	-	ID HUMAN SERVICES			FOI	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	LE CONSTRUCTION		TE SURVEY MPLETED
		345509	B. WING		0	C 3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD		
				ABERDEEN, NC 28315		
(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)	I SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
F 157	03/28/2017 where the F281 and F42 was ch 483.10(g)(14) NOTIF	Y OF CHANGES	F 15	.7		4/14/17
SS=D	(INJURY/DECLINE/R (g)(14) Notification of					
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-				
		ving the resident which as the potential for requiring ;				
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or				
	a need to discontinue	erse consequences, or to				
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).	-				
	(14)(i) of this section, all pertinent information	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					03/23/2017

**Electronically Signed** 

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/17/2017 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED C
		345509	B. WING		03	/03/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OD NURSING CENTER			915 PEE DEE ROAD		
RINGSWO	OD NORSING CENTER			ABERDEEN, NC 28315		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	Continued From page	e 1	F 15	.7		
		also promptly notify the dent representative, if any,				
	(A) A change in room as specified in §483.7	or roommate assignment 10(e)(6); or				
	· · · · ·	ent rights under Federal or ns as specified in paragraph				
	update the address (in phone number of the	record and periodically mailing and email) and resident representative(s). is not met as evidenced				
	staff interviews, the far physician of an incide	iew, physician interview and acility failed to notify the ent until the next day which hysician assessment and		F Tag 157 Notification of Cha All occurrence/incident reports reviewed daily, Monday-Friday, Clinical team in the Clinical Mon	will be , by the	
		oled resident (Resident		Meeting. Occurrences that hap Saturday and Sunday will be re the Morning Meeting on Monda	pen eviewed in	
	admitted on 8/19/201	vealed Resident #36 was 0 and expired on 2/17/2017.		Clinical Team consists of the Di Nursing, Staff Development Co the Wound Care Nurse and the Coordinator.	ordinator,	
	set (MDS) assessme	ive annual minimum data nt was dated 1/9/17. ded on the assessment as		All Licensed Nurses, including and prn staff, will be in-serviced		
	total care for all activi	ties of daily living and n intake. The resident's		Notification of Changes to the F by the Director Of Nursing (DO Staff Development Coordinator	Physician N) or the	
	hemorrhoids, constipuidad gastro-esophageal re	ation, dysphagia, insomnia, flux, polyarthritis, anxiety, entia with behaviors. The		In-services were started on 3/7, be completed by 4/7/17.		
		y, admitted to Hospice		The in-service will include: • Facility Policy for reporting		

Facility ID: 970412

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		ECONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /		COMPLETED
					с
		345509	B. WING		03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
KINGSWO	OD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 157	Continued From pag	le 2	F 157		
	The facility's occurre assurance tool (OI/G reviewed. The OI/G "report was provided administrative nurse During incontinence was taken out of Res bowel movement. T (centimeters) in leng a piece of wash cloth monitor bowel move sounds, a KUB (an a kidneys, ureters, and rounds. The residen chewing or gnawing The resident was un happened. The residen occurrence was repor report, 24-hour sum Director of Nursing ( cause determined to and confusion, and t attempt to eat foreig the occurrence form A review was conduct by Nurse #1 dated 2 designated as a late specified NA #1 repor	ance investigation - quality (AT) dated 2/7/17 was (AT documented that a 1 to the on-coming on 2/7/17 at 5:30 am. care a foreign cloth object sident #36's rectum with a he cloth was sized at 5-6 cm th with strings, believed to be n. Treatment provided was to ment output and bowel abdominal x-ray that included d bladder), and frequent it was observed at times on bed linen when in bed. able to verbalize what had dent's assessment was alert on at 95-96%. The orted on shift report, verbal mary, 24-hour board, and the DON) was notified. The root be the resident's dementia he resident was known to n objects." Nurse #1 signed on 2/7/17. cted of a nurse's note signed /7/17 at 11:00 am which was entry for 2/6/17. The note orted Resident #36 had a ed of what was believed to be n with stool in his rectum on		<ul> <li>occurrences/changes to physician timely manner</li> <li>Procedure</li> <li>All accidents/ incident must be reported to department supervisor incident form completed on the sh occurred.</li> <li>Nurse must complete their par incident report completely prior to of the shift.</li> <li>Physician is to be notified of a incident resulting in injury or unust occurrence after the resident is as Notification must take place prior thend of shift in which the incident on Document any new orders on a tere order sheet and transcribe approp A nurses' note is to be made in the medical record stating physician with notified.</li> <li>A new Incident Log was developed 3/8/17 and revised on 3/24/17. Thing is designed to validate notification will be updated daily Administrator or Director of Nursin Monday through Friday in the moriclinical meeting.</li> <li>The Administrator will bring the rest the Incident Log to the monthly QA meetings until 100% compliance is sustained for three months.</li> </ul>	e s and ift that it ift that if ift that ift that ift ift that ift that ift ift that ift that ift ift that ift that ift ift that ift that ift that ift ift that ift that ift ift that ift that ift ift that ift that ift ift that ift that ift that ift ift that ift that ift that ift ift that ift that ift that ift that ift ift that ift that ift that ift ift that ift that ift that ift that ift ift that ift that ift that ift that ift that ift ift that ift that ift that ift that ift that ift ift that ift that ift that ift that ift that ift that ift ift that ift th

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SUPPLIER/CLIA COMPLET COMPLET	ETED
345509 B. WING 03/03/	
815 PEE DEE ROAD	
ABERDEEN, NC 28315	
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE     C       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     C	(X5) COMPLETION DATE
F 157       Continued From page 3 On 2/27/17 at 4:40 pm, an interview was conducted with Nurse #1. She stated Physician #1 was notified of the incident via telephone on 27/17 and a KUB was ordered. Nurse #1 stated she believed Resident #36 was stool impacted. She stated Physician #1 ordered Lactudes 17 grams mixed in liquid twice a day for three days and the bowel protocol on 2/10/17.         On 3/1/17 at 10:35 am, an interview was conducted with Physician #1. The physician stated he discussed this incident with the Administrator and believed that the wash cloth was at the rectum. If the cloth was inside the rectum, this type of care was a violation of how residents are cleaned. Physician #1 stated that the consequences of having a cloth in the rectum, was pain and suffering.         An interview was conducted on 3/1/17 at 3:32 pm with the Director of Nursing (DON) who stated she was informed about the incident late in the day on 2/6/17, about 5:30 pm. Nurse #1 informed the DON as she was leaving. The DON instructed Nurse #1 to complete an incident report and instructed N #1 to write a statement. The DON stated Physician #1 stated may be out the was not on the incident until 27/17 by Nurse #1. Physician #1 gave orders for a KUB, enema and something else she could not remember, but the goal was to get Resident #36 's bowels moving.         An interview was conducted on 3/1/17 at 3:47 pm with the facility Administrator. The Administrator was made aware of the incident 36's rectum by NA #3 on 27/17 at 3:30 pm. The DON was aware of the incident 36's	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 103/2017
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWC	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157 F 159 SS=D	pm, but had not inform Physician #1 was not Administrator stated s incidences to her imm An interview was com- via telephone with Ph communication with fa #36's orders after the stated that he spoke to informed about the im- mid-day. The physici orders for constipation he had concerns, to ri- sure an investigation #1 stated he believed rectum, possibly durir unusual. Physician # remember if he spoke 483.10(f)(10)(i)-(iv) F/ PERSONAL FUNDS (f)(10)(i)If a resider personal funds with the authorization of a resid a fiduciary of the resider specified in this section (f)(10)(ii) Deposit of F (A) In general: Exception (ID)(ii)(B) of this section an interest bearing action separate from any of	med the Administrator. ified on 2/10/17. The she expected staff to report hediately. ducted on 3/3/17 at 9:19 am ysician #1 about his acility staff for Resident incident. Physician #1 to the nurse and was cident on 2/7/17 about an provided Nurse #1 n and KUB, and stated that ule out abuse and to make was conducted. Physician the cloth was placed in the ng dis-impaction, which was 1 stated he could not to the Director of Nursing. ACILITY MANAGEMENT OF the facility, upon written ident, the facility must act as dent's funds and hold, and account for the personal deposited with the facility, as on. unds. t as set out in paragraph (f) on, the facility must deposit al funds in excess of \$100 in count (or accounts) that is the facility's operating edits all interest earned on		157			4/14/17

Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			_		C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 159	for each resident's sh maintain a resident's sh maintain a resident's sh exceed \$100 in a non interest-bearing accou- (B) Residents whose The facility must depo- funds in excess of \$50 account (or accounts) the facility's operating all interest earned on account. (In pooled ac separate accounting f The facility must main not exceed \$50 in a n interest-bearing accou- (f)(10)(iii) Accounting (A) The facility must e system that assures a separate accounting personal funds entrus resident's behalf. (B) The system must of resident funds with funds of any person o (C)The individual fina available to the reside statements and upon (f)(10)(iv) Notice of ce must notify each reside	be a separate accounting are.) The facility must personal funds that do not -interest bearing account, unt, or petty cash fund. care is funded by Medicaid: osit the residents' personal 0 in an interest bearing that is separate from any of accounts, and that credits resident's funds to that cocunts, there must be a for each resident's share.) itain personal funds that do oninterest bearing account, unt, or petty cash fund. and records. establish and maintain a a full and complete and according to generally principles, of each resident's ited to the facility on the preclude any commingling facility funds or with the ther than another resident. ncial record must be ent through quarterly	F	159				

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345509	B. WING			C 03/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD			
RINGSWC	JOD NORSING CENTER			ABERDEEN, NC 28315	8315		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 159	reaches \$200 less that one person, specified the Act; and (B) That, if the amount to the value of the rest resources, reaches the person, the resident in Medicaid or SSI. This REQUIREMENT by: Based on resident in the facility failed to pretheir personal funds of residents reviewed we #39). The findings in Resident #39 was ad 10/20/15. The annual assessment dated 100 cognition was intact. An interview was con 2/27/17 at 11:22 AM. personal fund accourt banking hours were to he was unable to accourt banking hours were to he was unable to accourt banking hours were to he facility had been to Manager (BOM) since the Administrator indicate Resources Manager of the BOM. She com- personal fund accourt	an the SSI resource limit for in section 1611(a)(3)(B) of at in the account, in addition sident's other nonexempt the SSI resource limit for one may lose eligibility for the section of the section of the section terview and staff interview, ovide residents access to on the weekends for 1 of 8 ith personal funds (Resident cluded: mitted to the facility on I Minimum Data Set (MDS) /18/16 indicated his ducted with Resident #39 on He indicated he had a it with the facility. He stated Aonday through Friday and ess his funds over the	F 159	<ul> <li>F159 Facility Management of Resi Funds</li> <li>A new petty cash system has been implemented to ensure residents have access to their personal funds after business hours and on holidays and weekends. The petty cash system wil managed by the Nursing Supervisor of licensed nurse on the Tanglewood wir A new process has been put in place allow the residents to have access to personal funds after business hours, of weekends and holidays. Business Off Manager (BOM), personally spoke wit resident # 39 on 4/4/17 and explained him the process to access his funds of the weekends and holidays. He verbalized understanding.</li> <li>Residents were notified verbally durin the Resident Council Meeting on 4/3/2 by Activity Director. The Activity Direct and/or the BOM will also speak individually with residents having reside fund monies by 4/14/17. Families and Representatives of residents with dementia or cognitive impairment will</li> </ul>	e I be r the ig. to their on tice h to n 2017 cor lent		

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/17/2017 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COM	E SURVEY PLETED
		345509	B. WING			C 03/03/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			91	15 PEE DEE ROAD		
				A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 159	funds between 8:00 A through Friday. She needed money over t requested money on revealed the facility h	AM and 5:00 PM on Monday indicated that residents who	F	159	notified by letter from the Business Of Manager by 4/14/2017. A record of each transaction will be m by the Nursing Supervisor or Tanglew nurse at the time of the transaction. T BOM will reconcile the record daily Monday through Friday. Monday the B will reconcile transactions made on th week end to ensure the protection of resident funds. Licensed nurses, including weekend a prn nurses, will be in-serviced by the Administrator or the BOM on the new procedure by 4/14/17. The BOM or Administrator, will recond cash and withdrawals daily, Monday through Friday, and post such informa to each resident s ledger. She will all replace any cash withdrawn from the cash box. Any discrepancies or disput will be promptly reported to the Administrator. One of the department managers will randomly conduct an interview of five residents per week for four (4) consecutive weeks to determine if the were able to access their personal fur after normal business hours or during weekend or holidays. Random audits after hour and week end banking will continue monthly for a minimum of the (3) months. Audit results will be brought to the mod QAPI Meetings by the BOM. The plat correction and audit results will be reviewed by the QAPI Committee dur monthly meetings. The QAPI Commit will determine continued need for aud after four (4) months.	ade ood he BOM e and cile ation so petty tes (5) cy nds the of ree of ree onthly n of	

Event ID: 5IT011

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING				C 03/2017
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
KINGOWO			9'	15 PEE DEE ROAD			
KINGSWO	OD NURSING CENTER		A	BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIA (IENCY)		(X5) COMPLETION DATE
F 159	Continued From page	8	F 159	Completion Date is 4/1	4/17		
F 160 SS=B	483.10(f)(10)(v) CON FUNDS UPON DEAT	VEYANCE OF PERSONAL H	F 160				4/14/17
	(v) Conveyance upon death.	discharge, eviction, or					
	facility, the facility muresident's funds, and funds, to the resident, individual or probate j resident's estate, in a This REQUIREMENT by: Based on record revi facility failed to conve balances within 30 da for 4 of 4 residents re #75, and #129). The 1. Resident #30 was a 9/8/15. A review of th Resident #30 expired	hal fund deposited with the st convey within 30 days the a final accounting of those or in the case of death, the urisdiction administering the ccordance with State law. is not met as evidenced ew and staff interviews, the y personal fund account ys of the resident's death viewed (Residents #30, #38, findings included: admitted to the facility on he medical record indicated on 10/30/16. #30's personal fund account		F160 Conveyance of after Death The Business Office Ma check in the amount of Resident #30's estate of Review of the statement 38's account, found that required as a bookkeep recorded the deposit two	\$101.00 to on 3/21/2017. hts for Resident # at no refund is bing error had	а	
	at the time of her dear a check was written in Resident #30's Respo	he had a balance \$101.00 th on 10/30/16. On 2/17/17 in the amount of \$101.00 to possible Party (RP). This was nt #30's date of death.		A refund check will be s #75 in the amount of \$3 the Business Office Ma The Business Office Ma refund check in the am	3.00 on 4/6/17 by inager. anager sent a	y	
	Administrator on 3/1/1 the facility had been v Manager (BOM) since	17 at 2:37 PM. She stated vithout a Business Office e she began her position as he facility on 8/31/16. The		The Business Office Ma Administrator complete	nt #129 on 4/5/1 anager and		

Facility ID: 970412

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLF	CONSTRUCTION	(X3) DATE	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
							С
		345509	B. WING			03	/03/2017
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
KINCSWO	OD NURSING CENTER			91	5 PEE DEE ROAD		
RINGSWO	OD NORSING CENTER			A	BERDEEN, NC 28315		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 160	Continued From page	9	F 1	60			
		ed she and the Human		00	discharged residents in the last six		
		had been sharing the duties			months on 3/22/17. Of 64 residents		
	of the BOM.	0			discharged 6 residents were identified	to	
					still have funds in their Resident Trust		
		as conducted with the			Fund past 30 days. All funds were		
	Administrator on 3/1/				conveyed to residents on 3/21/2017 by	y the	
		tion was for the conveyance			Business Office Manager.		
	of personal fund acco	days of the resident's date of			The new Pusiness Office Manager, wh		
		the facility had an as needed			The new Business Office Manager, wh started in February 2017, was trained		
	(PRN) staff member a	-			the facility Administrator and outgoing	<i>by</i>	
	conveyance of persor				Business Office Manager on policy an	d	
	, ,				procedures, to include the Resident Tr		
	An interview was con	ducted with PRN			Fund. Training was conducted from		
	Administrative Staff #	1 on 3/1/17 at 5:35 PM.			February 9, 2017 to 3/21/17.		
		orked about 6-8 hours per					
	-	sisting with business office			The facility Administrator will conduct		
		e began this PRN work per of 2016. She indicated			audits of discharged residents who ha Resident Trust Fund weekly for four (4		
	her job duties include				weeks, then monthly for three (3) mon		
		It balances for residents who			to ensure any trust fund money is		
	•	ported she conveyed the			conveyed to the resident, responsible		
		t balances to the Clerk of			party or estate.		
	Courts within 30 days	s of the resident's date of					
	death.				The plan of correction action(s) will be		
	<b></b>				monitored at the QAPI meeting for a		
		RN Administrative Staff #1			minimum of four (4) months. Audit res		
		at 5:38 PM. Resident #30's 16), the personal fund			will be taken to monthly QAPI meeting the Business Office Manager.	sby	
	•	th a balance of \$101.00 on			the busiliess Onice Manager.		
		01.00 check dated 2/17/17					
		Resident #30's RP were					
	reviewed with PRN A	dministrative Staff #1. She					
		ance of funds was late. She					
		nveyed the funds to Resident					
		to the Clerk of Courts. She					
		have conveyed the funds to					
	Cierk of Courts within	1 30 days of Resident #30's					

Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMP	SURVEY LETED	
		345509	B. WING _				C 03/2017	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD	<u> </u>		
KINGSWO	OD NURSING CENTER				BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 160	Continued From page	9 10	F 1	60				
	facility on 7/18/13 and 10/10/16. A review of	nitially admitted to the I readmitted to the facility on f the medical record 8 expired on 10/18/16.						
	statement indicated s at the time of her dea a check was written ir	#38's personal fund account he had a balance of \$39.35 th on 10/18/16. On 2/21/17 in the amount of \$39.35 to This was 127 days after of death.						
	the facility had been w began her position as facility on 8/31/16. Th	17 at 2:37 PM. She stated vithout a BOM since she the Administrator at the ne Administrator indicated Resources Manager had						
	of personal fund acco completed within 30 c	17 at 3:40 PM. She tion was for the conveyance unt balances to be lays of the resident's date of the facility had a PRN staff						
	She indicated she wo week at the facility as tasks. She stated she sometime in Septemb her job duties include personal fund account	1 on 3/1/17 at 5:35 PM. rked about 6-8 hours per sisting with business office began this PRN work per of 2016. She indicated						

Facility ID: 970412

If continuation sheet Page 11 of 160

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345509	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 160	within 30 days of the f The interview with PR continued on 3/1/17 a date of death (10/18/' account statement with 10/18/16, and the \$39 that was made out to reviewed with PRN Ad revealed this conveya also revealed she corr #38's RP rather than indicated she should Clerk of Courts within date of death. 3. Resident #129 was 3/8/15. A review of th Resident #129 expire A review of Resident # account statement ind \$1,028.76 at the time On 10/18/16 a payme deducted from Reside Patient Liability. This Resident #129's account An interview was conf Administrator on 3/1/' the facility had been w began her position as facility on 8/31/16. Th	s to the Clerk of Courts resident's date of death. RN Administrative Staff #1 at 5:39 PM. Resident #38's 16), the personal fund th a balance of \$39.35 on 0.35 check dated 2/21/17 Resident #38's RP were dministrative Staff #1. She ance of funds was late. She hveyed the funds to Resident to the Clerk of Courts. She have conveyed the funds to 30 days of Resident #38's admitted to the facility on he medical record indicated d on 9/29/16. #129's personal fund dicated she had a balance of of her death on 9/29/16. ent of \$1,028.76 was ent #129's account for deduction depleted ount. ducted with the 17 at 2:37 PM. She stated without a BOM since she is the Administrator at the he Administrator indicated Resources Manager had es of the BOM.	F	160			

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/17/2017 APPROVED ). 0938-0391	
STATEMENT OF DEFICIEN AND PLAN OF CORRECTI	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345509	B. WING					C 03/2017	
NAME OF PROVIDER OF	R SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE			
KINGSWOOD NURS	ING CENTER				15 PEE DEE ROAD ABERDEEN, NC 28315				
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
Adminis indicated of perso complet death. S member persona An intern Adminis She indi week at tasks. S sometim her job o persona expired. fund acc within 30 The inter continue date of o account 9/29/16, for Patie were rev She indi resident Liability balance revealed suppose resident should h within 30	d her expecta nal fund acco ed within 30 c She reported : assisting with I funds. view was con- trative Staff # cated she wo the facility as She stated she be in Septemb duties include I fund accoun She reported count balance 0 days of the in erview with PR ed on 3/1/17 a death (9/29/16 statement with and the 10/1 ent Liability fro viewed with P cated there w 's family requipayment was prior to the co d she was awa ed to be made had died. Sh nave conveyed 0 days of Res	e 12 17 at 3:40 PM. She tion was for the conveyance unt balances to be lays of the resident's date of the facility had a PRN staff in the conveyance of ducted with PRN 1 on 3/1/17 at 5:35 PM. rked about 6-8 hours per sisting with business office e began this PRN work ber of 2016. She indicated d the conveyance of t balances for residents d she conveyed the personal s to the Clerk of Courts resident's date of death. 2N Administrative Staff #1 tt 5:40 PM. Resident #129's 6), the personal fund th a balance of \$1,028.76 on 8/16 \$1,028.76 deduction om Resident #129's account RN Administrative Staff #1. rere occasions when the ested that the Patient deducted from the account onveyance of funds. She are that no deductions were e for Patient Liability after a he also revealed the balance d to the Clerk of Courts ident #129's date of death.	F	160					

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345509	B. WING		_		C 03/2017	
NAME OF PF	ROVIDER OR SUPPLIER		- <u>-</u>	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
KINGSWO	OD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 160	A review of Resident is statement indicated h the time of his death of payment of \$3.00 was #75's account for Pati depleted Resident #7 An interview was cond Administrator on 3/1/1 the facility had been w began her position as facility on 8/31/16. Th she and the Human R been sharing the dution A second interview was Administrator on 3/1/1 indicated her expecta of personal fund accoor completed within 30 of death. She reported to member assisting with personal funds. An interview was cond Administrative Staff # She indicated she wo week at the facility as tasks. She stated she sometime in Septemb her job duties include personal fund account expired. She reported fund account balance	<ul> <li>'5 expired on 12/13/16.</li> <li>#75's personal fund account e had a balance of \$3.00 at on 12/13/16. On 1/17/17 a s deducted from Resident ient Liability. This deduction 5's account.</li> <li>ducted with the 17 at 2:37 PM. She stated without a BOM since she the Administrator indicated Resources Manager had es of the BOM.</li> <li>as conducted with the 17 at 3:40 PM. She tion was for the conveyance unt balances to be lays of the resident's date of the facility had a PRN staff in the conveyance of</li> <li>ducted with PRN 1 on 3/1/17 at 5:35 PM. rked about 6-8 hours per sisting with business office e began this PRN work per of 2016. She indicated</li> </ul>	F 160		DEFICIENCY)			
	The interview with PR	N Administrative Staff #1						

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	-	D HUMAN SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SU COMPLE	
		345509	B. WING		_		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 160 F 166 SS=D	date of death (12/13/1 account statement with 12/13/16, and the 1/1 Patient Liability from F reviewed with PRN Ac- indicated there were of resident's family requi- Liability payment was balance prior to the of revealed she was awa supposed to be made resident had died. Sr should have conveyed within 30 days of Res 483.10(j)(2)-(4) RIGH TO RESOLVE GRIEV (j)(2) The resident has must make prompt eff grievances the reside with this paragraph. (j)(3) The facility must to file a grievance or of resident. (j)(4) The facility must to ensure the prompt regarding the resident paragraph. Upon requi a copy of the grievance (i) Notifying resident in postings in prominent facility of the right to f	tt 5:41 PM. Resident #75's 16), the personal fund th a balance of \$3.00 on 7/17 \$3.00 deduction for Resident #75's account were dministrative Staff #1. She boccasions when the ested that the Patient deducted from the account onveyance of funds. She are that no deductions were for Patient Liability after a ne also revealed the balance d to the Clerk of Courts ident #75's date of death. T TO PROMPT EFFORTS YANCES as the right to and the facility forts by the facility to resolve nt may have, in accordance cestablish a grievance policy resolution of all grievances ts' rights contained in this uest, the provider must give to policy to the resident. The include: ndividually or through locations throughout the	F 16				4/14/17

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345509	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	•				(X5) COMPLETION DATE
F 166	grievances anonymou of the grievance offici can be filed, that is, h address (mailing and number; a reasonable completing the review to obtain a written ded grievance; and the co- independent entities w be filed, that is, the pe Quality Improvement Agency and State Loo program or protection (ii) Identifying a Griev responsible for overse receiving and tracking conclusions; leading a by the facility; maintai information associate example, the identity grievances submitted written grievance dec coordinating with state necessary in light of se (iii) As necessary, tak prevent further potent right while the alleged investigated; (iv) Consistent with §4 reporting all alleged v abuse, including injur and/or misappropriatia anyone furnishing ser	usly; the contact information al with whom a grievance is or her name, business email) and business phone e expected time frame for v of the grievance; the right cision regarding his or her intact information of with whom grievances may ertinent State agency, Organization, State Survey ng-Term Care Ombudsman and advocacy system; ance Official who is eeing the grievance process, g grievances through to their any necessary investigations ining the confidentiality of all d with grievances, for of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as specific allegations; ing immediate action to tial violations of any resident d violation is being 483.12(c)(1), immediately iolations involving neglect, ies of unknown source, on of resident property, by vices on behalf of the histrator of the provider; and	F	166			

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		ID HUMAN SERVICES				FORM	APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING		COMPLETED	
		345509	B. WING				C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	03/	03/2017
-					915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER				ABERDEEN, NC 28315		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	(	Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG	RECOLATORY ON		IAG		DEFICIENCY)	ΠĽ	
F 166	Continued From page	e 16	F	166	5		
	(v) Ensuring that all w	ritten grievance decisions					
		rievance was received, a					
		of the resident's grievance,					
	-	estigate the grievance, a					
		nent findings or conclusions					
		t's concerns(s), a statement evance was confirmed or not					
	•	ctive action taken or to be					
	-	s a result of the grievance,					
		en decision was issued;					
	(vi) Taking appropriate	e corrective action in					
		e law if the alleged violation					
	-	s is confirmed by the facility					
		having jurisdiction, such as					
		ncy, Quality Improvement law enforcement agency					
		or any of these residents'					
	rights within its area of	-					
	(vii) Maintaining evide	ence demonstrating the					
		s for a period of no less than					
	3 years from the issue	ance of the grievance					
	decision.						
		is not met as evidenced					
	by: Based on record revi	iew and resident and staff			F166 Resolve Grievances		
	interview, the facility f				A grievance form was filled out for		
		ot notifying the person filing			resident #72 on 2/2/17 by the Social		
		esult of the investigation and			Worker. The grievance for resident #7		
	the resolution to the g	-			was investigated 2/3/17-2/8/17 by Dire		
		olving the grievance filed for			of Nursing. Resolution was determined	d	
		26) of 2 sampled residents			on 2/8/17 by DON. DON, notified the		
	reviewed for grievanc	es. Findings included:			resident of the resolution on 2/8/17 at 2:40pm as validated by DON on		
	The facility's arievance	e policy dated 12/30/16 was			3/28/2017.		
		read in part "grievances					
		y to a staff member who will			A grievance form for Resident # 26 wa	s	

Facility ID: 970412

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			0.00			OMB NC	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
	-		A. BUILDIN	G			C
		345509	B. WING				
		343303			REET ADDRESS, CITY, STATE, ZIP CODE	03/	03/2017
NAME OF P	ROVIDER OR SUPPLIER						
KINGSWO	OOD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315		
		ATEMENT OF DEFICIENCIES					()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 166	Continued From page	e 17	F 16	66			
		evance form. All grievance			completed on 2/6/17 by the former So	cial	
		rded to the Social Worker			Worker. It was investigated and		
	Coordinator (SWC).	The SWC will review and			corrective action completed on 2/6/17.		
		e form will be brought to the			The Director of Nursing notified reside		
	• •	eview. The grievance form			#26 s son on $4/4/17$ of the action take		
	will then be given to t				The son confirmed this was addressed		
		rea. The grievance will be lution achieved. Resolution			and he was previously notified in Febr 2017. The January grievance log for	uary	
		on the grievance form.			Resident #72 s Notification of results		
		grievance form will be			section was completed by the		
		Grievances must be			Administrator in February 2017.		
	resolved within 5 wor	king days of the date the					
	report is filed."				Grievance Policy was revised to reflect		
					1) Written grievance decisions includ		
					the date the grievance was received, a	3	
	1 Resident # 72 was	admitted to the facility on			summary statement of the residents grievance, the steps taken to investiga	ite	
	86/16 with multiple di				the grievance, a summary of the pertir		
		elopathy (degenerative joint			findings or conclusions regarding the		
		on. The quarterly Minimum			residents concern(s), a statement as to	D	
	Data Set (MDS) asse	ssment dated 1/14/17			whether the grievance was confirmed	or	
	indicated that Reside				not confirmed, any corrective action ta		
	cognitive impairment.				or to be taken by the facility because o		
	On 2/27/17 at 12 Nor	n Resident # 72 was			the grievance, and the date the written	1	
		on, Resident # 72 was ted that she had concerns			decision was issued. 2) The person filing the grievance,		
		inistering her medications			resident and/or resident s representa	tive	
	on time especially he	-			will be informed of the resolution by the		
		-			Social Services Director or Administration	tor.	
		M, Resident # 72 was again			3) A new grievance log was develop	ed	
		med that she had concerns			and implemented in February 2017.		
		sing her medications on time			An in convice for all staff including and		
		edication. She added that concerns to the staff but			An in-service for all staff, including pro		
		ne about it. Resident # 72			and weekend staff, regarding grievanc process will be done by 4/14/2017. Th		
		had a concern with a staff			in-services will be presented by the So		
		alled for a pain medication			Worker and/or Administrator.		
		ting. The night nurse came					
	in and put the medica	ation on top of the over the			The Social Services Director and/or		

Facility ID: 970412

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES			FOR	D: 04/17/2017 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345509	B. WING			C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315		
(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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 166	bed table. The medic She called again and She told the nurse that medication. The nurse resident's chest and le was unable to rememinic indicated that she had The grievance log wa 2017 grievance log wa 2017 grievance log lis The log revealed that grievance on 1/2/17. was "concerns with st date resolved were bl The February 2017 gr # 72's name. The log had filed a grievance grievance/complaint windicated that the grie 2/8/17. The grievance form dd Resident #72 had file staff member. The gr and corrective action At the bottom of the fo "person making grieva result, yes or no and to person notified." This answered. On 3/1/17 at 10:25 AM (DON) was interviewed the resident's name with 2017 grievance log th grievance form but the	ation was out of her reach. the same nurse came in. at she could not reach the e placed the medication on eff the room. Resident # 72 ber the exact date of the of the nurse but she d reported the nurse. s reviewed. The January ted Resident # 72's name. Resident # 72 had filed a The grievance/complaint aff". The resolution and the ank. rievance log listed Resident revealed that Resident # 72 on 2/2/17. The vas"nursing". The log vance was resolved on ated 2/2/17 indicated that d a grievance regarding a ievance was investigated was completed on 2/8/17. orm, there was a statement ance has been notified of he date, time and name of	F 166		nthly for eviewed olution ification e ke ke e QAPI ion of	

Facility ID: 970412

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		D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE			
		345509	B. WING			C 03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 166	resolution made. The she had investigated Resident # 72 in Febr investigation, the form who would then notify grievance of the result corrective action. The grievance form dated that the person who fin notified of the result of corrective action. The was no longer employ SWC was not availab 2. Resident #26 was 1/26/17 and discharge 2/13/17. Cumulative squamous cell carcino syndrome and liver tra A physician's order da order for Erivedge (m cell carcinoma) 150 m not send-family to pro An Admission Minimu indicated Resident #2 in cognition. A review of the Febru Administration Record no documentation tha Erivedge on 2/1/17, 2 On 3/1/17 at 9:36AM, conducted with Resid He stated the medica taken to the facility or	e DON also indicated that the grievance filed by uary 2017 and after the was forwarded to the SWC the person filing the t of the investigation and the e DON reviewed the 2/2/17 and acknowledged led the grievance was not f the investigation and the DON stated that the SWC yed at the facility. le for interview. admitted to the facility ed to the hospital on diagnoses included: oma of the ear, chronic pain ansplant. ated 1/31/17 revealed an edication to treat squamous hilligrams by mouth daily. Do wide. m Data Set dated 2/1/17 66 was moderately impaired	F	166				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPLETED		
		345509	B. WING				C 03/2017	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	00/2011	
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD			
RINGSWO	OD NORSING CENTER				ABERDEEN, NC 28315			
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	F	(X5) COMPLETION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX         (EACH CORRECTIVE ACTION SHOULD BE           TAG         CROSS-REFERENCED TO THE APPROPRIATE			DATE		
					DEFICIENCY)			
F 166	Continued From none			4.04				
F 100	Continued From page		F	166	6			
		to take that medication thy medication that could						
		portant it was for him to						
	receive it. The family							
		o make sure Resident #26						
	• •	cine and it wasn't on the						
		mber said he spoke to the n 1/31/17 and was informed						
		order to administer the						
	medication. She info	rmed the family member						
	-	order and she reassured						
		δ would get his medication m. The family member						
	•	e MAR on 2/3/17 and noted						
		d only received Erivedge one						
		On 2/6/17, he said he called						
	the facility and asked							
		he social worker at that time uation to her. He said he						
		er to file a grievance for him						
		she would file the grievance						
	at that time. He stated	d he never heard from the						
	facility as to a resolut	ion to his concern.						
	A review of the grieva	ances for January and						
	-	led no grievances were filed						
	on behalf or by Resid	-						
	The social worker wh	o was at the facility on						
	2/6/17 was no longer	-						
		,						
	On 3/2/17 at 10:25AM							
		irector of Nursing. She						
	•••••	nce policy, a grievance the staff member who took						
	the complaint. If the							
		ould not be a grievance file.						
	However, if someone	asked that a grievance be						
	filled out, one would b	be filled out at the time the						

