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 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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F 689	Continued From page 12 documented the resident had an increased risk for falls and required assistance with her activities of daily living for bed mobility, transfers, bathing, and personal hygiene. Resident #18's nurses' note dated 11/29/2024 at 7:36 am documented by Nurse #4 documented the resident fell from her bed to the floor. Nursing Assistant (NA) #3 informed Nurse #4 she was attempting to provide care to the resident, turned her, and the resident fell off the bed onto the floor. The resident was assessed and she complained of pain in her head and her right hip. The on-call physician was notified, an order was given to send the resident to the Emergency Department (ED) for assessment. Resident #18's change in status note dated 11/29/2024 at 6:05 am written by Nurse #4 documented the resident had fallen. At the time of evaluation, the resident's vital signs were: Blood Pressure (BP): 109/67, Pulse (P): 60, Respiratory Rate: 18, Temperature: T 98.1, oxygen saturation- 98.0 % on room air and Mental Status Evaluation: No changes observed A fall incident report for Resident #18 dated 11/29/24 was documented by Nurse #4. Resident #18 fell out of bed during care provided by NA #3. The staff was educated on resident bed mobility during care. The resident was sent to the ED. On 1/8/25 at 11:46 am Nurse #4 was interviewed. Nurse #4 stated she remembered Resident #18 and the fall incident on 11/29/24. Nurse #4 stated NA #3 was assigned and reported to her that when care was provided to Resident #18 the NA turned the resident and the resident rolled out of bed. Nurse #4 was not aware whether there were	F 689	updated on 11/29/24 to include two people for bed mobility. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 1/29/25 the Director of Nursing identified residents that were potentially impacted by this practice by completing an audit of all current residents to ensure they had the appropriate bed mobility on the Kardex and care plan. This audit was completed on: 1/29/25. The results included: 109 of 109 residents had the appropriate number of staff for bed mobility identified on the care plan and Kardex. On 1/29/25 there was no corrective action initiated due to no deficient practice identified. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/29/25 the Staff Development Clinician began in-servicing all nursing staff including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nurse Assistants (CNAs), full time, part time, as needed, including agency, on the fall prevention and post care. This training included: " Utilizing the Kardex/care plan for bed mobility prior to providing care. This in-service was incorporated in the new employee facility orientation for all nursing staff listed above. Any of the RNs, LPNs, and CNAs who do not receive scheduled in-service training will not be	

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	345039	A. BUILDING _____ B. WING _____	C 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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F 689	Continued From page 13 any side rails. The resident required maximal assistance in bed for turning and the NA should have 2 staff to prevent rolling out of bed when turning a dependent resident. Resident #18 was assessed and had no apparent injury and had no complaints. The resident was sent to the hospital for evaluation. Nurse #4 stated she asked NA #3 what happened, and the NA stated she provided care by herself and when she turned the resident for care she rolled out of bed onto the floor. Nurse #4 stated she provided the NA education to use 2 staff for a dependent resident. The Director of Nursing (DON) was informed. The physician was notified, and the resident was sent to the Emergency Department (ED) for an evaluation. The resident returned from the ED the same day and had no injury. Attempts were made to interview NA #3 by phone on 1/09/25 and 1/10/25. A voice mail was left but NA #3 did not return the calls. On 1/9/25 at 2:42 pm an interview was conducted with Resident #18. Resident #18 stated she remembered when she fell out of bed. Resident #18 stated when the NA was providing care she placed her on the side of the bed (the resident pointed to the right side of her bed) and "I fell off." She further stated "I was not hurt." The resident did not remember if the bed was raised for care. Resident #18's ED after visit summary dated 11/29/24 documented the resident was evaluated after a fall. A CAT (radiograph of the brain) scan of head showed no injury. The resident had pain in both knees and an x-ray was completed. The results were negative for injury. The resident had a history of osteoarthritis to both knees. The resident was sent back to the facility.	F 689	allowed to work until training has been completed by 02/03/25. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee beginning 2/4/25 monitor compliance utilizing the F689 QA Tool: Bed Mobility. 5 random nurses and or certified nurse aids will be monitored weekly x 4 weeks then monthly x 3 months to ensure compliance. Reports will be presented to the monthly Quality Assurance (QA) committee by the Director of Nursing or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly QAPI Meeting or until no longer deemed necessary. The QAPI Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 2/4/25	

