PRINTED: 02/22/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _				C 11/2016
	ROVIDER OR SUPPLIER	NSTON		907 CL	ET ADDRESS, CITY, STATE, ZIP CODE UNNINGHAM ROAD TON, NC 28501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTION SHOULD BE THE APPROPRIATE	
F 160 SS=B	FUNDS UPON DEAT Upon the death of a rideposited with the fact within 30 days the residence accounting of those for probate jurisdiction acceptate. This REQUIREMENT by: Based on documentate facility failed to forward expired resident's funding one (1) of five (5) expired reviewed. (Resident # The findings include: Resident #90 expired Social Security check into Resident #90's point of the 10/5/15 the facility de #90's account for the 10/5/15 the facility for resident's account to resident's estate. During an interview of facility Business Office Resident #90 expired facility for his cost of experience of the system automatically resident's cost of care Manager explained the side of the system automatically resident's cost of care Manager explained the side of the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's cost of care Manager explained the system automatically resident's care automatically resident's c	esident with a personal fund cility, the facility must convey sident's funds, and a final unds, to the individual or dministering the resident's is not met as evidenced ation and interviews, the rd the full balance of an ds to the Clerk of Court for irred resident fund accounts (#90). on 10/1/15. On 10/2/15 a for \$815.00 was deposited ersonal funds account. On bited \$785.00 from Resident resident's cost of care. On osed Resident balance of \$60.00 and on twarded the balance of the the Clerk of Court for the n 2/11/16 at 1:10 PM, the e Manager revealed on 10/1/15 and he owed the care. She revealed the data allocated the money to the extremely the care in the resident's check was at the resident's check was	F	160			
ABODATODY	<u> </u>	o his account and the money			TITLE		(X6) DATE

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 02/11/2016	
NAME OF PR	ROVIDER OR SUPPLIER	0.0000		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	02/	11/2016
SIGNATUR	RE HEALTHCARE OF KII	NSTON			CUNNINGHAM ROAD STON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 161 SS=C	account to the resider Office Manager stated the Corporate Office of to the facility before a 2/11/16, the facility ha from the Corporate O balance of the resider Court. During an interview o the Administrator of th not control policy. He #90's money was tran on 10/2/15 and the fa refund check from the stated the facility did do on their end. 483.10(c)(7) SURETY PERSONAL FUNDS The facility must purc otherwise provide ass Secretary, to assure to funds of residents dep This REQUIREMENT by: Based on staff interv facility failed to provid designated the oblige aggregate of the nam Department of Human	nsferred from the resident's nt's liability. The Business of the facility had to wait for so send a refund check back nything could be done. As of ad not received the check ffice in order to send the nt's account to the Clerk of n 02/11/2016 at 3:49 PM, ne facility revealed he could explained that Resident nsferred to the Clerk of Court cility was waiting for the excorporate Office. He what they were supposed to of BOND - SECURITY OF thase a surety bond, or surance satisfactory to the she security of all personal posited with the facility.		160			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 161	8/1/15, read in part, to finamed facility as Finsurance company a ourselves unto the Dorselves of North Carolin Thousand and \$ no/1 payment of which we executors, administrated benefit and use of the facility who deposit, a managed for them, refor in 42 CFR 483.10 Medicaid Requirement Facilities, TAG #F17. The Department of Hof Facility Services of does not have any profunds to individuals in addition TAG #171 as does not address the During an interview of Business Office Manasurety bond, but the dinsurance company we renewed. During another intervite the Business Office Manasurety bond, but the dinsurance company we renewed. During another intervite Business Office Manasurety bond, but the dinsurance company we renewed.	surety bond effective date the "Owner/Representative principal and named as Surety, hereby bind epartment of Human of Facility Services of the that in the penal sum of Eighty 100 Dollars (\$80,000), the bind ourselves, our heirs, thors and assigns for the the resident's funds of said of have deposited or resident's funds as provided (c) (7) and Medicare and that of Participation for Nursing 1. " uman Resources, Division of the State of North Carolina, tovisions for distributing of long term care facilities. In the mentioned in the document surety bond. In 2/11/16 at 9:35 AM the that ager stated she had the old company went with another when the surety bond was liew on 2/11/16 at 12:58 PM, Manager stated she would cone from the corporate send a copy of the surety surety bond from last year inguage in the surety bond. M, the Administrator was	F 1	61			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