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STATEMENT OF DEFICIENCIES AND PLANT OF CORRECTION     (M) PLANTIFICATION NUMBER IDENTIFICATION NUMBER 345599     (M) PLANTIFICATION A BUILINNG COMPLETE A BUILINNG EXAMPLE OF PROVIDER OR SUPPLIE TO 2 BUILINNG     (M) PLANTIFICATION A BUILINNG EXAMPLE OF PROVIDER OR SUPPLIE TO 2 BUILINNG     (M) PLANTIFICATION A BUILINNG EXAMPLE OF PROVIDER OR SUPPLIE TO 2 BUILINNG     (M) PLANTIFICATION A BUILINNG EXAMPLE OF PROVIDER OR SUPPLIE TO 2 BUILINNG SUBMARY STATEMENT OF DEFICIENCIES     (M) PLANTIFICATION A BUILINNG EXAMPLE OF PROVIDER SUPPLIE TO 2 BUILINNG SUBMARY STATEMENT OF DEFICIENCIES SUBMARY STATEMENT OF SUBMARY STATEMENT SUBMARY STATEME		-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
34559         E. WNO         03/03/2017           INME OF PROVIDER OR SUPPLIER         STREET ADDRESS. CITY, STATE. JP CODE SIGNED ADDRESS. CITY, STATE. JP CODE SIGNED ADDRESS. CITY, STATE. JP CODE SIGNED ADDRESS ADDRESS. CITY, STATE. JP CODE SIGNED ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS STREET ADDRESS. CITY, STATE. JP CODE SIGNED ADDRESS ADDR				· /			COMF	LETED
INREGWOOD NURSING CENTER     915 FEE DEE ROAD ABERDEEN, NC 2315       CMUID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES TAG     DEFICIENCY MUST BE PRECEDED BY FULL REQUIRING YOUR SECTION (CLOUD TO THE STORMTION)       F 166     Continued From page 21 concern was voiced. The grievance is turned in to the social worker who logs it in the grievance log and it would be given to the appropriate department head to address and handle. She said the facility had 5 days to investigate the grievance. There was a section at the bottom to document the date and time the person filing the grievance was a section at the bottom to document the date and time the person filing the grievance was a section at the bottom to document the date and time the person filing the grievance was a section at the bottom to document the date and time the person filing the grievance was a section at the bottom to document the date and time the person filing the grievance was a section at the bottom to document the date and time the person filing the grievance was a section at the bottom to document the date and time the person filing the grievance was a section at the bottom to document when she informed them on the bottom of the grievance form.     F 166       The Director of Nursing stated Resident #26'S family member came to her directly regarding the Erivedge. She saided she told him the medication and was informed it was an encologist. The family member taked it was provided by the family and was already in the building locked in the medication cart. She obtained an Physician's order on 131/17 and notified the filied virte 280 on 131/17 and did not know why twas not on the grievance log or in the grievance book.     F 225     4/14/17			345509	B. WING	 	_		
KINGSWOOD NURSING CENTER     ABERDEEN, NC 28315       (A) ID PRETIX     BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENT WIST & FERCEDED BY FULL RECOLLATORY OR LSC DENTFYING INFORMATION)     ID PROVIDERS FUND CORRECTIVE ATTON HOULD BC CROSS-AEFLERICE TO THE APPROPRIATE DEFICIENCY     Continued From page 21 CORSS-AEFLERICE TO THE APPROPRIATE DEFICIENCY     Continued From page 21 Concern was voiced. The grievance is turned in to the social worker who logs it in the grievance log and it would be given to the appropriate department head to address and handle. She said the facility had 5 days to investigate the grievance. There was a section at the bottom to document the date and time the person filing the grievance was notified. The Director of Nursing stated the grievances she had written had been obtained verably or by phone. After the investigation had been completed, the grievance was griven back to the social worker who would inform the residuent responsible party family of the resolution and document twhen she informed them on the bottom of the grievance form.     The Director of Nursing stated Resident #28's family member care to the directly regarding the Erivedge. She saids the asked the family member who ordered the medication and was informed it was an oncologia's order on 13/17 and notified the family member stated it was provided by the family and was already in the building locked in the medication cart. She obtained a physician's order on 13/17 and notified the family member the order had been obtained and Resident #28 on 13/17/1 and did not know why it was not on the grievance log or in the grievance book.     F 225     4/14/17	NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
PREFIX TAG         CEACH OBFICENCY MUST BE PRECEDED BY FULL REGULTATORY OR I.SC IDENTIFYING INFORMATION)         PREFIX TAG         CEACH OBFICITIVE AFTION SHOULD BE CROSS REFERENCES TO THE APPROPRIATE         COMMETTION DEFICIENCY           F 166         Continued From page 21 concern was voiced. The grievance is turned in the social worker who logs in the grievance log and it would be given to the appropriate department head to address and handle. She said the facility had 5 days to investigate the grievance. There was a section at the bottom to document the date and time the person filing the grievances she had written had been obtained werbaily or by phone. After the investigation had been completed, the grievance was given back to the social worker who would inform the residuent and document the date. The Birector of Nursing stated the grievances she had written had been obtained werbaily or by phone. After the investigation had been completed the grievance was given back to the social worker who would inform the residuent and document the date. The Director of Nursing stated Resident #20's family member came to her directly regarding the Erivedge. She said she asked the family member who ordered the medication and was informed it was an oncologist. The family member told her he obtained une medication from the pharmaceutical company. She stated she told him the medication would not be covered by insurance and the family member told her he building locked in the medication cart. She obtained and Physician's order on 1/31/17 and did not know why it was not on the grievance to tained of physician's order on 1/31/17 and did not know why it was not on the grievance provided by the family member the order had been obtained and Resident #26 would receive the medication. The Director of Nursing said she filled out grievance for Resident #26 would receive the medication. The Director of Nursing said she filled out grievan	KINGSWO	OD NURSING CENTER						
<ul> <li>concern was volced. The grievance is turned in to the social worker who logs it in the grievance log and it would be given to the appropriate department head to address and handle. She said the facility had 5 days to investigate the grievance. There was a section at the bottom to document the date and time the person filing the grievance was notified. The Director of Nursing stated the grievance she had written had been obtained verbally or by phone. After the investigation had been completed, the grievance was given back to the social worker who would inform the resident/ responsible party/ family of the resolution and document who she informed them on the bottom of the grievance form.</li> <li>The Director of Nursing stated Resident #26's family member can to her directly regarding the Erivedge. She said she asked the family member who ordered the medication from the pharmaceutical company. She stated is bail of the pharmaceutical company. She stated is bail on the bottom of the family and was already in the building locked in the medication cart. She obtained a physician's order on 1/31/17 and did not know why it was not on the grievance is point with grievance by insurance and the family member table en obtained and Resident #26 on 1/31/17 and did not know why it was not on the grievance is point the grievance for Resident #26 on 1/31/17 and did not know why it was not on the grievance is point the grievance for Resident #26 on 1/31/17 and did not know why it was not on the grievance is point the grievance for Resident #26 on 1/31/17 and did not know why it was not on the grievance is point the grievance for Resident #26 on 1/31/17 and did not know why it was not on the grievance is point the grievance for Resident #26 on 1/31/17 and did not know why it was not on the grievance is go in the grievance for Resident #26 on 1/31/17 and did not know why it was not on the grievance is go in the grievance for Resident #26 on 1/31/17 and did not know why it was not on the grievance is go in the gri</li></ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		COMPLETION
	F 225	concern was voiced. to the social worker w log and it would be gi department head to a said the facility had 5 grievance. There was document the date an grievance was notified stated the grievances obtained verbally or b investigation had bee was given back to the inform the resident/ re the resolution and doo them on the bottom o The Director of Nursin family member came Erivedge. She said s who ordered the med was an oncologist. Th he obtained the media pharmaceutical comp him the medication w insurance and the family building locked in the obtained a physician's notified the family me obtained and Resider medication. The Dire filled out a grievance and did not know why log or in the grievance 483.12(a)(3)(4)(c)(1)- ALLEGATIONS/INDIN	The grievance is turned in tho logs it in the grievance ven to the appropriate ddress and handle. She days to investigate the is a section at the bottom to ad time the person filing the d. The Director of Nursing she had written had been y phone. After the in completed, the grievance e social worker who would esponsible party/ family of curnent when she informed if the grievance form. In g stated Resident #26's to her directly regarding the he asked the family member ication and was informed it he family member told her cation from the any. She stated she told ould not be covered by nily member stated it was y and was already in the medication cart. She is order on 1/31/17 and mber the order had been at #26 would receive the ctor of Nursing said she for Resident #26 on 1/31/17 y it was not on the grievance e book. (4) INVESTIGATE/REPORT /IDUALS		5			4/14/17

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 // APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	LETED
		345509	B. WING		_		C 03/2017
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
KINGSWO	OD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	22	F 225				
	(3) Not employ or othe who-	erwise engage individuals					
		uilty of abuse, neglect, priation of property, or ırt of law;					
	or her professional lic						
	licensing authorities a actions by a court of l	e nurse aide registry or ny knowledge it has of aw against an employee, unfitness for service as a cility staff.					
		gations of abuse, neglect, atment, the facility must:					
	abuse, neglect, exploincluding injuries of un misappropriation of re- reported immediately, after the allegation is cause the allegation in serious bodily injury, of the events that cause						

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		D HUMAN SERVICES MEDICAID SERVICES			F	ORM APPROVED 8 NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) I	DATE SURVEY COMPLETED	
		345509	B. WING _			C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(X5) COMPLETION DATE		
F 225	the administrator of th officials (including to t adult protective servic for jurisdiction in long- accordance with State procedures. (2) Have evidence tha thoroughly investigate (3) Prevent further po- exploitation, or mistre investigation is in prog (4) Report the results administrator or his or representative and to with State law, includi Agency, within 5 work if the alleged violation corrective action mus This REQUIREMENT by: Based on record revi facility hired an emplo substantiated allegation on the Nursing Assista in an employee with s behavior provided diru 1 of 1 Nursing Assista and the facility failed fu unknown source to Ha Investigations which r non-compliance for 1 (Resident #36). Findings included:	the facility and to other the State Survey Agency and the state Survey Agency and the state Survey Agency and the state Survey for the stablished at all alleged violations are ed. tential abuse, neglect, atment while the gress. of all investigations to the ther designated other officials in accordance ing to the State Survey ting days of the incident, and is verified appropriate t be taken. is not met as evidenced ew and staff interviews, the typee who had a on of neglect of a resident ant Registry, which resulted substantiated-neglect ect care to the residents for ant (Nursing Assistant #2) to report an injury of ealth Care Personnel esulted in facility reporting of 1 sampled resident	F2	F225 Investigate/Repor The Nurse Aide Registry cl 1/25/2017. Re-verification certification. Nurse Aide Re clearance of allegations of The Staff Development Co conducted an audit on all c employed Nursing Assistar Nurse Aide Registry on 2/2 re-verify none had a finding no negative findings. Resident #36 injury of unkr reported via the 24-hour re Health Care Personnel Inv	leared NA #2 on of NA#2 egistry returned alleged abuse. oordinator currently nts with the 25/17 to g. There were nown origin was eport to the	

Facility ID: 970412

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			0.00			OMB NO. 0938-03 (X3) DATE SURVEY		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · ·	E SURVEY PLETED		
			A. BUILDING			с		
		345509	B. WING		03	/ <b>03/2017</b>		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		100/2011		
				915 PEE DEE ROAD				
KINGSWC	OOD NURSING CENTER			ABERDEEN, NC 28315				
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE		
F 225	Continued From page	24	F 22	5				
1 220	Human Resources re		F ZZ	by the Administrator on 3/24	/17 An			
		of neglect of a resident,		investigation was conducted				
		she was employed in a		Nursing and the Administrate	•			
		nformation was entered on		5-day report was completed				
	the Registry on 10/8/			on 3/28/17. This was placed				
				March Allegation of Abuse lo	g.			
	On 3/1/17 at 11:00 ar	-						
	conducted with the H			The facility Administrator and				
		Supervisor). The Supervisor ar with NA #2. NA #2 had a		Services Director are respon				
		on of neglect of a resident		reporting allegations of abus HCPR.	emegieci io			
		on the NA Registry when she		HOFK.				
		ty on 11/22/2016. NA #2		The facility initiated a new hi	re process on			
	had requested to hav	-		3/27/2017. The Administrato				
	-	Registry on 10/13/16, but		all applicants background su				
	the removal was not a	approved until 1/25/17.		results of the Nurse Aide Re	gistry search			
	There was a 90-day-p			prior to orientation. The Hur				
		moval was made to the time		Resources Director will perfo				
	of an actual removal.			background checks and Nur				
	0 0/0/47 1 44 45			Registry searches. The Hun				
	On 3/2/17 at 11:15 an	-		Resources Director will com				
		usiness Officer (BO). The ed all the NA Registry		list of all completed paper we applicants, to include the bas				
		plications and provided		check. The HR Director was	-			
		of Nursing during the hiring		responsibilities as described				
	process.			Administrative Consultant ar	•			
				Administrator on 3/22/17.	· · · · · · · · · · · · · · · · · · ·			
	On 3/2/17 at 9:40 am	, an interview was						
		irector of Nursing (DON).		In-service was done on 3/2/2	-			
		was responsible for hiring		Director of Nursing Services				
		As, including NA #2. The		Administrator with direct care				
		on obtained for potential		including prn and weekend s				
		y the BO at the time of		addressing unusual occurrer				
	only provided to the A	ound check information was		require reporting including a time frame.	phiopilate			
		d information to the DON						
	-	ere were issues with the		An Allegation of Abuse Repo	orting Log has			
	background check.			been developed to track time				
				compliance of allegations of		1		

Event ID: 5IT011

Facility ID: 970412

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 345509 B. WING 03/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 25 F 225 An Interview was conducted on 3/3/17 at 11:24 log will be maintained by the Administrator and/or the Social Services Director. am with the Administrator regarding the processing and screening of new hires. The Administrator stated that she reviewed the The Business Office Manager will complete an audit of all applicants background checks of all applicants, which included the NA Registry. NA #2's NA registry scheduled for orientation weekly for eight results were overlooked. NA #2 was currently off (8) weeks to verify applicant does not have a finding entered in the State Nurse the NA Registry, but NA #2 was still on the NA Registry at time of hire on 11/22/2016. Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. 2. An interview was conducted on 3/3/17 at 9:19 am via telephone with Physician #1 about his The facility Administrator will send the communication with facility staff for Resident Allegation of Abuse Reporting Log to the #36's orders after the incident. Physician #1 Corporate Consultant for the next 5 stated that he spoke to the nurse 2/7/17 about occurrences to verify appropriate mid-day and provided orders for constipation and reporting time frames. This will be sent to KUB (an abdominal x-ray that included kidneys, the Corporate Consultant at the same ureters, and bladder), and stated that he had time the 5 day is sent to the Health Care concerns, to rule out abuse and make sure an Personnel Investigation Office. investigation was performed. All audits regarding Nurse Aide Registry checks will be taken to the monthly QAPI An interview was conducted on 3/1/17 at 3:47 pm with the facility Administrator. The Administrator meetings by the HR Director. Abuse logs was made aware of the cloth in Resident #36's will be taken to the monthly QAPI rectum by NA #3 on 2/7/17 at 9:30 am. The DON meetings by the Administrator. was aware of the incident 1/6/17 at about 5:30 pm, but had not informed the Administrator. The This plan of correction will be monitored at Administrator, Staff Development Coordinator, the monthly QAPI until resolved. and DON discussed the incident. The Administrator stated she directed Nurse #1 to obtain a statement from all who were involved. Statements were obtained from Nurse #1 and DON. Physician was notified on 2/10/17. The Administrator stated she expected staff to report incidences to her immediately. The Administrator stated that she did not consider the incident abuse, and the 24 hour and 5 day reports were not completed. The Administrator stated

FORM CMS-2567(02-99) Previous Versions Obsolete

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	OF DEFICIENCIES	MEDICAID SERVICES		CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /		· · ·	IPLETED
					С	
		345509	B. WING		03	8/03/2017
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			5 PEE DEE ROAD BERDEEN, NC 28315		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 225	Continued From page		F 225			
	that corporate office of	completed an investigation.				
	with the Corporate Co present at the facility policies and procedur heard about the incid Administrator. The C incident happened or Administrator was no CC stated she condu #1 and NA #1. The C	ducted on 3/1/17 at 4:03 pm onsultant (CC). The CC was to provide assistance with res. The CC stated she ent from the DON and C stated she was aware the a 2/6/17 and that the t notified until 2/7/17. The cted interviews with Nurse CC stated that the incident a concern of abuse based				
F 226 SS=D	via telephone with Ph communication with f #36's orders after the stated that he spoke f mid-day and provided KUB (an abdominal x ureters, and bladder), concerns, to rule out f investigation was per he believed the cloth possibly during dis-im 483.12(b)(1)-(3), 483. DEVELOP/IMPLMEN POLICIES 483.12 (b) The facility must of written policies and p	acility staff for Resident incident. Physician #1 to the nurse 2/7/17 about d orders for constipation and e-ray that included kidneys, , and stated that he had abuse and make sure an formed. Physician #1 stated was placed in the rectum, npaction, which was unusual. .95(c)(1)-(3) IT ABUSE/NEGLECT, ETC	F 226			4/14/17

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FO	RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING				C )3/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	<b>I</b>	
KINGSWO	OOD NURSING CENTER				EE DEE ROAD RDEEN, NC 28315		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	<ul> <li>6 Continued From page 27</li> <li>(2) Establish policies and procedures to investigate any such allegations, and</li> </ul>		F 2	26			
	(3) Include training as §483.95,	required at paragraph					
	the freedom from aburrequirements in § 483	nd exploitation. In addition to se, neglect, and exploitation 3.12, facilities must also rir staff that at a minimum					
	exploitation, and misa	c)(1) Activities that constitute abuse, neglect, xploitation, and misappropriation of resident roperty as set forth at § 483.12.					
		reporting incidents of abuse, or the misappropriation of					
	prevention.	agement and resident abuse					
	staff interviews, the fa potential new hire wh Assistant hired with a neglect of a resident of	ew, physician interview, and acility failed to screen a ich resulted in a Nursing substantiated allegation of on the Nursing Assistant Nursing Assistant (Nursing		Th 1/ Ce	226 Abuse/Neglect Policies ne Nurse Aide Registry cleared N 25/2017. Re-verification of NA# ertification. Nurse Aide Registry r earance of allegations of alleged	2 eturned	
	Assistant #2) and faile reporting an allegation Care Personnel Invest facility reporting non-( resident (Resident #3) Findings included:	ed to follow the policy for n of abuse to the Health tigations which resulted in compliance for 1 out of 1		cc er Ni re	ne Staff Development Coordinate onducted an audit on all currently nployed Nursing Assistants with urse Aide Registry on 2/25/17 to -verify none had a finding. Ther o negative findings.	/ the	

Facility ID: 970412

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		רוסי ר	CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /			<b>I</b> ` /	DMPLETED
			A. DOILDI	<u> </u>			С
		345509	B. WING				03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	00/00/2011
				9'	15 PEE DEE ROAD		
KINGSWC	OD NURSING CENTER			Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page	28	F	226			
		reporting and investigations		220	Resident #36 injury of unknown origin	was	
		aled: "Procedure: The facility			reported via the 24-hour report to the	1 11/03	
		ugh investigation of an			Health Care Personnel Investigation of	office	
	-	e appropriate staff. The			by the Administrator on 3/24/17. An	Jinee	
		gnee will provide notice to			investigation was conducted by Direct	tor of	
		d all appropriate state and			Nursing and the Administrator and the		
	regulatory agencies.	The Director of Nursing or			5-day report was completed and faxed	d in	
	designee will initiate t	he investigation along with			on 3/28/17. This was placed on the		
	notifying the Departm Service."	ent of Health and Human			March Allegation of Abuse log.		
	A review of the facility	/ ' s administrative policies			The facility Administrator and/or the S	ocial	
	and procedures empl	oyment screening section			Services Director are responsible for		
	dated 3/11/2004 reve	aled: "A verification of the			reporting allegations of abuse/neglect	to	
		tification status, including			HCPR.		
	-	jistry, will be obtained to					
	include whether any of taken against them."	disciplinary action has been			The facility initiated a new hire proces 3/27/2017. The Administrator will revie	ew	
					all applicants background summary a		
		onducted on 3/3/17 at 9:19			results of the Nurse Aide Registry sea	arch	
	-	n Physician #1 about his			prior to orientation. The Human		
		acility staff for Resident			Resources Director will perform all		
		incident. Physician #1			background checks and Nurse Aide		
	-	e nurse 2/7/17 and provided n and KUB, and stated that			Registry searches. The Human Resources Director will complete a ch	ock	
		ule out abuse and make			list of all completed paper work for	ICCK	
	sure an investigation				applicants, to include the background		
		n Nurse #1 stated that she			check. The HR Director was educate		
	-	could not remember the			responsibilities as described by the		
		a KUB, Miralax, and Fleets			Administrative Consultant and the fac	ility	
	and to r/o abuse. Nur	se #1 could not recall when			Administrator on 3/22/17.		
	she informed the Adn	ninistrator about the orders,					
	but remembered she				An in-service was conducted 3/2/17 b	y the	
		ducted on 3/1/17 at 3:47 pm			Director of Nursing Services and the		
		histrator. The Administrator			Administrator with all direct care staff,	,	
	stated she was made				including prn and weekend staff,		
		m by NA #3 on 2/7/17 at 9:30			addressing unusual occurrences that		
		ware of the incident 1/6/17			require reporting including appropriate	9	
	Administrator. The A	had not informed the			time frame.		

Facility ID: 970412

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED		
				С			
		345509	B. WING		03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC		
F 226	Continued From page	29	F 22	6			
	Development Coordin the incident. The Adr directed Nurse #1 to who were involved. S from Nurse #1 and th stated she expected a her immediately. Th she did not consider to 24 hour and 5 day re The Administrator sta completed an investig An interview was con with the Corporate Co present at the facility policies and procedur heard about the incid Administrator. The C incident happened or Administrator was no CC stated she condur #1 and NA #1. The C	hator, and DON discussed ministrator stated she obtain a statement from all Statements were obtained e DON. The Administrator staff to report incidences to e Administrator stated that the incident abuse, and the ports were not completed. ted that corporate office gation. ducted on 3/1/17 at 4:03 pm onsultant (CC). The CC was to provide assistance with res. The CC stated she ent from the DON and C stated she was aware the		<ul> <li>An Allegation of Abuse Reporting L been developed to track timely compliance of allegations of abuse. log will be maintained by the Admin and/or the Social Services Director.</li> <li>The Business Office Manager will complete an audit of all applicants scheduled for orientation weekly for (8) weeks to verify applicant does n have a finding entered in the State Aide Registry concerning abuse, ne exploitation, mistreatment of reside misappropriation of their property.</li> <li>The facility Administrator will send t Allegation of Abuse Reporting Log f Corporate Consultant for the next 5 occurrences to verify appropriate reporting time frames. This will be the Corporate Consultant at the sar time the 5 day is sent to the Health Personnel Investigation Office.</li> </ul>	The istrator reight not Nurse eglect, nts or he to the sent to me		
	search results docum Human Resources re substantiated finding which occurred while nursing facility. The i the Registry on 10/8/ On 3/1/17 at 11:00 ar conducted with the H Registry Supervisor ( stated she was famili substantiated allegati on 10/8/15 and was c	of neglect of a resident, she was employed in a nformation was entered on 15. n an interview was ealth Care Personnel Supervisor). The Supervisor ar with NA #2. NA #2 had a on of neglect of a resident on the NA Registry when she ty on 11/22/2016. NA #2		All audits regarding Nurse Aide Reg checks will be taken to the monthly meetings by the HR Director. Abus will be taken to the monthly QAPI meetings by the Administrator. This plan of correction will be monit the monthly QAPI until resolved.	QAPI se logs		

Facility ID: 970412

If continuation sheet Page 30 of 160

		ND HUMAN SERVICES			FOF	ED: 04/17/20 RM APPROVE IO. 0938-039
TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/03/2017	
		345509	B. WING			
NAME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CC		
KINGSWO	OD NURSING CENTER		91	5 PEE DEE ROAD		
			AE	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 226	Continued From page	e 30	F 226			
		A Registry on 10/13/16, but	1 220			
		approved until 1/25/17.				
	There was a 90-day-	period from the time a				
		emoval was made to the time				
	of an actual removal. On 3/2/17 at 11:15 a					
		Business Officer (BO). The				
	BO stated she retriev	ved all the NA Registry				
		oplications and provided				
	them to the Director of process.	of Nursing during the hiring				
	•	an interview was conducted				
	with the Director of N	lursing (DON). The DON				
	stated she was respo					
	-	including NA #2. The NA				
		obtained for potential hires BO at the time of interview.				
		k information was only				
		nistrator. The Administrator				
		to the DON regarding				
	check.	ssues with the background				
		nducted on 3/3/17 at 11:24				
	am with the Administ					
	-	ening of new hires. The				
		that she reviewed the of all applicants, which				
		istry. NA #2 's NA registry				
	results were overlook	ked. NA #2 was currently off				
		NA #2 was still on the NA				
E 257	Registry at time of hi 483.10(i)(6) COMFO		F 257			4/14/17
F 257 SS=E	TEMPERATURE LEV		F 207			4/14/1/
		d safe temperature levels.				
		ified after October 1, 1990				
	-	perature range of 71 to 81				
	degrees F.					

Facility ID: 970412

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	STOR MEDICARE &	MEDICAID SERVICES				8 NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		C 03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE	
F 257	Continued From page 31		F 25	57			
	This REQUIREMENT	is not met as evidenced					
	resident interview, far interview the facility fa ongoing problem with comfortable room air rooms resulting in the common area during awake to avoid the co their room for 2 of 2 rd #8) reviewed for safe temperatures. The fi 1. Resident #8 was in on 8/14/13 and readn multiple diagnoses th dementia. The annual Minimum	temperatures in resident residents remaining in the the hours when they were old air temperature inside of esidents (Residents #7 and and comfortable		<ul> <li>F257 Temperature Levels</li> <li>Ambient room temperatures are checked on the 400 hall every in the maintenance staff. Resider</li> <li>#8 rooms are on the 400 hall.</li> <li>maintenance director replaced</li> <li>strips in the air handler for 400</li> <li>March 18th, 2017.</li> <li>Extra blankets were available for residents, including #7 and #8 meat strips were received and monoce the heat strips were in plated</li> <li>400 hall room temperatures have a 71-81-degree range.</li> <li>The Maintenance Director was by the Administrator and the Net Consultant on 3/6/2017 regardia air temperatures in the facility.</li> <li>Maintenance Director initiated a daily temperature audit, and a comorning audit for rooms on the</li> </ul>	morning by nt #7 and The the heat hall on or until the eplaced. ace, the ve been in in-serviced urse ng ambient a random daily		
	room 418 through 12/ moved to room 412. An interview was con 2/27/17 at 10:27 AM. a common area of the had not wanted to go interview because it v indicated she avoided when she was awake cold. She reported sh area of the 400 unit b Resident #8 stated sh	ted Resident #8 resided in (13/16. On 12/13/16 she ducted with Resident #8 on Resident #8 was seated in e 400 unit. She stated she into her room for the vas cold in her room. She d her room during the hours because her room was ne stayed in the common ecause it was warmer there. he "told the [Maintenance he couldn' t fix it". She		Inside and Outside heating and are checked randomly every we ensuring all units are checked r If the ambient temperature is no acceptable parameters (71-81) the thermostats are adjusted ac by the Maintenance Departmer On 3/9/2017, Wilheim's Heating replaced the compressor and re condenser. Maintenance Director will contin random Monday through Friday day temperature audits thoroug 3/31/2017 to ensure comfortable temperatures.	eek while monthly. ot within degrees), ccordingly nt. g and Air e-wired the nue / 4 times a gh		

Facility ID: 970412

						OMB NO. 0938-03 (X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY PLETED		
					С			
		345509	B. WING		03	/03/2017		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE				
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315				
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORF		()(5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE		
F 257	Continued From page	e 32	F 25	7				
	years and her room h	ad continued to be cold		monitored to ensure the practic	e will not			
		Resident #8 reported she		recur:				
		few months ago. She room (412) and her old		a. Maintenance Director will c conduct random audits of ambie				
	room (418) were both			temperatures weekly times one				
		· · · · · · · · · · · · · · · · · · ·		and with any significant change				
	An interview was con	•		temperature from 4/1/2017- 4/3				
		2/27/17 at 11:38 AM. She		all areas to include rooms 409-4	112 and			
		rked at the facility for 13 e 2 rooms on each corner of		415-418. b. Maintenance Supervisor w	ill conduct			
	-	be cold (Rooms 409		monthly inspections of affected				
		through 418). She indicated		monthly x three (3).				
		ided in those rooms spent		Results of Ambient Air Tempera				
		he common area when they		will be brought to the QAPI com				
		eir rooms being cold. NA #6 an an ongoing problem for		monthly by the Maintenance Dir review until compliance has bee				
		lly revealed the Maintenance		achieved as determined by the				
		f the problem, but nothing		Committee.				
	had been done to imp	prove it.		Finding of the April temperature				
	A	durate divitte Nevera #0 are		be discussed at the Resident C	ouncil in			
		ducted with Nurse #3 on he indicated the rooms on		May.				
		0 unit tended to be cold						
		412 and 415 through 418).						
	Nurse #3 reported the	e residents were encouraged						
		heir rooms open so the heat						
		ea could warm up their						
		Resident #8 had complained I cold as she resided in one						
		Nurse #3 revealed this was						
	an ongoing problem.	She additionally revealed						
		ector was aware of the issue,						
	but he indicated it wa	s unable to be fixed.						
	An interview was con	ducted with the Maintenance						
		8:15 AM. He stated he						
		facility in June of 2016 as						
		istant. He indicated he took						
	over as Maintenance	Director sometime between						