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F 689	Continued From page 14 A nurses' note dated 11/29/24 documented Resident #18 complained of right hip pain and had an x-ray completed at the facility after return from the ED. The x-ray result showed no fracture. There was moderate osteoarthritis of the hip joint. On 1/9/25 at 1:04 pm an interview was conducted with the DON. The DON was aware that Resident #18 had rolled out of bed during care by NA #3. The DON stated NA #3 was provided education. On 1/9/25 at 12:10 pm an interview was conducted with the Nurse Practitioner (NP). The NP stated he was not aware Resident #18 had rolled out of the bed. The NP stated the resident complained of left hip pain and an x-ray was done 11/30/24. The x-ray result was osteoarthritis, no injury. He further stated that the resident long standing pain from osteoarthritis in both hips and knees.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		2/4/25

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F 690	Continued From page 15 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility record reviews, the facility failed to keep a urinary catheter bag and/or its tubing from touching the floor to reduce the risk of infection for 1 of 2 residents (Resident #9) reviewed for urinary catheters. The findings included: Resident #9 was admitted to the facility on 12/8/24 from a hospital. Her cumulative diagnoses included neuromuscular dysfunction of the bladder and a history of a urinary tract infection.	F 690	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 690 1. Corrective action for resident(s) affected by the alleged deficient practice: On 1/9/25 the floor nurse secured Resident #9□s catheter tubing and	

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F 690	Continued From page 16 An admission Minimum Data Set (MDS) assessment dated 12/14/24 revealed Resident #9 had intact cognition. No behaviors nor rejection of care were reported. The assessment indicated Resident #9 required set-up or clean-up assistance for eating and personal hygiene, substantial to maximum assistance for bathing and bed mobility, and was totally dependent on staff for toileting and chair to bed to chair transfers. The MDS reported Resident #9 had an indwelling urinary catheter. Resident #9's care plan included an area of focus related to the resident having an indwelling urinary catheter due to her neuromuscular dysfunction of the bladder (Initiated on 12/9/24; Revision on 12/10/24). An initial observation and interview was conducted on 1/6/25 at 3:10 PM as Resident #9 was sitting in her wheelchair with a urinary catheter collection bag hanging from the back of her wheelchair. At the time of this observation, 2 to 3 inches of the bottom of Resident #9's urinary catheter bag and approximately 10 inches of the catheter tubing were lying on the floor. When asked about the use of the indwelling urinary catheter, the resident reported she had the catheter prior to admission to the facility. Resident #9 added that she was prone to developing urinary tract infections. On 1/7/25 at 9:25 AM, the resident was again observed to be sitting in her wheelchair. The urinary catheter bag was hanging from the back of the wheelchair and positioned so that the catheter bag was 1 inch from the floor. However, 3-4 inches of the urinary catheter tubing was again observed to be lying on the floor.	F 690	catheter bag to the wheelchair so that neither would touch the floor. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 1/29/25 the Director of Nursing identified current residents with the potential to be affected by this practice completing a 100% audit of all current residents with indwelling catheters. The results included: 7 of 7 residents had indwelling catheters were appropriately secured to the wheelchair or bed and not touching the floor. On 1/29/25 there was no corrective action initiated due to no deficient practice identified. 3. Systemic changes: All nurses (Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aids) were educated on Securing Indwelling Catheter Bags Properly off the floor to include: " Catheter bags and tubing should be attached to bed frame or wheelchair and never touching the floor. This in-service was incorporated in the new employee facility orientation for all nursing staff listed above. Any of the RNs, LPNs, and CNAs who do not receive scheduled in-service training will not be allowed to work until training has been completed by 2/3/25. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

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SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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F 690	Continued From page 17 An additional observation was conducted on 1/9/25 at 8:18 AM as approximately 5 inches of the bottom of Resident #9's urinary catheter bag was lying directly on the floor in front of the resident's wheelchair. The catheter bag was not attached to the wheelchair at the time of this observation. An interview was conducted with Nurse Aide (NA) #1 on 1/9/25 at 8:20 AM. NA #1 reported she was assigned to care for Resident #9. During the interview, the NA was asked about the positioning of resident's catheter bag lying on the floor without being attached to the wheelchair's frame. The NA stated she knew this was the case and "had told the nurse about it." She reported the resident would be going out for an appointment later this morning and needed to have the catheter bag covered and the bag/tubing secured. When asked if the catheter bag and/or tubing should be on the floor, the NA stated Resident #9's wheelchair was low, so the catheter bag sometimes ended up on the floor when she was sitting in the wheelchair. On 1/9/25 at 8:23 AM, the facility's Staff Development Coordinator (SDC) joined the conversation as she approached Resident #9's room. The SDC confirmed she was also the facility's Infection Preventionist. Upon inquiry, the SDC stated she was heading into Resident #9's room to take care of her urinary catheter and tubing. Upon informing the SDC of the previous observations made on 1/6/25 and 1/7/25, the SDC was asked if the resident's urinary catheter bag and/or tubing should be on the floor. The SDC stated, "No."	F 690	specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing will use the QA Tool: Securing indwelling catheter properly to monitor 5 residents with indwelling catheters beginning 2/3/25 weekly for 4 weeks and then monthly for 3 months for compliance with the process. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 2/4/25	

