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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summerstone Health and Rehabilitation Center	485 Veterans Way Kernersville, NC 27284

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and resident and staff interviews, the facility failed to provide nail care for 1 of 3 dependent resident reviewed for activities of daily living (ADL) (Resident #104).Findings include:Resident #104 was admitted on [DATE] with diagnoses including diabetes and bilateral hand contractures.A Physician order dated 8/25/25 indicated that Resident #104 needed daily nail cleaning and weekly trimming was to be done on the 7:00 AM to 7:00 PM shift for diabetic care. A review of the Medication Administration Record for March 2026 indicated that diabetic care should be done daily on the 7:00 AM to 7:00 PM shift including fingernails should be cleaned daily and trimmed as needed. The feet should be kept clean and dry and assessed for injury and the need for toenails to be trimmed. The MAR was initialed as nail care being assessed each day as completed through 3/19/26.Resident #104's quarterly Minimum Data Set (MDS) dated [DATE] specified the resident had intact cognition, limited range of motion to bilateral hands, use of hand guards and had no rejection of care. Resident #104 required dependent care for hygiene and nail care.A review of the quarterly care plan dated 3/9/26 indicated Resident #104 received minimum to maximum assistance for ADL care from staff for bathing, range of motion, set up for feeding, hygiene, toileting, nail and skin care. Resident #104 was not care planned for any rejection of care. An observation and interview on 3/16/26 at 9:50 AM, revealed Resident #104's fingernails on both hands were long, dirty, had brown matter under the thumbs and a whitish substance underneath the 2nd, 3rd and 4th fingers of both hands. The left thumbnail was orange in color. The resident stated it had been a long time since his nails were cleaned or cut on either hand and reported that staff did not offer nail care. An observation on 3/17/26 at 11:20 AM showed Resident #104's nails were long and dirty with brown matter under the thumb nails on both hands, white matter under the others. An interview with NA #6 on 3/17/26 at 11:30 AM indicated that she had not given the resident a bath because he was already up when she got there. She stated he was bathed by the 7:00 PM to 7:00 AM shift and put it into his electric wheelchair because he got up early, and she had not noticed his nails needed to be cleaned.An interview and observation with Nurse #3 who was assigned to Resident #104 on 3/18/26 at 9:30 AM revealed that the physician orders read that Resident #104 was to have his nails cleaned daily and trimmed weekly and as needed. She indicated that due to his contractures it was difficult to trim them but agreed they did need to be cleaned and trimmed. The March 2026 MAR was reviewed with Nurse #3 during the interview, and the MAR was not initialed on 3/18/26 for diabetic care including fingernails being cleaned and trimmed daily. Nurse #3 further stated she had not looked at Resident #104's nails that morning.An interview with Nurse Aide (NA) #4 on 3/19/26 at 9:28 AM was assigned to Resident #104 on 3/18/25 and 3/19/26 on the 7:00 AM to 7:00 PM shift. She stated she did not bathe Resident #104 on 3/18/26 or 3/19/26 because she thought night shift (7:00 PM to 7:00 AM) had done so. Resident #104's fingernails were observed during the interview, and she agreed they needed to be cleaned and trimmed and had not been cleaned by 7:00 PM to 7:00 AM shift. NA #4 indicated that Resident #104 was diabetic and she could not trim his nails but could soak and clean them. NA #4 reported that Resident #104 did not refuse care. The NA further stated the nurse would have to trim Resident #104's nails because he had diabetes.A phone interview on 3/19/26 at 10:56 AM with NA #5 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Summerstone Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 485 Veterans Way Kernersville, NC 27284	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed she was assigned to Resident #104 on 3/18/26 from 7:00 PM to 7:00 AM on 3/19/26. NA #5 reported she bathed the resident that morning (5:30 AM), but stated she was unable to clean or trim his nails due to his contracted hands into fists. She did not indicate that she had reported the condition of the nails to nursing.On 3/19/26 at 3:30 PM a joint interview was conducted with the Director of Nursing (DON) and the Administrator. The DON reported that the Administrator trimmed the resident's nails the previous day and stated the resident was a messy eater, making it difficult to keep his hands clean, but the aides giving care should be making sure the residents hands and nails are trimmed are clean. The Administrator stated the DON had talked with him regarding Resident #104's nail care and he understood the importance of maintaining the resident's diabetic nail care and would ensure the nail care was completed.