If continuation sheet Page 33 of 160

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTON       (Y1) PROVIDERUSULA IDENTIFICATION NUMBER       (Y2) MULTIPLE CONSTRUCTION A BUILDING       (Y3) DATE SUPPLY COMPLETED         NAME OF PROVIDER OR SUPPLIER       345509       STREET ADDRESS, CITY, STREET, 2IP CODE 915 PEE DEE ROAD ABERDEEN, NC 2315       (Y3) DATE SUPPLY COMPLETED         (Y4) ID PRETEX       STREET ADDRESS, CITY, STREET, 2IP CODE 915 PEE DEE ROAD ABERDEEN, NC 2315       (Y2) MULTIPLE CONSENT CODE 915 PEE DEE ROAD ABERDEEN, NC 2315         (Y4) ID PRETEX       STREET ADDRESS, CITY, STREET, ACTION SHOULD BE RECOLLATIONY ON LSC DEVITIPING INFORMATION)       PROVIDERS PLAN OF CORRECTION (EACH OFFICIENCIES) TO THE APPROPRIATE DEFICIENCY ON LSC DEVITIPING INFORMATION)       PROVIDERS PLAN OF CORRECTION ABERDEEN, NC 2315         (Y4) ID PRETEX       Continued From page 33 August and October. He reported there were 8 rooms in the 400 unit that were on the ends of the building and tended to be colder than the rest of the facility. He stated thase rooms were 409 through 412 and 415 through 418. He indicated this included Resident #87 som. The Maintenance Director stated that because of the way the facility was built and the insulation within the facility, these corner rooms were color than the other rooms. He reported the themostat was centralized and there were no individual thermostatis for each room. The thermometer sensor with a laser to obtain the air temperature inside of Resident #87s room. The thermometer sensor with a laser to obtain the air temperature was 66 degrees Fahrenheit (F).       The interview with the Maintenance Director continued on SU/17 at 8:22 AM. He indicated sometimes the staff or a resident complained to hum of a room being cold. He reported that he turned up the temperature o		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
345599     B. WING     03/33/2017       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       YING SUMMARY STATEMENT OF DEFICIENCIES       GY10 ID PRECTX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY WIST EAR DERCORDED BY FULL REQUESTIONCY OR LSC IDENTIFYING INFORMATION)     D O PRECTX TAG     PRECTX (EACH OFFICENCY MUST EAR DEFICIENCY)     O DEFICIENCY     PRECTX (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     O DATE       F 257     Continued From page 33 August and October. He reported there were 8 rooms in the 400 unit that were on the ends of the building and tended to be colder than the rest of the facility. He stated these rooms were 409 through 412 and 415 through 418. He indicated this included Resident #8's room. The Maintenance Director stated the becoulder than the other rooms. He reported the thermostat was centralized and there were no individual thermostatis for each room.     F 257       An observation was conducted of the Maintenance Director on 32/17 at 8:20 AM utilizing a thermometer sensor revailed Resident #8's room. The thermometer sensor revailed Resident #8's room arit temperature inside of Resident #8's room. The thermometer sensor revailed Resident #8's room arit temperature as 66 degrees Fahrenheit (F).     The interview with the Maintenance Director continued on 32/17 at 8:22 AM. He indicated sometimes the staff or a resident complained to him of a room being cold. He reported that he turned up the temperature on the central thermostatis then he reported that he turned up the temperature of a complaint. He stated he had not logged the air temperature of a     Image temperature for a complaint. He	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /			COMPLETED		
VIDENTIFY       VIDENTIFY       CMIGNOOD NURSING CENTER     PISPER PRODUCES DEPORT     PROVIDER'S PLANOF CORRECTION (EACH OFFICENCY MIST BE PRECIDENCIES TAG     PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE (EACH OFFICENCY MIST BE PRECIDENCIES) (EACH OFFICENCY MIST BE PRECIDENCIES) (EACH OFFICENCY MIST BE PRECIDENCIES) (EACH OFFICENCY MIST BE PRECIDENCY MIST			345509	B. WING					
KINSSWOOD NURSING CENTER     ABERDEEN, NC 28315       Mail D PREFIX TAG     SUMMARY STRUEMENT OF DEFICIENCIES (EACH OFFICIENCY MUSTER PERCEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUSTER PROCEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY)     COMPLET (EACH OFFICIENCY)       F 257     Continued From page 33 August and October. He reported there were 8 rooms in the 400 unit that were on the ends of the building and tended to be colder than the rest of the facility. He stated these arooms were 409 through 412 and 415 through 418. He indicated this included Resident #8's room. The Maintenance Director stated that because of the way the facility was built and the insulation within the other rooms. He reported the thermostat was centralized and there were no individual thermostats for each room.     F 257       An observation was conducted of the Maintenance Director on 3/2/17 at 8:20 AM utilizing a thermometer sensor revealed Resident #8's room air temperature inside of Resident #8's room. The thermorenter sensor revealed Resident #6'n ar assident complained to him of a room being cold. He reported that he turned up the temperature on the contral thermostat when he received a complaint. He stated he had not logged the air temperature of a	NAME OF PF	ROVIDER OR SUPPLIER		•			-		
PREFIX TAG       IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       IEACH DEFICIENCY       COMPLETE DEFICIENCY         F 257       Continued From page 33 August and October. He reported there were 8 rooms in the 400 unit that were on the ends of the building and tended to be colder than the rest of the facility. He stated these rooms were 409 through 412 and 415 through 418. He indicated this included Resident #8's room. The Maintenance Director stated that because of the way the facility was built and the insulation within the facility. Hese corner rooms were cooler than the other rooms. He reported the thermostat was centralized and there were no individual thermostats for each room.       F 257         An observation was conducted of the Maintenance Director stated thas the set of obtain the air temperature inside of Resident #8's room. The thermometer sensor with a laser to obtain the air temperature was 66 degrees Fahrenheit (F).       The interview with the Maintenance Director continued on 3/2/17 at 8:22 AM. He indicated sometimes the staff or a resident complained to him of a room being cold. He reported that he turned up the temperature on the central thermostat when he received a complaint. He stated he had not logged the air temperature of a	KINGSWO	OD NURSING CENTER							
August and October. He reported there were 8         rooms in the 400 unit that were on the ends of the         building and tended to be colder than the rest of         the facility. He stated these rooms were 409         through 412 and 415 through 418. He indicated         this included Resident #8's room. The         Maintenance Director stated that because of the         way the facility. Hese corner rooms were cooler than         the other rooms. He reported the thermostat was         centralized and there were no individual         thermostats for each room.         An observation was conducted of the         Maintenance Director state of the lessident #8's room. The         Maintenance Director on 3/2/17 at 8:20 AM         utilizing a thermometer sensor with a laser to         obtain the air temperature inside of Resident #8's room. The thermometer sensor revealed         Resident #8's room air temperature was 66         degrees Fahrenheit (F).         The interview with the Maintenance Director         continued on 3/2/17 at 8:22 AM. He indicated         sometimes the statf or a resident complained to         him of a room being cold. He reported that he         turned up the temperature on the central         thermostat when he received a complaint. He         stated he had not logged the air temperature of a	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	3E	COMPLETION	
room if a complaint was reported. He also stated he had not conducted any monitoring of the room air temperatures. The Maintenance Director revealed he was unaware of what the air temperature inside the facility was supposed to be. He stated he had minimal training provided to him when he took over as the Maintenance Director. An interview was conducted with the Administrator on 3/2/17 at 8:30 AM. She	F 257	August and October. rooms in the 400 unit building and tended to the facility. He stated through 412 and 415 this included Residen Maintenance Director way the facility was b the facility, these corr the other rooms. He centralized and there thermostats for each An observation was c Maintenance Director utilizing a thermomete obtain the air temperat room. The thermomete Resident #8's room a degrees Fahrenheit (f The interview with the continued on 3/2/17 a sometimes the staff o him of a room being of turned up the temperat thermostat when he re stated he had not logg room if a complaint w he had not conducted air temperatures. The revealed he was unay temperature inside the be. He stated he had him when he took ove Director.	He reported there were 8 that were on the ends of the o be colder than the rest of these rooms were 409 through 418. He indicated t #8's room. The stated that because of the uilt and the insulation within her rooms were cooler than reported the thermostat was were no individual room. conducted of the on 3/2/17 at 8:20 AM er sensor with a laser to ature inside of Resident #8's eter sensor revealed ir temperature was 66 F). Maintenance Director at 8:22 AM. He indicated or a resident complained to cold. He reported that he ature on the central eceived a complaint. He ged the air temperature of a as reported. He also stated d any monitoring of the room e Maintenance Director ware of what the air e facility was supposed to I minimal training provided to er as the Maintenance	F	257				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345509	B. WING			C 03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 257	indicated she expected within the facility to be residents. She stated on the corners of the cooler, but she was n temperatures in those 2. Resident #7 was an 6/27/11 and readmitted diagnoses that include Record review indicate room 418. The quarterly MDS as indicated Resident #7 understood, she had problems, and long te An interview was con- 2/27/17 at 11:38 AM. worked at the facility to 2 rooms on each corr be cold (Rooms 409 to through 418). She inter resided in those room the common area who their rooms being cold been an ongoing prot additionally revealed was aware of the prot done to improve it. A family interview was on 2/27/17 at 3:40 PM member indicated the corners of the 400 un	ed the air temperatures e comfortable for the d she was aware the rooms 400 unit tended to be ot aware of the actual air e rooms. dmitted to the facility on ed on 5/8/15 with multiple ed Alzheimer's. ted Resident #7 resided in essessment dated 1/25/17 ' was rarely/never short term memory erm memory problems. ducted with NA #6 on She indicated she had for 13 years. She stated the her of the 400 unit tended to hrough 412 and 415 dicated the residents that is spent most of their time in en they were awake due to d. NA #6 revealed this had olem for years. She the Maintenance Director olem, but nothing had been es conducted for Resident #7 M. Resident #7's family e resident rooms on the it were cold in the winter d Resident #7 had resided in	F	257	7			

Facility ID: 970412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 1 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING		_	( 03/	) 03/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 257	Continued From page	35	F 257				
	3/2/17 at 8:10 AM. Si each corner of the 400 (Rooms 409 through 4 Nurse #3 reported the to keep the doors to the from the common are rooms. Nurse #3 reve problem. She addition Maintenance Director he indicated it was un An interview was come Director on 3/2/17 at 8 began working at the the Maintenance Assi over as Maintenance August and October. rooms in the 400 unit building and tended to the facility. He stated through 412 and 415 this included Residen Maintenance Director way the facility was be the facility, these corn the other rooms. He centralized and there thermostats for each the An observation was c Maintenance Director utilizing a thermometer	ealed this was an ongoing nally revealed the was aware of the issue, but able to be fixed. ducted with the Maintenance 3:15 AM. He stated he facility in June of 2016 as stant. He indicated he took Director sometime between He reported there were 8 that were on the ends of the be colder than the rest of these rooms were 409 through 418. He indicated t #7's room. The stated that because of the uilt and the insulation within the rooms were cooler than reported the thermostat was were no individual room. onducted of the on 3/2/17 at 8:21 AM er sensor with a laser to turue inside of Resident #7's ter sensor revealed					

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/17/201 MAPPROVE: 0.0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			E SURVEY PLETED
		345509	B. WING		03	C 6/03/2017
NAME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO		
KINGSWC	OD NURSING CENTER			PEE DEE ROAD RDEEN, NC 28315		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 257 F 278 SS=D	continued on 3/2/17 a sometimes the staff of him of a room being of turned up the temper thermostat when he r stated he had not log room if a complaint w he had not conducted air temperatures. Th revealed he was una temperature inside th be. He stated he had him when he took ow Director. An interview was con Administrator on 3/2/ indicated she expected within the facility to b residents. She stated on the corners of the cooler, but she was r temperatures in those 483.20(g)-(j) ASSES ACCURACY/COORD (g) Accuracy of Asses must accurately refle (h) Coordination A registered nurse m each assessment wit participation of health (i) Certification	e Maintenance Director at 8:22 AM. He indicated or a resident complained to cold. He reported that he ature on the central received a complaint. He ged the air temperature of a vas reported. He also stated d any monitoring of the room e Maintenance Director ware of what the air re facility was supposed to d minimal training provided to er as the Maintenance ducted with the 17 at 8:30 AM. She ed the air temperatures e comfortable for the d she was aware the rooms 400 unit tended to be not aware of the actual air e rooms. SMENT DINATION/CERTIFIED ssments. The assessment ct the resident's status. ust conduct or coordinate h the appropriate a professionals.	F 257			4/14/17

Facility ID: 970412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE	
		345509	B. WING				C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
			915 PEE DEE ROAD		915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER				ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	9 37	F	278	3		
	. ,	no completes a portion of the n and certify the accuracy of sessment.					
	<ul><li>(j) Penalty for Falsification</li><li>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</li></ul>						
		and false statement in a is subject to a civil money an \$1,000 for each					
	and false statement in	dividual to certify a material n a resident assessment is ey penalty or not more than ssment.					
	material and false sta	ent does not constitute a tement. is not met as evidenced					
	interview, the facility f Minimum Data Set (N of pressure ulcer for 1 residents reviewed fo	ew, observation and staff alled to accurately code the IDS) assessment in the area I (Resident #4) of 4 sampled r pressure ulcer and in the (Residents # 86 & #81) of 2			F278 Assessment Accuracy A new MDS Coordinator was hired on 2/20/2017. A new treatment nurse was hired on 1/19/2017. The MDS Coordinator will be in-service	-d	
	sampled residents rev Findings included:	viewed for hospice.			on assessment accuracy by the Nurse Consultant no later than 4/14/2017. The treatment nurse will be in-serviced accurately coding Section M by the Nu	lon	
	facility on 12/1/16 with including Dementia an ulcer on left buttock.	riginally admitted to the n multiple diagnoses nd unstageable pressure The admission Minimum ssment dated 12/7/16			Consultant no later by 4/14/2017. A modification assessment was completed on 4/5/2017 by the treatmen nurse for Resident #4 to add the dimensions of the identified pressure	nt	

Facility ID: 970412

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	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	ATE SURVEY OMPLETED
			A. BUILDING	G		С
		345509	B. WING			03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 278	Continued From page	e 38	F 27	78		
		nt #4 ' s cognition was d she had unstageable		ulcer. A modified assessmen	t was completed on	
		as present on admission.		4/3/2017 for resident #	-	
		healed pressure ulcer"		Coordinator to code te	•	
		ment was not completed		prognosis section.		
	with width, length and	d depth of the pressure ulcer.		A modification assess		
	Posidont #4's proces	re uleer on the left butteek		completed on 4/5/2017 Coordinator for resider	-	
		re ulcer on the left buttock nission (12/1/16). The		coding for hospice.	ni #61 to conect the	
		a 7 centimeter (cm) (width)		A random audit will be	completed on 10%	
	x (by) 6 cm (length) x			of current residents to	-	
				the MDS by 4/13/17.		
	On 3/1/17 at 10:40 Al			completed by Nurse C		
	observed during the o	left buttock was deep with		Moving forward, the tre be responsible for com		
	eschar on the wound	•		the MDSs.	ipleting section with	
		500.		Prior to closing of any	MDS, the MDS	
	On 3/2/17 at 10:45 Al	M, the Director of Nursing		Coordinator and at lea		
		ed. The DON stated that		Administrative Nurse v	vill review Section	
	she expected the MD	S assessments to be		M, J1400 and O0100 t		
	accurate.			for a minimum of week	•	
	On 3/2/17 at 12:27 Pl	M, the MDS Nurse was		twice a month for one monthly for one monthly		
		S Nurse stated that the		The deficiency will be		
		s responsible for completing		program for monitoring		
		ction. She indicated that if a		resolution/correction.		
		ire ulcer, the dimension		audits will be reviewed		
	section of the MDS as			QAPI meetings for three		
	completed with the w pressure ulcer.	idth, length and depth of the		assure compliance is s QAPI Committee will d		
				continue or resolve the		
	On 3/2/17 at 2:25 PM	I, the Treatment Nurse was		will be brought to the C	-	
		ted that the Treatment Nurse		the MDS Coordinator.	,	
	-	dmission MDS assessment				
		o longer employed at the				
	-	ent Nurse further indicated				
	that she started as tre	reatment nurse end of				
	that she was respons					

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	pressure ulcer section She indicated that if a ulcer, the dimension s with the width, length ulcer. 2. Resident # 86 was 3/26/15 with multiple Dementia and Diabete change in status Mini assessment dated 11 Resident #86 had me problems and he had while a resident at the section of the MDS as indicating that the res condition or chronic c of less than 6 months On 3/2/17 at 10:45 Af (DON) was interviewe she expected the MD accurate. On 3/2/17 at 12:27 Pf interviewed. The MD MDS Nurse who com Resident #86 was no facility. She also india section of the MDS as "yes" if the resident w services. 3. Resident #81 was if facility on 6/29/11 and on 7/23/16. The quarterly Minimut	a of the MDS assessments. a resident has a pressure section should be completed and depth of the pressure admitted to the facility on diagnoses including es Mellitus. The significant mum Data Set (MDS) /18/16 indicated that mory and decision making received hospice services e facility. The prognosis ssessment was coded "no" ident did not have a ondition with life expectancy M, the Director of Nursing ed. The DON stated that S assessments to be M, the MDS Nurse was S Nurse stated that the pleted the assessment of longer employed at the cated that the prognosis ssessment should be coded vas receiving hospice initially admitted to the d most recently readmitted	F 27	8			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í					SURVEY PLETED
		345509	B. WING			-		03/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page had moderate cognitive the Special Treatment Programs section, indo received hospice care while a resident at the O0100K2). A review of the medice #81 was discharged f 10/4/16. The annual MDS asset indicated Resident #8 impairment. Section of Procedures, and Prog Resident #81 had rec the last 14 days while (Question O0100K2). An interview was come Nursing on 3/2/17 at she expected the MD An interview was come Coordinator on 3/2/17 she began working at indicated the previous longer worked at the f MDS dated 12/6/16 fc	e 40 ve impairment. Section O, its, Procedures, and dicated Resident #81 had e during the last 14 days e facility (Question cal record indicated Resident from hospice care on essment dated 12/6/16 81 had moderate cognitive O, the Special Treatments, grams section, indicated revived hospice care during e a resident at the facility ducted with the Director of 10:40 AM. She indicated S to be coded accurately. ducted with the MDS 7 at 12:18 PM. She stated t the facility on 2/20/17. She is MDS Coordinator no facility. Section O of the or Resident #81 that eived hospice care during the		278				
	(Question O0100K2) Coordinator. The me that indicated Resider hospice care on 10/4/ MDS Coordinator. Sh completed this MDS f	was reviewed with the MDS dical record documentation nt #81 was discharged from /16 was reviewed with the he stated she had not						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345509	B. WING			_		C 103/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279 SS=D	483.20(d);483.21(b)(1 COMPREHENSIVE C		F 27	79				4/14/17
	assessments complet months in the residen results of the assessm	st maintain all resident ted within the previous 15 it's active record and use the nents to develop, review nt's comprehensive care						
	483.21 (b) Comprehensive C	are Plans						
	comprehensive perso each resident, consist set forth at §483.10(c includes measurable to meet a resident's m and psychosocial nee	levelop and implement a on-centered care plan for tent with the resident rights )(2) and §483.10(c)(3), that objectives and timeframes nedical, nursing, and mental eds that are identified in the ssment. The comprehensive ibe the following -						
	or maintain the reside physical, mental, and required under §483.2	are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and						
	under §483.24, §483. provided due to the re	would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 8.10(c)(6).						
	provide as a result of	the nursing facility will						

Facility ID: 970412

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C 03/03/2017		
NAME OF PI	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				9	15 PEE DEE ROAD			
KINGSWC	OOD NURSING CENTER			4	ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD B       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)					(X5) COMPLETION DATE	
F 279	rationale in the resider (iv)In consultation with resident's representation (A) The resident's goad desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident's community was assess local contact agencies entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on record revisi interivew, the facility for for the use of antipsy medication for two of	RR, it must indicate its ent's medical record. In the resident and the tive (s)- als for admission and efference and potential for ilities must document is desire to return to the seed and any referrals to and/or other appropriate is and/or other appropr	F	279	F279 Comprehensive Care Plans Care plans addressing the use of psychotropic medications for residents #39, #44 were developed 3/2/2017 by MDS Coordinator. A care plan was developed for resident	t		
	8/15/15. Cumulative depressive disorder, s psychosis, unspecifie	d psychosis and insomnia.			#39 addressing his insomnia and use of hypnotic medications on 3/2/2017 by the MDS Coordinator. The MDS Coordinator will be in-serviced by the Clinical Nurse Consultant on ensuring care plans are developed as	ed		
	with over 10 inpatient #39 stated he was las	dated 8/19/16 stated d a history of schizophrenia hospitalizations. Resident st hospitalized over one year feelings of depressed mood,			indicated in the CAA and other identifie areas of need by 4/13/2017. An audit was completed on 4/2/17 of th 62 residents receiving psychotropic/hypnotic medications to			

Event ID: 5IT011

Facility ID: 970412

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		3 NO. 0938-039 DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· /	;	· · ·	COMPLETED
						С
		345509	B. WING			03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 279	Continued From page	e 43	F 27	9		
	anxiety, fatigue, hope Resident #39 rated h 10 being worse. Cu medications included Prozac for depression depression/ insomnia as needed Xanax for A review of the physic 2017 revealed ordered Geodon HCL (antipsy milligrams by mouth t (hypnotic medication) every bedtime. A care plan dated 11/ was currently taking p (antianxiety/ antidepri adverse reaction. Ap and record any displa problems. Encourage discourage inappropri effectiveness of psyc- involuntary movement and report to the physic every three months for Allow him to express Encourage by mouth Monitor for weight los needed. There was r antipsychotic medicar medication for insomn An Annual Minimum I	elessness and helplessness. is depression as 9/10 with irrent psychotropic : Geodon for psychosis, n/ anxiety, Elavil for a, Ambien for insomnia and anxiety. cian orders for February ed medications included ychotic medication) 40 twice daily and Ambien FC b 5 milligrams by mouth (23/16 stated Resident #39 psychotropic medications essant) and was at risk for ayed behavior or mood e appropriate behavior; riate behavior. Monitor hotropic meds. Monitor for ths and repetitive behaviors sician. Review medications or possible dose reduction. feelings as needed. intake within dietary limits. ss. Psychiatric consult as no care plan for the use of tion or the use of hypnotic nia. Data Set (MDS) dated		ensure that those residents corresponding care plan. residents have a care plan The MDS Coordinator has r updated/created care plans residents receiving psychot medications on 4/2/2017. Auditing of care plans for re- receiving psychotropic med completed weekly for 2 wee a month for one month, the four (4)) months by the Dire Nursing, Staff Development and/or Nurse Consultant, to plan addressing the use of medications is in place. The QAPI Committee will re- results for compliance mont months in the monthly QAP assure compliance is susta results will be brought to Q/ DON. Date of Compliance 4/14/17	100% of those in place. reviewed and for all ropic esident⊡s lications will be eks, then twice n monthly for ector of t Coordinator o ensure a care psychotropic eview audit thly for six (6) PI meeting to ined. Audit API by the	
	intact. Mood was doo interest and pleasure No behaviors were no	sident #39 was cognitively cumented as having little in doing things 711 days. oted. Medications he look back period included				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/17/2017 // APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING					C 03/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 279	medication, antidepre hypnotic medication. A Care Area Assessm well-being dated 12/4 stayed in his room du the evening. He parti Direct staff tried to an issues. This would be A CAA for psychotrop 12/4/16 stated Reside adverse effects assoc psychotropic medicati from falls. Psychiatric adjust medications an medications as needed sheets were complete reported to the physic adjusted as needed a This would be care pl On 2/28/2017 at 9:12/ conducted with Resid doing fairly well with the had received Geodon facility in 2015 and wa decreased his dosage Resident #39 said he anxious and took Xam he had insomnia and taking helped him sleat On 3/2/17 at 12:19PM conducted with MDS had assumed the pos	c medication, antianxiety ssant medication and ent (CAA) for psychosocial /16 stated Resident #39 ring the day and came out in cipated in evening activities. ticipate and meet all social care planned. ic medications dated ent#39 was at risk for dated with use of ons, such as serious injury services were available to d pharmacy was to review ed. Behavior monitoring ed and abnormal behaviors ian. Medications were nd ordered per physician. anned. AM, an interview was ent #39. He stated he was his medications. He said he prior to coming to the as aware they had e to 80 milligrams a day. still had episodes of feeling ax as needed. He stated the medication he was now ep.	F	279				
	On 3/2/17 at 12:19PM conducted with MDS had assumed the pos 2/20/17. She stated s	I, an interview was coordinator who stated she ition of MDS Coordinator on						

Facility ID: 970412

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		D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		345509	B. WING			03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	was included in the per that care plan was no and anti-anxiety medi should have been a c insomnia and the use 2. Resident #44 was 6/3/16. Cumulative d without behavioral dis A Quarterly Minimum 12/14/16 indicated Re- impaired in cognition. noted. Behavioral syn towards others was n days. Medication dur included 7 days of an A care plan dated 1/6 aberrant behavior as showers. Approaches behaviors and assess Psychological evaluat physician/ family of in Encourage compliance living (ADL's) daily. M Explore with resident non-compliance. Ther the use of antipsycho A physician's progres Resident #44 receiver changes. A review of physician revealed an order for	sychotropic care plan and t just for antidepressants cation. She said there are plan for the diagnosis of of Ambien. admitted to the facility iagnoses included dementia aturbance. Data Set (MDS) dated esident #44 was moderately No mood indicators were mptoms not directed oted as having occurred 1-3 ing the look back period tipsychotic medication. /17 stated Resident #44 had evidenced by refusing s included monitoring sing for trends. tion if needed. Notify creased behaviors. ee with activities of daily //edications as ordered. reason or reasons for re was not a care plan for tic medication. s note dated 1/27/17 stated d Haldol for behavioral orders for February 2017 Haldol (antipsychotic rams by mouth every night	F	279	9			

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE	. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		ECONSTRUCTION	COMPI	
			A. DOILDING			2
		345509	B. WING			, )3/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.0	
KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From page	e 46	F 279			
		, an interview was conducted				
		nator who stated Resident				
	#44 should have had Haldol.	a care plan for the use of				
	On 3/2/17 at 5:15 PM	l, an interview was				
		irector of Nursing who stated				
		Haldol to have been care				
F 280	planned. 483 10(c)(2)(i-ii iv v)(	3),483.21(b)(2) RIGHT TO	F 280			4/14/17
SS=D		NING CARE-REVISE CP				
	483.10					
		ticipate in the development				
	and implementation of plan of care, including	of his or her person-centered g but not limited to:				
	(i) The right to particip	pate in the planning process,				
		dentify individuals or roles to				
	be included in the pla request meetings and	nning process, the right to				
		on-centered plan of care.				
	(ii) The right to partici	pate in establishing the				
	expected goals and o	outcomes of care, the type,				
		nd duration of care, and any to the effectiveness of the				
	plan of care.					
	(iv) The right to receiv	ve the services and/or items				
	included in the plan o					
	(v) The right to see th	e care plan, including the				
	right to sign after sign of care.	ificant changes to the plan				
	(c)(3) The facility sha right to participate in	ll inform the resident of the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345509	B. WING			C 03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 280	<ul> <li>shall support the reside planning process must (i) Facilitate the inclust resident representative (ii) Include an assess strengths and needs.</li> <li>(iii) Incorporate the recultural preferences in 483.21</li> <li>(b) Comprehensive C</li> <li>(2) A comprehensive C</li> <li>(2) A comprehensive C</li> <li>(i) Developed within 7 the comprehensive ast (ii) Prepared by an intrincludes but is not lime</li> <li>(A) The attending phy</li> <li>(B) A registered nurse resident.</li> <li>(C) A nurse aide with resident.</li> <li>(D) A member of food</li> <li>(E) To the extent pract the resident and the resident and the resident and the resident record if the process of the resident of the resident and the resident of the reside</li></ul>	dent in this right. The st sion of the resident and/or re. ment of the resident's sident's personal and n developing goals of care. are Plans care plan must be- ' days after completion of ssessment. rerdisciplinary team, that ited to rsician.	F	280				

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		D HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 04/17/2017 RM APPROVED IO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA	E SURVEY IPLETED
		345509	B. WING		0	C 3/03/2017
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		0,00,2011
			9'	15 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER		A	BERDEEN, NC 28315		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 280	Continued From page	e 48	F 280			
	not practicable for the resident's care plan.	development of the				
		staff or professionals in ned by the resident's needs e resident.				
	team after each asses comprehensive and q assessments.	ised by the interdisciplinary ssment, including both the uarterly review is not met as evidenced				
	by: Based on observation interview, the facility f the care plan for weig	n, record review and staff ailed to review and revise ht loss for one of three		F280 Planning Care/Rev Plan		
		r nutrition who experienced ss in 6 months (Resident cluded:		The weight loss care plan for re- was reviewed and revised and u facility Registered Dietician 3/23 Care plans of residents with sign	pdated by 2017.	
		mitted to the facility 7/7/15. s included dementia without e and depression.		weight changes will be audited to Divisional Registered Dietician/ Dietician to ensure a care plan is and that appropriate interventior	Facility s present	
	12/13/16 indicated Re impaired in cognition. with eating. Weight d	Data Set (MDS) dated esident #87 was severely She required supervision ocumented during the as 121 pounds with no		correct diet are included by 4/14 In-service provided to Food Sen Director and facility dietician by Registered Dietician on develop updating revision of nutritional c on 3/23/2017. Resident #87 will be added to th	/2017. vice Divisional ing and are plans	
	indicated Resident #8 Additions to the proble weight loss due to dep plan goals specified th have significant weigh included diet as order			Standard Of Care (SOC) meetin reviewed for weight changes. In-service to ALL dietary staff by Registered Dietician on 3/22/20 regarding definition of fortified for preparation and use of fortified for Regional Dietician and Facility D completed a comparison of Mea	ng to be 7 Divisional 17 pod, foods. Dietician	

Facility ID: 970412

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•
KINGSWO	OOD NURSING CENTER			115 PEE DEE ROAD ABERDEEN, NC 28315	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 280	record. Encourage a compliance. Dietary physician of change of and symptoms of def added on 12/28/16 w times daily for nutritic potassium rich foods. the management of th weight loss was indic 1/2/17. A review of weights fit February 2017 revea pounds; 9/28/16122 pounds; 11/5/16122 pounds; 11/5/16-	percentage eaten and dequate intake and consult. Notify family/ of status. Monitor for signs hydration. Interventions as protein supplement three onal support and on 1/2/17 . No further interventions for he resident's continued ated on the care plan after rom August 2016 through led the following: 8/7/16-132 5.4 pounds; 10/1/16124.6 2.8 pounds; 12/4/16121.4 and 2/5/17116.2 pounds. 1.97 percent a significant as from 8/7/16 through 2/5/17 eriod). February 2017 revealed a no added salt diet with . House supplement powder ounces of water three times 0AM, 1:00PM and 5:00PM) ician order dated 7/24/15. top in 4 ounces of fluid three ement (8:00AM, 12 noon and jinal physician order dated a not a physician's order for	F 280	diets with those listed for resident ensure proper diet was being serv 3/23/17. Care plans of residents with signif weight change will be audited wee weeks, then 2 times a month for of month, then monthly for 2 months facility Registered Dietician or Fac Food Service Director (CDM) to e care plan is present with appropria interventions. The Food Service Director and fac Registered Dietician will be respo for all nutritional care plans. The facility Registered Dietician/ O update care plans with all significa weight changes. Facility Food Service Director (CD perform a nutritional assessment new admissions for nutritional need during the first week of stay in the The DON or Assistant Director of (ADON) will give the CDM a copy new diet orders daily Monday-Fric morning clinical meeting. Weeker orders will be given to the CDM of Mondays. SOC team will review all residents significant weight changes in SOC meetings weekly until weight is star resident has been deemed as "Unavoidable Weight loss" by phy In-service will be presented to nur direct care staff by the CDM regar what fortified foods are and how th monitor to ensure residents orders fortified foods are receiving fortifie at meals by 4/14/2017.	ved on ficant ekly for 4 one by cility nsure a ate cility nsible CDM will ant DM) will on all eds facility. Nursing of all day after nd n s with C able or sician. rsing rding hey can ed

Facility ID: 970412

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STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) D	NO. 0938-039
ND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	Co	OMPLETED
		345509	B. WING			C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIO DATE
F 280	Continued From page	e 50	F 28	30		
	pounds with a weight last 6 months. Potent might be due to hypo no new recommenda #87's continued weig! On 2/28/17 at 12:40P conducted during the was feeding herself a protein supplement a of a grilled cheese sa green beans and con Resident #87's diet sl was no added salt wit On 3/1/17 at 10:10AN conducted with Physi usually received a list weight loss was noted the dietician for a refe (antidepressant) or M appetite). Physician s a house supplement- sometimes powder. stated she had noted #87 on 2/14/17 but ha anything. She said sl The physician stated Remeron to increase	PM, an observation was lunch meal. Resident #87 ind consumed 100% of the ind approximately 75 percent indwich. Resident #87 had sumed very few bites. lip indicated her current diet th super foods. A, an interview was cian #2. She stated she t of weights monthly. If d, she would normally call erral, order Remeron larinol (used for loss of #2 said she would also order -sometimes liquid, She reviewed her notes and weight loss for Resident ad not implemented he must have just missed it. she would order Marinol or Resident #87's appetite and supplement to address the		notified of significant weig CDM as soon as she/he is Audits will be performed to Registered Dietician or Cl experiencing significant weig weekly x 4, then bi-week then monthly for two mon Audits will be performed to Registered Dietician or Cl then twice monthly for or monthly for 2 months on a correctly reviewed/revised The CDM will do an audit physician's order to meal weekly for 4 weeks, then for 1 month, then monthly The District Manager for H Services (dietary departm an audit on 4/6/17 compa to meal served . Thereaff perform this audit weekly then twice a month for on monthly for two months. This deficiency will be pla program for monitoring by Committee for a period of months. Audit results will QAPI program by the Face Dietician or CDM.	s aware. by facility DM on residents veight change ly for one month, ths by Facility DM weekly x4, ne month, then care plans d for weight loss. comparing the tracker tickets twice a month of two months. Healthcare nent) will perform ring meal ticket ter, the CDM will for four weeks e month, then ced in the QAPI of three (3) be taken to the	
	conducted with the R stated Resident #87 r her intake averaged 5 the chart on 2/16/17.	28AM, an interview was egistered Dietician. She received super foods and 50-75% when she reviewed The RD stated she ordered /16 for added protein to help				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OD NURSING CENTER				15 PEE DEE ROAD		
		ATEMENT OF DEFICIENCIES		A	BERDEEN, NC 28315		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280 F 281 SS=E	order for protein powe unaware that Resider receiving a protein po- stated she had not re to address Resident # recommendation in D reviewed the care pla revised due to the we On 3/02/2017 at 12:1 conducted with the M she had assumed the said she was respons was working on upda not had a chance to r 483.21(b)(3)(i) SERV PROFESSIONAL ST/ (b)(3) Comprehensive The services provided as outlined by the cor must- (i) Meet professional This REQUIREMENT by: Based on record revi and staff interviews, r the physician's order blood glucose monito resident (Resident #1	to get extra protein in eviewed the chart and 37's physician wrote the der on 12/28/16 and was nt #87 already had been owder supplement. The RD commended an intervention #87's weight loss since her recember 2016. She in and stated it should be right loss. 9PM, an interview was DS Coordinator. She stated e position on 2/20/17. She sible for the care plans and ting all of them. She had eview all the care plans. ICES PROVIDED MEET ANDARDS e Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. ' is not met as evidenced news, physician interview, nursing staff failed to follow for Levemir (insulin) and ring for 1 of 1 sampled ) reviewed, failed to follow for Ativan (antianxiety ampled 5 residents		280	F281 1. Immediate action(s) taken for the resident(s) found to have been affected include: a. Resident #1 insulin is being administered as ordered. Blood glucose being obtained as ordered and sliding scale insulin provided as ordered based	e is	4/7/17