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F 690	Continued From page 18 An interview was conducted with the facility's Director of Nursing (DON) on 1/9/25 at 11:40 AM. During the interview, the observations of Resident #9's catheter bag and/or tubing lying on the floor were discussed. In response, the DON stated she would have preferred for the NA to take care of this issue when it was first identified. Upon further inquiry as to whether a urinary catheter bag and/or its tubing should be on the floor, the DON stated, "No, never."	F 690		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 29 opportunities, resulting in a medication error rate of 10.3% for 2 of 4 residents (Residents #32 and #86) observed during the medication administration observation. The findings included: 1-a. On 1/7/25 at 7:35 AM, Nurse #1 was observed as she prepared and administered 9 medications to Resident #32. The medications administered included one 81 milligram (mg) aspirin chewable tablet. A review of Resident #32's medication orders	F 759	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F759 1. Corrective action for resident(s) affected by the alleged deficient practice: On 1/7/25 Resident # 32 was assessed by the floor nurse. The medical provider was contacted and order was received to monitor for adverse reactions related to the Tylenol use. The resident is his own	2/4/25

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	345039	A. BUILDING _____ B. WING _____	C 01/10/2025

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SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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F 759	Continued From page 19 revealed the resident had a current order for one-81 mg aspirin "EC [Enteric Coated] Tablet Delayed Release" to be given as one tablet by mouth one time a day (ordered on 12/31/24). An interview was conducted on 1/7/25 at 3:55 PM with Nurse #1. During the interview, the discrepancy in the formulation of the 81 mg aspirin tablet administered to Resident #32 was discussed. Upon review of Resident #32's medication order, Nurse #1 confirmed she gave one-81 mg chewable aspirin tablet to Resident #32 instead of the enteric coated/delayed release formulation ordered for this resident. 1-b. On 1/7/25 at 7:47 AM, Nurse #1 was observed as she completed the administration of Resident #32's scheduled medications. At that time, Resident #32 reported he had pain and requested a pain medication. Nurse #1 returned to the medication cart and reviewed the resident's medication profile. Upon review, the nurse reported Resident #32 had an order for 650 milligrams (mg) acetaminophen to be given to the resident as needed (PRN) for pain. Nurse #1 was observed as she prepared and administered the PRN acetaminophen to Resident #32. A review of Resident #32's medication orders revealed the resident had a current order for 325 mg acetaminophen to be given as 2 tablets (total dose of 650 mg) every 8 hours as needed for pain. Further review of Resident #32's Medication Administration Record (MAR) revealed there was documentation which indicated 650 mg acetaminophen had previously been administered to Resident #32 on 1/7/25 at 6:04 AM. The resident also received the PRN dose of 650 mg acetaminophen observed and	F 759	responsible party and he was made aware. A medication error was completed. Nurse #1 has not worked at this location since the facility was made aware of the med error. On 1/7/25 Resident # 32 was assessed by the floor nurse. The medical provider was contacted with no new orders related to aspirin chewable being given versus order for 81 milligram delayed release. The resident is his own responsible party and he was made aware. A medication error was completed. Nurse # 1 has not worked at this location since the facility was made aware of the med error. On 1/7/25 the medication was administered to Resident #86 as ordered, by nurse #2 after being prompted by surveyor. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 1/31 the Staff Development Clinician and Director of Nursing completed medication administration observations with licensed nurses and medication aids to validate staff competency with medication administration. The results: 10 of 10 licensed nurses and or medication aids had no areas of concern related to medication administration. On 1/31/25 there was no corrective action implemented due to no deficient practice observed. 3. Systemic changes:	

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	345039	A. BUILDING _____ B. WING _____	C 01/10/2025

