STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piney Grove Nursing and Rehabilitation Center	728 Piney Grove Road 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record reviews, resident and staff interviews, the facility failed to provide the resident's preference of showers for 3 of 3 residents reviewed for choices (Resident #17, Resident #189 and Resident #64). The findings included: 1. Resident #17 was admitted to the facility on [DATE] with diagnoses which included debility, arthritis, and chronic pain. Resident #17's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and required substantial to maximal assistance with showering and bathing. The assessment also revealed Resident #17 had no rejection of care behaviors and according to the assessment, it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. The shower schedule for the middle hall revealed Resident #17 was scheduled for showers on Tuesday and Friday on 1st shift (7:00 AM to 3:00PM). The documentation of showers in the electronic medical record for Resident #17 for 08/13/24 through 10/11/24 revealed she received showers as scheduled on 08/13/24, 08/16/24, 08/20/24, 08/27/24, 09/03/24, 09/10/24, 09/17/24, 09/20/24, and 09/24/24. On the other days she was scheduled for showers the following was documented: Friday 08/23/24 no shower provided Friday 08/30/24 partial bath provided Friday 09/06/24 no shower provided Friday 09/13/24 no shower provided Friday 09/27/24 no shower provided Tuesday 10/01/24 no shower provided (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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Friday 10/04/24 no shower provided Tuesday 10/08/24 no shower provided Friday 10/11/24 no shower provided An observation and interview on 10/08/24 at 9:23 AM revealed Resident #17 sitting up in her wheelchair and dressed for the day. The Resident's skin was visibly dry and flaky. Resident #17 stated she was not getting her showers two times a week as scheduled and stated she preferred to take showers because the hot water felt good to her arthritis. Resident #17 further stated she had not refused any of her showers and had not been offered showers two times per week, every week and had sometimes gone two weeks without a shower. On 10/10/24 at 4:00 PM a Resident Council Meeting was held, and Resident #17 was in attendance and again she and others complained about not getting showers during the meeting. She stated that she was not getting her showers two times per week as scheduled. A telephone interview was attempted several times with agency NA #13 who cared for Resident #17 on 08/23/24 during the 7:00 AM to 3:00 PM shift with voicemail messages left for return call with no response. A telephone interview on 10/11/24 at 3:55 PM with agency NA #8 revealed she had cared for Resident #17 on 08/30/24 during the 7:00 AM to 3:00 PM shift. She stated she usually tried to give all her showers or bed baths but said sometimes their schedule changed during their shift and showers sometimes got missed. Agency NA #8 further stated the scheduled changed frequently and it was difficult to keep up with showers when changes were made mid-day. A telephone interview on 10/10/24 at 12:07 PM with Agency Nurse Aide (NA) #3 revealed she had cared for Resident #17 on 09/06/24 during the 7:00 AM to 3:00 PM shift. She stated she couldn't remember why she had not given Resident #17 a shower on that day but said sometimes their assignments were changed during the shift and residents may have missed their showers. Agency NA #3 stated she usually gave all her showers and bed baths unless the schedule was changed and said that happened a lot because staff worked different hours. She further stated the staff worked 4, 8, 12 and 16-hour shifts. A telephone interview was attempted several times with agency NA #12 who cared for Resident #17 on 09/13/24 and 10/11/24 during the 7:00 AM to 3:00 PM shift with voicemail messages left for return call with no response. An interview on 10/11/24 at 4:42 PM with Unit Manager #2 revealed she was not aware, and no one had told her that Resident #17 was not receiving her showers as scheduled. She stated the NAs should be reporting not getting showers done to the nurse or to her so they could have adjusted the schedule to accommodate the residents. Unit Manager #2 further stated she could have moved NAs around or added them to an assignment to get the resident showers done if she had been told they were not done. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed she expected residents to have their bed baths or showers as scheduled. She stated the NAs should report to the nurses or unit managers any residents refusing care or who didn't receive their bed bath or shower as scheduled so they could be accommodated on the next shift or next day. The DON further stated there were changes sometimes to the schedule because they had staff working 4, 8, 12 and 16-hour shifts. She indicated they were trying to cover the schedule with agency staff as they hired their own staff, and it was difficult with using so many agencies to get dependable staff to cover the schedule. The DON further indicated they needed to interview the residents and make sure their preferences were documented correctly. 2. Resident #64 was admitted to the facility on [DATE] with diagnoses which included hemiparesis due to cerebrovascular accident (CVA) or stroke. Resident #64's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired and required partial to moderate assistance with showering and bathing. The assessment also revealed Resident #64 had no rejection of care behaviors and according to the assessment, it was somewhat important to the resident to choose between a tub bath, shower, bed bath or sponge bath. The shower schedule for the middle hall revealed Resident #64 was scheduled for showers on Wednesday and Saturday on 2nd shift (3:00 PM to 11:00 PM). The documentation of showers in the electronic medical record for Resident #64 for 08/05/24 through 10/09/24 revealed she received showers on 08/20/24 which was not a scheduled shower day (Tuesday), 09/04/24, 09/11/24, 10/02/24 and 10/07/24 which was not a scheduled shower day (Monday). On the other days she was scheduled for showers the following was documented: Wednesday 08/07/24 partial bath provided Saturday 08/10/24 partial bath provided Wednesday 08/14/24 no shower provided Saturday 08/17/24 complete bed bath Wednesday 08/21/24 no shower provided Saturday 08/24/24 no shower provided Wednesday 08/28/24 partial bath provided Saturday 08/31/24 complete bed bath provided Saturday 09/07/24 no shower provided Saturday 09/14/24 complete bed bath provided Wednesday 09/18/24 no shower provided (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Saturday 