Event ID: 5IT011

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 281	orders for Remeron ( medication/appetite s (nutritional suppleme residents (Resident # Findings included: 1. A review of nursing records performed fo was admitted on 9/28 data set assessment resident was assesses The resident required activities of daily livin resident's diagnosis v diabetes, hyperlipide encephalopathy, gas disease, malaise, chr generalized weakness Review of Resident # administration record were three doses of I subcutaneous (insulin administration of re 12/8/16. There was n on 12/22/16 through MAR revealed blood frequently elevated o Review of physician's revealed orders for L subcutaneous at bed scale: BG 151-200 gi 3 units, BG 251-300 gi	ed to follow the physician's antidepressant stimulant) and Resource nt) for 1 of 3 sampled 4117) reviewed for nutrition. g and the minimum data set r Resident #1 revealed she 8/16. The quarterly minimum was on 1/5/17. The ed as cognitively impaired. d extensive assistance for g and had to be fed. The were anemia, hypertension, mia, metabolic tro-esophageal reflux ronic kidney disease, as, and dysphagia. 41's medication Is (MAR) revealed that there Levemir 12 units n) at bedtime not 1/16, 12/13/16, and 12/15/16. 3G) was not monitored prior egular insulin sliding scale on no blood glucose monitored 12/25/16 at bedtime. The glucose levels were ver 200. s order dated 12/1/17 evemir 12 units time; Regular Insulin sliding ive 2 units, BG 201-250 give give 4 units, BG 301-350 400 give 8 units, BG >400	F 281	<ul> <li>on blood glucose.</li> <li>b. Physician and pharmacist widely blood glucose for Resident #1 to current insulin orders and sliding coverage is adequate</li> <li>c. Resident #7 is receiving Atively ordered. Orders have been revieted ensure accuracy and correctnessed. The Medical Administration F (MAR) for Resident #7 has been to ensure medication is administed ordered.</li> <li>e. Resident #117 was discharg has since been re-admitted to fact 1/31/2017.</li> <li>f. All new orders will be review Morning Clinical Meeting. Applic orders will be compared to the M Administration Record (MAR) by to 7am (24 hour chart check) nurre assure order has been properly transcribed to the MAR.</li> <li>2. Action taken/system put in p a. 11pm to 7 am nurses will be in-serviced on completing chart of each evening by 4/7/2017.</li> <li>b. All nurses will be in-serviced correct procedure in transcribing physician orders by 4/7/2017.</li> <li>c. MARs for the upcoming more double checked by administrative against current monthly MARs.</li> <li>3. How the corrective action(s) monitored to ensure the practice recur:</li> <li>a. Director of Nursing or design audit 10% of new orders to ensure accuracy of new order transcriptii weekly for four weeks, bi-weekly</li> </ul>	ensure scale an as wed to s. Record reviewed ered as ed but cility on red in able new edication the 11pm se to lace: checks d on the enurses will be will not nee will re on. Audit

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 04/17/2017 DRM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		ATE SURVEY DMPLETED C
		345509	B. WING			03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTION CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 281	scale coverage; and the bedtime. An Interviewed was cam with the Director of stated she expected a orders and to provide medication as ordered glucose. An interview was atten Nurse #4, but she was atten Nurse #7 was atten Nurse #4, but she was atten Nurse #7 was atten Nurse #1/25/17 indicated Resunderstood. She was and long term memorin had no noted behavior. She was indicated to medication on 7 of 7 operiod. An MDS Care Area Atten Atten Atten Nurse #4 was attended was attended behavior.	efore meals with sliding blood glucose monitoring at onducted on 3/2/16 at 9:55 of Nursing (DON). The DON all nurses to follow physician insulin or any other d and to monitor the blood mpted via telephone with s unavailable. dmitted to the facility on ently readmitted on 5/8/15 es that included anxiety and Resident #7 included the f psychotropic medications. ea was initiated on Resident D/16. ated 7/25/16 indicated Ativan on) 0.25 milligrams (mg) nt #7. et (MDS) assessment dated sident #7 was rarely/never a assessed with short term y problems. Resident #7 ors or rejections of care. have received antianxiety days during the MDS review ssessment progress note for ated 1/25/17 indicated she	F 2	81 month, and monthly fe b. At the beginning of MARs will be comp MAR for accuracy. Au weeks, bi-weekly for o monthly for one mont The QAPI Committee Order audit for compli three (3) months in th meeting to assure cor sustained. Will re-eva for compliance and if met will continue for a months.	of each month 10% bared to last month udit weekly for four one month, and h. will review New iance monthly for e monthly QAPI mpliance is iluate for compliance compliance is not	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	discontinuation of the (0.25mg once daily) a 0.25mg twice daily for Resident #7. A nursing progress not the physician was in f (2/14/17) and had ord frequency of Ativan 0 twice daily for Reside Resident #7's plan of medications was upd intervention, "[Reside agitation, change in m A review of the Febru Administration Record indicated she was ad once daily from 2/1/17 physician 's order da increase in the freque once daily to twice da onto Resident #7's Fe in 14 omitted doses of Resident #7 from 2/12 The March 2017 MAF the inclusion of the pt 2/14/17 for Ativan 0.2 An interview was con Nursing (DON) on 3/2 reviewed the process physician's order onto nurse who obtained to transcribing the order	ated 2/14/17 indicated a previous Ativan order and the initiation of Ativan r increased agitation for bet dated 2/14/17 indicated the facility that morning lered an increase in the .25mg from once daily to nt #7. care related to psychotropic ated on 2/14/17 with a new nt #7] had an increase in hedication [Ativan]". ary 2017 Medication d (MAR) for Resident #7 ministered Ativan 0.25mg 7 through 2/28/17. The ted 2/14/17 that indicated an ency of Ativan 0.25mg from illy had not been transcribed ebruary MAR. This resulted f Ativan 0.25mg for 5/17 through 2/28/17. R for Resident #7 indicated hysician's order dated 5mg twice daily. ducted with Director of 2/17 at 11:20 AM. She for the transcription of new to the MAR. She stated the he order was responsible for	F	281			

Facility ID: 970412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING		-		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 281	daily to twice daily for with the DON. The For Resident #7 that reve order for an increase was not transcribed o with the DON. The D obtained the 2/14/17 J should have transcrib #7's MAR. She indica physician's orders to D An interview was cond 3/2/17 at 11:30 AM. S for the transcription of the MAR. She stated order was responsible onto the MAR. The p 2/14/17 that indicated frequency of Ativan 0. daily for Resident #7 She stated she had h s order for Resident #7 She stated she had h s order for Resident #7 for Resident #7 that re physician's order for a of Ativan was not tran reviewed with Nurse # responsible for adding Resident #7's Februa made a mistake by no A phone interview wa #7's physician on 3/2/ physician's order date increase in the freque daily to twice daily for with her physician. S ordering the increase	Ancy of Ativan 0.25mg once Resident #7 was reviewed ebruary 2017 MAR for aled the 2/14/17 physician's in the frequency of Ativan nto the MAR was reviewed ON stated Nurse #3 had physician's order and she ed the order onto Resident ated her expectation was for be followed. ducted with Nurse #3 on She reviewed the process f new physician's order onto the nurse who obtained the e for transcribing the order hysician's order dated an increase in the .25mg once daily to twice was reviewed with Nurse #3. ad obtained that physician ' i7. The February 2017 MAR evealed the 2/14/17 an increase in the frequency scribed onto the MAR was #3. She indicated she was g the 2/14/17 order onto ry MAR. She stated she of transcribing the order. s conducted with Resident	F 281				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF F	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	DOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	agitation for Resident MAR for Resident #7 physician's order for a of Ativan was not tran- reviewed the physicia been made aware the #7's Ativan had not be was a concern to her followed. The physic expectation for medic ordered. 3. Resident #117 was 11/26/16 with multiple cerebral infarction (st disease with heart fai Mellitus. The admission Minim assessment dated 12 #117 was cognitively A physician's order da dietary consultation for (nutritional supplement times daily with medic (antidepressant and a milligrams (mg) once The December 2016 Record (MAR) for Re It indicated Resource added to the MAR on administered to Resid throughout the remain indicated Remeron 7. was added to the MAR	#7. The February 2017 that revealed the 2/14/17 an increase in the frequency iscribed onto the MAR was in. She stated she had not e 2/14/17 order for Resident een followed. She revealed it when her orders were not ian indicated it was her tations to be administered as a admitted to the facility on e diagnoses that included roke), hypertensive heart lure, and type 2 Diabetes um Data Set (MDS) t/2/16 indicated Resident intact. ated 12/21/16 indicated a or weight loss, Resource nt) 90 milliliters (ml) three cation pass, and Remeron appetite stimulant) 7.5 daily at bed time. Medication Administration sident #117 was reviewed. 90 ml three times daily was	F	28			

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	LETED
		345509	B. WING		-		C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	00/	
			9,	15 PEE DEE ROAD			
KINGSWC	OD NURSING CENTER			BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From page time the remainder of The medical record in on a leave of absence During the leave of ab the hospital on 1/19/1 the facility. The January 2017 M/ 1/16/17 for Resident a MAR revealed no doc #117 having been ad once daily at bed time times daily. An interview was com Nursing (DON) on 2/2 January 2017 MAR for indicated she had not Resource 90 ml three 7.5mg once daily at b 1/1/17 through 1/16/1 DON. She verified th Resident #117 receive from 1/1/17 through 1 A second interview wa on 2/28/17 at 2:20 PM copy of a Medication indicated the facility h medication errors and Error Report forms or identified. She reveal Medication Error Rep	e 57 December. adicated Resident #117 went e with family on 1/16/17. osence she was admitted to 7 and was discharged from AR from 1/1/17 through #117 was reviewed. The cumentation of Resident ministered Remeron 7.5 mg e or Resource 90 ml three ducted with the Director of 28/17 at 12:18 PM. The or Resident #117 that a been administered times daily or Remeron ed time at any point from 7 was reviewed with the ere was no evidence that ed Resource or Remeron /16/17. as conducted with the DON <i>A</i> . The DON provided a Error Report form. She	F 281				
	(2/28/17 at 12:18 PM) medication error was	terviewed earlier this day ). The form indicated a identified for Resident #117 : #117 was noted to have not					

Facility ID: 970412

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		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 04/17/201 RM APPROVEI NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		ATE SURVEY
		345509	B. WING			C )3/03/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
KINGSWO	OD NURSING CENTER			915 PEE DEE ROAD		
				ABERDEEN, NC 28315		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 281	through 1/16/17 due MAR. The form reve poor appetite and cou DON indicated when were transcribed from 2017 the Remeron at mistakenly omitted at identified until 1/17/17 the error the MARs w nurses and were not Nurses. She indicate had since been assis checks. A phone interview wa 2/28/17 at 4:00 PM. familiar with Residen order dated 12/21/16 daily at bed time and daily for Resident #17 RD. The medication that indicated Reside ordered Remeron or through 1/16/17 was indicated she had no error. She indicated of those types of error A follow up interview DON on 3/2/17 at 10 expectation was for p followed.	Resource from 1/1/17 to a transcription error on the aled Resident #117 had a ntinued to lose weight. The the MARs for Resident #117 in December 2016 to January and Resource had been not the error was not 7. She stated at the time of vere transcribed by floor reviewed by Administrative ed the Administrative Nurses ting with monthly MAR as conducted with the RD on She indicated she was t #117. The physician's for Remeron 7.5mg once Resource 90 ml three times 17 were reviewed with the error report dated 1/17/17 nt #117 had not received the Resource from 1/1/17 reviewed with the RD. She t been made aware of the she expected to be informed ors. was conducted with the table indicated her ohysician's orders to be VICES BY QUALIFIED RE PLAN	F 28	11	,	4/14/17
		d or arranged by the facility,				

Facility ID: 970412

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/17/201 M APPROVE <u>D. 0938-039</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COM	E SURVEY PLETED
		345509	B. WING			C / <b>03/2017</b>
NAME OF PF	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINCSWO	OD NURSING CENTER			915 PEE DEE ROAD		
RINGSWO	OD NORSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y 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 282	Continued From page		F 282	2		
	as outlined by the co must-	mprehensive care plan,				
	(ii) Be provided by quaccordance with each care.	ualified persons in h resident's written plan of				
		Γ is not met as evidenced				
	review, the facility fai	on, staff interview, and record led to follow the care		F282 Services by Qualified Based on review, Resident # 8	1 is	
	-	t #81), dietary supplements		receiving Coumadin as ordered Director of Nursing (DON) and	Nurse	
		l restorative nursing services of 17 resident's care plans		Consultant reviewed the Medic Administration Record (MAR) a		
	reviewed. The findin	•		orders on 3/6/17. Resident #117's physician orde		
		initially admitted to the dimost recently readmitted		reviewed by the DON on 3/6/17 Medication and supplements a	7.	
		noses that included heart		administered as ordered.	re being	
	disease.			Resident #42 is no longer in fac All therapy screens for the last		
	need/problem area o This need/problem a	Resident #81 included the f anticoagulant drug use. rea was initiated on Resident		were reviewed on 4/6/17 by the Director to ensure that resident to Restorative program are rec	ts referred	
		20/16. The interventions tration of medications as #81.		service. Review revealed all re- referred to the Restorative Prog being seen.		
	A physician's order d Coumadin (anticoagu milligrams (mg) once Resident #81.	,		All residents on Coumadin are via the Coumadin Audit tracking was initiated December 2016. receiving Coumadin were revie	g toll that All resident wed for	
		2/6/16. He was indicated to agulant medication on 7 of 7		accuracy of their dosage order MAR by the DON on 3/6/17. T Coumadin Audit Tracking is ma the Director of Nurses (DON) a Staff Development Coordinator	he aintained by and/or the	
	A physician's order d	ated 12/7/16 indicated to		Facility Registered Dietician an	d Divisional	

Facility ID: 970412

If continuation sheet Page 60 of 160

		MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	· · ·	MPLETED
			A. DOILDING			С
		345509	B. WING			)3/03/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		0.00.2011
				915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 282	Continued From page	- 60	E 20	2		
F 202	1.0		F 28		1.4.1.	
		Coumadin (9.5mg) that		Registered Dietician comp		
	• • • •	d then start Coumadin 9mg		comparison of physician s	•	
	daily on 12/8/16.			against Meal Tracker soft 100% accuracy of diets ar		
	A physician's order da	ated 12/19/16 indicated		on 3/23/17. All residents v		
		or Resident #81. A follow up		ensure dietary supplemen		
		s written on 12/19/16 that		given as ordered by the F		
	indicated a discontinu			Registered Dietician and t		
		the start of Coumadin 9.5mg		Registered Dietician.		
	for Resident #81.					
				New referrals from therap		
		mber 2016 Medication		the Director of Nurses (DC		
		d (MAR) for Resident #81		bring referral to Morning C	•	
	indicated he was adm	at bed time from 12/1/16		to be care planned and ve		
	-	rdered. On 12/7/16 the		Restorative that resident is		
	-	old Coumadin was followed		restorative case load. Au		
		rther review of the MAR		therapy to restorative refe	•	
		hrough 12/18/16 Resident		audited in the Morning Cli		
		d 9.5mg of Coumadin once		the Restorative Nurse.		
		ead of Coumadin 9mg once				
		ne physician on 12/7/16.		Restorative referrals audit		
		Iministrations of a higher		weekly for one month; the		
	dose of Coumadin the	an ordered for Resident #81.		for one month, then month	•	
		ducted with the Director of		month by the Restorative Restorative Nurse will also		
		ducted with the Director of 2/17 at 10:40 AM. She		validate the Restorative C	•	
		ation was for care planned		Assistances are working v	-	
	-	llowed and for medications		being audited.		
		s ordered by the physician.		The QAPI Committee will	review audit	
				results for compliance mo		
				(3) months in the monthly		
		s admitted to the facility on		to assure compliance is su		
	-	ses that included cerebral		re-evaluate for compliance		
		pertensive heart disease		compliance is not met will		
	• •	e 2 Diabetes Mellitus, and		another three (3) months.		
	severe protein calorie	e mainutrition.		be responsible for brining		
	The odmission Minim	Num Data Sat (MDS)		Audit log summary to the		
	The admission Minim	um Data Set (MDS)		Committee. Facility Dietici	ian or the Food	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	COM	E SURVEY PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER			91	15 PEE DEE ROAD		
	OD NOROINO OENTER			Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	<ul> <li>#117 was cognitively supervision from staff for eating. Resident is swallowing issues an edentulous (no natural On 1/13/17 the plan of was updated to includ weight loss. The inter provision of a dietary</li> <li>The January 2017 M/ 1/16/17 for Resident is MAR revealed no doo #117 having been ad milliliters (ml) three the An interview was con 2/28/17 at 12:18 PM. Resident #117 that in administered Resource any point from 1/13/11 reviewed with the DC no evidence that Ress Resource 1/13/17 thr</li> <li>A follow up interview DON on 3/2/17 at 10: expectation was for the interventions to be for supplements to be prior</li> <li>3. Resident #42 was</li> </ul>	2/2/16 indicated Resident intact. She required f with set up assistance only #117 was assessed with no d she was indicated to be al teeth). of care for Resident #117 de the need/problem area of erventions included the supplement as ordered. AR from 1/13/17 through #117 was reviewed. The cumentation of Resident ministered or Resource 90 mes daily. ducted with the DON on The January 2017 MAR for idicated she had not been ce 90ml three times daily at 7 through 1/16/17 was DN. She verified there was ident #117 received rough 1/16/17. was conducted with the :40 AM. She indicated her he care planned llowed and for dietary	F	282	Service Director (CDM) will bring aud dietary supplements being given as ordered to the QAPI meeting. The Restorative Nurse will bring the result the QAPI meeting for regarding referr to Restorative being treated.	s to	
	Resident #42 ' s quar	terly Minimum Data Set					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	(MDS) dated 11/22/16 cognitive impairment coded as independent and ambulating in his coded for supervision toileting, hygiene and for any falls. Resident #42 was car moderate risk for falls reviewed on 11/29/16 was updated on 1/25/ with interventions to in non-skid socks, re-ed assistance and a ther Resident #42 sustaine and 2/6/17 and again A therapy screen was screen indicated reste for a maintenance pro- range of motion (ARC extremities for 15 min ambulation using a ro two person assistance. Therapy Communicat physical therapist was signed off by the staff (SDC) acknowledging restorative program. Resident #42 ' s care SDC on 2/4/17 for inc extremities and ambu- assistance.	6 indicated moderate with no behaviors. He was t with transfers, bed mobility room. Resident #42 was with ambulating in the halls, bathing. He was not coded re planned on 9/14/16 for a 5. This care plan was last . Resident #42 ' s care plan '17 to include actual falls include frequent rounds, ucation to call for apy referral.	F	282			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345509	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	February 2017 in the ambulation and active week starting on 2/6/ #42 was discharged f There were no minute	e 63 paper medical record listed e range of motion 6 days a 17 and indicated Resident from restorative on 2/15/17. es listed and no restorative cating Resident #42 received	F	282	2		
	#42 stated he had no services that he could In an interview on 2/2 Rehabilitation Directo therapist completed to 2/3/17 and the referra	28/17 at 12:00 PM, the or stated the physical he restorative referral on als were usually given to the se at the time the Therapy					
	stated he completed dated 2/4/17 for ARO was uncertain why th He stated it was his u nurse was over restor week when she went	28/17 at 12:15 PM, the SDC the restorative care plan M and ambulation but he e services were not started. Inderstanding the MDS rative nursing up until this out on medical leave. He to provide any restorative 2/3/16 to 2/15/17.					
	RA #2 stated they did nursing with Resident on their caseload, the their minutes on the F Record. RA #1 and R	/17 at 10:10 AM, RA #1 and I not recall doing restorative t #42. RA #1 stated if he was ey would have documented Restorative Care Flow A #2 stated they normally from either the MDS nurse					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 103/2017
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page	9 64	F	282			
F 285 SS=D	stated it was her expe would have received care planned.	/17 at 9:30 AM, the DON ectation that Resident #42 the restorative services as ASRR REQUIREMENTS	F	285	5		4/14/17
	pre-admission screen (PASARR) program u of this part to the max	nate assessments with the ing and resident review inder Medicaid in subpart C timum extent practicable to ng and effort. Coordination					
	PASARR level II dete	recommendations from the rmination and the PASARR a resident's assessment, ansitions of care.					
		esident review upon a					
		eening for individuals with a ndividuals with intellectual					
	(1) A nursing facility n January 1, 1989, any	nust not admit, on or after new residents with:					
	(i) of this section, unlease authority has determine	defined in paragraph (k)(3) ess the State mental health ned, based on an and mental evaluation					

Facility ID: 970412

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       345509       B. WING       03/03/2017         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       03/03/2017         KINGSWOD NURSING CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       915 PEE DEE ROAD         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)		-	ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED NO. 0938-0391
Multe OF PROVIDER OR SUPPLIER         345599         B. WING         OBJOINT           NUME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STREE, DP CODE         STREET ADDRESS, S	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3)	DATE SURVEY COMPLETED
KINGSWOOD NURSING CENTER     915 PEE DEE ROAD ABERDEEN, KC 28315       MULD TRG     SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY NILST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PROVIDER'S FLANG CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)     CONSECTIVE (CROSS-REFERENCE)       F 285     Continued From page 65 performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual requires the level of services provided by a nursing facility; and     F 285       (B) If the individual requires specialized services; or     (i) Intellectual disability authority as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-       (A) That, because of the physical and mental condition of the individual requires specialized services; or     (i) Intellectual disability or developmental disability authority has determined prior to admission-       (A) That, because of the physical and mental condition of the individual requires specialized services provided by a nursing facility; and     (b) If the individual requires specialized services provided by a nursing facility; and       (B) If the individual requires the level of services provided by a nursing facility.     (2) Exceptions. For purposes of this section-       (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission			345509	B. WING				-
KINGSWOOD NURSING CENTER     ABERDEEN, NC 23315       (PA) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENC NUST BE REPICIENCE NURS) RECOUNT OFFICIENC NUST BE REPICIENCE NURS REGULATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG     PREFIX (EACH OFFICIENC NUST BE APROPRIATE DEFICIENCY)     D PREFIX TAG       F 285     Continued From page 65 performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and     F 285       (B) If the individual requires such level of services, whether the individual requires specialized services; or     (A) That, because of the physical and mental condition of the individual requires specialized services; or     (B) If the individual requires specialized services; or       (B) If the individual requires such level of services, whether the individual requires specialized services; or     (A) That, because of the physical and mental condition of the individual requires specialized services from the individual requires the level of services provided by a nursing facility; and     (B) If the individual requires specialized services for intellectual disability.       (2) Exceptions. For purposes of this section- in a nursing facility of an individual requires specialized services for intellectual disability.     (C) Exceptions. For purposes of this section- to a nursing facility of an individual requires specialized services of the readmission to a nursing facility of an individual with or A fier	NAME OF PF	ROVIDER OR SUPPLIER						
PRÉFIX TAG     (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)     PRÉFIX TAG     (EACH ORFECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     Continued DEFICIENCY       F 285     Continued From page 65 performed by a person or entity other than the State mental health authority, prior to admission,     F 285     F 285       (A) That, because of the physical and mental condition of the individual requires the level of services; or     F 285     F 285       (B) If the individual requires such level of services, whether the individual requires specialized services; or     (i) Intellectual disability, authority has defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability of evelopmental disability authority has determined prior to admission-     (A) That, because of the physical and mental condition, the individual requires specialized services provided by a nursing facility; and     (B) If the individual requires such level of services, whether the individual requires the level of services provided by a nursing facility; and     (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.       (2) Exceptions. For purposes of this section-     (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual when, after	KINGSWO	OD NURSING CENTER						
performed by a person or entity other than the State mental health authority, prior to admission,       (A) That, because of the physical and mental condition of the individual requires the level of services provided by a nursing facility; and         (B) If the individual requires such level of services, whether the individual requires specialized services; or       (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-         (A) That, because of the physical and mental condition of the individual requires the level of services, whether the individual requires the level of services provided by a nursing facility; and         (B) If the individual the individual requires the level of services provided by a nursing facility; and         (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.         (2) Exceptions. For purposes of this section-         (i)The preadmission screening program under paragraph(k)(1) of this section nued not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	COMPLETION
transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission	F 285	performed by a perso State mental health a (A) That, because of the condition of the individual the level of services period and (B) If the individual reservices, whether the specialized services; (ii) Intellectual disability (k)(3)(ii) of this section intellectual disability of authority has determined (A) That, because of the condition of the individual reservices, whether the specialized services period and (B) If the individual reservices, whether the specialized services for (2) Exceptions. For per- (i)The preadmission separagraph(k)(1) of this for determinations in the to a nursing facility of being admitted to the transferred for care in (ii) The State may chep preadmission screeni	n or entity other than the uthority, prior to admission, the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires or ity, as defined in paragraph n, unless the State or developmental disability ned prior to admission- the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires for intellectual disability. urposes of this section- screening program under s section need not provide the case of the readmission an individual who, after nursing facility, was a hospital. pose not to apply the ng program under	F	28	5		

	-					FORM	APPROVED
			(X2) MUL	TIPLE	CONSTRUCTION		
-		IDENTIFICATION NUMBER:	. ,				
						(	C
		345509	B. WING			03/	03/2017
NAME OF PI	At. BOILDING     C       345509     B. WING     03/03/2017       OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     915 PEE DEE ROAD       SWOOD NURSING CENTER     915 PEE DEE ROAD     ABERDEEN, NC 28315       DID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (x5)       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     CAUCH CORRECTIVE ACTION SHOULD BE     COMPLETIN       G     ID     PREFIX     CROSS-REFERENCED TO THE APPROPRIATE     COMPLETIN						
KINGSWC	OD NURSING CENTER						
				A			
(X4) ID PREFIX				Х		E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG			<b>ATE</b>	DATE
	1						
F 285	Continued From page	<u> 66</u>	E	285			
1 200			Г.	200			
	-	g acute inpatient care at the					
	hospital,						
	(B) Who requires nurs	sing facility services for the					
	the hospital, and						
	(C) Where attending	nhysisian has partified					
		-					
	facility services.						
	(2) Definition For put	rnaaaa of this costion					
		rposes of this section-					
	(i) An individual is cor	nsidered to have a mental					
	disorder defined in 48	33.102(b)(1).					
	(ii) An individual is co	nsidered to have an					
		of this chapter.					
	(k)(4) A nursing facili	ty must notify the state					
	mental health authorit						
		applicable, promptly after a					
		the mental or physical t who has mental illness or					
	intellectual disability f						
	-	is not met as evidenced				ľ	
	by:						
		iew and staff interview the			F285 PASRR Requirements		
	-	oorate a Preadmission Review (PASRR) level II			Resident #81,s level 2 PASRR for SMI was incorporated into his care plan on		
		to Serious Mental Illness			3/3/2017 by the MDS Coordinator. Ca		

Facility ID: 970412

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TATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONNECTION	BENTH IOATION NOMBER.	A. BUILDING		C
		345509	B. WING		03/03/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETIO
F 285	Continued From page	e 67	F 28	5	
	(Resident #81) review findings included: Resident #81 was initi on 6/29/11 and most 7/23/16 with diagnose depression, delirium of factors, and other pro- psychosocial circums A review of the medic #82 had a PASRR lev The annual Minimum assessment dated 12 #81 had moderate co assessed as a PASR #81 indicated he had doing things on 7-11 review period. He wa behaviors and no reje	tances. cal record indicated Resident vel II related to SMI. Data Set (MDS) 2/6/16 indicated Resident gnitive impairment. He was R level II for SMI. Resident little interest or pleasure in days during the 14 day s assessed with no		<ul> <li>plan for PASRR level 2 indicating th diagnosis and potential for complicative related to diagnosis were added.</li> <li>On 3/3/2017, the Clinical Nurse Consultant in-serviced the MDS Coordinator on incorporating PASRI 2 information into care plans.</li> <li>The Admission Coordinator conduct audit on each resident's PASRR level 3/27/2017.</li> <li>Any residents identified during audit PASRR level 2 will have a PASRR level 3/27/2017.</li> <li>Any residents identified during audit pasRR level 2 will have a PASRR level 2 will have a PASRR level 2 may reflect PASRR level 2. All of these have be care planned to reviewed and updative reflect PASRR level 2 presence.</li> <li>The Admission Coordinator will verified admissions' PASRR screening. Wh completed , the Admission Coordinator if reside a PASRR level 2.</li> <li>The Administrator and/or Social Ser Director will audit all new residents and past and past of the second sec</li></ul>	tions R level red an el on r with a evel 2 Fhere a ren ted to fy new en tor will int has vice
	MDS indicated Resid schizophrenia and op The CAA for Cognitiv indicated not to be ca Resident #81 as it wa The CAA for Psychos indicated to be trigge assessment, but was that time for Resident currently any issues.	ent #81 had paranoid positional defiant disorder. e Loss and Dementia were are planned at that time for as presently not a problem. social Well Being was red by the MDS not to be care planned at t #81 as there were not date 12/7/16 indicated		10% of current residents for accurace PASRR level 2 and corresponding of plan monthly for 3 months. The QAPI Committee will review autresults for compliance monthly for th (3) months in the monthly QAPI meet to assure compliance is sustained. A re-evaluate for compliance for compliance and if compliance is not met will com- for another three (3) months. Social Service Director will bring audit resu- the QAPI Committee Meeting.	cy of care dit nree eting Will bliance ntinue

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING			03/2017
NAME OF PI	Env.       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPH DEFICIENCY)         285       Continued From page 68 of care, most recently revised on 2/27/17, revealed no identification or incorporation of his PASRR level II determination for SMI.       F 285         An interview was conducted with the Director of Nursing (DON) on 3/2/17 at 10:40 AM. She indicated it was her expectation that plans of care be comprehensive, accurate, and followed. She stated she was unsure how the PASRR level II determinations were incorporated in the care planning process. The DON indicated that was a question for the MDS Coordinator.       An interview was conducted with the MDS Coordinator on 3/2/17 at 12:18 PM. She stated she began working at the facility on 2/20/17. She indicated the previous MDS Coordinator no longer worked at the facility. She stated that was reviewed. She stated she had not completed the plan of care for Resident #81 was reviewed. She stated she had not completed the plan of care for Resident #81 was nerexpectation that his level 2 PASRR determination for SMI was incorporated into his plan of care.					
KINGSWC	OOD NURSING CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROF	) BE	(X5) COMPLETION DATE
F 285 F 309 SS=D	of care, most recently revealed no identifica PASRR level II deterr An interview was con Nursing (DON) on 3/2 indicated it was her e be comprehensive, ac stated she was unsur determinations were if planning process. The question for the MDS An interview was con Coordinator on 3/2/17 she began working at indicated the previous longer worked at the creating and revising responsibility. The pl was reviewed. She s the plan of care for Re was her expectation t determination for SMI plan of care. 483.24, 483.25(k)(I) F FOR HIGHEST WELI 483.24 Quality of life Quality of life is a fund applies to all care and residents. Each resid facility must provide ti services to attain or n practicable physical, f well-being, consistent	revised on 2/27/17, tion or incorporation of his mination for SMI. ducted with the Director of 2/17 at 10:40 AM. She xpectation that plans of care ccurate, and followed. She e how the PASRR level II incorporated in the care is DON indicated that was a Coordinator. ducted with the MDS 7 at 12:18 PM. She stated the facility on 2/20/17. She s MDS Coordinator no facility. She stated that plans of care was her an of care for Resident #81 tated she had not completed esident #81, but revealed it that his level 2 PASRR I was incorporated into his PROVIDE CARE/SERVICES L BEING				4/14/17

Facility ID: 970412

If continuation sheet Page 69 of 160

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345509	B. WING			03/	_ 03/2017
NAME OF P	ROVIDER OR SUPPLIER			(	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
KINGSWO	OD NURSING CENTER			9	915 PEE DEE ROAD		
Rindowe	OD NOROMO OENTER			1	ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	483.25 Quality of care Quality of care is a fur applies to all treatment facility residents. Base assessment of a resident that residents receive accordance with profe- practice, the comprehe- care plan, and the residents but not limited to the fill (k) Pain Management The facility must ensu- provided to residents consistent with profess the comprehensive pe- and the residents' goa (I) Dialysis. The facility residents who requires services, consistent with of practice, the compre- care plan, and the resis- preferences. This REQUIREMENT by: Based on record revia and staff interviews, t administer a Fentanyl a resident which resu- increased need and re- Percocet (pain medica- residents (Resident # Findings include: Resident #40 had dia- cervical laminectomy, syndrome. According data set dated 11/23/	e ndamental principle that at and care provided to ed on the comprehensive lent, the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices, including following:	F	309	F309 Care and Services Resident #40 is receiving fentanyl pato and prn Percocet. Pain assessment was completed for resident #40 on 3/23/2017 by her staff nurse. Plan of care was updated on 3/23/2017 the MDS LPN Coordinator to reflect pa management program, which includes non- pharmacological interventions. Interview with resident #40 has been completed to ensure pain is managed her satisfaction. Interview was conduct	7 by iin	

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If continuation sheet Page 70 of 160

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/17/20 <sup>-</sup> MAPPROVE D. 0938-039
TATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	
KINGSWC	OOD NURSING CENTER				PEE DEE ROAD ERDEEN, NC 28315		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From page staff member and wa impaired.	e 70 s moderately cognitively	F 3	ł	by DON. Resident states she is satist with the management of her pain.	fied	
	Resident #40's care p administration of pair other modalities. The to administer pain me evaluate for effect. T quarterly, and the las Record review reveal 1/1/17 for a Fentanyl micrograms (mcg) pe hours. [The Fentanyl management of persi chronic pain.] The resident 1/1/17 for Perce every six hours as ne Resident #40's Janua Administration Recor MAR indicated the Fe applied on 1/20/17. indicated the medicate Further review of the	n medication and use of e care plan intervention was edication as ordered and to he care plan was reviewed t review was on 1/12/17. led a physician's order dated Transdermal Patch 50 er hour, topically every 72 Patch is indicated for istent, moderate to severe sident also had an order occet 10-325 milligrams eeded for pain.			Education for all nurses on importance administrating medication as ordered be completed by Omnicare Pharmacy Director of Nursing by 4/14/2017. All Nurses will be in-serviced on pain management to include non-pharmacological interventions by Director of Nursing or Staff Developm Coordinator by 4/14/ 2017. Pain will be assessed at least each s and documented on Medication Administration Record (MAR) for all residents by the floor nurse. Identified pain will be addressed appropriately. All residents will have comprehensive assessment completed on admission re-admission, quarterly, and with any significant change as assigned to the nurse providing care. All resident who have pain medication	will y or hent hift pain , floor	
	once a day, when the on 1/20/17, the reside more often. Percoce 1/20/17, twice on 1/2 and three times on 1/ A review of the medic 1/23/17 was reviewed of error: "(Resident # mcg/hour apply one p hours was scheduled and it was not. The F The Fentanyl patch w medication error was "medication was not "the medication was not	e new patch was not applied ent asked for the Percocet t was administered twice on 1/17, three times on 1/22/17,			scheduled will have a pain medicated scheduled will have a pain managem care plan reviewed, updated or initiat the MDS LPN Coordinator by 4/13/17 An audit of all residents receiving scheduled fentanyl pain patches will l completed by the Medical Records cl by 4/13/17 to determine if any other omissions occurred. She will review March 2017 MAR's and April MAR's t date. The Treatment Nurse will conduct an monthly for three (3) months, on 25% the MAR's for residents with schedule fentanyl patches to determine if omis have occurred. The QAPI Committee will review mor	ent ed by be erk o audit of ed sions	