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(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 759	Continued From page 20 documented as given by Nurse #1 on 1/7/25 at 7:52 AM. The second dose of 650 mg acetaminophen was administered to the resident only 1 hour and 48 minutes after the first dose he received earlier that morning (instead of 8 hours later). An interview was conducted on 1/7/25 at 3:55 PM with Nurse #1. During the interview, Nurse #1 reviewed Resident #32's Medication Administration Record (MAR). The nurse stated that if she had known that a dose of acetaminophen was already given to the resident at 6:04 AM that morning, she would not have given him a second dose. The nurse reported she would have told the resident he had already received the medication and if his pain was not adequately managed, she may have consulted with his provider. 1-c. On 1/7/25 at 7:55 AM, Nurse #2 was observed as he prepared to administer 8 medications to Resident #86. The medications administered included one tablet of 81 milligram (mg) delayed release (DR) aspirin. A review of Resident #86's medication orders included a current order for one-81 mg aspirin "EC [Enteric Coated] Tablet Delayed Release" to be given as one tablet by mouth one time a day (ordered on 11/1/24). As Nurse #2 pulled Resident #86's medications from the medication (med) cart, he placed the tablet(s) and capsule(s) into a small medication (med) cup. In the process of pulling the medications scheduled for administration, Nurse #2 identified two stock medications that were not stored on the med cart. On two separate	F 759	All licensed nurses (RNs and LPNs) and medication aids including agency will be inserviced on the medication error policy. This education includes: " Medication Error/Discrepancy: An incorrect medication prescribed, dispensed, or administered to a resident; an omission of a vital medication due to a prescribing, dispensing, or administering error. " TYPES OF MED ERRORS!!!!! " Dose omission: medication not given. Even if due to unavailability. It is our responsibility to assure we have ordered meds available to administer. If a medication is unavailable check your med dispenses to see if it is supplied there. If not the physician is to be notified before the med is missed and the DON notified. " Wrong form of product: ex. Extended release given instead of immediate. Aspirin chewable cannot substitute EC Aspirin or DR. " Wrong Time: medication given outside scheduled time. IF a PRN says every 8 hours it cannot be given in two hours. You must wait the duration or call the provider for guidance. The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 2/3/25.	

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	345039	A. BUILDING _____ B. WING _____	C 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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F 759	Continued From page 21 occasions, the nurse locked the med cart and went to obtain the medications needed from the medication storeroom and/or other med carts. Nurse #2 took the small med cup (containing the tablets and capsules pulled thus far) with him each time he left the med cart. Upon his last return to the medication cart, the med cup was observed to be missing the one-81 mg EC Delayed Release tablet of aspirin previously pulled for administration to Resident #86. Nurse #2 was not aware of the missing tablet. On 1/7/25 at 8:30 AM, Nurse #2 reported he was ready to administer the medications prepared for Resident #86. The nurse locked his medication cart and computer screen, picked up the med cup containing the tablets and capsules (but without the aspirin tablet), then left the med cart and headed to the resident's room. At that time, a request was made for the nurse to return to the med cart. Upon his return to the med cart, the nurse was asked if the aspirin tablet that he had pulled was in the med cup. The nurse reviewed the medications in the med cup and confirmed the aspirin tablet was no longer in the cup. Nurse #2 stated he did not know what happened to the aspirin tablet. He reported he would need to pull another 81 mg aspirin EC tablet from the cart for administration to the resident. Nurse #2 was observed as he obtained an 81 mg EC aspirin tablet from a stock bottle on the med cart, added it to the med cup, and administered the medications to Resident #86. An interview was conducted on 1/8/25 at 9:22 AM with the facility's Director of Nursing (DON). During the interview, the medication administration observations were discussed. The DON reported she would expect the nursing staff	F 759	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will begin monitoring on 2/11/25 using the QA tool: Med Pass Observation 5 licensed nurses and or medication aids, weekly for 4 weeks and then monthly for 3 months to ensure compliance with the medication administration process. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 2/4/25	

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 01/10/2025

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F 759	Continued From page 22 to be following the 5 rights of medication administration, including the right dosage and dosage form. She also confirmed that if there was an order for a medication to be given, she would expect it to be given. With regards to the PRN acetaminophen being given too soon for Resident #32, the DON stated, "that shouldn't have happened." She reported if the computer software failed to automatically indicate when the last dose of a PRN medication was given, the nurse was expected to check the documentation to determine if enough time had elapsed to administer another dose.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the staff, Nurse Practitioner (NP), and dispensing pharmacist, and hospital and facility record reviews, the facility failed to correctly transcribe an order to administer the full course of an antibiotic treatment to a resident upon her return from a hospital stay for a urinary tract infection (UTI). This occurred for 1 of 3 residents (Resident #27) reviewed for antibiotic use. The findings included: Resident #27 was admitted to a hospital from 12/7/24 to 12/10/24. A review of the resident's hospital Discharge Summary dated 12/10/24 reported Resident #27	F 760	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 1. Corrective action for resident(s) affected by the alleged deficient practice: On 1/8/25 Resident #27 was assessed by the nurse on duty. The provider was notified and an order was already in	2/4/25

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F 760	Continued From page 23	F 760		

had been admitted to the hospital with symptomatic acute cystitis with hematuria (a bladder infection with visible blood present in the urine) and associated weakness. The Discharge Summary indicated, "Due to her prior history of ESBL [Extended-spectrum beta-lactamases] she was placed on ertapenem [an intravenous antibiotic generally reserved for pathogens that are resistant to other antibiotics]. Urine culture did confirm ESBL E. coli [a strain of bacteria that produces enzymes which make an infection more difficult to treat]." The resident's hospital Discharge Summary noted she would be discharged from the hospital on "fosfomycin [an oral antibiotic] to start on 12/11/24 and repeat dose 3 days later."

