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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piney Grove Nursing and Rehabilitation Center	728 Piney Grove Road 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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and resident and staff interviews, the facility failed to maintain Packaged Terminal Air Conditioner (PTAC) units in good condition in 8 of 26 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], Room#109, room [ROOM NUMBER], and room [ROOM NUMBER]) reviewed for a comfortable, safe, and homelike environment. The findings included: An observation of room [ROOM NUMBER] on 1/20/26 at 9:50 AM revealed 4 out of 5 slats on the PTAC unit contained a patchy black, irregularly shaped residue that covered 50% of the surface of left side of each slat. room [ROOM NUMBER] was occupied by 2 residents. An observation of room [ROOM NUMBER] on 1/20/26 at 9:58 AM revealed 5 out of 5 PTAC unit slats contained a patchy black, raised residue that covered 75% of the entire surface of each slat and the internal surface behind the vent slats. room [ROOM NUMBER] was occupied by 2 residents. On 1/20/26 at 10:15 AM an observation of room [ROOM NUMBER] revealed 4 out of 5 PTAC unit slats contained a patchy black, raised residue that covered 25% of the surface on left side of each slat. room [ROOM NUMBER] was occupied by 2 residents. An observation of Room# 106 on 1/20/26 at 10:32 AM revealed the base of the internal surface behind the slats contained brown, white and black particles that covered 75% of the area. room [ROOM NUMBER] was occupied by 2 residents. An observation of room [ROOM NUMBER] on 1/20/26 at 10:53 AM revealed the base of the internal surface behind the slats contained brown, white, and black particles that covered 50% of the area. room [ROOM NUMBER] was occupied by 2 residents. An observation of room [ROOM NUMBER] on 1/20/26 at 10:57 AM revealed 5 out of 5 PTAC unit slats contained a patchy, raised black residue that covered 50% of the surface of each slat. room [ROOM NUMBER] was occupied by 2 residents. An observation of room [ROOM NUMBER] on 1/20/26 at 11:12 AM revealed 5 out of 5 PTAC unit slats contained a patchy black, raised residue that covered 25 % of the entire surface of each slat. The base of the internal surface behind the vent slats was 75% covered with brown and black particles. room [ROOM NUMBER] was occupied by 2 residents. An observation of room [ROOM NUMBER] with 2 residents on 1/20/26 at 11:29 AM revealed 5 out of 5 PTAC unit slats contained a patchy black, raised residue that covered 50% of the entire surface of each slat. room [ROOM NUMBER] was occupied by 2 residents. An interview was conducted with the Director of Maintenance on 1/22/26 from 12:12 PM-12:42 PM. During this time, an observation was conducted with the Director of Maintenance of room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] and the issues observed on 1/20/26 remained. The Director of Maintenance stated staff were to report any damage/issues through the electronic tracking system. He shared he received immediate notification of staff reported issues on his phone app work order system once staff have entered a work order request. He stated he had not received notification of the PTAC issues in these rooms. The Director of Maintenance stated room rounds are done monthly with the corporate consultant to identify major (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY 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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	repairs. He stated he inspected each room in the facility once a week to determine if repairs were needed but looked at the PTAC units only when a monthly filter change was scheduled. He stated that he was unaware of the PTAC concerns for Resident Rooms #101, #102, #103, #106, #107, #109, #110, and #115 but the residue on the slats appeared to be caused by condensation produced by the units and then dust particles adhered and dried. He stated the particle build up on the base behind the slats was most likely from housekeeping when floors are clean floors particles fly into the register. He further stated cleaning of this area of the register was the responsibility of housekeeping; maintenance was only responsible for changing out the filters, which were done monthly. Housekeeping does the outside of the units, we do the inside. The Director of Maintenance was unable to describe a routine inspection or cleaning schedule for the affected areas of the PTAC units located in resident rooms. An interview and observations of room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] was conducted with the Director of Housekeeping on 1/22/26 PM from 12:54 PM-1:14 PM. She stated housekeeping touched all low and high touch areas in each room daily. This included the PTAC units but only the perimeter area. She stated monthly a deep clean was completed in each room and at that time she audited the completion of the task. When asked if she considered the unit slats and the base behind the slats inside or outside of the unit, she stated outside and that would fall to Maintenance. The Housekeeping Director was unable to describe a routine inspection or cleaning schedule for the affected areas of the PTAC units located in resident rooms. She stated that she was unaware of the concerns for the PTAC units for resident rooms #101, #102,#103, #106, #107,#109, #110, and #115. The Administrator was interviewed on 1/22/26 at 3:50 PM. He stated it was unacceptable to have dirty PTAC units in resident rooms. He stated it was the responsibility of the Maintenance Department to clean the base behind the slats and housekeeping to clean the slats during daily room cleaning, if needed. He stated he was unaware of this issue and did not know why Housekeeping and Maintenance Departments were unaware of who was responsible for cleaning each section of the PTAC units.