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F 161	Continued From pag		F 1	61		
5 000	State of North Carol provision for distribution term care facilities.	of Facility Services of the ina, does not have any iting funds to individuals in ties in the case of loss.	5.0			
F 280 SS=D	483.20(d)(3), 483.10 PARTICIPATE PLAN	D(k)(2) RIGHT TO NNING CARE-REVISE CP	F 2	80		
	incompetent or othe incapacitated under	the laws of the State, to ng care and treatment or				
	within 7 days after the comprehensive asson interdisciplinary team physician, a register for the resident, and disciplines as determined, to the extent puther resident, the resident, the resident in the res	are plan must be developed the completion of the dessment; prepared by an and that includes the attending ared nurse with responsibility of their appropriate staff in mined by the resident's needs, racticable, the participation of ident's family or the resident's and periodically reviewed arm of qualified persons after				
	by: Based on record re facility failed to invite resident's family me Meeting and the fac results of the Care F #31) resident's fami	view and staff interviews, the e (1) of (3) (Resident #31) mbers to the Care Plan illity also failed to share the Plan with (1) of (3) (Resident by members reviewed ticipation in Care Planning.				

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F 280	Continued From pag	e 4	F 2	80			
	The findings include:						
	on 7/7/14 with diagno	iginally admitted to the facility oses including Cognitive orovascular Attack, and s.					
	Data Set (MDS) date Brief Interview for Me she had memory def	st recent Annual Minimum d 1/27/16, Resident #31's ental Status (BIMS) revealed icits. Resident #31 required assistance in most areas of g.					
	Plan Meeting was he Resident #31's family on the invitation lette receive the letter bed noted on the letter. F Minimum Data Set da	that Resident #31's Care ld on 12/24/15. Although member's name was noted r, the family member did not ause there was no address					
	not involved in decisi	/ member revealed she was ons regarding Resident she was not invited to attend					
	Minimum Data Set (N Resident #31's family to attend Resident #3 the family member hameetings. She reveal	member had been invited 31's Care Plan Meeting, but					

) DATE SURVEY COMPLETED				
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F 280	She shared that she letters to family memito attend Care Plan Melayed that they also members to determinafter Care Plan Meeting Resident #31's family assigned to her in ord the Care Plan Meeting presented a Care Plan Would document their members regarding Commenders of Care Plan Meeting Plan invitation letter with the facility did not have responsible party and review the Care Plan The MDS Nurse reversions of Care Plan Meeting During an interview of facility Social Worker #31's family members (POA) and had been the family members address in the record revealed the facility of Resident #31's Powed document. She stated #31's family member facility with the POA of family member had not stated the family member had not s	was responsible for sending bers inviting family members Meetings. The MDS Nurse assigned staff to call family in if they had any concerns ings. She stated that member had not been der to explain the results of g. The MDS Nurse in form which assigned staff in contact with family care Plan Meeting results. It would be a stated that member had not been der to explain the results of g. The MDS Nurse in form which assigned staff in contact with family care Plan Meeting results. It would be a stated that member had not one was assigned to with the family member. The facile of the state had she received notice in the facility. She revealed address should have been in the was not able to locate the had asked Resident several times to supply the documentation, however, the	F2	280		

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F 329 SS=E	not invited to attend Meeting nor was the regarding the results 483.25(I) DRUG RECUNNECESSARY DECEASE TO BEACH resident's drug unnecessary drugs. drug when used in eduplicate therapy); owithout adequate moindications for its use adverse consequences hould be reduced ocombinations of the Based on a comprehersident, the facility rwho have not used a given these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventions.	ent #31's family member was the resident's Care Plan family member informed of the Care Plan Meeting. GIMEN IS FREE FROM RUGS regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or enitoring; or without adequate except of the continued; or any reasons above. The ensure that residents entipsychotic drugs are not ease antipsychotic drug to treat a specific condition for the enductions, and	F 32			