09/21/24 complete bed bath provided Wednesday 09/25/24 no shower provided Saturday 09/28/24 partial bath provided Saturday 10/05/24 no shower provided Wednesday 10/09/24 no shower provided An observation and interview on 10/07/24 at 3:30 PM with Resident #64 revealed her lying in bed and said she had a shower today but prior to that it had been a while since she had one. Resident #64 stated she only got one shower about every 2 weeks and would like to get 2 showers a week as scheduled. She further stated she preferred a shower because the warm water felt good to her, and she felt cleaner after a shower than when she received a bed bath. A telephone interview was attempted several times with Nurse Aide (NA) #6 who cared for Resident #64 on 08/14/24 and 08/28/24 during the 3:00 PM to 11:00 PM shift with voicemail messages left for return call with no response. A telephone interview on 10/10/24 at 11:22 AM with agency NA #4 revealed she had cared for Resident #64 on 08/21/24 (along with agency NA #5), 08/31/24, and 09/18/24 during the 3:00 PM to 11:00 PM shift. She stated she usually tried to get all her showers done but sometimes their assignments changed 2 hours into the shift, and she may have been switched to other residents and not gotten her shower done before the assignment changed. Agency NA #4 stated there seemed to be a scheduling problem at the facility because assignments were constantly being changed during the shift. A telephone interview on 10/10/24 at 11:50 AM with agency NA #5 who cared for Resident #64 on 08/21/24 (along with agency NA #4), and 09/25/24 during the 3:00 PM to 11:00 PM shift revealed if they were fully staffed, she was able to get her showers done on 2nd shift but if not, she was not able to get all the showers done as scheduled. She stated there were times that staff would just not show up for their shift and would not call and that left them short and on those shifts it was difficult to get all the showers done. An interview on 10/11/24 at 4:42 PM with Unit Manager #2 revealed she was not aware, and no one had told her that Resident #64 was not receiving her showers as scheduled. She stated the NAs should be reporting not getting showers done to the nurse or to her so they could have adjusted the schedule to accommodate the residents. Unit Manager #2 further stated she could have moved NAs around or added them to an assignment to get the resident showers done if she had been told they were not done. An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed she expected residents to have their showers as scheduled. She stated the NAs should report to the nurses or unit managers any residents refusing care or who didn't receive their shower as scheduled so they could be accommodated on the next shift or next day. The DON further stated there were changes sometimes to the schedule because they had staff working 4-, 8-, 12- and 16-hour shifts. She indicated they were trying to cover the schedule with agency staff as they hired their own staff, and it was difficult with using so many agencies to get dependable staff to cover the schedule. The DON further indicated they needed to interview the residents and make sure their preferences were documented correctly. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #189 was admitted to the facility on [DATE] with diagnoses which included hemiplegia due to cerebrovascular accident (CVA) or stroke. Resident #189's annual Minimum Data Set (MDS) dated [DATE] revealed it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. Resident #189's quarterly MDS dated [DATE] revealed she was moderately cognitively impaired but could make her needs known and required setup with showering and bathing. The assessment also revealed Resident #189 had no rejection of care behaviors. The shower schedule for the middle hall revealed Resident #189 was scheduled for showers on Monday and Thursday on 2nd shift (3:00 PM to 11:00 PM). The documentation of showers in the electronic medical record for Resident #189 for 08/05/24 through 09/05/24 revealed she received no showers as scheduled during this time. On the days she was scheduled for showers the following was documented: Monday 08/05/24 no shower provided Thursday 08/08/24 no shower provided Monday 08/12/24 complete bed bath provided Thursday 08/15/24 no shower provided Monday 08/19/24 no shower provided Thursday 08/22/24 partial bath provided Monday 08/26/24 partial bath provided Thursday 08/29/24 partial bath provided Monday 09/02/24 complete bed bath provided Thursday 09/05/24 no shower provided Documentation for 09/06/24 through 10/09/24 was not provided for this resident. An observation and interview on 10/07/24 at 12:38 PM with Resident #189 revealed her sitting up in her wheelchair in her room dressed for the day. The Resident's skin that was visibly dry and flaky. Resident #189 stated she was not getting her showers two times a week as scheduled and stated she preferred to take showers because the hot water felt good to her, and she felt cleaner after a shower and getting her hair washed. A telephone interview was attempted several times with Nurse Aide (NA) #6 who cared for Resident #189 on 08/08/24, 08/12/24 and 08/26/24 during the 3:00 PM to 11:00 PM shift with voicemail messages left for return call with no response. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview on 10/10/24 at 12:07 PM with Agency NA #3 revealed she had cared for Resident #189 on 08/05/24 and 09/05/24 during the 3:00 PM to 11:00 PM shift. She stated she couldn't remember why she had not given Resident #189 a shower on those days but said sometimes their assignments were changed during the shift and residents may have missed their showers. Agency NA #3 stated she usually gave all her showers and bed baths unless the schedule was changed and said that happened a lot because staff worked different hours. She further stated the staff worked 4, 8, 12 and 16-hour shifts. A telephone interview on 10/10/24 at 11:57 AM with agency Nurse Aide (NA) #2 revealed she had cared for Resident #189 on 08/19/24 during the 3:00 PM to 11:00 PM shift. She stated she was not sure why she had not given Resident #189 a shower on that day but said sometimes their assignments were changed during the shift. She further stated it could have been that she originally had the resident and then was reassigned to another set of residents. Agency NA #2 indicated she always tried to give her showers and if she was not able to it was because the assignments were changed or there was not enough time during her shift to get it done. She also indicated there were times when staff called out or didn't show up and there was not enough time in the shift to give showers