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and resident and staff interviews, the facility failed to apply palm guards as ordered for 1 of 1 dependent resident reviewed for limited range of motion (Resident #104).Findings include: Resident #104 was admitted on [DATE] with diagnoses of bilateral hand contractures (permanent tightening of muscles, tendons, or ligaments causing joint stiffness and restricted movement).A review of the therapy discharge note dated 9/12/25 indicated that the resident had met maximum potential and he needed to wear palm guards every day to maintain maximum mobility and prevention of skin irritation.An order dated 9/8/25 indicated that Resident #104 was to wear palm guards as tolerated 6 hours daily, removing them during range of motion exercises, eating and activities of daily living care. Resident #104's care plan dated 3/9/26 identified limited physical mobility related to bilateral hand contractures and use of bilateral palm guards to be worn 6 hours each day and removed for range of motion and activity of daily living (ADL) care. A review of the care plan dated 2/3/26 indicated Resident #104 had limited physical mobility related to bilateral hand contractures. Interventions included to do range of motion to bilaterally contracted hands and apply bilateral hand guards worn 6 hours daily or as tolerated, and to do daily hygiene reporting any skin issues to nursing.Resident #104's most recent quarterly Minimum Data Set, dated [DATE] documented intact cognition, functional limitation in range of motion in both upper extremities, and dependent care for bathing, toileting, transfers and dressing, set up for eating and mouth care, minimum assistance for positioning. There were no behaviors or rejection of care. The Medication Administration Record (MAR) for March 2026 indicated the resident was to wear palm guards up to 6 hours daily as tolerated, as donned/doffed by nursing following ROM and hygiene, and with daily skin checks. The palm guards were signed off as applied at 9:00AM from 3/1/26 through 3/18/26.An observation and interview with Resident #104 on 3/16/26 at 9:50 AM revealed contractures to bilateral hands that were in loose-fisted positions. When asked if he had a hand roll or splints, Resident #104 stated he had palm guards but had not worn them in a long time. There were no palm guards observed in Resident #104's room. Resident #104 stated that he had not declined to wear them and added that they didn't hurt him and he would wear them as ordered if they prevented his contractures from worsening. A second observation of Resident #104 on 3/17/26 at 11:20 AM revealed the palm guards ordered were not on his hands and were not seen in the room.A third observation of Resident #104 on 3/18/26 at 4:12PM AM revealed the ordered palm guards were not on his hands and were not seen in the room. An interview with the Unit Manager (200 hall) on 3/18/26 at 12:10 PM revealed the nurse aides usually applied the palm guards for Resident #104 after care and the nurses were supposed to make sure they were applied.An interview was completed with Nurse #1 on 3/18/26 at 2:12 PM and included a review of Resident #104's MAR. After looking at the MAR Nurse #3 confirmed she had not initialed the MAR for the palm guards on 3/18/26 and she had not completed her treatments yet. Nurse #1 indicated the nurse aides were supposed to place the palm guards on Resident #104 when they got him up and bathed him. Nurse #1 was unable to say when she last saw Resident #104 wearing the palm guards.An interview with Nurse Aide (NA) #1 in Resident #104's room, on 3/19/26 at 9:28 AM, stated she had not seen Resident #104's palm guards in a long time. NA #4 then stated she knew Resident #104 used to wear the palm guards, but they must have gotten lost. NA #4 did attempt to look for the palm guards but could not locate them.An interview with the Therapy Director on 3/19/26 at 11:30 AM revealed Resident #104 was given palm guards for both hands to be worn daily on 8/26/25. The Therapy Director indicated that Resident #104 was discharged from therapy on 9/12/25, and it was the nursing staff's responsibility to make sure the palm guards were placed on both hands as ordered. The Therapy Director stated a functional maintenance program was established and staff were trained on the application of palm guards.An interview with the Director of (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON) on 3/19/26 at 3:30 PM revealed that she was not informed that Resident #104's palm guards were missing. The DON stated she would expect the staff to continue implementing active therapy orders and would check with the therapy department to see if the resident was supposed to have the palm guards. She then indicated the palm guards were to be applied after care and kept on at least 6 hours daily. On 3/19/26 at 3:30 PM, the Administrator stated the DON had talked with him regarding Resident #104's palm guards and that he was working with therapy to resolve the issue.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and resident and staff interviews, the facility failed to obtain routine dental services when requested for a resident with missing upper teeth for 1 of 1 sampled resident reviewed for dental care (Resident #9).The findings included: Resident #9 was originally admitted to the facility on [DATE] with diagnoses which included end-stage renal disease. Review of the Swallowing assessment dated [DATE] revealed Resident #9 had no swallowing disorders and received a diet of regular consistency and thin liquids. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 was cognitively intact and had no dental problems or significant weight loss. Resident #9 received dialysis services. Resident #9's active care plan revealed no information related to dental care. A review of Resident #9's medical record from 1/23/25 through 3/16/26 revealed no evidence of the resident receiving dental services since her admission to the facility. During an observation and interview on 3/17/26 at 11:08 a.m., Resident #9 was noted with no upper teeth. The resident stated that she had two teeth in the left, upper back side of her mouth that needed to be extracted before she could be fitted for a partial denture. The resident did not indicate difficulty with chewing her food and did not currently have any mouth pain; but has had some pain in the past from the remaining two upper back teeth. Resident #9 revealed that since her admission to the facility she had not been examined by a dentist. She stated that she made requests to several nurses (unable to recall names) to see a dentist, but the nurses would always inform her the dentist's visits at the facility were during the time she was at the dialysis center. The resident's scheduled dialysis treatments were on Mondays, Wednesdays, and Fridays. An interview was conducted on 3/19/26 at 10:53 a.m. with the Appointment Schedular. She stated that the process for obtaining dental services included: the contracted dentist examined residents at the facility during scheduled visits every three months and the date of the visit was determined by the dental provider. However, if a resident requested to be examined by a dentist, the resident's name would be added to the list of residents' to be seen during the next scheduled dental visit unless the resident required an emergency dental visit. If an emergency dental appointment was needed or if a resident was unable to meet with the dentist during on-site visits, she would schedule a dental visit with the contracted dentist's office or the first available dental practice. The facility would be responsible for transporting the resident to and from the dental office. The Appointment Schedular revealed she was not informed by any of the facility's nurses that Resident #9 requested a dental appointment. During a follow-up interview on 3/19/26 at 1:30 p.m., the Appointment Schedular stated that after the interview with this Surveyor, she reviewed the dental appointment records and contacted the visiting dentist's office. She confirmed Resident #9 had not been seen by a dentist since her admission to the facility and was not included on the list of residents scheduled to be examined by the dentist during his most recent on-site visit at the facility on 1/30/26. As a result, she instructed the facility's current Social Worker (began working at the facility the prior week and would be responsible for maintaining names of residents to be examined by the dentist) to include Resident #9's name on the list of residents to be examined by the dentist during the next dentist's visit (exact date determined by the dental office) to the facility. During an interview on 3/19/26 at 4:27 p.m., the Administrator acknowledged Resident #9 should have received dental services since her admission to the facility and when the resident requested.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review and staff interviews, the facility failed to ensure nurse staffing sheets were accurate for 4 of 7 days reviewed for nurse staffing information (2/2/26, 2/9/26, 2/22/26, and 3/16/26). The findings included:The daily posted nurse staffing sheet for 2/2/26 revealed 9 Licensed Practice Nurses (LPNs) and 22 Nurse Aides (NAs). The nursing staff assignment sheet dated 2/2/26 revealed 6 Licensed Practical Nurses (LPNs) and 27 Nurse Aides (NAs) worked. The daily posted nurse staffing sheet for 2/9/26 revealed 8 LPNs and 24 NAs worked. The nursing staff assignment sheet dated 2/9/26 revealed 3 LPNs and 11 NAs worked. The daily posted nursing staffing sheet for 2/22/26 revealed 10 LPNs and 27 NAs worked. The nursing staff assignment sheet dated 2/22/26 revealed 11 LPNs and 23 NAs worked. The daily posted nursing staffing sheet for 3/16/26 revealed 10 LPNs worked. The nursing staff assignment sheet dated 3/16/26 revealed 11 LPNs worked.An interview was conducted with the Director of Nursing (DON) on 3/19/26 at 2:20 PM. She stated she was responsible for both the nursing staff schedules and completion and posting of the daily staffing posting sheet as the facility did not have a Staff Scheduling Coordinator. She stated if a nursing staff member called out or left early the daily staffing posting sheet should have been adjusted. The DON stated that the difference between LPNs scheduled and posted was because a Registered Nurse was counted as an LPN. The DON stated she was unaware the posting sheets were not correct for 2/2/26, 2/9/26, 2/22/26, and 3/16/26. She stated that currently she does not have someone reconcile the nurse staff schedules with the daily posting nurse staffing sheet. During an interview on 3/19/26 at 2:40 PM, the Administrator stated the Director of Nursing was responsible for posting and updating the daily nurse staffing sheets. He was unable to give a reason for the staff sheets not being filled out correctly. The Administrator stated he was not involved in the staff posting sheets; however, he would expect them to display the correct information.