	by: Based on record revices consulting pharmacis	T is not met as evidenced view, staff interview and st interview, the facility failed receiving an antipsychotic				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	COME	(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C / 11/2016
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	1 02	711/2010
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F 329	tardive dyskinesia (Tresidents reviewed for (Resident #71, and 7). The findings included 1. Resident # 71 was 7/16/14 and re-admit diagnoses including. A review of the Physrevealed Resident # milligrams (mg) 1 by for hallucinations." A review of the AIMS Resident 71 under shad incapacitation diagnoses including.	to perform an AIMS by movement scale) for cD) for two (2) of four (4) or antipsychotic drug use cO). d: s admitted to the facility tted on 11/25/14 with dementia with hallucinations. ician's orders dated 2/16/15 control (po) twice a day (bid) s dated 3/18/15 revealed ection D (Global Judgments) ue to abnormal movements. illed there were no other AIMS	F 32	29		
	dated 4/3/15 revealed antipsychotic medical with hallucinations and altered perceptions. A review of the Phare 9/23/15 through 1/26 reference to the AIM AIMS 3/15. The other AIMS with no date. The documenting that the concerning the AIMS. The most recent annual reveals are also and a second and a seco	Area Assessment (CAA) d Resident 71 triggered for ations related to dementia and she continued to have macy Progress Notes for 6/16 reflected three notes in S. One note documented for two notes documented for two notes documented for the were no notes a facility had been notified assessment was due.				

* 7		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 907 CUNNINGHAM ROAD KINSTON, NC 28501		2/11/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329	for hallucinations. A review of the most dated 1/21/16 reveal for adverse effects or related to daily used and hallucinations. resident would be from psychotropic medical intervention # 3 date negative outcomes and drug be reported to the A review of Medicati (MAR) for dates from Resident 71 was received for hallucinations. On 2/11/16 at 1:35 First stated the AIMS shows an AIMS evaluation of the AIMS evaluation of the AIMS evaluation of the AIMS evaluation. Resident 71 had not since March 2015. On 2/11/16 at 2:05 First consultant stated the resident on an antipute AIMS evaluation. Resident 71 had not since March 2015.	t recently updated care plan alled the resident was at risk of psychotropic medications of antipsychotic medication. The goal was that the ee from adverse effects of ations. A review of ed 5/12/15 revealed any associated with the use of the the physician. Ion Administration Record on 2/1/16 - 2/29/16 revealed beiving Risperdal .5 mg 1 po	F 32	29			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
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F 329	Continued From pag receiving an antipsyc evaluation every 6 m	chotic to have an AIMS	F 3	29		
	facility on 9/8/14 with Disorder with Psychological A review of a Physici read in part. " D/C (0.5mgs. twice daily for the content of the con	an 's order dated 2/11/16 discontinue) Risperdal or mood disorder with erdal syrup 1mg./ml., give 1				
	A review of the Abno Scale (AIMS) dated 3 #70 under section D severity of abnormal had no incapacitation movements and ther awareness of abnorm	rmal Involuntary Movement B/18/15 revealed Resident (Global Judgements) had no movements, the resident of due to abnormal e were no resident 's nal movements. Review of there were no other AIMS				
	5/19/15 revealed on receiving Seroquel 1 pharmacist consultar	cist consultant note dated 4/29/15 Resident #70 was 2.5 mgs. three times daily. A note dated 6/19/15, noted oquel was increased on nree times daily.				
	revealed on 7/1/15 R					
	Review of a pharmac	cist consultant note dated				

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F 329	Continued From page		F 32	29	
	9/24/15 recommende Review of a pharmac 10/28/15 recommend	ist consultant note dated			
	11/23/15, revealed or Seroquel dosage was	ist consultant note dated 1 11/20/15 Resident #70 ' s s changed to 25mgs. three macist recommended an			
	1/26/16, revealed on	ist consultant note dated 1/14/16, Seroquel was perdal started twice daily.			