because of the increased workload. A telephone interview on 10/10/24 at 11:22 AM with Agency NA #4 revealed she had cared for Resident #189 on 08/22/24 during the 3:00 PM to 11:00 PM shift. She stated she usually tried to get all her showers done but sometimes their assignments changed 2 hours into the shift, and she may have been switched to other residents and not gotten her shower done before the assignment changed. Agency NA #4 stated there seemed to be a scheduling problem at the facility because assignments were constantly being changed during the shift. A telephone interview was attempted several times with agency NA #15 who cared for Resident #189 on 08/29/24 during the 3:00 PM to 11:00 PM shift with voicemail messages left for return call with no response. A telephone interview was attempted several times with agency NA #7 who cared for Resident #189 on 09/02/24 during the 3:00 PM to 11:00 PM shift with voicemail messages left for return call with no response. An interview on 10/11/24 at 4:42 PM with Unit Manager #2 revealed she was not aware, and no one had told her that Resident #189 was not receiving her showers as scheduled. She stated the NAs should be reporting not getting showers done to the nurse or to her so they could have adjusted the schedule to accommodate the residents. Unit Manager #2 further stated she could have moved NAs around or added them to an assignment to get the resident showers done if she had been told they were not done. An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed she expected residents to have their preferred showers as scheduled. She stated the NAs should report to the nurses or unit managers any residents refusing care or who didn't receive their shower as scheduled so they could be accommodated on the next shift or next day. The DON further stated there were changes sometimes to the schedule because they had staff working 4-, 8-, 12- and 16-hour shifts. She indicated they were trying to cover the schedule with agency staff as they hired their own staff, and it was difficult with using so many agencies to get dependable staff to cover the schedule. The DON further indicated they needed to interview the residents and make sure their preferences were documented correctly.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on record review and interviews with resident, staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to notify the NP and MD that a resident was completely out of her narcotic pain medication resulting in her missing 14 consecutive doses for 4 1/2 days for 1 of 3 residents reviewed for notification (Resident #17). The findings included: Resident #17 was admitted to the facility on [DATE] with diagnoses which included debility, arthritis, and chronic pain. The physician's order dated 10/25/23 revealed Resident #17 had an order to receive one tablet of oxycodone-Acetaminophen oral tablet 5-325 milligrams (mg) (oxycodone with acetaminophen) or Percocet (a type of opioid analgesic consisted of oxycodone/acetaminophen that acted on the central nervous system to relieve pain) by mouth three times a day for pain. The medication was scheduled to be given at 8:00 AM, 2:00 PM and 8:00 PM. The Medication Administration Record (MAR) for August 2024 revealed Resident #17 had not received her medication the following dates and times: - August 1 8:00 AM, 2:00 PM and 8:00 PM - August 2 8:00 AM, 2:00 PM and 8:00 PM - August 3 8:00 AM, 2:00 PM and 8:00 PM - August 4 8:00 AM, 2:00 PM and 8:00 PM - August 5 8:00 AM and 2:00 PM for a total of 14 doses missed. The August 2024 MAR revealed on the following dates and times, Agency Nurse #3 had taken care of Resident #17 and had not administered her Percocet: - August 1 at 8:00 AM and 2:00 PM - August 3 at 8:00 AM, 2:00 PM and 8:00 PM - August 4 at 8:00 AM and 2:00 PM A telephone interview was attempted with Agency Nurse #3 on 10/10/24 at 3:15 PM; however, the number had been disconnected and Nurse #3 was no longer employed through the Agency. The August 2024 MAR revealed on the following dates and times, Nurse #2 had taken care of Resident #17 and had not administered her Percocet: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- August 2 at 8:00 AM and 2:00 PM - August 5 at 8:00 AM and 2:00 PM A telephone interview on 10/10/24 at 4:00 PM with Nurse #2 revealed she couldn't recall the specifics but said generally if a resident does not have their medication, she typically contacts the pharmacy and then if a script was needed, she contacted the NP to send an electronic script to the pharmacy for the medication. Nurse #2 stated she couldn't recall if they had oxycodone with acetaminophen in their narcotic Emergency Kit but stated she felt like if they had she would have given it from the Emergency Kit. She further stated she could not recall notifying the NP or MD that the resident was completely out of her pain medication. The August 2024 MAR revealed on August 4 at 8:00 PM Agency Nurse #4 had taken care of Resident #17 and had not administered her Percocet on that day and time. A telephone interview was attempted several times with Agency Nurse #4 without success. Review of Resident #17's significant change MDS dated [DATE] revealed she was cognitively intact and received scheduled pain medication and no as needed pain medication. The assessment also revealed the resident had almost constant pain at a level of 10 out of 1-10. An interview on 10/10/24 at 10:03 AM with Resident #17 revealed she had gone 4 1/2 days the first of August without receiving her pain medication as ordered. She stated during that time she had an increase in her pain level to an 8 on a scale of 1-10, instead of her usual pain level of 0 to 3 with her pain medication. She stated the staff (couldn't remember names) kept telling her it was on order and had not come from the pharmacy and said one nurse (couldn't remember name) finally told her it was too soon to refill her prescription for her pain medication. An interview on 10/10/24 at 4:35 PM with the MD revealed she was not aware Resident #17 had completely ran out of her pain medication. The MD stated she or the NP should have been notified the resident was completely out of her pain medication so they could have ordered pain medication to cover her while awaiting her order from the pharmacy. She further stated she was familiar with Resident #17 and her chronic pain and her concern with her not receiving her pain medication for over 4 days would have been her increased intensity in pain. A telephone interview on 10/11/24 at 2:04 PM with the NP revealed she was not aware that Resident #17 had completely ran out of her pain medication. The NP stated had she known she could have ordered additional pain medication and potentially other modalities such as heat to help with her pain. The NP further stated her concern with Resident #17 not receiving her pain medication would have been her increased intensity in pain making it difficult to get the pain back under control. An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed it her expectation that residents received their medications as ordered by the providers. The DON stated the nurses or Unit Manager #2 should have contacted the NP or MD to obtain orders for pain medication and utilized other modalities such as heat to assist the resident in managing her pain.