Resident #27's hospital Discharge Medication List dated 12/10/24 included in part: fosfomycin (3 gram pack) with instructions to take 3 grams by mouth every 3 days for 2 doses. Start date: 12/11/24; End date: 12/15/24.

Resident #27 was discharged from the hospital to the facility on 12/10/24. A review of the resident's admission orders included an order transcribed into the resident's electronic medical record (EMR) on 12/10/24 by Nurse #3 for the following: fosfomycin oral packet 3 grams to be given as 3 grams by mouth one time a day for ESBL for one (1) administration (Start Date 12/14/24). The order did not include initiating a dose of fosfomycin on 12/11/24.

An interview was conducted on 1/8/25 at 3:28 PM with Nurse #3. Nurse #3 was identified as the staff member who transcribed the order for fosfomycin into the facility's computer software on 12/10/24 upon Resident #27's admission to the

progress for a urinalysis. The provider gave an order to give one dose of Fosfomycin 3 grams one packet by mouth for cystitis. Resident was her own responsible party and she was made aware. She received the medication on 1/9/25 with no adverse reactions.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:

All residents had the potential to be affected. An audit was completed on 1/31/25 of all admissions and readmissions from 1/23/25 to 1/30/25 to ensure medications were transcribed as ordered. The audit revealed: 19 of 24 admissions or readmissions had transcription errors. The audit also revealed 0 of the 24 admissions or readmissions contained errors with antibiotic orders.

3. Systemic changes:

On 1/29 the Staff Development Clinician began inservicing all Registered and Licensed Practical Nurses on Significant Medication Error policy. This education included:
" Transcription error: Order is written incorrectly from what the original physician order stated. Example: If an order says start on 12/11 and give one dose every three days for two doses then the order must start on 12/11 and end on 12/15.
Any of the staff listed above that does not

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	345039	A. BUILDING _____ B. WING _____	C 01/10/2025

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F 760	Continued From page 24 facility. When asked, the nurse pulled up the resident's hospital discharge medication (med) list for review. He confirmed her Discharge Medication (med) List indicated two doses of fosfomycin were to be administered every 3 days upon discharge from the hospital with a start date of 12/11/24 and end date of 12/15/24. Nurse #3 also confirmed the order he transcribed into the computer system on 12/10/24 had a start date of 12/14/24 (not 12/11/24). The nurse was unable to explain why he incorrectly transcribed the order for fosfomycin to include only one dose instead of two. A review of the resident's December 2024 Medication Administration Record (MAR) revealed only one dose of fosfomycin was administered to Resident #27 after her admission to the facility. This one dose of fosfomycin was documented as administered on 12/14/24. Resident #27's admission Minimum Data Set (MDS) dated 12/16/24 indicated the resident had moderately impaired cognition. The resident's care plan included an area of focus which read, "I am at increased risk for UTI [urinary tract infection] due to history of recurrent urinary tract infections. Hx [History] of ESBL" (Date Initiated 12/10/24). On 1/6/25, the resident's Nurse Practitioner (NP) ordered a urinalysis with a culture and sensitivity test. A culture and sensitivity test is a lab test that identifies the specific type of bacteria causing an infection and then identifies which antibiotics are most effective against the bacteria present. The urinalysis report dated 1/7/25 noted the urine sample was positive for several factors suggestive of a UTI (including urine white blood	F 760	receive this scheduled inservice training by 2/3/25 will not be allowed to work until it is completed. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing will begin monitoring compliance on 2/6 using the QA Tool: Medication Transcription 5 residents weekly x 4 weeks and then monthly for 3 months for compliance with the process. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 2/4/25	

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F 760	Continued From page 25	F 760		

cells and urine bacteria).