	Data Set (MDS) date	ecent Quarterly Minimum d 1/7/16 revealed Resident chotic medication for a			
	revealed Resident #7 effects of psychotropi use of antipsychotic r resident would be free psychotropic medicat receive the least dosa psychotropic drug to a bility both mentally a intervention #2 dated physician any negativ use of drug and interv revealed discus/aims	ensure maximum functional and physically. A review of 2/23/15 revealed report to be outcomes associated with vention #7 dated 2/23/15 per protocol.			
		d (MAR) dated 2/1/16 aled Resident #70 was e 1mg/ml solution for a mood			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
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F 329	consulting pharmacis	n 2/11/16 at 1:35 PM the t stated the AIMS evaluation	F 3	29		
F 428 SS=E	regional facility nurse would expect every reantipsychotic medicate evaluation every 6 medical record and R AIMS evaluation since. During an interview of Director of Nursing (Expendication to have the months. She revealed an AIMS evaluation since. During an interview of Administrator stated heavy resident receiving medication to have almonths. 483.60(c) DRUG REGIRREGULAR, ACT of The drug regimen of reviewed at least once pharmacist. The pharmacist must the attending physicial	n 2/11/16 at 1:40 PM the consultant stated that she esident receiving an tion to have an AIMS onths. The regional facility he had reviewed the esident #70 had not had an e March 2015. n 2/11/16 at 1:50 PM the DON) stated her expectation dent on an antipsychotic e AIMS evaluation every 6 dt Resident #70 had not had ince March 2015. n 2/11/16 at 2:05 PM the his expectation would be that g an antipsychotic h AIMS evaluation every 6	F 4	28		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 428	Continued From pag	e 12	F 4	28			
	by: Based on record revices consulting pharmacis to perform AIMS (about movement scale) for (two) of 4 (four) sample antipsychotic medical Resident #70) by fail physician and the Dirthe facility staff had food (abnormal involuntar tardive dyskinesia (Tisampled residents remedications (Reside on the consulting phat that the facility staff prinvoluntary movement tardive (TD) for (1) or receiving antipsychological residence (TD). The findings included	tardive dyskinesia (TD) for 2 pled residents receiving tions (Resident #71 and ing to notify the attending rector of Nursing (DON) that ailed to perform an AIMS by movement scale) for (1) of 4 (four) preciving antipsychotic and #71) and by failing to act armacist recommendations perform an AIMS (abnormal and scale) for dyskinesia for 4 (four) sampled residents tic medications. (Resident discovered)					
	and re-admitted on 1 including dementia w A review of the Physrevealed Resident #7	ician 's orders dated 2/16/15 71 was ordered "Risperdal by mouth (po) twice a day					
	Resident #71 under s Judgments) had inca	dated 3/18/15 revealed section D (Global pacitation due to abnormal were no other AIMS located					

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON				STREET ADDRESS, CITY, STATE, ZIP COD 907 CUNNINGHAM ROAD KINSTON, NC 28501	 E	02/11/2010	
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F 428	dated 4/3/15 revealed antipsychotic medical with hallucinations and altered perceptions. A review of the Phare 9/23/15 through 1/26 reference to the AIM documented AIMS 3 documented AIMS work notes documenting to notified concerning to due. The most recent annotified concerning to due. The most recent annotified concerning to due. A review of the most dated 1/21/16 reveal for adverse effects of related to daily use of antidepressant medical to daily use of antidepressant medica	Area Assessment (CAA) d Resident #71 triggered for ations related to dementia and she continued to have macy Progress Notes for 1/16 reflected three notes in 1/16 sevaluation. One note 1/15. The other two notes 1/15. The other two notes 1/16 into date. There were no hat the facility had been the AIMS assessment was 1/16 under the facility had been the AIMS assessment was 1/16 revealed ceiving an antipsychotic inations. recently updated care planted the resident was at risk of psychotropic medications and hallucinations. The resident would be free from the psychotropic medications. A 1/16 at 1/16 revealed 1/1	F 4				
	A review of Medication (MAR) for dates from Resident 71 was recommended for hallucinations	on Administration Record n 2/1/16 - 2/29/16 revealed eiving Risperdal .5 mg 1 po					