Facility ID: 970412

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · /	E SURVEY IPLETED
			A. BUILDING			С
		345509	B. WING		03/03/2017	
IAME OF PI	ROVIDER OR SUPPLIER	I	<b>L</b>	STREET ADDRESS, CITY, STATE, ZIP CODE		
				915 PEE DEE ROAD		
INGSWO	OD NURSING CENTER			ABERDEEN, NC 28315		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 309	Continued From page	⊳ 71	F 309			
1 000		I medication pass audit."	F 303	for compliance monthly for three	(3)	
		ication error report, the		months in the monthly	(0)	
	2	OON) was notified on 1/23/17		QAPI meeting to assure complia	nce is	
		sician #1 was notified on		sustained. Will re-evaluate for co		
	1/23/17 at 11:10 am.			for compliance and if compliance	e is not	
		ducted on 2/28/17 at 4:50		met will continue for another three	• •	
	•	). The resident stated she		months. Treatment nurse will brin	-	
		Fentanyl patch was missed		results of the random audit to the	e QAPI	
		The miss was discovered		Committee meeting.		
		lyl patch was due. During				
		e resident stated she had ale of 1-10 (with 10 being the				
	worst pain) and had a					
		to relieve the pain. The				
		oticed the pain was not				
	relieved as usual.	·				
	An interview was con	ducted on 3/1/17 at 12:30				
		regarding Resident #40's				
		h on 1/20/17. Physician #1				
		meet expectation if the				
	resident had pain eve					
		#1 stated he expected the				
	Fentanyl order to be f	mpted with Nurse #6 on				
	3/2/17 and 3/3/17, bu					
	available.					
		ducted with the Director of				
	Nursing (DON) 3/2/17	7 at 10:40 am regarding the				
	staff's responsibility to	o follow physician's orders.				
		she expected staff to follow				
	physician's orders.					
F 315 SS=G	483.25(e)(1)-(3) NO ( RESTORE BLADDEF	CATHETER, PREVENT UTI, R	F 31	5		4/14/17
	(e) Incontinence.					
		ensure that resident who is				
		and bowel on admission				
	receives services and		1			1

Facility ID: 970412

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	-	D HUMAN SERVICES				FORM	04/17/2017 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	LETED
		345509	B. WING		_	03/	C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	00/	00/2011
			g	15 PEE DEE ROAD			
KINGSWO	OOD NURSING CENTER			ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	continence unless his or becomes such that to maintain. (2)For a resident with on the resident's com facility must ensure th (i) A resident who entri indwelling catheter is resident's clinical con catheterization was no (ii) A resident who entri indwelling catheter or is assessed for removal spossible unless that demonstrates that cat and (iii) A resident who is receives appropriate to prevent urinary tract if continence to the exter (3) For a resident with on the resident's com facility must ensure the incontinent of bowel retreatment and services bowel function as poses This REQUIREMENT by: Based on record revisi interview, the facility f care and failed to sec (Resident #4) of 1 sat indwelling urinary cat	a or her clinical condition is continence is not possible urinary incontinence, based prehensive assessment, the nat- ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary incontinent of bladder treatment and services to nfections and to restore ent possible. In fecal incontinence, based prehensive assessment, the nat a resident who is eceives appropriate es to restore as much normal	F 315	F315 No Cather Resident #4's urina discontinued on 3/ order. All residents identif	ter/Prevent UTI ary catheter was 15/2017 per physicia		

Facility ID: 970412

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				91	15 PEE DEE ROAD		
KINGSWC	OOD NURSING CENTER			A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 315	Tract Infection (UTI). Resident #4 was origi on 12/1/16 with multip insufficiency. The ad (MDS) assessment da Resident #4 had seve she was frequently in Resident #4 had a do insert an indwelling un unstageable pressure Resident #4's physici 2016, January and Fe Resident #4 did not h care or for securing th Resident #4's care pla reviewed. One of the resident had an indwe she was at risk for inc the catheter would rei would not develop inc over the next 90 days to change catheter tu order, monitor urine for amount of urine and r doctor, encourage flu keep tubing and cathe The care plan also in pulled out her urinary 2/27/17. The medical records of	Findings included: inally admitted to the facility ble diagnoses including renal mission Minimum Data Set ated 12/7/16 indicated that ere cognitive impairment and continent of bladder. ctor's order dated 12/7/16 to rinary catheter due to e ulcer on the left buttock. an's orders for December ebruary 2017 were reviewed. ave an order for catheter	F	315	verified by MDS LPN Coordinator on 3/27/2017. All residents with urinary catheters wer observed on 4/5/17, by the treatment nurse to ensure that catheters were in place and secured. The treatment nur reports that all residents with urinary catheters were in place and secure. Ou resident refuses drainage bag cover ar will move his drainage up above waist while he is up in wheel chair. He refuse to have it placed lower while he is in w chair. All nursing staff will be in-serviced on catheter care, per facility policy, by the Nurse Consultant by 4/14/2017 a. Facility Policy: i. Gather supplies and set up ii. Explain procedure prior to beginni iii. Position resident on back, place protective covering on linens iv. Wash hand and put on gloves v. Wash area front to back, side ther other side, then center always turning cloth to clean area before moving to ne area. Clean stool prior to starting peri/catheter care. vi. Hold catheter gently but firmly nea insertion site. Clean at insertion site the down the catheter with a twisting motio away from the body. vii. Rinse and dry viii. Attach tubing to inner thigh using a fastening devise ix. Place drainage bag in a cover and secure below resident waist. x. Clean area xi. Position resident for comfort xii. Report anything abnormal to nurse	se ne nd es heel ng n ext en on a	

Facility ID: 970412

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · /	TE SURVEY MPLETED
			A. BUILDING	3		С
		345509	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		3/03/2017
	NOVIDER OR OUT FLER			915 PEE DEE ROAD	-	
KINGSWO	OD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO
F 315	Continued From page	e 74	F 31	5		
	The hospital records			follow up.		
		tal discharge summary with		The Treatment Nurse, on 3/27	/17, added	
	admission date of 12	<b>u</b>		Catheter care to the Certified		
	revealed a diagnosis	of "poly microbial UTI		Assistants documentation on t		
	secondary to E coli a	nd enterococcus."		of Daily Living tracking form for		
				residents with a urinary cathet		
		ge summary with admission		Catheter care was observed b	•	
	date of 1/12/ through			Consultants from 3/28/17-3/30		
	secondary to UTI and	etabolic encephalopathy		Floor nurses will be responsib for checking that urinary cathe		
				place and secured. They will c		
	The hospital dischare	ge summary with admission		this on the MAR through the n		
		2/17/17 revealed a diagnosis		April		
		atheter associated UTI."		Audits will be done by the 11p	m-7am	
				Charge Nurse of all residents		
	On 2/28/17 at 4:10 P	M, Resident #4 was		urinary catheter to ensure doc	umentation	
	observed in bed with	<b>u</b>		of catheter care will be done w	eekly for	
		e urinary catheter tubing		one month; then random audit		
	was not secured duri	ng the observation.		done monthly for three (3) mo		
				ensure compliance. 11pm-7a	-	
		1, Resident #4 was observed		Nurse will compile results and		
		ling urinary catheter in place.		Staff Development Coordinate		
	during the observatio	tubing was not secured		Staff Development Coordinato Unit Manager and/or staff nurs	•	
		<i>и</i> <b>1</b> .		observe Certified Nurse Aides		
	On 3/1/17 at 9:06 AM	1, Nurse #3 was interviewed.		urinary catheter care each shi		
		she was the nurse assigned		two weeks then twice a month	-	
		stated that the Treatment		month, then monthly for one m		
	Nurse was responsib	le for providing catheter care		residents with indwelling urina		
	and for ensuring the	catheter tubing was secured.		Observations will be documen	ted and	
		at Resident #4 had history of		turned in to the Staff Developr	nent	
		out and the last time she		Coordinator.		
	pulled it out was on 2	2/27/17.		The QAPI Committee will revie		
	0- 2/4/47 -10:00 41			results for compliance monthly		
		1, NA #6 was interviewed.		(3) months in the monthly QAP		
		e nurses were responsible for		to assure compliance is sustain		
	catheter care but she	e had cleaned the urinary		re-evaluate for compliance for and if compliance is not met w		
	resident had a bowel			for another three (3) months.		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · /		· · · ·	IPLETED
						С
		345509	B. WING			3/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(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)	SHOULD BE	(X5) COMPLETIO DATE
F 315	F 315 Continued From page 75 On 3/1/17 at 9:12 AM, the Treatment Nurse was interviewed. She stated that the nurses working on the floor were responsible for providing		F 31	5 Development Coordinator will to the QAPI meeting.	bring results	
	catheter care and for catheter tubing. The that she was only res to suprapubic catheter catheter. At 10:40 AM indicated that Resider catheter on 2/27/17 a	securing the urinary Treatment Nurse indicated ponsible for providing care r and not indwelling urinary <i>I</i> , the Treatment Nurse nt #4 had pulled out her				
F 323 SS=D	(DON) was interviewed she expected the cath all times and catheter residents with a urina indicated that the num for providing catheter could not find docume was provided to Resid	sing aides were responsible care every shift but she entation that catheter care dent #4. (3) FREE OF ACCIDENT	F 32	3		4/14/17
		onment remains as free				
		s as is possible; and eives adequate supervision es to prevent accidents.				
	appropriate alternativ	acility must attempt to use es prior to installing a side or ide rail is used, the facility				

Facility ID: 970412

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	-	ID HUMAN SERVICES				FORM	APPROVED
							0.0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDI	ING .			с
		345509	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
KINGOW					915 PEE DEE ROAD		
KINGSWC	OOD NURSING CENTER				ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	to the following eleme (1) Assess the reside from bed rails prior to (2) Review the risks a the resident or reside informed consent prior (3) Ensure that the be appropriate for the reside This REQUIREMENT by: Based on observatio interviews and record investigate the root ca monitor for delayed co for 1 of 2 sampled residents. Findings in Resident #42 was add cumulative diagnoses anemia. Resident #42's quarte (MDS) dated 11/22/16 cognitive impairment coded as independent and ambulating in his coded for supervision	nstallation, use, and ails, including but not limited ents. In for risk of entrapment installation. and benefits of bed rails with nt representative and obtain or to installation. ed's dimensions are sident's size and weight. is not met as evidenced n, staff and resident review, the facility failed to ause of 2 falls and failed to omplications related to a fall sidents reviewed for ncluded: mitted 8/22/16 with a of epilepsy, diabetes and erly Minimum Data Set 5 indicated moderate with no behaviors. He was it with transfers, bed mobility room. Resident #42 was with ambulating in the halls,	F	323	F323 Accidents and Hazards Resident #42 is no longer at the facility Nurses and Certified Nursing Aides we in-serviced by the Director of Nursing (DON), Staff Development Coordinato and the Nurse Consultant on Preventic and Reporting of Accidents / Incidents March 2, 2017. Department heads were educated on 3/22/2017 concerning Ro Cause Analysis by the Risk Control Specialist from TIS Health Care Service Division. All Department heads were educated concerning Accident/Incidents on 3/23/2017 by Risk Control Specialist fr TIS Health Care Service Division. All nursing staff will be re-educated on Accident/Incident investigations by	ere r, on on re ot ce	
	continent of bladder a any falls.	bathing. He was coded as and bowel and not coded for isk Assessment was last			<ul> <li>4/14/2017 by DON or Staff Developme Coordinator.</li> <li>Policy and Procedures related to falls were in-serviced with all staff on 3/14/2017</li> <li>All Accidents/incidents will have a</li> </ul>		

Facility ID: 970412

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				PRINTED: 04/17/ FORM APPRC OMB NO. 0938-(	OVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	345509	B. WING		_	,
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE COMPLE E APPROPRIATE DATE	TION
updated 11/22/16 and for falls. Resident #42 was ca moderate risk for falls reviewed on 11/29/16 was updated on 1/25 with interventions to i non-skid socks, re-ed assistance and a the recent care plan revis Resident #42 was red	d it indicated moderate risk re planned on 9/14/16 for a s. This care plan was last 3. Resident #42's care plan /17 to include actual falls nclude frequent rounds, ducation to call for rapy referral. The most sion dated 2/10/17 indicated ceiving physical therapy for	F 32	Accident/Incident form comp shift it occurred or was noted ii. Witness statements will from all involved. iii. Staff is to maintain the s resident. iv. Appropriate preventive i will be initiated on recognitio and after each fall will be up v. DON or Staff Developm Coordinator will investigate a cause. Initiation of appropria	d. be obtained cafety of the nterventions n of fall risk dated. ent all falls for root te	
Falls and Their Caus 2010 read nursing sta resident after a fall for approximately 48 hou suspected fall. The p staff were to identify f A review of the incide #42 sustained falls on 2/6/17 and again on 2 reports indicated the -1/23/17 at 5:10 PM, the floor in front of his getting up from the re- wheelchair when he s were no injuries. The poor safety awarenes noted increased swel	es" last revised October aff were to observe a r a delayed complication for urs after an observed or olicy also read that nursing the possible cause of the fall. ents logs revealed Resident in 1/23/17, 1/25/17, and 2/22/17. The incident following: Resident #42 was found on is recliner. He stated he was ecliner to get into his slipped onto the floor. There root cause was indicated as as and unassisted transfer. It lling to bilateral feet.		Restorative Nursing will be g DON. DON will bring referral Morning Clinical Meeting, ref given to MDS Coordinator to planned and verified with Re Nursing that resident is on co load. The Master Incident Log was include environmental assess falls. Falls identified as havir environmental factor will be of Maintenance Director or faci Administrator. All residents will have a fall r assessment completed by th Nurse. Residents identified a will have a fall care plan and prevent falls updated or initia be completed by 4/13/2017.	viven to the to the ferrals will be be cared storative urrent case s revised to sment on ag a possible evaluated by lity isk the Treatment as a fall risk measures to ated. This will	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DOD NURSING CENTER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page updated 11/22/16 and for falls. Resident #42 was ca moderate risk for falls reviewed on 11/29/16 was updated on 1/25 with interventions to in non-skid socks, re-ec assistance and a their recent care plan reviss Resident #42 was read muscle weakness an A review of the facility Falls and Their Caus 2010 read nursing star resident after a fall for approximately 48 hours suspected fall. The p staff were to identify for A review of the incide #42 sustained falls on 2/6/17 and again on 2 reports indicated the -1/23/17 at 5:10 PM, the floor in front of his getting up from the re- wheelchair when he s were no injuries. The poor safety awarenes noted increased swell	CORRECTION       IDENTIFICATION NUMBER:         345509       345509         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 77 updated 11/22/16 and it indicated moderate risk	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         A BUILDING         345509         ROVIDER OR SUPPLIER         ODD NURSING CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 77 updated 11/22/16 and it indicated moderate risk for falls.         Resident #42 was care planned on 9/14/16 for a moderate risk for falls. This care plan was last reviewed on 11/29/16. Resident #42's care plan was updated on 1/25/17 to include actual falls with interventions to include frequent rounds, non-skid socks, re-education to call for assistance and a therapy referral. The most recent care plan revision dated 2/10/17 indicated Resident #42 was receiving physical therapy for muscle weakness and unsteady gait.         A review of the facility policy titled "Assessing Falls and Their Causes" last revised October 2010 read nursing staff were to observe a resident after a fall for a delayed complication for approximately 48 hours after an observed or suspected fall. The policy also read that nursing staff were to identify the possible cause of the fall.         A review of the incidents logs revealed Resident #42 sustained falls on 1/23/17, 1/25/17, and 2/2/17 and again on 2/22/17. The incident reports indicated the following: -1/23/17 at 5:10 PM, Resident #42 was found on the floor in front of his recliner. He stated he was getting up from the recliner to get into his wheelchair when he slipped onto the floor. There were no injuries. The root cause was indicated as poor safety awareness and una	S FOR MEDICARE & MEDICAID SERVICES         or DEFICIENCIES       (X1) PROVIDERSUPPLERCLIA IDENTFICATION NUMBER       (X2) MULTIPLE CONSTRUCTION A BUILDING         SCORRECTION       345509       STREET ADDRESS, CITY, STATE, ZIP CO 915 PEE DEE ROAD ABERDEEN, NC 28315         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       ID PROVIDER ROAD ABERDEEN, NC 28315         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       ID PREVIDER ROAD ABERDEEN, NC 28315         Continued From page 77 updated 11/22/16 and it indicated moderate risk for fails.       F 323         Resident #42 was care planned on 9/14/16 for a moderate risk for fails. This care plan was last resident freque rounds, non-skid socks, re-education to call for assistance and a thrapy referral. The most recent care plan revision dated 21/01/1 indicated Resident #42 was receiving physical therapy for muscle weakness and unsteady gait.       New referrais from Therapy I Restorative Nursing will be put in pla root cause analysis.         A review of the facility policy titled "Assessing Fails and Their Causes" last revised October 2010 read nursing staff were to observe a suspected fail. The policy also read that nursing staff were to identify the possible cause of the fail. A review of the incidents logs revealed Resident #42 sustained fails on 1/23/17, 1/25/17, and 2/6/17 and again on 1/23/17, 1/25/17, and 2/6/17	MENT OF HEALTH AND FUNAN SERVICES         FORM APPRE           SE OR MEDICARE & MEDICARE BERICAR & MEDICARE

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					OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		(X3) DATE SURVEY COMPLETED
					С
		345509	B. WING		03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 323	Continued From page	e 78	F 32	3	
	nursing staff obtained monitored Resident # that occurred on 1/23 recliner. There was r assessment of how h personal recliner as a -1/25/17 at 7:45 AM. sitting on the floor in f the wheelchair folded wheelchair brakes on was barefooted. The improper footwear an Interventions included neurological check ar	no mention of an e transfers from his a potential fall hazard. Resident #42 was observed front of the toilet. He stated up behind him with the . There were no injuries. He root cause was listed as d poor safety awareness.		<ul> <li>confusion, 1 equipment issue, 3 behrelated, 1 related to positioning, 8 wrelated to resident who over estimate their ability to perform a task and 1 to another resident in a wheelchair.</li> <li>Master Incident Log will be updated Morning Clinical Meeting Monday the Friday. Weekend incidents will be avoid to the Master Incident Log on follow Monday. Master Incident Log on follow Monday. Master Incident Log will be completed by Administrator or DON New referrals from therapy to Restor Nursing will be given to the DON/ designee. DON will bring referrals to Morning Clinical meeting; referral will given to the MDS Coordinator to be planned and verified with Restorative Nursing to ensure resident is on the load.</li> <li>Restorative referrals audit will be downed weekly for one month, twice a month</li> </ul>	ere related in irrough dded ing
	nursing staff failed to or document any mor occurred on 1/25/17 v screen was complete restorative nursing fo A review of the Resto February 2017 in the ambulation and active week starting on 2/6/ #42 was discharged f There were no minute	medical record revealed the obtain neurological checks nitoring after the fall that while toileting. A therapy d and he was referred to r ambulation on 2/3/17. rative Care Flow Record for paper medical record listed e range of motion 6 days a 17 and indicated Resident from restorative on 2/15/17. es listed and no restorative cating Resident #42 received		<ul> <li>one month, then monthly for one monthly for one monthly for one monthly for one monthly the Restorative Nurse. Restorative Nurse will also visually validate the Restorative Certified Nursing Assists are working with the residents being audited.</li> <li>The QAPI Committee will review au results from Master Log Form and Restorative Referrals for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-eval for compliance. If compliance is not review will continue for another three months. The Director of Nursing will responsible for bringing the Coumage Audit log summary to the monthly QAPI meeting to the monthly QAPI meeting the Coumage Audit log summary to the monthy the coumage the coumage the co</li></ul>	ive ants dit dit e uluate met e (3) II be din

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
KINGSWC	OD NURSING CENTER			91	15 PEE DEE ROAD		
				A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 323	sitting on the floor with next to the bathroom. something in the close weak. He stated he le door and slid to the flo The root cause was in	esident #42 was observed h his back against the wall He stated he was getting et and his legs became eaned against the closet por. There were no injuries. dentified as unsteady gait	F	323	bring audits of dietary supplements to monthly QAPI meetings. The Restora Nurse will bring the results of the restorative audits to the monthly QAP Meetings. Date of Compliance 4/14/17	tive	
	encouraged to call for clothes out of the clos neurological checks.	veakness. Resident #42 was assistance with getting his set, a therapy consult and medical record revealed the					
	nursing staff obtained monitored Resident #	neurological checks and 42 as ordered for the fall 17 while trying to retrieve					
	stated he was transfe wheelchair to go to be unsteady gait, unassi- safety awareness. In consult, neurological call for assistance. T	Resident #42 was ht in front of his recliner. He rring from the recliner to the ed. The root cause was sted transfers and poor terventions included therapy check and re-education to he form indicated Resident iving physical therapy.					
	nursing staff obtained	o mention of an e transfers from his					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING _			_		C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	K	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	80	F	323				
		esident #42 was on 7 until 2/24/17 when he n potential. A restorative						
	#42 cautioned the sur personal recliner beca it was easy to slide ou	7/17 at 9:17 AM, Resident rveyor against sitting in his ause it would tip forward and ut onto the floor. He stated <i>v</i> ing to get up from the						
	RA #2 stated they did with Resident #42. R/ caseload, they would minutes on the Resto RA #1 and RA #2 stat	/17 at 10:10 AM, RA #1 and not recall doing restorative A #1 stated if he was on their have documented their rative Care Flow Record. ted they normally got their her the MDS nurse or the bordinator (SDC).						
	reviewed falls weekly stated she did not rea Resident #42 ' s occu recliner. The rehabilita Resident #42 ' s famil home but it should ha	stated the facility met and to find the root cause. She lize until 3/1/17 that two of rred from his personal						

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	S FOR MEDICARE &	MEDICAID SERVICES			DNSTRUCTION		B NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	` <i>`</i>			COMPLETED	
		345509	B. WING				C 03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP COL	DE	
KINGSWC	OOD NURSING CENTER				PEE DEE ROAD ERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 323 F 325 SS=D	stated he did not real 2/21/17 were from Re recliner. He stated the assessed for safety a non-skid material in t be removed, it should before 3/1/17. The SI practice to do neurold residents who fall for was unable to explain monitoring or assess on 1/25/17. In an interview on 3/2 of Nursing stated it w Resident #42's perso assessed for a possil stated it was her exp would have been mo fall on 1/25/17. 483.25(g)(1)(3) MAIN UNLESS UNAVOIDA (g) Assisted nutrition (Includes naso-gastri both percutaneous en	<ul> <li>2/17 at 3:40 PM, the SDC</li> <li>ize the fall on 1/23/17 and</li> <li>exident #42 's personal</li> <li>e recliner should have been</li> <li>and if it needed some</li> <li>he seat or maybe needed to</li> <li>d have been addressed</li> <li>DC stated it was the facility</li> <li>bgical checks and monitor</li> <li>48 hours after the fall but</li> <li>n why no follow up</li> <li>sment was done after the fall</li> <li>2/17 at 9:30 AM, the Director</li> <li>as her expectation that</li> <li>nal recliner would have been</li> <li>ble fall hazard. She further</li> <li>ectation that Resident #42</li> <li>nitored for 48 hours after his</li> <li>ITAIN NUTRITION STATUS</li> <li>BLE</li> <li>and hydration.</li> <li>c and gastrostomy tubes,</li> <li>ndoscopic gastrostomy and</li> <li>copic jejunostomy, and</li> </ul>		323			4/14/17
	ensure that a residen (1) Maintains accepta status, such as usual body weight range ar	able parameters of nutritional body weight or desirable nd electrolyte balance, unless condition demonstrates that					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				915 PEE DEE ROAD	
KINGSWO	OD NURSING CENTER			ABERDEEN, NC 28315	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
F 325	Continued From page	e 82	F 325		
	indicate otherwise;	5.02	1 020		
	nutritional problem an orders a therapeutic	peutic diet when there is a nd the health care provider diet. F is not met as evidenced			
	review, the facility fai orders for Remeron ( stimulant/antidepress (nutritional suppleme			F325 Nutrition Status Resident #117: On 3/22/17, the R Registered Dietician reviewed resi status. She recommended diet liberalization to regular/mechanica with thin liquids to maximize intake	ident's al soft
	to address weight los sampled 3 residents	is (Resident #87) for 2 of reviewed for Nutrition. The		cup every day at lunch for nutrition support and to increase protein, he	nal ouse
	findings included:			supplement 120ml three times a d discontinue ensure. Change supp	plement
		s admitted to the facility on		to provide increased calories and	-
		ses that included cerebral pertensive heart disease		for low protein level and aide woul healing, and add vitamin C and zir	
		type 2 Diabetes Mellitus.		days to promote wound healing. T physician approved the	
	•	te from the Dietary Manager ndicated Resident #117 was ded Salt (NAS) diet.		recommendations. Resident #87: The Regional Regi Dietician reviewed resident's statu	
		ht was 109 pounds (lbs).		3/23/17. She Recommended discontinuation of protein powder	
	12/1/16, included the	Resident #117, initiated on need/problem area of a		secondary to increased protein	ovide by use
	-	. The goal for Resident #117 ht weight loss during the 90		supplement and magic cups. Phy approved recommendations. Weight management plans of care	e for
	The admission Minim	um Data Set (MDS) 2/2/16 indicated Resident		both Residents #87 and #117 hav reviewed and updated by the MDS Coordinator Residents will be we	S LPN
	#117 was cognitively			Coordinator. Residents will be wei weekly and discussed in Standard	-
		f with set up assistance for		Care (SOC) meeting weekly to en	
	-	7 was assessed with no		residents' nutritional needs are be	
	-	d she was indicated to be		Consultant Pharmacist reviewed	<b>J</b>

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING \_\_\_ С 345509 B. WING 03/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 325 Continued From page 83 F 325 edentulous (no natural teeth). Her documented medications for Resident #117 on 3/28/17 weight was 109 lbs. and recommended a Hemoglobin A1C be ordered. The Consultant Pharmacist A DM note dated 12/8/16 indicated Resident reviewed medications for resident # 87 on #117's weight was 104 lbs. Resident #117 3/28/17 and recommended reducing reportedly consumed 45-50% of meals. No dosage of Lexapro. Physician accepted changes were indicated for Resident #117 's diet. recommendation and order was carried out A physician's order dated 12/21/16 indicated a Resident #87 and #117, all physician dietary consultation for weight loss, Resource orders were reviewed by the Director of (nutritional supplement) 90 milliliters (ml) three Nursing (DON) on 3/6/17. Medications are times daily with medication pass, and Remeron being administered as ordered. (antidepressant and appetite stimulant) 7.5 Facility Registered Dietician and Divisional milligrams (mg) once daily at bed time. Registered Dietician will complete a comparison of physician signed orders A DM note dated 12/22/16 indicated Resident against Meal Tracker software to ensure #117's weight was 103 lbs. Her weight was down 100% accuracy of diets and supplements 6 lbs since 12/1/16 (109 lbs). by 4/14/17. Residents with significant weight loss A Registered Dietician (RD) note dated 12/22/16 noted will be weighed weekly until weight indicated Resident #117's weights included is stable. Residents with significant weight 12/13/16: 103 lbs and 12/1/16: 109 lbs. She was loss will be discussed in SOC meeting recently ordered a nutritional supplement and weekly until weight is stable or it Remeron. Laboratory results dated 12/7/16 determined resident is "Unavoidable indicated Resident #117 had low Albumin Weight Loss". Food Service Director (measurement of protein) results of 3.4 (normal (CDM) will generate the list of those range was 3.5-5.0). The RD had no additional residents with significant weight loss to be recommendations for Resident #117 at that time. weighed weekly. Staff Nurses may contact the Food Service Director (CDM) to add Laboratory results dated 12/30/16 indicated to this list resident's they suspect have a Resident #117 had low Albumin results of 2.8. weight loss. All new admissions and newly identified The December 2016 Medication Administration residents with weight loss will be Record (MAR) for Resident #117 was reviewed. communicated with facility Registered It indicated Resource 90 ml three times daily was Dietician by the Food Service Director added to the MAR on 12/21/16 and was (CDM). These residents will also be administered to Resident #117 three times daily added to the weekly weight list maintained throughout the remainder of December. It also by the Food Service Director. indicated Remeron 7.5mg once daily at bed time **Restorative Certified Nursing Assistants**

FORM CMS-2567(02-99) Previous Versions Obsolete

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			(20) 1411		CONSTRUCTION		D. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
			A. BUILDING	G			С
		345509	B. WING				
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03	/03/2017
					15 PEE DEE ROAD		
KINGSWC	OD NURSING CENTER			ABERDEEN, NC 28315			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 325	Continued From page	- 94	E 00	0.5			
1 525	Continued From page		F 32	25	(DONA) weigh all regidents. They will		
		R on 12/22/16 and was dent #117 once daily at bed			(RCNA) weigh all residents. They will follow facility policy to weigh all new		
	time the remainder of	-			admissions weekly x4, then monthly		
					unless otherwise indicated by the		
	Resident #117's weig	ht record indicated a weight			Restorative Nurse upon review of weig	hts.	
		This was a 14% weight loss			All residents are weighed monthly.		
	since 12/1/16 (109 lb	s) for Resident #117.			Residents with significant weight change	ges	
					will be weighed weekly at direction of		
		of care for Resident #117			Restorative Nurse or by agreement of		
	-	de the need/problem area of			SOC Committee (members include: DC	ON,	
		rventions included the			Staff Development/Restorative Nurse,		
	provision of a dietary	supplement as ordered.			MDS LPN Coordinator, Treatment Nurs	se,	
	The medical record in	ndicated Resident #117 went			Food Service Director, Social Service Director and therapy representative.)		
		e with family on 1/16/17.			All resident's weights were reviewed for	or	
		bsence she was admitted to			significant changes in weight by the		
		7 and was discharged from			Divisional and Facility Registered		
	the facility.	<u> </u>			Dieticians on 3/23/2017 and 4/7/17.		
					Another audit checking for weight loss	will	
	The January 2017 M/	AR from 1/1/17 through			be done on 4/11/17. Care plans were		
	1/16/17 for Resident	#117 was reviewed. The			updated by the Divisional and Facility		
		cumentation of Resident			Registered Dieticians and by the Food		
	-	ministered Remeron 7.5 mg			Service Directors.		
	-	e or Resource 90 ml three			Facility Registered Dietician will		
	times daily.				communicate his/her findings to the		
	An interview was con	ducted with the Director of			Administrator and Director of Nursing. Weights are monitored weekly by the		
		28/17 at 12:18 PM. The			CDM. Residents with significant weigh	ht	
		or Resident #117 that			loss will be reviewed in Standards Of C		
	indicated she had not				(SOC) meeting weekly until weight is		
	Resource 90 ml three	e times daily or Remeron			stable. Food Service Director will bring		
		ped time at any point from			printed copies of weights to SOC meet		
	-	7 was reviewed with the			for all members to review. This is an		
		ere was no evidence that			ongoing process to manage significant		
		ed Resource or Remeron			weight changes in the facility.		
	from 1/1/17 through 1	1/16/17.			All new admissions and newly identifie	d	
		as conducted with the DON			residents with weight loss will be		
		as conducted with the DON			communicated with Registered Dieticia	411	
		M. The DON provided a			by the Food Service Director.		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · /	PLETED
						с
		345509	B. WING		03/	03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 325	Continued From page	9 85	F 32	5		
	indicated the facility h medication errors and Error Report forms or identified. She revea Medication Error Rep forgotten about this m #81 when she was im (2/28/17 at 12:18 PM medication error was on 1/17/17. Resident received Remeron or through 1/16/17 due to MAR. The form revea poor appetite and cor DON indicated when were transcribed from 2017 the Remeron ar mistakenly omitted ar identified until 1/17/17 the error the MARs w nurses and were not Nurses. She indicated	d had completed Medication n each error that had been led she had a "stack" of orts. She reported she had nedication error for Resident terviewed earlier this day ). The form indicated a identified for Resident #117 #117 was noted to have not Resource from 1/1/17 to a transcription error on the aled Resident #117 had a ntinued to lose weight. The the MARs for Resident #117 n December 2016 to January and Resource had been		An audit will be completed by 4/13 a nurse manager, of resident's wil for Remeron and supplements to they are being given as ordered. be completed monthly for three (3 months. The QAPI Committee will review a results for compliance monthly for (3) months in the monthly QAPI m to assure compliance is sustained re-evaluate for compliance for cor and if compliance is not met will c for another three (3) months. The Service Director will bring significa weight change report to QAPI met monthly.	h orders ensure Audit will ) audit three eeting . Will npliance pontinue Food ant	
	2/28/17 at 4:00 PM. familiar with Resident order dated 12/21/16 daily at bed time and daily for Resident #11 RD. The medication that indicated Reside ordered Remeron or through 1/16/17 was indicated she had not	s conducted with the RD on She indicated she was #117. The physician's for Remeron 7.5mg once Resource 90 ml three times 7 were reviewed with the error report dated 1/17/17 nt #117 had not received the Resource from 1/1/17 reviewed with the RD. She been made aware of the she expected to be informed				