An interview was conducted on 1/8/25 at 10:57 AM with the NP assigned to care for Resident #27. At the time of the interview, the NP had access to Resident #27's EMR. During the interview, the NP was asked how many doses of fosfomycin were intended to be given to the resident upon her admission to the facility. He confirmed he had understood the hospital recommended two doses of fosfomycin should have been given to the resident (one dose on 12/11/24 and one on 12/14/24). Upon further inquiry, the NP stated he "absolutely" would have wanted 2 doses of fosfomycin to be administered to the resident after her admission to the facility. During the interview, the NP stated he saw Resident #27 on 1/3/25 and noted the family reported she had increased confusion. For this reason, he was concerned the resident may have a UTI and ordered a urinalysis and urine culture be sent out. The NP reported he was primarily waiting for the culture results to come back from the lab before he considered initiating an antibiotic.

A telephone interview was conducted on 1/8/25 at 3:58 PM with a pharmacist at the facility's contracted dispensing pharmacy. When asked about Resident #27's fosfomycin, the pharmacist reported one (1) dose of 3 grams oral fosfomycin was dispensed and delivered from the pharmacy for Resident #27 on 12/10/24. When asked, the pharmacist reported a second dose of fosfomycin was not requested by the facility (or dispensed) for Resident #27.

An interview was conducted with the facility's Director of Nursing (DON) on 1/9/25 at 11:40 AM.

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F 760	Continued From page 26 During the interview, the DON was informed of the concern related to the facility's failure to administer the full course of fosfomycin treatment ordered for Resident #27's UTI. During a follow-up interview conducted on 1/9/25 at 1:05 PM, the DON confirmed the resident was supposed to receive two doses of fosfomycin upon admission to the facility. She reported the provider was called and the NP decided he wanted to order another dose of fosfomycin for the resident at this time. A telephone follow-up interview was conducted on 1/9/25 at 2:34 PM with the NP. During the interview, the NP reported Resident #27's lab report from her urine culture came back "inconclusive," so he decided to order the second dose of fosfomycin initially missed upon her admission to the facility. When asked, the NP reported he did not think missing this second dose of fosfomycin after her admission to the facility resulted in harm to the resident.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		2/4/25

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F 761	Continued From page 27 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Store a medication in accordance with the manufacturer's storage instructions on 1 of 3 medication (med) carts observed (200 Hall Med Cart); and 2) Remove and dispose of expired medications observed to be stored in the drawer of 1 of 3 med carts observed (300 Hall Med Cart). The findings included: 1. According to the manufacturer, intact (unopened) bottles of latanoprost eye drops should be stored under refrigeration at 36 degrees Fahrenheit (o F) to 46 o F. An observation of the 200 Hall Med Cart was conducted on 1/9/25 at 2:10 PM in the presence of Nurse #4. The observation revealed an unopened 2.5 milliliter (ml) bottle of latanoprost eye drops was stored on the med cart. The pharmacy label on the latanoprost eye drops indicated the medication was dispensed from the pharmacy on 1/7/25 for Resident #76. A pharmacy auxiliary sticker placed on the	F 761	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 761 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/9/25 Nurse # 4 removed the latanoprost for Resident # 76 from the medication cart and placed it in the refrigerator per pharmacy recommendation until opened. On 1/9/25 Nurse #5 removed the two bottles of magic mouthwash from the medication cart for Resident # 418 and	

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	345039	A. BUILDING _____ B. WING _____	C 01/10/2025

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F 761	Continued From page 28 container of the medication read, "Refrigerate until opened." Upon inquiry, the nurse confirmed the eye drop bottle was unopened and should have been stored in the refrigerator. 2. An observation of the 300 Hall Med Cart was conducted on 1/9/25 at 2:25 PM in the presence of Nurse #5. The observation revealed one-300 milliliter (ml) bottle, and one-240 ml bottle of Magic Mouthwash (a compounded medication) were labeled by the pharmacy as having been dispensed for Resident #418 on 12/21/24. The expiration date on the pharmacy label of both bottles indicated the medication had an expiration date of 1/4/25. An auxiliary sticker placed on the 240 ml bottle of Magic Mouthwash read, "Keep in refrigerator Do not Freeze." Upon inquiry, Nurse #5 confirmed both bottles of the Magic Mouthwash should have been stored in the refrigerator. He also acknowledged the pharmacy labeling on both bottles indicated the medication was expired. An interview was conducted on 1/9/25 at 3:10 PM with the facility's Director of Nursing (DON). During the interview, the medication storage observations were discussed. When asked, the DON reported she would expect the nursing staff to pay attention to any special instructions for the storage of medications when they were delivered from the pharmacy, including whether the medication should be refrigerated. Additionally, expired medications needed to be removed from the med cart.	F 761	sent it back to the pharmacy. Resident # 418 had an order to end magic mouthwash on 1/4/25 so no corrective action needed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/29/25, the Director of Nurses (DON) identified residents that had the potential to be affected by this practice by completing a 100% audit of all medication and treatment carts to ensure medications were not expired and they were stored per pharmacy recommendations. This completed on 1/29/25. The audit revealed: 3 of 7 medication and treatment carts had expired medications that were removed by the DON and sent to back to pharmacy or discarded in drug buster. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 1/29/25 the Staff Development Clinician began educating all licensed nurses (RN□s and Licensed Practical Nurses, full time, part time, PRN staff, and agency staff on Drug Storage and Biologicals. This education includes: " Latanoprost eye drops should be stored under refrigeration at 36-46 degrees Fahrenheit until opened. " Magic mouthwash should be stored in	