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON				STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	02/11/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 428	evaluations and she stated the facility sho notified them. The FAIMS should be don During an interview 2/11/16 at 1:40 PM sexpect every resider medication to have a months. The facility reviewed the medication thave any AIMS of the Constant of the AIMS evaluation the pharmacist before usually come up to have any issues that would also send a Pfollow up. She state but did not remember notification. A follow were no Pharmacy Considered to Pharmacy Considere	y had been late with the AIMS had notified the facility. She buld have a copy if she had charmacist further stated the e every 6 months. with the facility consultant on the stated that she would not receiving an antipsychotic an AIMS evaluation every 6 consultant stated she had all record and Resident 71 did evaluations since 3/15. PM the Director of Nursing pectations would be for any sychotic medication to have as every 6 months. She stated be leaving the facility would her and let her know if there is needed to be resolved and harmacy Consultant note to dishe would review the notes are ever receiving any of up interview revealed there consultant notes concerning any of the Administrator stated all did be that any resident chotic have an AIMS months. He further stated the exit the facility know if a gifthe AIMS evaluation.	F 42			
		originally admitted to the n diagnoses including Mood osis and Dementia.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345365	B. WING_			C 02/11/2016	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON				STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		02/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	Continued From pag	e 15	F 4	28			
	read in part. "D/C (ditwice daily for mood	an's order dated 2/11/16 scontinue) Risperdal 0.5mgs. disorder with psychosis, start ./ml., give 1 mg. by mouth					
	Scale (AIMS) dated 3 #70 under section D severity of abnormal had no incapacitation movements and the of abnormal movements	rmal Involuntary Movement 3/18/15 revealed Resident (Global Judgements) had no movements, the resident of due to abnormal resident had no awareness ents. Review of the record no other AIMS evaluations					
	5/19/15 revealed on receiving Seroquel 1 pharmacist consultar	cist consultant note dated 4/29/15 Resident #70 was 2.5 mgs. three times daily. A note dated 6/19/15, noted oquel was increased on nree times daily.					
	revealed on 7/1/15 R						
	Review of a pharmace 9/24/15 recommended	cist consultant note dated ed an AIMS.					
	Review of a pharmad 10/28/15 recommend	cist consultant note dated ded an AIMS.					
Review of a pharmacist consultant note dated 11/23/15, revealed on 11/20/15 Resident #70 's Seroquel dosage was changed to 25mgs. three							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 02/11/2016	
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	'	22.1.1.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	Continued From pag	e 16	F 4	28			
	times daily. The phar AIMS.	macist recommended an					
	1/26/16, revealed on	cist consultant note dated 1/14/16, Seroquel was perdal started twice daily.					
	Data Set (MDS) date	ecent Quarterly Minimum d 1/7/16 revealed Resident /chotic medication for a					
	revealed Resident #7 effects of psychotrop use of antipsychotic resident would be fre psychotropic medica receive the least dos psychotropic drug to ability both mentally intervention #2 dated physician any negati	recent updated Care Plan 70 was at risk for adverse ic medication related to the medication. The goal was the refrom adverse effects of tions and the resident would age of the prescribed ensure maximum functional and physically. A review of 1 2/23/15 revealed report to we outcomes associated with vention #7 dated 2/23/15 s per protocol.					
	through 2/29/16 reve	d (MAR) dated 2/1/16 aled Resident #70 was e 1mg/ml solution for a mood					
	consulting pharmacis been late with the All notified the facility. S have a copy if she ha	ated the AIMS should be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 02/11/2016	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON				STREET ADDRESS, CITY, STATE, ZIP COD 907 CUNNINGHAM ROAD KINSTON, NC 28501		02/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 428	she would expect ever antipsychotic medicate evaluation every 6 mostated she had review Resident #70 did not since March 2015. During an interview or Director of Nursing (Dexpectations would be antipsychotic medicate evaluation every 6 most pharmacist before leasusually come up to he were any issues that would also send a Ph follow-up. She stated but did not remember notification. A follow-uwere no Pharmacy Coresident #70 's AIMS. During an interview or Administrator stated if that every resident remedication have an Amonths. He further states.	ith the facility nurse at 1:40 PM, she stated that ery resident receiving an ion to have an AIMS onths. The facility consultant wed the medical record and have any AIMS evaluations on 2/22/16 at 1:50 PM the eron any resident on an ion to have an AIMS onths. She stated the eving the facility would er and let her know if there needed to be resolved and armacist Consultant note to I she would review the notes	F 4	28			