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED 8 NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) [	DATE SURVEY COMPLETED
		345509	B. WING				C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	Continued From page	86	F	325	5		
	DON on 3/2/17 at 10: expectation was for p followed. 2. Resident #87 was 7/7/15. Cumulative di without behavioral dis low potassium level ir A Quarterly Minimum 12/13/16 indicated Re impaired in cognition. with eating. Weight d assessment period w weight loss or gain. A nutritional assessm Resident #87 weigher There was no decrea	Data Set (MDS) dated esident #87 was severely She required supervision locumented during the as 121 pounds with no ent dated 12/13/16 indicated d 121.4 pounds on 12/4/16. se in food intake and no d. Resident #87 was within					
	12/13/16 at 1:20 PM s weight was 121.4 pour added salt/ double por herself and might req Weight was down 1.1 3.19% in three month months. Resident was problems at this time index) of 22. Continue A care plan dated 7/6 indicated Resident #8 Additions to the probl	s doing well with no and had a BMI (body mass e to monitor. /16 and last reviewed 1/2/17 87 was on a therapeutic diet. em dated 11/2/16 stated pression. Goals were to be					

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION			LETED
		345509	B. WING			_		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	loss. Approaches inc equivalent substitute i weight as appropriate and record. Encourag compliance. Dietary o physician of change o and symptoms of deh added on 12/28/16 wa times daily for nutritio protein rich foods. A nursing note dated #87 had to be encoura- her medicine every da diet. Physician orders for F diet order for regular of potassium rich foods. (protein powder) in 8 daily after eating (9:00 with the original physi Protein powder 1 scor- times daily for supple 4:00PM) with the orig 12/28/16. There was super foods or for dour A Registered Dieticiar at 5:40PM stated Res added salt diet. She scoop three times dai was noted at 50-75% snacks. Weight was of pounds with a weight the last 6 months. Por might be due to hypot	ot have significant weight luded diet as ordered. Offer if needed. Monthly/ weekly . Monitor percentage eaten ge adequate intake and consult. Notify family/ of status. Monitor for signs ydration. Interventions as protein supplement three nal support and on 1/2/17 1/12/17 indicated Resident aged a great deal to take ay and ate very little of her February 2017 revealed a no added salt diet with House supplement powder ounces of water three times DAM, 1:00PM and 5:00PM) cian order dated 7/24/15. op in 4 ounces of fluid three ment (8:00AM, 12 noon and inal physician order dated not a physician's order for uble portions. n's (RD) note dated 2/16/17 ident #87 was on a no received protein powder 1 ly and super foods. Intake and she accepted bedtime	F 3	25				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 // APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE	
		345509	B. WING	-			C 03/2017
	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	03/2017
					915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER				ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 325	2016 through Februar	nt loss. #87's weights from August ry 2017 revealed the	F	325	5		
	pounds; 10/1/16124 pounds; 12/4/16121 pounds and 2/5/171	percent weight loss from					
	Resident #87 reveale 50-100% of breakfast	rsonal Care Record for d she usually consumed , 0-25% of lunch and dinner. ently documented as refused					
	Resident #87 reveale 50-100% of breakfast	Personal Care Record for d she usually consumed and dinner and usually unch. Bedtime snacks were					
	conducted during the was feeding herself a protein supplement an of a grilled cheese sa	M, an observation was lunch meal. Resident #87 nd consumed 100% of the nd approximately 75 percent ndwich. Resident #87 had getable and consumed very					
	and also usually ate c	illed cheese sandwiches only pancakes for breakfast.					
		PM, an interview was etary Manager. The Dietary dent #87 received super					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KINGSWC	OD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 325	oatmeal (add brown s calories) and/or fortifi each meal. She said Resident #87 should as ordered by the phy resident's tray card in foods. The Dietary M was still at a good we were no changes to F December 2016. On 2/28/17 at 4:59PM reviewed Resident #8 current diet was no ac When asked why Res any super foods or po lunch meal of 2/28/17 should have received for the super food. SI should have potassiu On 3/1/17 at 10:10AM conducted with Physic reviewed her notes an weight loss for Reside not implemented anyf weight loss. The physic just missed it. She st Marinol or Remeron to appetite and would or supplement. On 03/01/2017 at 10:: conducted with the Res She stated Resident a meals and she noted averaged 50-75% wh	consisted of foods such as sugar, fortified milk for extra ied mashed potatoes at she was not aware that have potassium rich foods visician 1/2/17 and said the dicated regular diet/ super anager stated Resident #87 ight and that was why there Resident #87's diet in 4, the Dietary Manager it's diet slip that stated her died salt with super foods. sident #87 did not receive btassium rich foods for the c, she stated Resident #87 fortified mashed potatoes he was unaware that she m rich foods. 4, an interview was cian #2. The physician hd stated she had noted ent #87 on 2/14/17 but had thing to prevent further sician said she must have ated she would order o increase the resident's	F	325			

Facility ID: 970412

If continuation sheet Page 90 of 160

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 103/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 325 F 329 SS=E	Resident #87's nutrition 2/16/17, she review skilled nursing summares ident's average maindicated Resident #8 and 100% of snacks. review the resident's meal consumption, winursing assistants, and #87 consumed less of documented the reside summary. The RD states something else in planes ident #87's weight loss if she had eating less at meals to on the resident's wee 483.45(d)(e)(1)-(2) DI FROM UNNECESSA 483.45(d) Unnecessary drugs. Adrug when used	onal status and weight loss wed the resident's weekly ary to determine the eal consumption which 7 consumed 75% of meals The RD stated she did not Personal Care Record for hich was completed by the nd reflected that Resident f her meals than what was lent's weekly skilled nursing ated she would have put ce on 2/16/17 to address t loss and prevent further I known the resident was han what was documented kly skilled nursing summary. RUG REGIMEN IS FREE RY DRUGS ary Drugs-General. regimen must be free from An unnecessary drug is any (including duplicate drug ation; or		325			4/14/17

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/17/201 MAPPROVEI D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	paragraphs (d)(1) thr 483.45(e) Psychotrop Based on a compreh- resident, the facility n (1) Residents who ha drugs are not given th medication is necess	of the reasons stated in ough (5) of this section. bic Drugs. ensive assessment of a nust ensure that ave not used psychotropic hese drugs unless the	F	329			
	gradual dose reduction interventions, unless an effort to discontinu This REQUIREMENT by:	clinically contraindicated, in ue these drugs; Γ is not met as evidenced					
	facility failed to obtain monitor the use of a s (Residents #39) of 5 for unnecessary drug 1. Resident #39 was 8/15/15. Cumulative hypercholesterolemia	admitted to the facility on			F329 Drug Regimen Resident #39: Upon reviewing of media record by the Consultant Pharmacist ar the Staff Development Coordinator, lab results were found for a general chemis profile that included liver function resul as well. This was completed 10/4/16, therefore no new liver function panel was ordered. A Lipid panel was drawn 3/24 and indicated the following results: Cholesterol 134 Normal Ran	nd stry ts as /17	
	revealed an order for	medication) 20 milligrams			-199 Triglycerides 177 (H) -149 HDL-Cholesterol 38.4 (L) 40-60	0	
		w revealed there were no a lipid panel or liver panel			LDL-Calculated 60 -99	0	

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 04/17/20 FORM APPROVE MB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	()	X3) DATE SURVEY COMPLETED
		345509	B. WING				C 03/03/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OD NURSING CENTER			91	15 PEE DEE ROAD		
RINGSWO	OD NORSING CENTER			Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	Continued From page		F	329			
		e facility 8/15/15. (These completed for the monitoring			VLDL 35 All residents with cholesterol lowe	6-40	)
	A review of the month reviews revealed no in laboratory monitoring atorvastatin calcium. On 2/28/2017 at 4:25 conducted with the D the last lipid panel was had changed the phat first visit was in Febru recommendations an recommendation for in On 3/1/17 at 1:05PM with Physician #1. He have at least a yearly panel. Physician #1 pharmacy consultant monitoring by writing he had not received a	hly pharmacy consultant recommendations for for the use of the PM, an interview was irector of Nursing who stated as in 2015. She said they irmacy consultant and his uary. She reviewed the d said there was not a resident. , an interview was conducted e stated Resident #39 should a lab for cholesterol and liver said he relied on the to help him remember the recommendations. He said any pharmacy at Resident had not had any			medications have had a lipid panel performed in the last 12 months of completed by 4/6/17 as noted by pharmacist and Staff Development Coordinator. All residents receiving cholestero lowering medications will have a lip panel performed annually. A file his developed to alert Unit Managers Director of Nursing (DON) when I due for each resident, which inclu- those with cholesterol lowering medications so that lipid panels a annually. Consultant Pharmacist will review medical record of same residents ensure cholesterol lowering medi- have been monitored. Consultant Pharmacist visited on 3/27 & 3/28 reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs pres- needed. Consultant Pharmacist will review record of residents with cholester lowering medications to ensure th of medications have been monito evidenced by lab results. This wa on 3/27 & 3/28/17. He will continu- part of his routine monthly review All new admission and re-admiss be reviewed for cholesterol lower	el or was the nt lipid has bee and abs are ides re done w and cations cations and cations cations cations cations cations cations cations cations cations cations cations cations cations cations cations cations cations cati	e al s
					medication monitoring by the DO Assistant Director of Nursing and Staff Development Coordinator. Current residents with new choles	/or the	DL.

Event ID: 5IT011

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		LETED
		345509	B. WING				C 03/2017
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD		
					BERDEEN, NC 28315		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	93	F 3	329	lowering medications ordered will be reviewed to ensure lab monitoring is in place. They will be added to the file tha alerts Unit Managers and the DON to upcoming labs when orders are reviewe in Morning Meeting by the DON and Ur Manager/ Staff Development Coordinat The QAPI Committee will review Consultant Pharmacist report brought b the Consultant Pharmacist or DON for compliance monthly for three (3) month in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluat for compliance for compliance and if compliance is not met will continue for another three (3) months.	it ed hit tor. Dy	
F 333 SS=D	SIGNIFICANT MED E 483.45(f) Medication I The facility must ensu (f)(2) Residents are fr medication errors. This REQUIREMENT	ERRORS Errors. ure that its-	F 3	333			4/14/17
	physician interview, th physician's order for 0 medication) resulting higher dose than order (Resident #81) review medications. The fac physician's order for A medication) resulting higher dose than order	ility also failed to follow the			F333 Medication Errors Resident #81, Coumadin is being administered as ordered. Review was done by the Director of Nursing (DON) and Nurse Consultant, of the Medicatio Administration Record (MAR) and curre orders on 3/6/17. Resident #81's physician orders have been reviewed to ensure they are curre and accurate. Review was done by the Director of Nursing (DON) and Nurse	ent ent	

Event ID: 5IT011

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2 FORM APPRON OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345509	B. WING		03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER	1	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWC	OOD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETI
F 333	Continued From page	e 94	F 333		
		I records. The findings		Consultant, of the Medication Administration Record (MAR) and orders on 3/6/17.	current
	facility on 6/29/11 and	initially admitted to the d most recently readmitted noses that included heart		Resident #81's MARs have been reviewed to ensure current does is given as ordered. Review was dor Director of Nursing (DON) and Nu Consultant, of the Medication	ne by the
	need/problem area o This need/problem a	Resident #81 included the f anticoagulant drug use. rea was initiated on Resident 20/16. The interventions		Administration Record (MAR) and orders on 3/6/17. Resident #87 Ativan is being admi as ordered Review was done by th	inistered
	included the administ ordered for Resident	tration of medications as #81.		of MAR and current physician's or 3/6/17. Resident #87's physician orders h	der on ave
	A physician's order d Coumadin (anticoagu milligrams (mg) once Resident #81.	-		been reviewed to ensure current a accurate. Review was done by the of MAR and current physician's or 3/6/17.	DON
	#81 had moderate co indicated to have rec	2/6/16 indicated Resident ognitive impairment. He was		Resident #87's MARs have been reviewed to ensure current does is given as ordered. Review was dor DON of MAR and current physicia order on 3/6/17. Resident #87's is accurate as of M 2017 as reviewed by the DON.	ne by the in's
	Resident #81's PT/IN Time/International No	ated 12/6/16 indicated IR (Prothrombin ormalized Ratio), a test used veness of anticoagulant		All nurses will be educated on imp of documenting narcotic pain med on MAR as well as maintenance th narcotic count sheet accurately by 4/14/2017.	ications he
	medication, was outs Resident #81's PT wa (normal range of 10.7	veness of anticoaguiant ide of the normal limits. as indicated as high at 37.2 7-13.4) and his INR was also range of 0.89-1.11). The		Narcotic Audit sheet for each resid been placed in resident's MAR to medications are documented as g coming and off going staff nurse w	ensure iven. On
	laboratory results ind notified on 12/7/16 of	icated the physician was FResident #81's PT/INR sician's orders were received.		that documentation is complete at change of shift. The Coumadin Audit tracking tool initiated on December 22, 2016 to	each was

Facility ID: 970412

		MEDICAID SERVICES				<u>VO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,			TE SURVEY MPLETED
			A. BUILDIN	IG		
		345509	B. WING			C
		545509		STREET ADDRESS, CITY, STATE, ZIP CODE		3/03/2017
NAME OF P	ROVIDER OR SUPPLIER					
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC
F 333	Continued From page	e 95	F 3	33		
		ated 12/7/16 indicated to		Coumadin administration as or	dered in	
		Coumadin (9.5mg) that		response to the medication error		
		d then start Coumadin 9mg		December 19, 2016. This tool		
	daily on 12/8/16.			maintained by the DON.		
				11pm to 7am and 7pm -7am nu		
		ated 12/19/16 indicated		be in-serviced on completing c		
		or Resident #81. A follow up		each evening by 4/14/2017 by		
	indicated a discontinu	s written on 12/19/16 that		Consultant or the Corporate Cl Nurse.	inical	
		the start of Coumadin 9.5mg		All nurses will be in-serviced or	n the	
	for Resident #81.			correct procedure in transcribir		
				physician orders by 4/14/2017.		
	A review of the Decer	mber 2016 Medication		MARs for the upcoming month	will be	
		d (MAR) for Resident #81		double checked by administrat		
	indicated he was adn			against current monthly MARs.		
		at bed time from 12/1/16		Narcotic Audit sheet for each re		
	-	rdered. On 12/7/16 the		been placed in resident's MAR		
		old Coumadin was followed rther review of the MAR		reviewed daily Monday through 11p-7a Charge Nurse, Narcotic		
		through 12/18/16 Resident		Sheets for Saturday and Sunda		
		d 9.5mg of Coumadin once		included with the audit done or	-	
		ead of Coumadin 9mg once		for one month then weekly for	-	
		ne physician on 12/7/16.		weekly x 2 for one month. Cha		
		Iministrations of a higher		will give completed audits with	summary	
	dose of Coumadin the	an ordered for Resident #81.		to the DON weekly on Fridays.		
				a. The Coumadin Audit track	0	
		ducted with the Director of 28/17 at 2:20 PM. She		monitored by the Director of Nu Monday through Friday. Orders	•	
	indicated the facility h			changes received Saturday an		
		d had completed Medication		will be updated to the log on M		
		n each error that had been		orders initiating and change or		
	-	d she had a "stack" of		will be transcribed by the staff		
	Medication Error Rep	oorts.		receiving order to include corre		
				transcription to the MAR and la		
		M the DON provided a		requested completed as neede	ed.	
		ort for Resident #81. The				
		ication error was identified		An audit of all residents receivi	-	
		12/19/16. Resident #81 was dministered the incorrect		Coumadin will be completed to medication errors by 4/13/17.	verity no	
				11000000000000000000000000000000000000		

Facility ID: 970412

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	E CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			PLETED
		345509	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	545505			STREET ADDRESS, CITY, STATE, ZIP CODE	03	/03/2017
					015 PEE DEE ROAD		
KINGSWC	OD NURSING CENTER			A	ABERDEEN, NC 28315		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	dosage of Coumadin 12/18/16 due to a trai The form indicated no occurred for Resident section that indicated taken to prevent the r errors. This section h An interview was com physician on 3/1/17 a Error Report dated 12 was reviewed with the she had been made a 12/19/16 and she ord #81 when she was in after assessing Resid from 12/19/16 she fel any harm by the error concern to her that he dated 12/7/16 for Cou 12/8/16 had not been indicated it was her e be followed. An interview was con 3/2/17 at 10:40 AM. expectation was for p followed. 2. Resident #87 was 7/7/15. Cumulative of dementia without beh depression. A Quarterly Minimum	from 12/8/16 through nscription error on the MAR. o harm or adverse reaction t #81. The form had a the measures that were reoccurrence of similar had not been completed. ducted with Resident #81's t 10:02 AM. The Medication 2/19/16 for Resident #81 e physician. She indicated aware of the error on lered a PT/INR for Resident formed. She reported that dent #81's PT/INR results t he had not been caused r. She revealed it was a er order for Resident #81 umadin 9mg starting on followed. The physician expectation for her orders to ducted with the DON on She indicated her shysician 's orders to be admitted to the facility on diagnoses included havioral disturbance and Data Set (MDS) dated esident #87 was severely	F 3	333	The QAPI Committee will review result the Narcotic Audit and the Coumadin A for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for complia and if compliance is not met will contin for another three (3) months. Audits w be brought to the QAPI Committee meeting by the DON.	Audit o ince nue	
	A physician's order da	ated 12/19/16 revealed an					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVE COMPLETED         NAME OF PROVIDER OR SUPPLIER       345509       B. WING       C         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       03/03/20         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       915 PEE DEE ROAD ABERDEEN, NC 28315       915 PEE DEE ROAD ABERDEEN, NC 28315         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM         F 333       Continued From page 97 order for Ativan (anti-anxiety medication) 0.25 milligrams by mouth daily. Discontinue Ativan 0.5 milligrams by mouth twice daily.       F 333       F 333		ARTMENT OF HEALTH AN ITERS FOR MEDICARE &					FORM	): 04/17/2017 1 APPROVED ). 0938-0391
345509     B. WING     03/03/20       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     915 PEE DEE ROAD       KINGSWOOD NURSING CENTER     915 PEE DEE ROAD     ABERDEEN, NC 28315       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COM COM COM CROSS-REFERENCED TO THE APPROPRIATE     COM COM CROSS-REFERENCED TO THE APPROPRIATE       F 333     Continued From page 97 order for Ativan (anti-anxiety medication) 0.25 milligrams by mouth daily. Discontinue Ativan 0.5 milligrams by mouth daily. Discontinue Ativan 0.5     F 333	ATEMENT OF	IENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · ·			(X3) DATE COMP	SURVEY LETED
915 PEE DEE ROAD ABERDEEN, NC 28315         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Comment Comment Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Comment Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Comment Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Comment Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Comment (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       State (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       State (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       State (EACH CORRECTIVE ACTION SHOULD SH			345509	B. WING		_		
KINGSWOOD NURSING CENTER         KINGSWOOD NURSING CENTER       ABERDEEN, NC 28315         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM COM COM COM COM COM COM COM COM COM	NAME OF PRO	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMING         F 333       Continued From page 97 order for Ativan (anti-anxiety medication) 0.25 milligrams by mouth daily. Discontinue Ativan 0.5 milligrams by mouth twice daily.       F 333       F 333	KINGSWOO	SWOOD NURSING CENTER						
order for Ativan (anti-anxiety medication) 0.25 milligrams by mouth daily. Discontinue Ativan 0.5 milligrams by mouth twice daily.	PREFIX	FIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
A review of the Control drug reconciliation sheet revealed Ativan 0.25 milligrams was administered two times daily on 12/19/16, 12/20/16, 12/27/16 and 12/28/16, 12/25/16, 12/26/16, 12/27/16 and there was no documentation that Resident #87 had any adverse effects from medication. On 3/11/17 at 10:15AM, an interview was conducted with Physician #2. She stated she had been informed by one of the facility staff that Resident #87 had received two doses of Ativan daily instead of one dose as ordered. The physician said she thought Resident #87 became more somolent possibly due to the added dose and she expected staff to follow physician orders. On 3/2/17 at 8:30AM, an interview was conducted with the MDS Coordinator who stated she was doing the end of the month reconciliation of physician orders and Medication Administration Records (MAR) from December to January when she found that Resident #87 had received Ativan in the evening as well as on day shift. She said the nurse who administered the evening medication no longer worked at the facility. On 3/02/17 at 10:13AM, an interview was conducted with the Director of Nursing who stated the nurse should have administered the medications by reading the MAR that had the correct dosage documented the medications by memory.		order for Ativan (anti- milligrams by mouth of milligrams by mouth of A review of the Contr revealed Ativan 0.25 two times daily on 12 12/22/16, 12/23/16, 1 and 12/28/16. Nursing notes were re and there was no doo #87 had any adverse On 3/1/17 at 10:15AM conducted with Physic been informed by one Resident #87 had red daily instead of one of physician said she th more somnolent poss and she expected sta On 3/2/17 at 8:30AM with the MDS Coordin doing the end of the re physician orders and Records (MAR) from she found that Reside in the evening as well the nurse who admin medication no longer On 3/02/17 at 10:13A conducted with the D the nurse should hav medications by readin correct dosage docur	anxiety medication) 0.25 daily. Discontinue Ativan 0.5 twice daily. ol drug reconciliation sheet milligrams was administered /19/16, 12/20/16, 12/21/16, 2/25/16, 12/26/16, 12/27/16 eviewed for December 2016 cumentation that Resident effects from medication. <i>A</i> , an interview was cian #2. She stated she had e of the facility staff that ceived two doses of Ativan lose as ordered. The ought Resident #87 became sibly due to the added dose aff to follow physician orders. , an interview was conducted hator who stated she was month reconciliation of Medication Administration December to January when ent #87 had received Ativan I as on day shift. She said istered the evening worked at the facility. M, an interview was irector of Nursing who stated e administered the ng the MAR that had the mented on 12/19/16 and not	F 33	33			

Facility ID: 970412

If continuation sheet Page 98 of 160

TATEMENT C	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY PLETED
	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDI	NG _			C
		345509	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER		915 PEE DEE ROAD ABERDEEN, NC 28315		15 PEE DEE ROAD BERDEEN. NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIO DATE
F 333	conducted with Nurse employed at the facili	, a telephone interview was e #5 who was no longer ity. She stated she had not e medication change and	F	333			
F 354 SS=D		VER-RN 8 HRS 7	F	354			4/14/17
	(f) of this section, the	ed nurse for at least 8					
	(f) of this section, the	ved under paragraph (e) or facility must designate a erve as the director of basis.					
	nurse only when the occupancy of 60 or fe	rsing may serve as a charge facility has an average daily ewer residents. Γ is not met as evidenced					
	interviews, the facility a Registered Nurse ( of Nursing (DON) or (MDS), for 8 consecu average daily census	ons, record review and 7 failed to use the services of RN), other than the Director the Minimum Data Set RN utive hours daily with an 5 of 79 residents for 38 of 59 7 through 2/28/17) Findings			F354 RN Waiver The facility is using the services of a registered nurse for at least eight (8) consecutive hours seven days a week. The Administrator will receive the staffin sheet for the next day with the name of the RN providing RN coverage. The Administrator will then give the sheet to the Human Resource Director (HR). HR	-	
	sheets for January 1, indicated the followin	-			will verify that the RN named did provide hours of coverage on the assigned day checking Time Tender. An audit will be completed daily to reflect	e 8 by ct	
	On Monday 1/2/17, the RN coverage.	ne MDS nurse was listed as			the required registered nurse coverage. Audit will be done daily by Human		

Facility ID: 970412

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/17/2017 RM APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DAT	e survey Ipleted
		345509	B. WING			03	C 3/03/2017
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER			91	15 PEE DEE ROAD		
KINGSWC	JOD NORSING CENTER			Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 354	On Wednesday 1/4/1 as the RN coverage. On Thursday 1/5/17, the RN coverage. On Friday 1/6/17, the the RN coverage. On Monday 1/9/17, the the RN coverage. On Tuesday 1/10/17, as the RN coverage. On Wednesday 1/11/ listed as the RN coverage. On Thursday 1/12/17 and the RN coverage. On Friday 1/13/17, the the RN coverage. On Monday 1/16/17, the RN coverage. On Wednesday 1/18/ listed as the RN cover On Thursday 1/19/17 listed for 24 hours. On Monday 1/23/17, the RN coverage. On Tuesday 1/24/17, RN coverage. On Wednesday 1/24/17, RN coverage. On Wednesday 1/24/17, RN coverage. On Wednesday 1/24/17, kn coverage. On Wednesday 1/24/17, RN coverage. On Wednesday 1/24/17, RN coverage. On Wednesday 1/24/17, listed for 24 hours. A review of the Week Sheets for January 1 indicated the followin On Saturday 1/28/17 listed for 24 hours. A review of the Week sheets for January 1, indicated the followin	7, the MDS nurse was listed as the MDS nurse was listed as MDS nurse was listed as the MDS nurse was listed as the MDS nurse was listed (17, the MDS nurse was trage. 7, the MDS nurse was listed (27, the MDS nurse was listed (28, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10	F	354	Resources or Administrator by reviewi time tender and comparing with the st sign in sheet. Nursing schedule is currently managed by the Director of Nursing (DON) with the Staff Development Coordinator. They revier staffing daily for each shift to ensure th there is eight (8) hour coverage by an An audit will be completed daily to refl the required registered nurse coverag Human Resources, Administrator and Director of Nursing (DON) daily for fou- weeks, bi-weekly for one month, and monthly for one month. The QAPI Committee will review resul the Registered Nurse Audit for complia monthly for three (3) months in the monthly QAPI meeting to assure compliance is not met will continue for another three (3) months. Audit will be brought to the QAPI Committee by Human Resource Director	aff w nat RN. ect e by /or ur ts of ance ate	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 1 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345509	B. WING		_	03/	C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				915 PEE DEE ROAD			
KINGSWC	OOD NURSING CENTER			ABERDEEN, NC 28315	;		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 354	Continued From page	100	F 3	54			
	-	Staffing Sheet for January 1, 2017 indicated the lowest nonth.					
		day Nursing Assignment , 2017 to February 28, 2017 g:					
	listed for 24 hours On Friday 2/3/17, the listed for 24 hours. On Monday 2/6/17, the listed for 24 hours. On Tuesday 2/7/17, the listed for 24 hours. On Wednesday 2/8/1 coverage listed for 24 On Thursday 2/9/17, 1 listed for 24 hours. On Friday 2/10/17, the listed for 24 hours. On Monday 2/13/17, the listed for 24 hours. On Tuesday 2/14/17, listed for 24 hours. On Wednesday 2/15/ coverage listed for 24 On Thursday 2/16/17 listed for 24 hours.	hours. there was no RN coverage re was no RN coverage ere was no RN coverage nere was no RN coverage 7, there was no RN coverage there was no RN coverage ere was no RN coverage there was no RN coverage there was no RN coverage					
	A review of the Week	end Nursing Assignment					

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345509	B. WING _				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		1	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 354	Sheets for February 1 indicated the following On Saturday 2/18/17, listed for 4 hours in a	1, 2017 to February 28, 2017 g: , there was RN coverage 24 hour period. :here was RN coverage	F	354	4		
		day Nursing Assignment , 2017 to February 28, 2017					
	listed for 24 hours. On Tuesday 2/21/17, listed for 24 hours. On Wednesday 2/22/ coverage listed for 24 On Thursday 2/23/17 listed for 24 hours. On Monday 2/27/17, was on 200 hall cart f	hours. , there was no RN coverage the schedule read the DON					
		Staffing Sheet for February 28, 2017 indicated the lowest nonth.					
	A review of the RN tir 2/28/17 revealed the	ne punches for 2/1/17 to following:					
	clock for 24 hours On Thursday 2/2/17, hours and 15 minutes	7, no RN punched the time an RN was punched in for 6 s. RN punched the time clock					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345509	B. WING				C 03/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWC	OD NURSING CENTER				915 PEE DEE ROAD			
					ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 354	clock for 24 hours. On Thursday 2/16/17 clock for 24 hours. On Friday 2/17/17, nc for 24 hours. On Saturday 2/18/17, hours and 30 minutes On Sunday, 2/19/17, hours and 45 minutes On Monday 2/20/17, n clock for 24 hours. On Tuesday, 2/21/17, 3 hour and 30 minute On Wednesday 2/22/ clock for 24 hours. On Thursday 2/23/17 clock for 24 hours. On Tuesday, 2/28/17, clock for 24 hours. On Tuesday, 2/28/17, clock for 24 hours. In an interview on 2/2 nurse stated she took 2/20/17 when the pre- confirmed she was a (LPN). In an interview on 3/2 scheduling coordinates schedule about three DON told her that she MDS nurse hours to r consecutive RN cover confused because on she could count her a	<ul> <li>a RN punched the time</li> <li>a no RN punched the time clock</li> <li>a RN punched the time clock</li> <li>a n RN was punched in for 3</li> <li>a n RN was punched in for 3</li> <li>a n RN was punched in for 3</li> <li>a n RN was punched the time</li> <li>a n RN was punched the time</li> <li>a n RN was punched the time</li> <li>a n RN punched the time</li> <li>b no RN punched the time</li> <li>a no RN punched the time</li> <li>b no RN punched the time</li> <li>c no RN punched the time</li> <li>b over as the MDS nurse on vious MDS resigned. She licensed practical nurse</li> <li>c rated she took over the weeks ago. She stated the</li> <li>c could count the DON or the</li> <li>a neet the required 8 hours of rage. She stated she was</li> <li>e minute the DON stated</li> <li>s the RN coverage and the</li> <li>told the DON could not</li> </ul>	F	354	1			

Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345509	B. WING				C 1 <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 354 F 428 SS=E	In an interview on 3/2 office manager stated scheduling coordinate she was told by the D DON as RN coverage business office manage there had to be 8 hou coverage 7 days a we MDS nurse could not in a building with more said this practice of or MDS nurse had been In an interview on 3/2 stated it was her under serve as the chargen situation but it was her scheduling coordinate additional RN coverage 483.45(c)(1)(3)-(5) DF REPORT IRREGULA c) Drug Regimen Rev (1) The drug regimen reviewed at least once pharmacist. (3) A psychotropic drubrain activities associ and behavior. These	<ul> <li>/17 at 8:50 AM the business</li> <li>/17 at 8:50 AM the business</li> <li>/18 be was the previous</li> <li>/19 or up until 1/9/17. She stated</li> <li>/20 N she could count the</li> <li>/20 in an emergency. The</li> <li>/20 ger stated she was aware</li> <li>/21 rs of consecutive RN</li> <li>/21 eek and the DON or the</li> <li>/21 count as the RN coverage</li> <li>/21 et al.</li> <li>/21 at 9:30 AM, the DON</li> <li>/21 er expectation that she could</li> <li>/21 her expectation that the</li> <li>/21 or was responsible to staff</li> <li>/22 count as the RN REVIEW,</li> <li>/23 REGIMEN REVIEW,</li> <li>/23 ACT ON</li> </ul>		354			4/14/17

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345509	B. WING				C 03/2017		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
KINGSWO	OD NURSING CENTER			9	15 PEE DEE ROAD				
KINGSWO	OD NORSING CENTER			A	BERDEEN, NC 28315				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
F 428	to the attending physi facility's medical direct and these reports mut- (i) Irregularities includ drug that meets the cc (d) of this section for a (ii) Any irregularities in during this review mut- separate, written report attending physician and director and director of minimum, the residen and the irregularity the (iii) The attending phy resident's medical rect irregularity has been taken be no change in the in physician should doct the resident's medical (5) The facility must d and procedures for th review that include, bu frames for the differen- steps the pharmacist identifies an irregularit to protect the resident This REQUIREMENT by: Based on medical rec- Pharmacy Consultant Consultant failed to ac	ust report any irregularities cian and the ctor and director of nursing, st be acted upon. le, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a ort that is sent to the nd the facility's medical of nursing and lists, at a tt's name, the relevant drug, e pharmacist identified. vsician must document in the cord that the identified reviewed and what, if any, n to address it. If there is to nedication, the attending ument his or her rationale in I record. levelop and maintain policies e monthly drug regimen ut are not limited to, time nt steps in the process and must take when he or she ty that requires urgent action	F	428	F428 Drug Regimen Review Resident #39: Upon reviewing of medi record by the Consultant Pharmacist at the Staff Development Coordinator, lab	nd			
	Consultant failed to a the lipid level and live	ddress the need to monitor			record by the Consultant Pharmacist an	nd o			