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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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on record review and interviews with residents, staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to protect a resident's right to be free from misappropriation of controlled medications for 1 of 3 residents reviewed for misappropriation of resident's property (Resident # 17). As a result of not getting her pain medication, Resident #17 had an increase in her pain of a level 8 on a scale of 1 to 10 which was increased from her usual pain level of 0 to 3 when getting her medication as prescribed. Resident #17 described the pain as constant aching and throbbing pain in her right hip and throbbing pain in her mouth. The findings included: The facility's Abuse, Neglect, or Misappropriation of Resident Property Policy, last revised on [DATE], revealed in part the facility would do whatever is in its control to prevent misappropriation of resident's property. Resident #17 was admitted to the facility on [DATE] with diagnoses which included debility, arthritis, and chronic pain. The physician's order dated [DATE] revealed Resident #17 had an order to receive one table of oxycodone-Acetaminophen oral tablet ,d+[DATE] milligrams (mg) (oxycodone with acetaminophen) or Percocet (a type of opioid analgesic consisted of oxycodone/acetaminophen that acted on the central nervous system to relieve pain) by mouth three times a day for pain. The medication was scheduled to be given at 8:00 AM, 2:00 PM and 8:00 PM. A Packing Slip dated [DATE] from the Pharmacy revealed Oxycodone/Acetaminophen tablets ,d+[DATE] mg tablets, 90 tablets were received for Resident #17 and signed for by Agency Nurse #1. The declining narcotic count sheets indicated Resident #17 had 2 sheets for a total of 60 tablets instead of 3 sheets for a total of 90 tablets as received and signed for by Agency Nurse #1 on [DATE]. The sheets had been altered at the top indicating there were 2 sheets (1 of 2 sheets and 2 of 2 sheets) received instead of 3 sheets (1 of 3 sheets, 2 of 3 sheets and 3 of 3 sheets) as indicated from the pharmacy at the top of the sheet as well as the packing slip from the pharmacy indicating 90 tablets with 3 sheets received. The declining narcotic count sheets indicated the last dose given was on [DATE] at 8:00 PM. There was no page 3, and 30 tablets were unaccounted for, for Resident #17. A telephone interview on [DATE] at 9:56 AM with Agency Nurse #1 who had signed for Resident #17's medications on [DATE] revealed she could not recall signing for the medications but stated if her signature was on the document then she had signed them in. She stated she did not remember how many tablets there were or how many declining count sheets there were attached to the medications. Nurse #1 further stated she did not recall altering the declining count sheets to say 1 of 2 sheets and 2 of 2 sheets instead of 1 of 3, 2 of 3 and 3 of 3 sheets from the pharmacy. She denied knowing anything about one of the sheets and one of the cards of medication going missing. Nurse #1 denied taking the medications and sheet and denied knowing anything about anyone else taking the medications or sheet. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	Review of Resident Council Meeting Minutes dated [DATE] revealed during the meeting when residents were asked about New Business concerns, Resident #17 stated in the meeting that she had not received her pain medications for 4 days. The MAR for [DATE] revealed Resident #17 had not received her medication the following dates and times: - [DATE]:00 AM, 2:00 PM and 8:00 PM - [DATE]:00 AM, 2:00 PM and 8:00 PM - [DATE]:00 AM, 2:00 PM and 8:00 PM - [DATE]:00 AM, 2:00 PM and 8:00 PM - [DATE]:00 AM and 2:00 PM for a total of 14 doses missed. Review of Resident #17's significant change MDS dated [DATE] revealed she was cognitively intact and received scheduled pain medication and no as needed pain medication. The assessment also revealed the resident had almost constant pain at a level of 10 out of ,d+[DATE]. An interview on [DATE] at 10:03 AM with Resident #17 revealed she had gone over 4 ,d+[DATE] days the first of August without receiving her pain medication as ordered. She stated during that time she had an increase in her pain level to an 8 on a scale of ,d+[DATE], instead of her usual pain level of ,d+[DATE] with her medication. Resident #17 described a constant aching and throbbing pain in her right hip and constant pain in her joints due to arthritis. Additionally, Resident #17 stated she had three teeth extracted during this time which further increased her pain and described her mouth pain as a throbbing pain in her mouth. She stated the staff (couldn't remember names) kept telling her it was on order and had not come from the pharmacy and said one nurse (couldn't remember name) finally told her it was too soon to refill her prescription for her pain medication. Resident #17 said they didn't offer her any other medication or treatment for her pain during those 4 ,d+[DATE] days she went without her scheduled pain medication. A telephone interview on [DATE] at 12:12 PM with the Pharmacy Manager stated on [DATE] 90 tablets and 3 medication sheets were sent to the facility for Resident #17. The Pharmacy Manager stated they had received a new electronic script on [DATE] for Resident #17 but it was too early to refill because the [DATE] order should have lasted until [DATE]. She further stated on [DATE] they received another electronic script, and it was still too early to refill the medication so on [DATE] they received approval from Unit Manager #2 to refill the medication and to bill the facility and send the medication out on special delivery. The Pharmacy Manager explained the medication had gone out on the afternoon of [DATE] to the facility and that usually their medication runs occurred during the night hours. She further explained that 90 tablets had been sent to the facility for Resident #17 along with 3 narcotic declining count records. Review of an invoice from the Pharmacy dated [DATE] revealed on [DATE] 90 pills were sent to the facility and billed to the facility for Resident #17. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	A telephone interview on [DATE] at 2:42 PM with the former Director of Nursing (DON) revealed she had been the interim DON at the facility in August of 2024. She stated no one had reported to her that any resident was missing Percocet or any other medications. The former DON further stated she remembered vaguely that someone had run out of their pain medication but said she had been told it was because the physician had increased the dosage of medication not that there were medications missing. She indicated she did not authorize any medications being paid for by the facility while there and no one had told her that narcotics were missing while she was interim DON at the facility. An interview on [DATE] at 4:35 PM with the Medical Director (MD) revealed she was not aware of missing medications for Resident #17 until just before this interview. She stated she was familiar with Resident #17 and her chronic pain and her concern with her not receiving her pain medication for over 4 days would have been her increased intensity in her pain. The MD further stated it seemed as though someone with access had diverted the medications belonging to Resident #17 and she would be mindful in the future of requests for refilling narcotic medications early. A telephone interview on [DATE] at 2:04 PM with the Nurse Practitioner (NP) revealed she was not aware that Resident #17 was missing medications or that she had completely ran out of her medications. The NP stated it seemed as though someone had diverted her pain medication, and she would pay better attention to early requests for narcotic medication refills. A telephone interview on [DATE] at 2:46 PM with the Consultant Pharmacist revealed they did monthly controlled substance inspections at the facility and looked in the books to ensure the count on the declining sheets matched the card count. She stated they looked at the carts and medication rooms for dates on medications, expired meds, and ensure medications were being stored appropriately. The Consultant Pharmacist further stated they might find a missed signature from time to time on medication sheets but had not noticed any medication sheets being altered or missing or missing cards of medication. She indicated it was unlikely they would have found an error such as this on their cart and medication room inspections because they spot checked the carts and medication rooms and this error would have been hard to identify with their current process. The Consulting Pharmacist further indicated an error like this should have been reported to the Medical Director and the pharmacy and should have been documented they were notified. An interview on [DATE] at 6:10 PM with the Director of Nursing (DON) revealed it was the expectation of the DON that resident's medications were not taken and unaccounted for and that residents received their medications as ordered by the providers. The DON stated she had been through all the files and was not able to locate the 3rd declining count sheet received on [DATE] for Resident #17. She further stated they could only assume the medications and sheet had been taken by one of the nurses with access to the medications and sheet.

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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 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** 37019 Based on observations, record review, and resident, family member, and staff interviews, the facility failed to clean and trim nails on both hands of a dependent resident and failed to shave chin hairs on a dependent resident for 1 of 3 dependent residents reviewed for activities of daily living (Resident #43). The findings included: Resident #43 was readmitted on [DATE]. Her diagnoses included diabetes mellitus type II, osteoporosis, and dementia. Resident #43's Care Area Assessment for activities of daily living (ADL) dated 07/14/24 revealed she needed assistance from staff with all activities of daily living due to her diagnoses of dementia, hemiplegia following a stroke affecting her left non-dominant side and osteoporosis. Resident #43's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired but was able to make her needs known. The assessment also revealed Resident #43 required substantial to maximal assistance with showering and bathing and required partial to moderate assistance with personal hygiene. The resident had no behaviors of rejection of care. Review of Resident #43's care plan last revised on 10/05/24 revealed she had a focus area for requiring assistance with activities of daily living (ADL) related to left sided hemiplegia from previous stroke. The interventions included in part, bed mobility required substantial to maximal assistance, showers/bathing required substantial to maximal assistance and personal hygiene required partial to moderate assistance from staff. An observation on 10/07/24 at 3:43 PM revealed Resident #43 resting in her bed eating crackers with her nails noted to be 1/4 inch beyond the end of her fingers with brown debris under all the nails on both her hands. Resident #43 was also noted to have visible white chin hairs that were 1/4 inch long on her chin. An interview with the resident revealed she did not like her nails to be long and would like for them to be trimmed and cleaned on both hands and said she didn't like having chin hairs and would like for someone to trim them off her chin for her. Resident #43 stated her family member usually had to trim her nails and the chin hair off her chin because the staff at the facility didn't offer to do it for her. She further stated her family member had not been able to come to the facility to visit her because she had fallen and broken her arm. A telephone interview on 10/11/24 at 3:55 PM with Agency Nurse Aide (NA) #8 revealed she had taken care of Resident #43 on 10/07/24 during the 7:00 AM to 3:00 PM shift and had given her a complete bed bath. Agency NA #8 stated she knew Resident #8 had long nails, but she was not used to taking care of her, so she didn't trim her nails. She further stated she had not reported to Unit Manager #2 that her nails were long and needed trimming. Agency NA #8 said she did not usually trim chin hairs on women and said she had not asked Resident #43 if she wanted her chin hairs trimmed and had not reported to Unit Manager #2 that her chin hairs needed to be trimmed. She indicated she was not aware she was expected to trim chin hairs on women. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 10/08/24 at 4:32 PM revealed Resident #43 resting in her bed and her nails were still long with brown debris under them and she still had visible white chin hairs on her chin. She stated she had received a bed bath on 10/07/24 but her nails had not been trimmed and she had not had her chin hairs shaved during her bath. Review of the shower schedule revealed Resident #43 was scheduled for showers/bed baths on Monday and Thursday on 2nd shift (3:00 PM to 11:00 PM). An interview on 10/09/24 at 3:15 PM with Nurse Aide (NA) #11 revealed she had taken care of Resident #43 on 10/08/24 and 10/09/24 during the 7:00 AM to 3:00 PM shift and stated she had not noticed Resident #43's nails being long or being dirty on both her hands. NA #11 stated she had not given her a bath on the days she had cared for her and had not paid attention to her nails or the hair on her chin. She stated usually resident's nails are trimmed and they are shaved on their shower days, and she had not provided Resident #43's shower when she cared for her on 10/08/24 and 10/09/24. NA #11 further stated she believed Resident #43 was diabetic and her nails would have to be trimmed by the nurse but said she had not reported her nails needing to be trimmed to Unit Manager #2. An observation on 10/09/24 at 3:03 PM revealed Resident #43 lying in bed with her family member at her bedside. Her nails were trimmed and cleaned, and her chin hairs had been shaved. The family member stated she had trimmed and cleaned the brown debris from under Resident #43's nails and shaved her chin hairs because the staff at the facility would not do it even though she had requested the resident's nails to be trimmed and kept clean and her chin hairs shaved from her face. The family member further stated she had not been able to visit for 3 weeks because she had fallen and broken her arm and had to heal herself. She indicated to her knowledge the facility staff had never offered to trim Resident #43's nails or shave the chin hairs from her face, so she tried to do it, but it had been difficult today with her broken arm. An interview on 10/10/24 at 2:54 PM with Unit Manager #2 revealed she was not aware, and no one had told her that Resident #43's nails were long and needed to be trimmed. She stated her nails would have to be trimmed by a nurse since she was diabetic but the NAs caring for her should keep them clean and they shouldn't have brown debris under the nails. Unit Manager #2 further stated that shaving residents both male and female was part of their routine when giving residents bed baths or showers and said Resident #43 should have been shaved on Monday when she received her bed bath. She indicated she was not aware the resident's family member had requested the resident be shaved and her fingernails trimmed but said it should be part of her routine ADL care and her family member should not have to trim her fingernails or shave her chin hairs. She further indicated that should be done by the facility staff. An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed she expected residents to have their nails trimmed and cleaned and be shaved as part of their bed bath or shower. She stated the NAs should report to the nurses or Unit Managers any diabetic residents with nails that needed to be trimmed, and they should be trimming the other resident's nails. The DON further stated all residents that wanted to be shaved male or female should be shaved as part of their ADL care.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record review, resident and staff interviews the facility failed to apply compression wraps daily per the physician's order for 1 of 1 resident (Resident #57) reviewed for edema (swelling). Findings included: Resident #57 was admitted to the facility on [DATE] with diagnoses that included lymphedema (chronic condition that causes swelling, most often in the arms or legs, due to a buildup of lymph fluid). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had intact cognition. She required substantial/maximum staff assistance with lower body dressing and received application of nonsurgical dressings other than to feet. It was further noted that Resident #57 had not rejected care during the MDS assessment reference period. An active physician's order dated 08/23/24 for Resident #57 read in part, apply compression garments (wraps) in the morning daily for 8 to 12 hours. Remove at night and elevate legs. Every shift for lymphedema of bilateral lower extremities. Review of the staff progress notes for October 2024 revealed no entries related to Resident #57 refusing application of the compression wraps. An observation and interview was conducted with Resident #57 on 10/07/24 at 4:08 PM. Resident #57 was sitting up in her motorized wheelchair, there was swelling noticed to both lower legs and she had no compression wraps applied. A rolling walker was placed at the end of Resident #57's bed and lying on the seat of were two compression wraps. Resident #57 stated she was supposed to wear the compression wraps on her lower legs due to edema and never refused to have them applied. Resident #57 explained she couldn't put them on herself and staff did not consistently apply them for her. Resident #57 stated staff did not apply the compression wraps on Thursday (10/3/24) or Friday (10/04/24) and had yet to apply them today (10/07/24). Review of Resident #57's Treatment Administration Record (TAR) for October 2024 revealed the compression wraps were initialed as applied daily except for 10/03/24 and 10/04/24. Further review revealed Nurse #5 initialed the TAR as applying the compression wraps on 10/07/24. During an interview on 10/11/24 at 10:04 AM, the Wound Nurse revealed he worked the medication cart on 10/03/24 when he was on-call and could not recall if he had offered to apply Resident #57's compression wraps. He stated if he had, it would not have been until late in the afternoon. The Wound Nurse stated Resident #57 had told him that her compression wraps were not applied last Thursday (10/03/24) or Friday (10/04/25) and typically didn't get applied when he or the weekend Wound Nurse were not working. During a telephone interview on 10/11/24 at 12:54 PM, Nurse #5 revealed she had offered to apply Resident #57's compression wraps on 10/04/24 but she had refused. Nurse #5 stated she had meant to document the refusal on Resident #57's TAR but she must have got distracted and forgot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/11/24 at 1:43 PM, Nurse #6 revealed she was assigned to do treatments on 10/07/24 but did not have Resident #57 on her list of treatments completed that day. Nurse #5 confirmed it was her initials that were noted on Resident #57's TAR for 10/07/24 and explained it was initialed as completed by mistake because she did not apply Resident #57's compression wraps that day. During an interview on 10/11/24 at 4:25 PM, the Director of Nursing (DON) stated Resident #57 did not typically refuse to have her compression wraps applied by staff, she might delay having them put on until after her shower but not refuse completely. The DON was unaware Resident #57's compression wraps were not applied by staff on 10/3/24, 10/04/24 or 10/07/24. She stated she would expect for the physician order to be followed and if the treatment nurse was not doing treatments, hall nurses were responsible for checking the TAR and completing treatments.