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	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review and interviews with staff, Nurse Practitioner (NP), and the resident's 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 [DATE] with the diagnosis of dementia and repeated falls. The admission Minimum Data Set (MDS) dated [DATE] 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 [DATE] 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. 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. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 conducted with Nurse #4. Nurse #4 stated Resident #205 was discharged on [DATE] 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 not be safely provided at this facility. Resident #205's Representative stated she provided one facility name in [NAME] 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. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 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 [DATE] 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 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 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. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 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 [DATE] with the diagnosis of osteoarthritis. Resident #18 had a significant change Minimum Data Set, dated dated dated [DATE] 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 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 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 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 [DATE]. 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 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. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27's admission Minimum Data Set (MDS) dated [DATE] 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 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. 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.