Facility ID: 970412

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	OME (X3)	DATE SUF	RVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · ·	OMPLET	
						С	
		345509	B. WING	· · · · · · · · · · · · · · · · · · ·		03/03/2	2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	DDE		
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	CI	(X5) OMPLETIO DATE
F 428	Continued From page	e 105	F 42	28			
	-	ed residents reviewed for		profile that included liver fu	nction results		
		tions. The findings included:		as well. This was complete			
				therefore no new liver funct			
		mitted to the facility on		ordered. A Lipid panel was			
	8/15/15. Cumulative hypercholesterolemia	a. An annual Minimum Data		and indicated the following Cholesterol 134	Normal Range	0	
		dicated Resident #39 was		-199	Normal Range	U	
	cognitively intact.			Triglycerides 177	(H)	0	
	A roviou of physician	orders for February 2017		-149 HDL-Cholesterol 38.4	(1)		
	revealed an order for	-		40-60	(Ľ)		
		medication) 20 milligrams		LDL-Calculated 60		0	
		. The atorvastatin calcium		-99			
		d 10/20/15 and Resident #39 dication since that date.		VLDL 35	6-40		
				All residents with cholester	-		
		w revealed there were no		medications have had a lipi performed in the last 12 mo	•		
		a lipid panel or liver panel ermine liver damage which		completed by 4/6/17 as not			
		e of cholesterol lowering		pharmacist and Staff Devel			
	medication) since ad			Coordinator. These resider	nts will also		
	8/15/15.			have a liver panel performe			
	The menthly Dham	ou Consultant reviews from		one has not been complete	d within the		
	6/14/16 through 2/21	cy Consultant reviews from		last 12 months. All residents receiving chole	esterol		
		laboratory monitoring for		lowering medications will ha			
	the use of the atorvas	, ,		panel and a liver panel perf			
				annually. A file has been de	•		
		PM, an interview was		alert Unit Managers and Di			
		irector of Nursing who stated Resident #39 was in 2015.		Nursing (DON) when labs a each resident, which includ			
	She said they had ch			cholesterol lowering medica			
		irst visit was in February.		lipid and liver panels are do			
		commendations from the		Consultant Pharmacist will			
		t on 2/21/17 and said there		medical record of same res			
	was not a recomment have liver function mo	dation for Resident #39 to		ensure cholesterol lowering have been monitored. Cons			
		งาแงาแห เธรเร.		Pharmacist visited on 3/27			
		, an interview was conducted		reviewed all resident's char			

Facility ID: 970412

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345509	B. WING				C / <b>03/2017</b>
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
KINGSWO	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	should have at least a cholesterol and liver p relied on the Pharma remember the monitor recommendations. H any pharmacy recom #39 had not had any since 2015. On 3/02/2017 at 11:5 conducted with the P stated his review inclu- medications and what been done with the m understanding and w had not been many re- in the past. The Phar tried to do as many re- could when he came overwhelming the face #39's recommendation recommendation rega Ambien. He had not calcium and did not k #39 had a fasting lipic and ALT (alanine ami detect liver injury) sho	e stated Resident #39 a yearly lab tests for banel. Physician #1 said he cy Consultant to help him oring by writing le said he had not received mendations that Resident liver function monitoring labs 7AM, an interview was harmacy Consultant. He uded a review of the t type of monitoring had hedications. From his hat he had been told, there ecommendations completed macy Consultant said he ecommendations as he in February without illity. He reviewed Resident ons and said he had written a		128	cholesterol lowering medications, monitoring dosages and labs present needed. Consultant Pharmacist will review me record of residents with cholesterol lowering medications to ensure this cl of medications have been monitored a evidenced by lab results. This was do on 3/27 & 3/28/17. He will continue th part of his routine monthly review. All new admission and re-admissions be reviewed for cholesterol lowering medication monitoring by the DON an Assistant Director of Nursing and/or th Staff Development Coordinator. Current residents with new cholesteror lowering medications ordered will be reviewed to ensure lab monitoring is i place. They will be added to the file th alerts Unit Managers and the DON to upcoming labs when orders are review in Morning Meeting by the DON and U Manager/ Staff Development Coordin The QAPI Committee will review Consultant Pharmacist report brought the Consultant Pharmacist or DON fo compliance monthly for three (3) mon in the monthly QAPI meeting to assur compliance is sustained. Will re-evalu for compliance for compliance and if compliance is not met will continue fo another three (3) months.	dical ass as ne is as will d/or ne ol n at Jnit ator. : by r ths e ate	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLE LE	TE/ACCURATE/ACCESSIB	F 5	514			4/14/17
	<ul><li>(i) Medical records.</li><li>(1) In accordance wit</li></ul>	h accepted professional					

Facility ID: 970412

If continuation sheet Page 107 of 160

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		345509	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER	L	1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 514	standards and practic maintain medical reco are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org (5) The medical recor (i) Sufficient informati (ii) A record of the res (iii) The comprehensir provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on record revi facility staff interview,	ented; ented; e; and ganized rd must contain- on to identify the resident; sident's assessments; ve plan of care and services v preadmission screening evaluations and incted by the State; c's, and other licensed	F	514		en	
	narcotic count were n administered on the r				ordered are current and accurate. Revi was done by the DON of MAR and curr physician □s order on 3/6/17. Resident #72 MAR and narcotic count		

Facility ID: 970412

		MEDICAID SERVICES				OMB NC	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	CONNECTION	BERTH IOATION NOWDER.	A. BUILDING	G			
		245500					C
		345509	B. WING			03/	03/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OD NURSING CENTER				5 PEE DEE ROAD		
				AE	BERDEEN, NC 28315		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETIC DATE
	1				DEFICIENCY)		
F 514	Continued From page	e 108	F 51	14			
	(Residents #125, #72				sheet have been reviewed to ensure		
		or complete and accurate			consistency in documentation. Review		
	clinical records. Find	•			was done by the DON of MAR and curr	rent	
					physician □s order on 3/6/17.		
	1. Resident # 72 was	admitted to the facility on			#125 was discharged on 2/21/17. Clos	ed	
	8/6/16 with multiple d				chart review was done 4/6/17 by Clinica		
		lopathy (degenerative joint			Nurse Consultant. physician orders, MA		
	disease) of cervical re				and nurses notes were reviewed.		
		IDS) assessment dated			Resident received medication as ordered	ed.	
	1/14/17 indicated that	-			Resident reported medication effective		
	moderate cognitive in	npairment and she had			Resident #125 narcotic count sheet have	ve	
	received scheduled a	nd as needed (PRN) pain			been reviewed to ensure consistency ir	n l	
	medication.				documentation. It was accurate. Resident #72 physician orders for Ativa	an	
	Resident #72's physic	cian's orders for January			have been reviewed to ensure ordered		
		The orders included Norco			are current and accurate Review was		
		ition) 5/325 milligrams			done by the DON of MAR and current		
	<b>`</b>	outh daily at 6 AM and 1			physician s order on 3/6/17.		
	tablet every 4 hours a				Resident #72 MAR and narcotic count		
					sheet have been reviewed to ensure		
	Review of the narcoti	c count and MARs for			consistency in documentation. Review	,	
		y 2017 was conducted. The			was done by the DON of MAR and curr		
		noted to have discrepancies			physician □s order on 3/6/17.		
	between the narcotic				Resident #87 s Ativan is being		
					administered as ordered Review was		
	January 7 & 8 - Norco	o was signed off 4 times			done by the DON of MAR and current		
		nt and was documented 3			physician $\Box$ s order on 3/6/17.		
	times on the MAR				Resident #87 s physician orders have		
		as signed off 5 times from			been reviewed to ensure current and		
		d was documented 4 times			accurate. Review was done by the DOI	N	
	on the MAR				of MAR and current physician s order		
	January 17 - Norco w	as signed off 2 times from			3/6/17.		
	-	d was documented once on			Resident #87⊡s MARs have been		
	the MAR				reviewed to ensure current does is beir	ng	
	January 18, February	2, February 6, February 17,			given as ordered. Review was done by	-	
		ruary 26 - Norco was signed			DON of MAR and current physician		
	-	arcotic count and was			order on 3/6/17.		
	documented 2 times of	on the MAR			Resident #87□s is accurate as of Marc	h	
	January 10 Norse w	as signed off 6 times from			3, 2017 as reviewed by the DON.		

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/17/201 MAPPROVE O. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		345509	B. WING		03	C 8/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	the narcotic count an MAR that Norco was January 21, January February 24- Norco w the narcotic count an on the MAR. January 22 - Norco w the narcotic count an on the MAR. January 25 & Februar times from the narcoti documented 3 times January 28, January 12 & February 18 - N form the narcotic count times on the MAR. February 5, Norco wa the narcotic count an on the MAR. February 10 - Norco the narcotic count an MAR one time. February 19, Norco w the narcotic count an on the MAR. February 27-Norco w the narcotic count an on the MAR. February 27-Norco w the narcotic count an on the MAR. February 27-Norco w the narcotic count an on the MAR.	d no documentation on the administered. 27, February 7, February 13, vas signed off 4 times from d was documented 3 times vas signed off 5 times from d was documented 4 times ry 4 - Norco was signed off 5 tic count and was on the MAR. 29, February 11, February lorco was signed off 5 times nt and was documented 2 as signed off 4 times from d was documented 1 time was signed off 3 times from d was documented on the vas signed off 4 times from d was documented 2 times vas signed off 4 times from d was documented 3 times ras signed off 4 times from d was documented 3 times mas signed off 4 times from d was documented 3 times mas signed off 4 times from d was documented 3 times mas signed off 4 times from d was documented 3 times mas signed off 4 times from d was documented 3 times	F 51	14 The Director of Nursing (DON) Development Coordinator has r all residents narcotics MAR co to resident s narcotic sheet to documentation. Review will be by 4/14/17. All nurses will be in-serviced on importance of documenting nar administration in the MAR and maintaining an accurate narcotic Pharmacy Nurse Representativ and Nurse Consultants. In-serv complete on 4/12/2017. A Narcotic Audit Sheet for each applicable resident will be place residents MAR to ensure accura documentation of narcotic medi given as ordered. Director of Nursing or Unit Man monitor a minimum of 15 narco sheets and compare with MAR 4 (4) weeks, twice a month for and then one time a month for to ensure consistency of docum The QAPI Committee will review Narcotic monitoring for complia monthly for three (3) months in monthly QAPI meeting to assur compliance is sustained. Will re for compliance for compliance a compliance is not met will contia another three (3) months. Audit be brought to QAPI Committee by the DON	reviewed comparing completed the cotic ic count by re, DON, ice will be the acy of ications ager will tic count weekly for 1 month, one month nentation. w of MAR nce the e-evaluate and if nue for r results will	

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY
AND FLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDII	NG _			C
		345509	B. WING			0	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWC	OD NURSING CENTER						
				4	ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 514	monitoring the nurses unit manager was wo the time so nobody ha nurses' documentatio On 3/2/17 at 3:45 PM interviewed. The Pha 2/8/17, a nurse from the facility to do an audit including the narcotic that the report from the DON. On 3/2/17 at 3:50 PM from the audit that was the nurse from the phi included issues with of signed off and not doo MAR as administered On 3/3/17 at 11:24 Af Coordinator (SDC) wa identified his initial on indicated that at times medication after admini MAR. On 3/3/17 at 11:43 Af pharmacy was intervi	<ul> <li>documentation but the rking on the floor most of ad been monitoring the on.</li> <li>, the Pharmacist was armacist stated that on he pharmacy came to the of the medication cart s. The pharmacist indicated hat visit was given to the</li> <li>, the DON shared the report so conducted on 2/8/17 by armacy. The report controlled medications being cumented on the resident's .</li> <li>M, the Staff Development as interviewed. The SDC the narcotic count and as he forgot to document the inistration on the resident's .</li> <li>M, the nurse from the ewed. The nurse confirmed d issues that nurses were medications and not</li> </ul>	F	514			
	2/7/17 with multiple d	s admitted to the facility on iagnoses including L2-L3 n. The admission Minimum					

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DEPARTMENT OF HEALTH A					FORM	: 04/17/2017 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE S COMPL	SURVEY _ETED
	345509	B. WING		_	C 03/0	; )3/2017
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
KINGSWOOD NURSING CENTE	R		15 PEE DEE ROAD BERDEEN, NC 28315			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
indicated that Resid intact and he had h needed pain medica assessment revealed discharged to home Resident #125 adm 2/7/17 included ord pain medication) 10 12 hours for 14 day tablets by mouth ev On 2/8/17, the order changed to 3 times the order was chan mouth every 8 hour Review of the narco February 2017 was dates were noted to the narcotic count at 1 on the MAR as adm February 17- Oxyco narcotic count at 6 documented on the February 18 - Oxyco narcotic count at 10 on the MAR as adm February 18 - Oxyco narcotic count at 10 on the MAR as adm February 18 - Oxyco narcotic count at 11 documented on the February 21 - Oxyco narcotic count at 11 documented on the MAR as adm	Sessment dated 2/14/17 dent #125 ' s cognition was ad received scheduled and as ation. The discharge MDS ed that Resident #125 was e on dission doctor ' s order dated ers for Oxycodone (narcotic 0 mgs 1 tablet by mouth every s and Oxycodone 5 mgs 2-3 rery 4 hours PRN for pain. The for Oxycodone 10 mgs was a day PRN and on 2/10/17 ged to Oxycodone 10 mgs by s PRN for pain. The following 0 have discrepancies between and the MAR: odone was signed off from the PM and was not documented hinistered. bodone was signed off from the AM and 9:15 PM and was not MAR as administered. odone was signed off from the 2 PM and was not documented hinistered. odone was signed off from the AM and 9:15 PM and was not MAR as administered. odone was signed off from the 2 PM and was not documented hinistered. odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered. Odone was signed off from the 2 PM and was not documented hinistered.	F 514				

Facility ID: 970412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		345509	B. WING				03/2017
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	On 3/2/17 at 10:15 AI was interviewed. The expected the nurses to the MARs when admit that the unit manager monitoring the nurses unit manager was wo the time so nobody ha nurses' documentati On 3/2/17 at 3:45 PM interviewed. The Pha 2/8/17, a nurse from to facility to do an audit including the narcotic that the report from the DON. On 3/2/17 at 3:50 PM from the audit that wa the nurse from the ph included issues with of signed off and were no resident 's MAR as a On 3/3/17 at 11:24 AN Coordinator (SDC) wa identified his initial on indicated that at times medication after admit MAR. On 3/3/17 at 11:43 AN pharmacy was intervit that she had identified signing off controlled documenting on the m administered. 3. Resident #87 was a 7/7/15. Cumulative of	M, the Director of Nursing a DON stated that she o document narcotics on nistered. She also indicated was responsible for ' documentation but the rking on the floor most of ad been monitoring the on. , the Pharmacist was urmacist stated that on he pharmacy came to the of the medication cart s. The pharmacist indicated at visit was given to the , the DON shared the report s conducted on 2/8/17 by armacy. The report controlled medications being ot documented on the dministered. M, the Staff Development as interviewed. The SDC the narcotic count and s he forgot to document the nistration on the resident ' s M, the nurse from the ewed. The nurse confirmed d issues that nurses were medications and were not esident ' s MAR as admitted to the facility on	F	514			

Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING					C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STA	TE, ZIP CODE		
KINGSWC	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 514	Continued From page	9 113	F 5	14				
	•	Data Set (MDS) dated esident #87 was severely						
	order for Ativan (anti-	ated 12/19/16 revealed an anxiety medication) 0.25 daily. Discontinue Ativan 0.5 wice daily.						
	revealed Ativan 0.25 two times daily at 8:0 12/19/16, 12/20/16, 1	ol drug reconciliation sheet milligrams was administered 0AM and 8:00PM on 2/21/16, 12/22/16, 12/23/16, 2/27/16 and 12/28/16.						
	for December 2016 re documentation that A been administered at 12/20/16, 12/21/16, 1 12/26/16, 12/27/16 ar the MAR was transcri	tivan 0.25 milligrams had 8:00PM on 12/19/16, 2/22/16, 12/23/16, 12/25/16, nd 12/28/16. The order on bed as Ativan 0.5 tab (0.25milligrmas) by						
	had been informed by Resident #87 had rec daily instead of one d physician said she the more somnolent poss and she expected sta On 3/2/17 at 8:30AM, with the MDS Coordir	ician #2. She stated she one of the facility staff that eived two doses of Ativan ose as ordered. The bught Resident #87 became ibly due to the added dose ff to follow physician orders. an interview was conducted nator who stated she was						
	-	nonth reconciliation of Medication Administration						

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	MENT OF HEALTH AN				FOF	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		345509	B. WING		0	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514 F 520 SS=G	Records (MAR) from found that Resident # the evening as well as the MAR to the orders sheet. She said the r Ativan at 8:00PM no I The MDS Coordinato have documented it o medication and must by memory and not cl physician orders. On 3/02/2017 at 10:12 conducted with the Di the nurse should have medications by readir medications b	December to January. She 87 had received Ativan in s on day shift in comparing s and the drug reconciliation hurse who administered the onger worked at the facility. r stated the nurse should on the MAR if she gave the have given the medication hecking the MAR and 3AM, an interview was irector of Nursing who stated e administered the ng the MAR and not giving ory. a telephone interview was ty. She stated she had not e medication change and medical record. Nurse #5 have been going on or an e occurred as the reason for medication on the MAR. (i)(ii)(h)(i) QAA ERS/MEET f. int and assurance.	F 5			4/14/17

Event ID: 5IT011

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345509	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2011
KINGSWO	OD NURSING CENTER			9	15 PEE DEE ROAD		
				4	ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	e 115	F t	520			
	(ii) The Medical Direc	tor or his/her designee;					
	staff, at least one of w administrator, owner,	a board member or other					
	individual in a leaders	ship role; and					
	(g)(2) The quality ass committee must :	essment and assurance					
	coordinate and evaluate	n respect to which quality					
		ement appropriate plans of tified quality deficiencies;					
	Secretary may not rec records of such comm such disclosure is rela	mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this					
	by: Based on record revi	and correct quality			F520		
	Quality Assessment a Committee failed to m procedures and moni committee put into pla	and Assurance (QAA)			¿¿¿         ¿¿         ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿	ίi	

Facility ID: 970412

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345509 B. WING 03/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 520 Continued From page 116 F 520 investigation for 3 recited deficiencies in the reviewed daily, Monday-Friday, by the areas of services provided as care planned Clinical team in the Clinical Morning (F282), well-being (F309), and accidents (F323); Meeting. Occurrences that happen following the 2/4/16 recertification survey for 5 Saturday and Sunday will be reviewed in recited deficiencies in the areas of assessment the Morning Meeting on Monday. The accuracy (F278), comprehensive care plans Clinical Team consists of the Director of (F279), nutrition (F325), unnecessary Nursing, Staff Development Coordinator, medications (F329), and complete and accurate the Wound Care Nurse and the MDS clinical records (F514); and following the 11/23/16 Coordinator. complaint investigation for 1 recited deficiency in area of urinary catheter care (F315). These 9 All Licensed Nurses, including weekend deficiencies were cited again on the current and prn staff, will be in-serviced regarding recertification survey of 3/3/17. The continued Notification of Changes to the Physician failure of the facility during 2 or more federal by the Director Of Nursing (DON) or the surveys of record show a pattern of the facility's Staff Development Coordinator. inability to sustain an effective Quality In-services were started on 3/7/17 and will Assessment and Assurance program. The be completed by 4/7/17. findings included: The in-service will include: This tag is cross referenced to: Facility Policy for reporting occurrences/changes to physician in a 1. F278: Assessment Accuracy - Based on record timely manner review, observation, and staff interview, the Procedure All accidents/ incident must be facility failed to accurately code the Minimum 0 Data Set (MDS) assessment in the area of reported to department supervisors and pressure ulcer for 1 (Resident #4) of 4 sampled incident form completed on the shift that it residents reviewed for pressure ulcer and in the occurred. area of hospice for 2 (Residents #86 and #81) of Nurse must complete their part of the 0 2 sampled residents reviewed for hospice. incident report completely prior to the end of the shift. During the recertification survey of 2/4/16 the Physician is to be notified of any 0 facility was cited F278 for failure to accurately incident resulting in injury or unusual code the MDS assessment for medications. On occurrence after the resident is assessed. the current recertification survey of 3/3/17 the Notification must take place prior to the facility failed to accurately code the MDS end of shift in which the incident occurred. assessment in the areas of pressure ulcer and Document any new orders on a telephone hospice. order sheet and transcribe appropriately. A nurses' note is to be made in the An interview was conducted with the medical record stating physician was

FORM CMS-2567(02-99) Previous Versions Obsolete

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	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '			· · /	PLETED
							С
		345509	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER		_ <b>_</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				91	15 PEE DEE ROAD		
KINGSWC	OD NURSING CENTER			Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE
F 520	Continued From page	o 117		- 20			
F 520	Continued From page		F 5	520			
	Administrator on 3/3/	17 at 11:45 AM. She tworked at the facility during			notified.		
		recertification survey of			A new Incident Log was developed on		
		ciency was cited and she			3/8/17 and revised on 3/24/17. This ne	w	
		eir Plan of Correction (POC)			log is designed to validate notification o	of	
	included. She stated	as of 2/20/17 a new MDS			the physician as well as all other aspec	ts	
	Coordinator was hire	d to replace the previous			of the policy. It will also serve as an au	dit	
		he indicated there were			tool and will be updated daily by the		
		bus MDS Coordinator's			Administrator or Director of Nursing,		
		ts that effected MDS coding			Monday through Friday in the morning		
	and care plans.				clinical meeting.		
	2. F279 - Compreher	nsive Care Plan: Based on			The Administrator will bring the results of	of	
		nt and staff interview, the			the Incident Log to the monthly QAPI		
	facility failed to devel	op a care plan for the use of			meetings until 100% compliance is		
		pnotic medication for two of			sustained for three months.		
	five residents reviewe	-					
	medication use (Resi	idents #39 and #44).					
	During the recertificat	tion survey of 2/4/16 the					
		9 for failure to develop a			For F159:		
	-	n the current recertification					
		facility failed to develop care			A new petty cash system has been		
		ntipsychotic medication and			implemented to ensure residents have		
	hypnotic medication.				access to their personal funds after		
					business hours and on holidays and		
	An interview was con				weekends. The petty cash system will		
	Administrator on 3/3/				managed by the Nursing Supervisor or		
		t worked at the facility during			licensed nurse on the Tanglewood wing		
		ecertification survey of ciency was cited and she			A new process has been put in place to allow the residents to have access to th		
		eir POC included. She			personal funds after business hours, on		
		a new MDS Coordinator was			weekends and holidays. Business Office		
		previous MDS Coordinator.			Manager (BOM), personally spoke with		
		vere issues with the previous			resident # 39 on 4/4/17 and explained to		
		valuation of residents that			him the process to access his funds on		
	effected MDS coding	and care plans.			the weekends and holidays. He		
					verbalized understanding.		
	3. F282 - Services Pr	rovided as Care Planned:					

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		<u>NO. 0938-03</u> ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		MPLETED
			A. BUILDING	G		С
		345509	B. WING			03/03/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		03/03/2017
				915 PEE DEE ROAD	0002	
KINGSWC	OOD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 520	Continued From page	- 110		20		
F 520	Continued From page		F 52			
		n, staff interview, and record		Residents were notified v the Resident Council Mee		
	review, the facility fail planned interventions			by Activity Director. The A	•	
		#81), dietary supplements		and/or the BOM will also		
		restorative nursing services		individually with residents	•	
		of 17 care plans reviewed.		fund monies by 4/14/17.	-	
	, ,	·		Representatives of reside		
	During the recertificat	tion survey of 2/4/16 the		dementia or cognitive imp	pairment will be	
	facility was cited F28	2 for failure to follow the care		notified by letter from the	Business Office	
		obtaining a psychiatric		Manager by 4/14/2017.		
	consultation and mon			A record of each transact		
		ropic medications. During		by the Nursing Superviso	-	
		gation survey of 9/23/16 the		nurse at the time of the tr		
		d F282 for failure to follow		BOM will reconcile the re-	•	
		nd care. On the current of 3/3/17 the facility failed to		Monday through Friday. N will reconcile transactions	•	
	follow the care planne			week end to ensure the p		
		ition, dietary supplements,		resident funds.		
	and restorative nursir			Licensed nurses, includin	a weekend and	
		5		prn nurses, will be in-serv	•	
	An interview was con	ducted with the		Administrator or the BOM	-	
	Administrator on 3/3/	17 at 11:45 AM. She		procedure by 4/14/17.		
		t worked at the facility during		The BOM or Administrato		
		ecertification survey of		cash and withdrawals dai		
		ciency was cited and she		through Friday, and post		
		eir POC included. She		to each resident's ledger.		
		n the 9/23/16 complaint		replace any cash withdra		
	investigation included	d daily Treatment d (TAR) audits completed by		cash box. Any discrepand will be promptly reported		
		hey hired a new treatment		Administrator.		
		ted a Standards of Care		One of the department m	anagers will	
		weekly to review residents		randomly conduct an inte	•	
		. She stated this meeting		residents per week for for	• •	
		Director of Nursing (DON),		consecutive weeks to det		
	Social Worker, Treatr			were able to access their		
	Manager, MDS, and			after normal business hou		
		ditionally stated the floor		weekend or holidays. Ra		
		ible for monitoring care plan		after hour and week end		
	interventions.			continue monthly for a mi	nimum of three	

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
						С
		345509	B. WING			03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE	
	OD NURSING CENTER			915 PEE DEE ROAD		
NINGSWC	OD NORSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 520	Continued From page	e 119	F 52	20		
				(3) months.		
	4. F309 - Well-Beina:	Based on record review,		Audit results will be brou	ught to the monthly	
	-	and staff interviews, the		QAPI Meetings by the B	• •	
		nister a Fentanyl patch (pain		correction and audit resu		
		dent which resulted in		reviewed by the QAPI C	committee during	
	increased pain and in	creased need and request		monthly meetings. The	QAPI Committee	
	for an as needed Per	cocet (pain medication) for 1		will determine continued	I need for auditing	
	of 2 residents (Reside	ent #40).		after four (4) months.		
				Completion Date is 4/14	/17	
	During the 2/4/16 rec	ertification survey the failed				
		ilure to provide psychological dents with behavioral issues.		For F160:		
		investigation survey of		The Business Office Ma	nager refunded a	
		as again cited F309 for the		check in the amount of \$		
		sident assessed/examined		Resident #30's estate or	n 3/21/2017.	
		for possible injuries before				
		er the fall and the failure to		Review of the statement		
	treat wounds as orde			38's account, found that		
		of 3/3/17 the facility failed to		required as a bookkeepi		
	administer a Fentany	I patch to resident.		recorded the deposit twi	ce.	
	An interview was con	ducted with the		A refund check will be se	ent to Resident	
	Administrator on 3/3/			#75 in the amount of \$3.		
		t worked at the facility during		the Business Office Mar	-	
	the time of previous r	ecertification survey of				
	2/4/16 when this define	ciency was cited and she		The Business Office Ma	nager sent a	
	was unaware what th	eir POC included. She		refund check in the amo	ount of \$1,028.76	
		the 9/23/16 complaint		to the estate of Resident	t #129 on 4/5/17.	
		daily TAR audits completed				
	•	ff, they hired a new treatment		The Business Office Ma	-	
	-	ted a SOC Meeting once		Administrator completed		
		dents based on their needs.		discharged residents in		
		ovided education to staff		months on 3/22/17. Of 6		
	about their policy and			discharged 6 residents v		
		She stated she believed the		still have funds in their F		
		inrelated the previous POC.		Fund past 30 days. All fu		
	-	ed she believed the previous		conveyed to residents of	-	
	deficiencies had beer	n corrected.		Business Office Manage	er.	

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			0.00			O. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	E SURVEY PLETED
			A. BUILDING	·		С
		345509	B. WING			
	OVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP CODE	03	/03/2017
				915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			ABERDEEN, NC 28315		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 520	Continued From page	120	F 50			
1 520			F 52		or who	
		heters: Based on record and staff interview, the		The new Business Office Manages started in February 2017, was tr		
		le catheter care and failed to		the facility Administrator and out	-	
	, i	ubing for 1 (Resident #4) of		Business Office Manager on pol	• •	
	1 sampled resident w	ith an indwelling urinary		procedures, to include the Resid	lent Trust	
		4 had three hospitalizations		Fund. Training was conducted f	rom	
	with diagnoses of Urir	nary Tract Infection (UTI).		February 9, 2017 to 3/21/17.		
	During the complaint	investigation of 11/23/16 the		The facility Administrator will cor	nduct	
		5 for the failure to obtain		audits of discharged residents w		
	-	Culture and Sensitivity (C&S)		Resident Trust Fund weekly for		
		sician and the failure to		weeks, then monthly for three (3		
		a symptomatic UTI. On the		to ensure any trust fund money		
	failed to provide cathe	survey of 3/3/17 the facility		conveyed to the resident, responsion party or estate.	ISIDIE	
	secure the catheter tu			party of estate.		
				The plan of correction action(s)	will be	
	An interview was con	ducted with the		monitored at the QAPI meeting		
	Administrator on 3/3/2			minimum of four (4) months. Au		
		om the 11/23/16 complaint		will be taken to monthly QAPI m	eetings by	
	investigation included			the Business Office Manager.		
		all laboratory tests ordered vell as daily follow up with the				
		d the DON was responsible				
		stem. She indicated she		For F166:		
	was unsure why it wa			A grievance form was filled out f		
				resident #72 on 2/2/17 by the So		
		Based on observation, staff		Worker, Fran Jacobs. The griev	ance for	
		vs, and record review, the igate the root cause of 2		resident #72 was investigated 2/3/17-2/8/17 by Casey Horne, I	Director of	
	falls and failed to mor	-		Nursing. Resolution was determ		
		to a fall for 1 of 2 residents		2/8/17 by Casey Horne, DON. C		
	(Resident #42) review			Horne, DON, notified the resider	•	
	,			resolution on 2/8/17 at 2:40pm a		
	-	tion survey of 2/4/16 the		validated by Casey Horne, RN,	on	
	-	3 for failure to properly		3/28/17.		
	secure a resident and				26	
		cording, failed to notify the ne incident, and failed to		A grievance form for Resident # completed on 2/6/17 by the form		

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		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 04/17/2017 FORM APPROVED //B NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		B) DATE SURVEY COMPLETED
		345509	B. WING			C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STAT	E, ZIP CODE	
				915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 520	During the 9/23/16 cc facility was again cite the lift gate up before sitting in a wheelchain van causing the resid current recertification failed to investigate th falls and failed to mor complications related An interview was con Administrator on 3/3/ indicated she had not the time of previous r 2/4/16 when this defic was unaware what th reported their POC for investigation included facility van for resider she believed the curren their previous POC. Se believed this was a re area of accidents was items fell under this c 7. F325 - Nutrition: Ba interview, and record follow the physician's (appetite stimulant/ar (nutritional supplement significant weight loss to address weight loss residents reviewed for During the recertificate facility was cited F322 nutritional supplement	e analysis of the incident. Implaint investigation the d F323 for failure to raise pushing a resident who was r out of the transportation lent to fall backward. On the survey of 3/3/17 the facility he root cause analysis of hitor for delayed to a fall. ducted with the 17 at 11:45 AM. She t worked at the facility during ecertification survey of ciency was cited and she eir POC included. She or the 9/23/16 complaint d discontinuing the use of the ht transportation. She stated ent citation was unrelated to She additionally stated she epeat deficiency because the as so broad that a variety of ategorization. ased on observation, staff review, the facility failed to orders for Remeron htidepressant) and Resource nt) for a resident with a (Resident #117) and failed s (Resident #87) for 2 of 3 r nutrition.	F 5	<ul> <li>Worker, Fran Jacobs and corrective action 2/6/17. The Director of resident #26's son or taken. The son, Todo this was addressed a notified in February 2 grievance log for Res "Notification of results completed by the Add February 2017.</li> <li>Grievance Policy was 1) Written grievance the date the grievance summary statement of grievance, the steps the grievance, a sum findings or conclusion residents concern(s), whether the grievance not confirmed, any co or to be taken by the the grievance, and th decision was issued.</li> <li>2) The person filing resident and/or reside will be informed of the Social Services Direc 3) A new grievance and implemented in F</li> <li>An in-service for all s and weekend staff, re process will be done in-services will be pre Worker and/or Admin</li> </ul>	It was investigated completed on of Nursing notified a 4/4/17 of the action d Maness, confirmed and he was previously 2017. The January sident #72's s" section was ministrator in a revised to reflect: e decisions include e was received, a of the residents' taken to investigate mary of the pertinent is regarding the a statement as to e was confirmed or prrective action taken facility because of the grievance, ent's representative e resolution by the ctor or Administrator. log was developed February 2017. taff, including prn egarding grievance by 4/14/2017. The esented by the Socia istrator.	y :
	nutritional supplement	t as ordered. On the current of 3/3/17 the facility failed to		The Social Services	Director and/or	

Facility ID: 970412

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
			A. DOILDING			С
		345509	B. WING		0	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				915 PEE DEE ROAD		
KINGSWC	OD NURSING CENTER			ABERDEEN, NC 28315		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	Continued From page	a 122	F 52	0		
1 020		orders for an appetite	F 52	Administrator will audit all grieva	20000	
		nal supplement and also		weekly for four (4) weeks then r		
	failed to address weight	••		3 months. All grievances will b	•	
		-		for completion of investigation,		
	An interview was con	ducted with the		made and documented and for	notification	
	Administrator on 3/3/			of resolution to the person filing	the	
		t worked at the facility during		grievance.		
		ecertification survey of		The Osciel Oscieta Discreteration		
		ciency was cited and she eir POC included. She		The Social Services Director wi		
		his was a repeat deficiency		audit results to the monthly QAI meetings for a minimum of four		
		ad not firmed up their		months. After the fourth month		
	-	on Administration Record		Committee will determine if reso		
		nonitoring. She reported		the problem has occurred or if it	t needs to	
	there had been some	changes made recently to		continue.		
	improve the process.					
	8. F329 - Unnecessa	ry Medications: Based on				
		aff interview, the facility failed		For F225:		
	-	alues to monitor the use of		The Nurse Aide Registry cleare		
	statin medication for			1/25/2017. Re-verification of N		
		viewed for unnecessary		certification, Nurse Aide Registr		
	drugs. During the recertificat	tion survey of 2/4/16 the		clearance of allegations of alleg	eu anuse.	
		9 for failure to administer		The Staff Development Coordin	ator	
	antipsychotic medica			conducted an audit on all curren		
	physician, failure to n			employed Nursing Assistants w	•	
	•	sychotropic medications, and		Nurse Aide Registry on 2/25/17		
		a medication as ordered.		re-verify none had a finding. Th	nere were	
		ification survey of 3/3/17 the		no negative findings.		
	facility failed to obtain			Decident #26 initial of unlarge		
	monitor the use of sta			Resident #36 injury of unknown reported via the 24-hour report		
	An interview was con	ducted with the		Health Care Personnel Investig		
	Administrator on 3/3/			by the Administrator on 3/24/17		
		t worked at the facility during		investigation was conducted by		
		ecertification survey of		Nursing and the Administrator a		
	-	ciency was cited and she		5-day report was completed and		
		eir POC included. She	1	on 3/28/17. This was placed or		