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on record review and interviews with residents, staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to ensure a resident's pain was assessed and that she received her pain medication to treat acute throbbing mouth pain from teeth being extracted and chronic constant aching and throbbing pain in her right hip for 1 of 3 residents reviewed for pain management (Resident #17). As a result of the resident not getting her pain medication as prescribed, her pain level increased to an 8 on a scale of 1 to 10 when her usual pain level was 0 to 3 when taking her pain medication as prescribed three times a day. The findings included: Resident #17 was admitted to the facility on [DATE] with diagnoses which included debility, arthritis, and chronic pain. The physician's order dated 10/25/23 revealed Resident #17 had an order to receive one tablet of oxycodone-Acetaminophen oral tablet 5-325 milligrams (mg) (a type of opioid analgesic consisted of oxycodone/acetaminophen that acted on the central nervous system to relieve pain) by mouth three times a day for pain. The medication was scheduled to be given at 8:00 AM, 2:00 PM and 8:00 PM. Review of Resident #17's Nurse Practitioner progress note dated 07/01/24, Resident #17's arthritis was described as polyosteoarthrits of multiple joints including right hip, left hip, bilateral knees and shoulders. According to the note the resident was being followed by the local pain clinic for assistance in managing her pain. Resident #17's topical pain patch was changed from as needed to scheduled one time a day to help with pain. Review of the physician's orders for August 2024 revealed Resident #17 was on the following medications for pain in addition to the oxycodone-acetaminophen oral tablet 5-325 mg by mouth three times a day: - Salonpas Pain Relieving External Patch 4% (Lidocaine) apply to right hip topically one time a day for hip pain with a start date of 07/02/24. Patch scheduled for 9:00 AM - Acetaminophen oral tablet give 1000 mg by mouth two times a day for chronic pain give as an alternating dose with oxycodone/acetaminophen with start date of 10/18/23. Tablets scheduled at 11:00 AM and 5:00 PM. - Diclofenac sodium external gel 1% (topical) apply 2 grams to left and right hip for arthritic pain two times daily. Scheduled for day and evening. - Diclofenac sodium external gel 1% (topical) apply 2 grams to right shoulder for arthritic pain two times daily. Scheduled for day and evening. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of a dental care note dated 08/01/24 for Resident #17 she had three teeth extracted on 08/01/24 at 12:46 PM. Teeth #9, #10, and #11 were extracted under local anesthetic and sutures placed for closure that would dissolve in 5 days. Resident #17 was given antibiotics prior to the dental appointment but no pain medication was administered. Review of Resident Council Meeting minutes dated 08/19/24 revealed during the meeting when residents were asked about New Business concerns, Resident #17 stated that she had not received her pain medications for 4 days the beginning of August 2024. The Medication Administration Record (MAR) for August 2024 revealed Resident #17 had not received her medication of oxycodone-acetaminophen 5-325 mg one tablet by mouth at 8:00 AM, 2:00 PM and 8:00 PM the following dates and times, the blocks on the MAR for these dates and times was blank and there was no indication of what her pain level was on these dates and times: - August 1 8:00 AM, 2:00 PM and 8:00 PM - August 2 8:00 AM, 2:00 PM and 8:00 PM - August 3 8:00 AM, 2:00 PM and 8:00 PM - August 4 8:00 AM, 2:00 PM and 8:00 PM - August 5 8:00 AM and 2:00 PM for a total of 14 doses missed Continued review of the MAR revealed on the following dates and times, Nurse #3 had taken care of Resident #17 and had not administered her Percocet and there was no indication of what her pain level was on these dates and times: - August 1 at 8:00 AM and 2:00 PM - August 3 at 8:00 AM, 2:00 PM and 8:00 PM - August 4 at 8:00 AM and 2:00 PM A telephone interview was attempted with Nurse #3; however, the number had been disconnected and Nurse #3 was no longer employed through the agency. Continued review of the MAR revealed on August 1 and August 2 at 8:00 PM Medication Aide (MA) #2 had taken care of Resident #17 and had not administered her Percocet on those days and times and there was no indication of what her pain level was on those dates and times. An interview on 10/10/24 at 3:31 PM with MA #2 revealed she did not recall the evening she cared for Resident #17 but stated usually if there were no medications available for a resident, she reported it to the nurse supervising her and the nurse would contact the pharmacy or the physician for orders. MA #2 stated if it was not signed out then she had not given the medication. She further stated she could not recall if the resident had complained of pain with not getting her narcotic medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Continued review of the MAR revealed on the following dates and times, Nurse #2 had taken care of Resident #17 and had not administered her Percocet on those dates and times and there was no indication of what her pain level was on those dates and times: - August 2 at 8:00 AM and 2:00 PM - August 5 at 8:00 AM and 2:00 PM A telephone interview on 10/10/24 at 4:00 PM with Nurse #2 revealed she couldn't recall the specifics but stated generally if a resident does not have their medication, she typically contacted the pharmacy and then if a script was needed, she would contact the Nurse Practitioner to send an electronic script to the pharmacy for the medication. Nurse #2 stated she couldn't recall if they had oxycodone with acetaminophen in their narcotic Emergency Kit but stated she felt like if they had she would have given it from the Emergency Kit. She further stated she could not recall if the resident had complained of pain with not getting her narcotic medication and could not recall if she had complained of mouth pain from having her teeth extracted. Continued review of the MAR revealed on August 4 