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F 761	Continued From page 29	F 761		

the refrigerator at all times when not in use. Label says keep refrigerated.
" Pay attention to medication expiration dates (ex. Magic mouthwash expired on 1/4/25 should be removed from circulation and returned to pharmacy).

The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 2/3/25.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:

The Director of Nursing or designee will monitor compliance utilizing the QA tool: Medication/ Treatment Cart Inspection beginning 2/6/25 weekly x 4weeks then monthly x 3 months. The DON or designee will monitor for compliance the proper way to store medications and remove expired medications. Reports will be presented to the monthly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality

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F 761	Continued From page 30	F 761	Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Compliance Date: 2/4/25	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label, date, safely store food including an open box of unsealed corn on the cob, and discard expired food items that included a plastic container of partially used ice cream stored in the freezer of 1 of 1 walk-in freezers.	F 812	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	2/4/25

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F 812	Continued From page 31 The findings included: Accompanied by the facility's Dietary Manager, an observation was made of the walk-in freezer on 1/06/25 at 11:31 AM. The following items were stored in the freezer: - One undated box of corn on the cob that was open to air in its original unsealed plastic bag - One opened and undated box of turkey sausage - One opened and undated box of hot dogs - One opened and undated box of hamburger patties - One plastic container of vanilla ice cream partially used and dated 8/29/24 The Dietary Manager was interviewed on 1/06/25 at 11:35 AM. She stated she had been in the role of manager for a couple weeks, but she had educated staff on the expectation that all food should be labeled, dated, and stored correctly. She stated containers of food that had been partially used should be dated and discarded after 3 days. On 1/10/25 at 3:03 PM the Director of Nursing was interviewed. She stated that all foods in storage should be dated. If they have been opened, then they should have been wrapped and placed in another container and used in the timeframe specified for that product. The Administrator was unreachable by phone for interview after multiple attempts.	F 812	deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 1/06/2025. During initial walk through of the kitchen on 1/06/2025, it was noted dietary services had failed to properly store, date, and discard out of date items. On 1/06/2025 it was noted in the freezer that dietary failed to proper seal a box of opened corn on the corn, multiple items noted to opened and undated: hot dogs, hamburger patties, and turkey sausage. Dietary also failed to discard a container of ice cream that was partially opened and dated 8/29/2024. On 1/06/2025 the Dietary Manager and Nutrition Service Coordinator discarded above mentioned items. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 1/06/2025, the Dietary Manager and Dietitian completed a walk-through and review of all storage areas in the kitchen to ensure all food items were within their dates and dated properly. 3. Systemic changes: In-service education was provided to all	

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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 812	Continued From page 32	F 812	full time, part time, and as needed dietary staff on 1/31/2025 by Dietary Manager. Topics included: " Storage and dating policy. " Shift inspections to observe all food are within their dates and tossed if out of date. " Use by Dates of common food items and where to find use by dates. Inspections on each shift to review all storage areas to ensure all food is labeled, dated, and stored properly. Food items left in original boxes (as appropriate) when received from truck to better track dates. Use by Date Posters posted. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure: The Dietary Service Director or assignee will monitor procedures for proper food storage weekly x 4 weeks then monthly x 2 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and stored properly in the kitchen and in the nourishment rooms. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action	

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F 812	Continued From page 33	F 812	initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Compliance date: 02/04/2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		2/4/25

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F 880	Continued From page 34 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement their infection control policy and procedure for hand hygiene when a nurse failed to perform hand hygiene after removing gloves while providing wound care for Resident #408. This occurred for 1 of 2 nurses observed for infection control practices (Nurse #3). The findings included: The facility's policy entitled Hand Hygiene last revised on 10/2022 indicated that hand hygiene included after contact with body fluids or excretions, non-intact skin, wound dressings, and after removing gloves. If gloves are worn for a procedure, hand hygiene is to be completed before putting gloves on and after removal and deposit of gloves in appropriate container. The use of gloves does not replace hand hygiene. An observation was completed on 1/08/25 at 10:37 AM of Nurse #3 performing wound care on Resident #408. Nurse #3 positioned the treatment cart outside of Resident #408's room. After he donned a gown and gloves to perform wound care, due to Resident #408 being on enhanced barrier precautions, Nurse #3 entered the resident's room and positioned him on his left side. Nurse #3 then began removing the soiled dressing from the resident's lower right back. The nurse discarded the dressing in the trash, removed his gloves and exited the room. He did not cleanse his hands after removing his gloves. At the treatment cart, Nurse #3 used his unclean hands and removed a small stack of 4x4 gauze, a	F 880	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F880 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: On 1/8/25 resident # 408 was assessed by nurse #5 for signs and symptoms of infection to include: fever, redness, sharp pain, or swelling at the site. There were no signs or symptoms of infection present. The provider was called and there were no new orders. On 1/8/25 Nurse #3 and nurse #5 were immediately educated by the Director of Nursing on hand hygiene and skills checklist was completed by the Staff Development Coordinator on infection prevention and control competency checklist for wound care (ICAR). On 1/8/25 both treatment carts were emptied of all supplies-they were discarded, cleaned and disinfected by the unit manager, and restocked with all new supplies. On 1/9/25 resident #408 was seen in the	

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F 880	Continued From page 36 bottle of wound cleanser, and 4 skin prep swabs from the drawer on the wound care cart. He then donned a clean pair of gloves. When Nurse #3 returned to the bedside he laid the stack of 4x4 gauze and the 4 wound prep swabs on Resident #408's bed. Nurse #3 cleaned the resident's wound and used one skin prep swab to wipe along the edges of the resident's wound. After cleaning the wound Nurse #3 picked up the unused gauze from the bed and threw it in the trash. He then picked up the unused skin prep swabs in his gloved hands and placed them back in the drawer of the treatment cart. He then removed his gloves and placed them in the trash. Without washing his hands, he then donned another pair of clean gloves as Nurse #5 entered Resident #408's room to complete the wound care procedure. Nurse #5 cleaned the bedside table with a disinfecting wipe and laid down a barrier once it dried. He then gathered the supplies needed, green foam sponge with clear occlusive dressing packet and scissors, to reapply the negative pressure dressing for the resident. Nurse #5 cut the green sponge to fit the size of the wound opening and placed it in the wound bed. He then cut the occlusive drape and placed it over the foam. Nurse #5 then cut a small hole in the drape and placed the suction tubing over the opening. He connected it to the vacuum canister and turned it on. Nurse #3 assisted in handing supplies to Nurse #5 throughout the application of the new dressing change. Nurses #3 and #5 then gathered up all used supplies and threw them in the trash. They removed their soiled gloves and washed their hands. Then Nurse #5 cleaned his scissors and laid them on a paper towel on the wound care cart to dry. On 1/08/25 at 11:10 AM Nurse #3 was	F 880	facility by wound provider and it was noted that wound showed improved healing. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 1/9/25 the Treatment Nurse identified residents that were potentially impacted by this practice by completing 100% audit on all current residents with wounds to ensure they had no signs or symptoms of infection related to wound care. This completed on 1/10/25. The results included: 17 of 17 residents showed no signs or symptoms of wound infection. There was no corrective action due to no deficient practice identified. 3. Systemic changes: All licensed RNs, LPNs, and treatment aids will be educated on hand hygiene beginning 1/9/25 by the Staff Development Coordinator or designee and wound care skills checklists will be performed by the treatment nurse beginning 1/9/25. This education will include: " Hand hygiene between changing gloves " Using a barrier for treatment supplies to place on a clean field " Never restocking supplies even if closed once they enter a resident□s room The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation	

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F 880	Continued From page 37 interviewed. He stated it was his usual practice to place a barrier down to lay supplies on before beginning wound care. He stated he was not sure why he did not place a barrier down when removing Resident #408's dressing during the procedure. He further stated that he thought he could return unused wound care supplies to the wound care cart if they were unopened. He was not aware he had not cleaned his hands after removing gloves and putting on a clean pair of gloves. The Director of Nursing (DON) and Administrator were interviewed on 1/08/25 at 11:18 AM. The DON stated staff were to follow the policy for providing wound care to residents. She further stated that she expected staff to wash their hands prior to wound care, in between glove changes, and after wound care is completed. She stated that she expected staff to throw away wound care supplies that came in contact with the resident's environment. The Administrator agreed that those were her expectations as well.	F 880	training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 2/3/25. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will begin on 2/10/25 monitoring 5 random dressing changes using the QA Tool: Infection Prevention and Control Competency Checklist: wound care weekly for 4 weeks and then monthly for 3 months for compliance with the process. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 2/4/25	