at 8:00 PM Nurse #4 had taken care of Resident #17 and had not administered her Percocet on that day and time and there was no indication of what her pain level was at that time or if she had any acute mouth pain from her teeth being extracted. A telephone interview was attempted several times with Nurse #4 without success. Continued review of the MAR revealed on August 5 at 8:00 PM when Resident #17 received her pain medication her pain level was 8 on a scale of 1-10. The Emergency Medication Kit for Controlled Substances revealed there were no Percocet in the kit at the facility available to administer to residents. Review of the nursing progress notes revealed the following: - 08/02/24 at 11:54 PM resident verbalized she's in constant pain in her right hip at a level of 10 for the last 5 days and level 8 while talking with this nurse. - 08/03/24 at 03:56 AM resident awake at intervals tonight. Inquired about pain medications and informed it was on order and awaiting pharmacy to send it. A telephone interview was attempted several times with Nurse #7 who wrote the above progress notes without success. Review of Resident #17's significant change MDS dated [DATE] revealed she was cognitively intact and received scheduled pain medication but no as needed (prn) pain medication. The assessment also revealed the resident had almost constant pain at a level of 10 out of 1-10. Review of Resident #17's care plan last revised on 09/14/24 revealed a focus area for chronic pain related to impaired mobility, leukemia, diabetes mellitus, type II, arthritis and coronary artery disease. The interventions included in part, administering pain medication as per MD orders and note effectiveness, and notify physician if pain management is not effective. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview on 10/10/24 at 10:03 AM with Resident #17 revealed she had gone several days, like over 4 days without receiving her pain medication as ordered. She stated during that time she had an increase in her pain level to an 8 instead of a 0 to 3 with her medication. She described having a constant aching, throbbing pain in her right hip and aching pains throughout her body due to arthritis in her joints. Resident #17 also described a throbbing pain in her mouth due to her teeth being extracted and being without her pain medication. She stated the staff (couldn't remember names) kept telling her it was on order and had not come from the pharmacy and one nurse (couldn't remember name) finally told her it was too soon to refill her prescription for her pain medication. Resident #17 said they didn't offer her any other medication or treatment for her pain during those 4 1/2 days she went without her scheduled pain medication. The resident further said it made it difficult without her pain medication to get up during the day and found herself lying back down and sleeping more during the day and then having trouble sleeping at night. Resident #17 indicated she had not been offered ice or heat to help with her constant pain and had used her topical Biofreeze (topical pain relief product that uses menthol to soothe minor muscle and joint pain), patch and topical gel but none of them really helped the pain she had like her pain medication. A telephone interview on 10/10/24 at 12:12 PM with the Pharmacy providing medications to the facility revealed during a conversation with the Pharmacy Manager that on 07/11/24 90 tablets were sent to the facility for Resident #17. The Pharmacy Manager stated they had received a new electronic script on 08/02/24 and 08/04/24 for Resident #17 but it was too early to refill because the 07/11/24 order should have lasted until 08/10/24. Then on 08/05/24 they received an approval from Unit Manager #2 to refill the medication and to bill the facility and send the medication out on special delivery. The Pharmacy Manager explained the medication had gone out on the afternoon of 08/05/24 to the facility. An interview on 10/10/24 at 4:35 PM with the Medical Director (MD) revealed she was not aware that Resident #17 had missed 14 consecutive doses or her narcotic medication for chronic pain until just before this interview. She stated she was familiar with Resident #17 and her chronic pain and the acute pain she had suffered getting her teeth pulled during this time and her concern with the resident not receiving her pain medication for over 4 days would have been her increased intensity in her pain. The MD further stated the facility staff should have told the Nurse Practitioner that she was out of her pain medication so she could have given orders for something else in the meantime while awaiting her medication from the pharmacy. The MD indicated it should have been made clear to the Nurse Practitioner that the resident was completely out of her medications and not that she just needed a refill script. The MD further indicated Resident #17 should have had her medication to keep her pain at a level that was manageable. A telephone interview with the Nurse Practitioner (NP) caring for Resident #17 revealed she was unaware the resident had gone over 4 days in a row without her pain medication and had missed 14 consecutive doses. She stated she tried to stay on top of ordering her medications due to her chronic pain but said she had not been notified that she was completely out or had not received her medications for over 4 days. The NP stated she was surprised the resident had not mentioned it to her unless she just didn't see her during that time. She further stated her concern with Resident #17 not receiving her medications for that period would have been the increase in intensity of her pain because of the chronic nature of her pain and the acute pain she suffered getting her teeth extracted. The NP stated she should not be going that long without her medicine and that she would have expected the nursing staff to have called her and told her she was out of her medicine and not just that she needed a refill prescription. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piney Grove Nursing and Rehabilitation Center	728 Piney Grove Road 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 0697 Level of Harm - Actual harm Residents Affected - Few	An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) and Administrator revealed it was the expectation of the DON that resident's pain medications were administered as ordered by the providers. The DON further stated the nurses should have made it clear to the Nurse Practitioner that Resident #17 was out of her pain medication so the NP could have ordered additional medication to relieve the resident's acute pain from her teeth being extracted and chronic pain she was suffering in her hip and other joints.