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						NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	OATE SURVEY
			A. BUILDING	3		С
		345509	B. WING			03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		03/03/2017
				915 PEE DEE ROAD	_	
KINGSWC	OOD NURSING CENTER			ABERDEEN, NC 28315		
(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 (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO DATE
				DEFICIENCY)		
F 520	Continued From page	<u>- 123</u>	F 52	20		
1 020			F 52			
		eceived a monthly report at included all residents who		March Allegation of Abuse log		
	were on psychotropic			The facility Administrator and/	or the Social	
		itions. She stated this list		Services Director are respons		
		oring purposes. She		reporting allegations of abuse		
		sure why it was a repeat		HCPR.	0	
	deficiency.					
				The facility initiated a new hire	e process on	
	9. F514: Complete ar	nd Accurate Clinical		3/27/2017. The Administrator	will review	
	Records: Based on re	ecord review and pharmacy		all applicants background sun	nmary and	
	and staff interview, th	ne facility failed to maintain a		results of the Nurse Aide Reg	stry search	
	-	te medical records as		prior to orientation. The Huma	an	
	evidenced by medica	tions signed off from the		Resources Director will perfor	m all	
	narcotic count were r	not documented as		background checks and Nurse		
	administered on the r			Registry searches. The Huma		
		d (MAR) consistently for 3		Resources Director will compl		
		2, and #87) of 5 residents		list of all completed paper wor		
	reviewed for complet	e and accurate clinical		applicants, to include the back	•	
	records.			check. The HR Director was		
				responsibilities as described b	-	
	-	tion survey of 2/4/16 the		Administrative Consultant and	the facility	
		4 for failure to maintain		Administrator on 3/22/17.		
		rogress notes in the medical				
		ent recertification survey of		In-service was done on 3/2/20		
	-	ed to maintain complete and		Director of Nursing Services a		
		ords as evidenced by		Administrator with direct care		
	-	ff from the narcotic count		including prn and weekend sta		
		d as administered on the		addressing unusual occurrence		
	resident's MAR consi	stentiy.		require reporting including app time frame.	propriate	
	An interview was con	ducted with the				
		17 at 11:45 AM. She		An Allegation of Abuse Report	ing Log has	
	indicated she had no	t worked at the facility during		been developed to track time		
		ecertification survey of		compliance of allegations of a		
		ciency was cited and she		log will be maintained by the A		
		eir POC included. She		and/or the Social Services Dir		
		nultiple changes with staff				
		s deficiency. She indicated		The Business Office Manager	will	
	that ultimately the Un			complete an audit of all applic		

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	-	D HUMAN SERVICES MEDICAID SERVICES			FO	ED: 04/17/2017 RM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · · ·	TE SURVEY MPLETED C
		345509	B. WING			3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page responsible for monito		F 5	<ul> <li>scheduled for orie</li> <li>(8) weeks to verify</li> <li>have a finding ent</li> <li>Aide Registry comexploitation, mistremisappropriation of</li> <li>The facility Admini Allegation of Abus</li> <li>Corporate Consultor</li> <li>occurrences to vereporting time frant</li> <li>the Corporate Consultor</li> <li>occurrences to vereporting time frant</li> <li>the Corporate Consultor</li> <li>All audits regarding</li> <li>checks will be taken to the meetings by the Hwill be taken to the meetings by the A</li> <li>This plan of correct the monthly QAPI</li> <li>For F226:</li> <li>The Nurse Aide R</li> <li>1/25/2017. Re-verecertification. Nurse clearance of alleged</li> <li>The Staff Develop conducted an aud employed Nursing Nurse Aide Regist</li> </ul>	istrator will send the se Reporting Log to the tant for the next 5 rrify appropriate mes. This will be sent to nsultant at the same sent to the Health Care gation Office. In Director. Abuse logs e monthly QAPI administrator. Ction will be monitored at until resolved. egistry cleared NA #2 on erification of NA#2 e Aide Registry returned ations of alleged abuse. oment Coordinator lit on all currently g Assistants with the try on 2/25/17 to d a finding. There were	

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
KINGSWO	OD NURSING CENTER			915 PEE DEE ROAD	
				ABERDEEN, NC 28315	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 520	Continued From page	e 125	F 52	20	
				<ul> <li>Resident #36 injury of unknown reported via the 24-hour reported via the 24-hour reported by the Administrator on 3/24, investigation was conducted Nursing and the Administrator 5-day report was completed on 3/28/17. This was placed March Allegation of Abuse low The facility Administrator and Services Director are responsed to reporting allegations of abuse HCPR.</li> <li>The facility initiated a new hit 3/27/2017. The Administrator and services Director will perform to orientation. The Hum Resources Director will perform to all completed paper will applicants, to include the background checks and Nurse Registry searches. The Hum Resources Director will complise of all completed paper with applicants, to include the background and the Administrator on 3/22/17.</li> <li>An in-service was conducted Director of Nursing Services Administrator with all direct of the administrator with all direct of the administration of the admi</li></ul>	ort to the stigation office /17. An by Director of or and the and faxed in d on the bg. d/or the Social hsible for se/neglect to are process on or will review ummary and gistry search man orm all se Aide man plete a check ork for ckground s educated on by the nd the facility d 3/2/17 by the and the
				including prn and weekend s addressing unusual occurrer require reporting including a time frame.	nces that

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE COMP	: 04/17/2017 APPROVED . 0938-0391
345509     B. WING     03/       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     915 PEE DEE ROAD       KINGSWOOD NURSING CENTER     915 PEE DEE ROAD     ABERDEEN, NC 28315       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 520     Continued From page 126     F 520       An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director.       The Business Office Manager will complete an audit of all applicants	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         KINGSWOOD NURSING CENTER       915 PEE DEE ROAD         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 520       Continued From page 126       F 520         An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director.         The Business Office Manager will complete an audit of all applicants	) 3/2017
KINGSWOOD NURSING CENTER       ABERDEEN, NC 28315         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 520       Continued From page 126       F 520         An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director.         The Business Office Manager will complete an audit of all applicants	
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 520       Continued From page 126       F 520         An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director.         The Business Office Manager will complete an audit of all applicants	
An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director. The Business Office Manager will complete an audit of all applicants	(X5) COMPLETION DATE
been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director. The Business Office Manager will complete an audit of all applicants	
<ul> <li>(8) weeks to verify applicant does not have a finding entered in the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.</li> <li>The facility Administrator will send the Allegation of Abuse Reporting Log to the Corporate Consultant for the next 5 occurrences to verify appropriate reporting time frames. This will be sent to the Corporate Consultant at the same time the 5 day is sent to the Health Care Personnel Investigation Office.</li> <li>All audits regarding Nurse Aide Registry checks will be taken to the monthly QAPI meetings by the ARD interval.</li> <li>This plan of correction will be monitored at the monthly QAPI until resolved.</li> </ul>	
For F257: Ambient room temperatures are being checked on the 400 hall every morning by the maintenance staff. Resident #7 and	

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I						RINTED: 04/17/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ISTRUCTION		(3) DATE SURVEY COMPLETED
	345509	B. WING				C 03/03/2017
NAME OF PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	<b>!</b>	
KINGSWOOD NURSING CENTER			915 PI	EE DEE ROAD		
RINGSWOOD NURSING CENTER			ABEF	RDEEN, NC 28315		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 520 Continued From page	e 127	F 5	#{ mst ME: refe O 4( a T by C ai M da m In ar er If a th by O ref c M rad a 3/ te 1. mref a. co te	B rooms are on the 400 hall. aintenance director replaced rips in the air handler for 400 larch 18th, 2017. xtra blankets were available f esidents, including #7 and #8 eat strips were received and r nce the heat strips were in pl 20 hall room temperatures ha 71-81-degree range. he Maintenance Director was y the Administrator and the Ni onsultant on 3/6/2017 regard r temperatures in the facility. laintenance Director initiated aily temperature audit, and a iorning audit for rooms on the iside and Outside heating and re checked randomly every w nsuring all units are checked the ambient temperature is n cceptable parameters (71-81 e thermostats are adjusted a y the Maintenance Director will conti indom Monday through Friday ay temperature audits thoroug '31/2017 to ensure comfortab imperatures. How the corrective action( ionitored to ensure the practice cur: Maintenance Director will of ambies imperatures weekly times one and with any significant change	the heat the heat the heat hall on for until the replaced. lace, the ave been in s in-service urse ing ambier a random daily 400 hall. d air units reek while monthly. lot within degrees), iccordingly nt. g and Air re-wired the inue y 4 times a gh ole and safe (s) will be ce will not continue to ient air e month	d nt e a e

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Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345509	B. WING		03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 520	Continued From page	2 128	F 52	<ul> <li>temperature from 4/1/2017- 4/30/2 all areas to include rooms 409-41 415-418.</li> <li>Maintenance Supervisor will monthly inspections of affected ur monthly x three (3).</li> <li>Results of Ambient Air Temperatu will be brought to the QAPI comm monthly by the Maintenance Direct review until compliance has been achieved as determined by the Committee.</li> <li>Findings of the April temperature 5 be discussed at the Resident Cour May.</li> <li>For F278:</li> <li>A new MDS Coordinator was hiret 2/20/2017.</li> <li>A new treatment nurse was hired 1/19/2017.</li> <li>The MDS Coordinator will be in-set on assessment accuracy by the N Consultant no later than 4/14/201</li> <li>The treatment nurse will be in-set accurately coding Section M by th Consultant no later by 4/14/2017.</li> <li>A modification assessment was completed on 4/5/2017 by the treat nurse for Resident #4 to add the dimensions of the identified press ulcer.</li> <li>A modified assessment was completed on 4/5/2017 by the treat nurse for Resident #4 to add the dimensions of the identified press ulcer.</li> <li>A modified assessment was completed on 4/5/2017 by the treat nurse for Resident #4 to add the dimensions of the identified press ulcer.</li> <li>A modified assessment was completed on 4/5/2017 by the treat nurse for Resident #4 to add the dimensions of the identified press ulcer.</li> <li>A modified assessment was completed on 4/5/2017 by the treat nurse for Resident #4 to add the dimensions of the identified press ulcer.</li> <li>A modified assessment was completed on 4/5/2017 by MDS</li> </ul>	2 and conduct hits re log ittee ctor for audit will incil in d on on erviced lurse 7. viced on he Nurse atment ure bleted on ADS

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/17/2017 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345509	B. WING				/03/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
KINGSWO	OD NURSING CENTER				5 PEE DEE ROAD		
				A	BERDEEN, NC 28315		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	a 129	F 5	520	Coordinator for resident #81 to correct coding for hospice. A random audit will be completed on 1 of current residents to assess accurace the MDS sections M, item J1400 and O0100 by 4/13/17. Audit will be completed by Nurse Consultants. Moving forward, the treatment nurse w be responsible for completing section the MDSs. Prior to closing of any MDS, the MDS Coordinator and at least one Administrative Nurse will review Section M, J1400 and O0100 to ensure accurate for a minimum of weekly for four week twice a month for one month, then monthly for one month. The deficiency will be placed in the QA program for monitoring of resolution/correction. The compliance audits will be reviewed during the mont QAPI meetings for three (3) months to assure compliance is sustained. The QAPI Committee will determine need to continue or resolve the problem. Audit will be brought to the QAPI Committee the MDS Coordinator.	0% y of /ill M of acy s, API thly co s by	
					<ul> <li>#39, #44 were developed 3/2/2017 by</li> <li>MDS Coordinator.</li> <li>A care plan was developed for residen</li> <li>#39 addressing his insomnia and use</li> <li>hypnotic medications on 3/2/2017 by t</li> <li>MDS Coordinator.</li> <li>The MDS Coordinator will be in-servic</li> </ul>	t of he	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/17/2017 RM APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING			0:	C 3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
KINGSWO	OOD NURSING CENTER			91	5 PEE DEE ROAD		
				AI	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	∋ 130	F	520	by the Clinical Nurse Consultant on ensuring care plans are developed as indicated in the CAA and other identifi- areas of need by 4/13/2017. An audit was completed on 4/2/17 of 62 residents receiving psychotropic/hypnotic medications to ensure that those residents had a corresponding care plan. 100% of th residents have a care plan in place. The MDS Coordinator has reviewed a updated/created care plans for all residents receiving psychotropic medications on 4/2/2017. Auditing of care plans for resident's receiving psychotropic medications w completed weekly for 2 weeks, then t a month for one month, then monthly four (4)) months by the Director of Nursing, Staff Development Coordina and/or Nurse Consultant, to ensure a plan addressing the use of psychotro medications is in place. The QAPI Committee will review audi results for compliance monthly for six months in the monthly QAPI meeting assure compliance is sustained. Aud results will be brought to QAPI by the DON. Date of Compliance 4/14/17.	ied the ose and ill be wice for tor care pic t (6) to it : #87 ed by 7.	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345509	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
KINGSWO	OD NURSING CENTER			91	15 PEE DEE ROAD		
				A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	≥ 131	F	520	Dietician to ensure a care plan is pres and that appropriate interventions and correct diet are included by 4/14/2017 In-service provided to Food Service Director and facility dietician by Division Registered Dietician on developing ar updating revision of nutritional care pl on 3/23/2017. Resident #87 will be added to the Standard Of Care (SOC) meeting to be reviewed for weight changes. In-service to ALL dietary staff by Divis Registered Dietician on 3/22/2017 regarding definition of fortified food, preparation and use of fortified foods. Regional Dietician and Facility Dieticia completed a comparison of Meal Trace diets with those listed for residents to ensure proper diet was being served of 3/23/17. Care plans of residents with significar weight change will be audited weekly weeks, then 2 times a month for one month, then monthly for 2 months by facility Registered Dietician or Facility Food Service Director (CDM) to ensure care plan is present with appropriate interventions. The Food Service Director and facility Registered Dietician will be responsib for all nutritional care plans. The facility Registered Dietician/ CDN update care plans with all significant weight changes. Facility Food Service Director (CDM) perform a nutritional assessment on a new admissions for nutritional needs during the first week of stay in the faci The DON or Assistant Director of Nurs	I onal dans e ional an ker on t for 4 re a le I will will II uity.	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
KINGSWC	OOD NURSING CENTER				I5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 520	Continued From page	≥ 132	F	520	(ADON) will give the CDM a copy of a new diet orders daily Monday-Friday a morning clinical meeting. Weekend orders will be given to the CDM on Mondays. SOC team will review all residents with significant weight changes in SOC meetings weekly until weight is stable resident has been deemed as "Unavoidable Weight loss" by physicia In-service will be presented to nursing direct care staff by the CDM regarding what fortified foods are and how they of monitor to ensure residents ordered fortified foods are receiving fortified foo at meals by 4/14/2017. The Facility Registered Dietician will b notified of significant weight loss by th CDM as soon as she/he is aware. Audits will be performed by facility Registered Dietician or CDM on reside experiencing significant weight change weekly x 4, then bi- weekly for one mo then monthly for two months Audits will be performed by Facility Registered Dietician or CDM weekly x then twice monthly for one month, the monthly for 2 months on care plans correctly reviewed/revised for weight la The CDM will do an audit comparing th physician's order to meal tracker ticke weekly for 4 weeks, then twice a month for 1 month, then monthly for two mon The District Manager for Healthcare Services (dietary department) will perf an audit on 4/6/17 comparing meal tick to meal served . Thereafter, the CDM perform this audit weekly for four weekly then twice a month for one month, the	or n. can ods e e ents e onth, d, en e sonth, d, en ths. he ths. horm ket will ks	

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391
	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	345509 B. WING			03/03/2017	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWO	OOD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 520	Continued From page	e 133	F 520	<ul> <li>monthly for two months.</li> <li>This deficiency will be placed in the O program for monitoring by the QAPI Committee for a period of three (3) months. Audit results will be taken to QAPI program by the Facility Register Dietician or CDM.</li> <li>For F281: <ol> <li>Immediate action(s) taken for the resident(s) found to have been affect include:</li> <li>Resident #1 insulin is being administered as ordered. Blood glucos being obtained as ordered and slidin scale insulin provided as ordered bas on blood glucose.</li> <li>Physician and pharmacist will reblood glucose for Resident #1 to ensite current insulin orders and sliding scale coverage is adequate</li> <li>Resident #7 is receiving Ativan a ordered. Orders have been reviewed ensure accuracy and correctness.</li> <li>The Medical Administration Receivity for Resident #7 has been reviewed ensure medication is administered ordered.</li> <li>Resident #117 was discharged thas since been re-admitted to facility 1/31/2017.</li> <li>All new orders will be reviewed in Morning Clinical Meeting. Applicable orders will be compared to the Medica Administration Record (MAR) by the to 7am (24 hour chart check) nurse tassure order has been properly transcribed to the MAR.</li> </ol> </li> </ul>	e the ered

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 520	Continued From page	≥ 134	F 52	<ul> <li>20</li> <li>2. Action taken/system put in place</li> <li>a. 11pm to 7 am nurses will be</li> <li>inserviced on completing chart check</li> <li>each evening by 4/7/2017.</li> <li>b. All nurses will be inserviced on</li> <li>correct procedure in transcribing</li> <li>physician orders by 4/7/2017.</li> <li>c. MARs for the upcoming month</li> <li>double checked by administrative n</li> <li>against current monthly MARs.</li> <li>3. How the corrective action(s) wi</li> <li>monitored to ensure the practice wi</li> <li>recur:</li> <li>a. Director of Nursing or designee</li> <li>audit 10% of new orders to ensure</li> <li>accuracy of new order transcription</li> <li>weekly for four weeks, bi-weekly for</li> <li>month, and monthly for one month.</li> <li>b. At the beginning of each month</li> <li>of MARs will be compared to last m</li> <li>MAR for accuracy. Audit weekly for</li> <li>weeks, bi-weekly for one month.</li> <li>The QAPI Committee will review Net</li> <li>Order audit for compliance monthly</li> <li>three (3) months in the monthly QA</li> <li>meeting to assure compliance is</li> <li>sustained. Will re-evaluate for compliance is</li> <li>sustained. Will re-evaluate for compliance is</li> <li>met will continue for another three (</li> <li>months.</li> <li>For F282:</li> <li>Based on review, Resident # 81 is</li> <li>receiving Coumadin as ordered. Th</li> <li>Director of Nursing (DON) and Nursi</li> <li>Consultant reviewed the Medication</li> <li>Administration Record (MAR) and corders on 3/6/17.</li> <li>Resident #117's physician orders with a substained with the substained orders or a substained orders or a substain orders with the substained orders on 3/6/17.</li> </ul>	cks the will be urses Il be Il not e will . Audit r one n 10% tonth four d ew for Pl Diance not (3)

Event ID: 5IT011

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	04/17/2017 APPROVED 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0000	
KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 135	F	520	reviewed by the DON on 3/6/17. Medication and supplements are bein administered as ordered. Resident #42 is no longer in facility. All therapy screens for the last 60 dat were reviewed on 4/6/17 by the Ther Director to ensure that residents refet to Restorative program are receiving service. Review revealed all residents referred to the Restorative Program at being seen. All residents on Coumadin are monitor via the Coumadin Audit tracking toll the was initiated December 2016. All resi receiving Coumadin were reviewed for accuracy of their dosage ordered to the MAR by the DON on 3/6/17. The Coumadin Audit Tracking is maintained the Director of Nurses (DON) and/or Staff Development Coordinator. Facility Registered Dietician and Divis Registered Dietician completed a comparison of physician signed order against Meal Tracker software to ens 100% accuracy of diets and supplem on 3/23/17. All residents were review ensure dietary supplements were bei given as ordered by the Facility Registered Dietician and the Division Registered Dietician. New referrals from therapy will be given the Director of Nurses (DON). DON v bring referral to Morning Clinical Meer referral will be given to MDS Coordin to be care planned and verified with Restorative that resident is on curren	ys apy rred s are ored hat ident or he ed by the sional rs ure ents ed to ng al ven to vill ting, ator	
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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391
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KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD		
				A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 136	F	520	restorative case load. Audit for track therapy to restorative referrals will be audited in the Morning Clinical Meetin the Restorative Nurse. Restorative referrals audit will be don weekly for one month; then twice a /r for one month, then monthly for one month by the Restorative Nurse. Restorative Nurse will also visually validate the Restorative Certified Nur Assistances are working with the resi- being audited. The QAPI Committee will review aud results for compliance monthly for thr (3) months in the monthly QAPI meet to assure compliance is sustained. W re-evaluate for compliance for and if compliance is not met will continue for another three (3) months. The DON w be responsible for brining the Couma Audit log summary to the QAPI Committee. Facility Dietician or the F Service Director (CDM) will bring aud dietary supplements being given as ordered to the QAPI meeting. The Restorative Nurse will bring the resul the QAPI meeting for regarding refer to Restorative being treated.	Ing by Ine month sing dent it ee ting fill or vill din ood lits of ts to rals	
	7(02-99) Previous Versions Obs	solete Event ID: 5IT	011		diagnosis and potential for complicati		age 137 of 160

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 1 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
KINGSWC	OD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 137	F	520	related to diagnosis were added. On 3/3/2017, the Clinical Nurse Consultant inserviced the MDS Coordinator on incorporating PASRR 2 information into care plans. The Admission Coordinator conducted audit on each resident's PASRR level 3/27/2017. Any residents identified during audit w PASRR level 2 will have a PASRR level incorporated into the plan of care. Th were found to be 15 residents with a PASRR level 2. All of these have beer care planned to reviewed and updated reflect PASRR level 2 presence. The Admission Coordinator will verify admissions' PASRR screening. Wher completed ,the Admission Coordinato notify the MDS Coordinator if resident a PASRR level 2. The Administrator and/or Social Servic Director will audit all new residents an 10% of current residents for accuracy PASRR level 2 and corresponding car plan monthly for 3 months. The QAPI Committee will review audit results for compliance monthly for thre (3) months in the monthly QAPI meeti to assure compliance is sustained. Wi re-evaluate for compliance for complia and if compliance is not met will contin for another three (3) months. Social Service Director will bring audit results the QAPI Committee Meeting. For F309: Resident #40 is receiving fentanyl pat and prn Percocet.	l an on ith a el 2 ere d to new r will has ce d of e se ng ll nce nue	
EOPM CMS 256	7(02-99) Previous Versions Obs	solete Event ID: 5IT0	11	Faa	sility ID: 970412 If continua	tion about D	age 138 of 160

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CENTER STATEMENT (		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	PRINTED: 04/17/20 FORM APPROVE OMB NO. 0938-03( (X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3	C
		345509	B. WING		03/03/2017
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KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD	
				ABERDEEN, NC 28315	1
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F 520	Continued From page	e 138	F 52	<ul> <li>Pain assessment was completer resident #40 on 3/23/2017 by nurse.</li> <li>Plan of care was updated on 3 the MDS LPN Coordinator to a management program, which non- pharmacological interver Interview with resident #40 ha completed to ensure pain is masses by DON. Resident states she with the management of her per Education for all nurses on im administrating medication as a be completed by Omnicare Ph Director of Nursing by 4/13/20 All Nurses will be in-serviced a management to include non-pharmacological interven Director of Nursing or Staff De Coordinator by 4/13/2017.</li> <li>Pain will be assessed at least and documented on Medication Administration Record (MAR) residents by the floor nurse. Identified pain will be address appropriately.</li> <li>All residents will have compreted assessment completed on addire-admission, quarterly, and wis significant change as assigned nurse providing care.</li> <li>All resident who have pain me scheduled will have a pain mark care plan reviewed, updated of the MDS LPN Coordinator by An audit of all residents receives cheduled fentanyl pain patch completed by the Medical Record pain the scheduled fentanyl pain patch completed by the Medical Record pain the scheduled fentanyl pain patch completed by the Medical Record pain the scheduled fentanyl pain patch completed by the Medical Record pain the scheduled pain the scheduled fentanyl pain patch completed by the Medical Record pain the scheduled pain pain patch completed by the Medical Record pain the scheduled pain pain patch completed by the Medical Record pain the scheduled pain the scheduled pain pain patch completed by the Medical Record pain the pain pain patch completed by the Medical Record pain the pain pain patch completed by the Medical Record pain the pain pain patch completed by the Medical Record pain the pain pain patch completed by the Medical Record pain the pain pain patch completed by the Medical Record pain the pain pain pain patch completed by the Medical Record paint pain patch completed by the</li></ul>	her staff 3/23/2017 by reflect pain includes ntions. is been nanaged to a conducted is satisfied ain. portance of ordered will narmacy or 17. on pain tions by evelopment each shift on for all ed hensive pain mission, vith any d to the floor edication anagement or initiated by 4/13/17. ving ues will be

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 APPROVED D. 0938-0391
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NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
KINGSWC	OOD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 520	Continued From page	÷ 139	F	520	by 4/13/17 to determine if any other omissions occurred. She will review March 2017 MAR's and April MAR's to date. The Treatment Nurse will conduct an a monthly for three (3) months, on 25% the MAR's for residents with scheduler fentanyl patches to determine if omiss have occurred. The QAPI Committee will review moni for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for complia for compliance and if compliance is no met will continue for another three (3) months. Treatment nurse will bring the results of the random audit to the QAF Committee meeting. Compliance date 4/14/17 For F315: Resident #4's urinary catheter was discontinued on 3/15/2017 per physici order. All residents identified with a urinary catheter have a plan of care in place a verified by MDS LPN Coordinator on 3/27/2017. All residents with urinary catheters we observed on 4/5/17, by the treatment nurse to ensure that catheters were in place and secured. The treatment nur reports that all residents with urinary catheters were in place and secure. O resident refuses drainage up above waist while he is up in wheel chair. He refus	audit of d ions tor since ot e Pl an as re re rse ne nd	

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CENTERS	-	ID HUMAN SERVICES MEDICAID SERVICES	(X2) MULT	IDI E	CONSTRUCTION	FORM	0: 04/17/201 APPROVE 0. 0938-039
AND PLAN OF		IDENTIFICATION NUMBER:				C	
		345509	B. WING			03/	03/2017
NAME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWOOD NURSING CENTER			91	5 PEE DEE ROAD			
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F 520	Continued From page	e 140	F	520	to have it placed lower while he is in v chair. All nursing staff will be in-serviced on catheter care, per facility policy, by the Nurse Consultant by 4/13/2017 a. Facility Policy: i. Gather supplies and set up ii. Explain procedure prior to beginn iii. Position resident on back, place protective covering on linens iv. Wash hand and put on gloves v. Wash area front to back, side the other side, then center always turning cloth to clean area before moving to r area. Clean stool prior to starting peri/catheter care. vi. Hold catheter gently but firmly ne insertion site. Clean at insertion site th down the catheter with a twisting moti away from the body. vii. Rinse and dry viii. Attach tubing to inner thigh using fastening devise ix. Place drainage bag in a cover an secure below resident waist. x. Clean area xi. Position resident for comfort xii. Report anything abnormal to nurs follow up. The Treatment Nurse, on 3/27/17, ad Catheter care to the Certified Nursing Assistants documentation on the Activ of Daily Living tracking form for all residents with a urinary catheter. Catheter care was observed by Nurse Consultants from 3/28/17-3/30/17. Floor nurses will be responsible each for checking that urinary catheters are	e ning en hext ar hen on a d se for ded <i>v</i> ity shift	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345509	B. WING				
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KINGSWO	KINGSWOOD NURSING CENTER				15 PEE DEE ROAD		
				A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	2 141	F	520	this on the MAR through the month o April Audits will be done by the 11pm-7am Charge Nurse of all residents with a urinary catheter to ensure documenta of catheter care will be done weekly f one month; then random audits will b done monthly for three (3) months to ensure compliance. 11pm-7am Char Nurse will compile results and provid Staff Development Coordinator to tur Staff Development Coordinator week Unit Manager and/or staff nurse will observe Certified Nurse Aides provid urinary catheter care each shift week two weeks then twice a month for one month, then monthly for one month for residents with indwelling urinary cath Observations will be documented and turned in to the Staff Development Coordinator. The QAPI Committee will review aud results for compliance monthly for thr (3) months in the monthly QAPI meet to assure compliance is sustained. W re-evaluate for compliance for compli and if compliance is not met will cont for another three (3) months. Staff Development Coordinator will bring re to the QAPI meeting.	ation for e ge to n into ly. ing ly for e or all eters. d it ree ting fill ance inue	
		olete Event ID: 5IT0:			For F323: Resident #42 is no longer at the facili Nurses and Certified Nursing Aides w in-serviced by the Director of Nursing (DON), Staff Development Coordinat and the Nurse Consultant on Prevent and Reporting of Accidents / Incident	vere I or, tion	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 520	Continued From page	e 142	F 52	<ul> <li>March 2, 2017. Department heads educated on 3/22/2017 concerning Cause Analysis by the Risk Control Specialist from TIS Health Care Set Division.</li> <li>All Department heads were educate concerning Accident/Incidents on 3/23/2017 by Risk Control Special TIS Health Care Service Division.</li> <li>All nursing staff will be re-educated Accident/Incident investigations by 4/14/2017 by DON or Staff Develo Coordinator.</li> <li>Policy and Procedures related to fawere in-serviced with all staff on 3/14/2017</li> <li>i. All Accidents/incidents will hav Accident/Incident form completed shift it occurred or was noted.</li> <li>ii. Witness statements will be ob from all involved.</li> <li>iii. Staff is to maintain the safety resident.</li> <li>iv. Appropriate preventive interver will be initiated on recognition of fa and after each fall will be updated.</li> <li>v. DON or Staff Development Coordinator will investigate all falls cause. Initiation of appropriate intervention will be put in place bas root cause analysis.</li> <li>New referrals from Therapy for Restorative Nursing will be given to MDS Coordinator to be caplanned and verified with Restorat Nursing that resident is on current</li> </ul>	g Root of ervice ted ist from d on 'pment alls ve an on the tained of the entions all risk s for root sed on o the entions ull risk

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 03/03/2017
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KINGSWOOD NURSING CENTER			915 PEE DEE ROAD		
				ABERDEEN, NC 28315	
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F 520	Continued From page	e 143	F 524		ent on possible luated by reatment fall risk assures to . This will were n February re related d to behavior 8 were mated d 1 related air. ated in by through be added llowing II be ON. estorative V/ lls to al will be o be cared rative their case e done
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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD	
				ABERDEEN, NC 28315	
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 520	Continued From page	e 144	F 52	<ul> <li>by the Restorative Nurse. Restoral Nurse will also visually validate the Restorative Certified Nursing Assis are working with the residents beir audited.</li> <li>The QAPI Committee will review a results from Master Log Form and Restorative Referrals for complian monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-exfor compliance. If compliance is no review will continue for another thr months. The Director of Nursing v responsible for bringing the Course Audit log summary to the monthly Meetings. The Food Service Direct bring audits of dietary supplements monthly QAPI meetings. The Restorative audits to the monthly QAPI meetings. The Restorative audits to the monthly QAPI meetings. The Restorative audits to the monthly QAPI meetings. Date of Compliance 4/14/17</li> <li>For F325:</li> <li>Resident #117: On 3/22/17, the R Registered Dietician reviewed resistatus. She recommended diet liberalization to regular/mech soft vilquids to maximize intake, magic of every day at lunch for nutritional stand to increase protein, house supplement 120ml three times a d discontinue ensure. Change supplot provide increased calories and por low protein level and aide wour healing, and add vitamin C and zir days to promote wound healing. The analyse intake is the restorative and a discontinue ensure.</li> </ul>	e stants ng nudit ce valuate ot met ree (3) vill be adin QAPI tor will s to the torative QAPI with thin cup upport ay and blement protein nd nc for 14

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Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/17/2017 RM APPROVED NO. 0938-0391
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		345509	B. WING				3/03/2017
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KINGSWO	OD NURSING CENTER			91	5 PEE DEE ROAD		
				Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 520	Continued From page	2 145	F	520	physician approved the recommendations. Resident #87: The Regional Reg Dietician reviewed resident's statu 3/23/17. She Recommended discontinuation of protein powder secondary to increased protein pr recommended supplements of ho supplement and magic cups. Phy approved recommendations. Weight management plans of care both Residents #87 and #117 hav reviewed and updated by the MDS Coordinator. Residents will be we weekly and discussed in Standard Care (SOC) meeting weekly to en residents' nutritional needs are be Consultant Pharmacist reviewed medications for Resident #117 on and recommended a Hemoglobin ordered. The Consultant Pharma reviewed medications for resident 3/28/17 and recommended reduci dosage of Lexapro. Physician act recommendation and order was c out. Resident #87 and #117, all physic orders were reviewed by the Direct Nursing (DON) on 3/6/17. Medica being administered as ordered. Facility Registered Dietician and I Registered Dietician will complete comparison of physician signed o against MealTracker software to e 100% accuracy of diets and suppl	us on orders ovide by use vsician e for re been S LPN ighed d Of sure sing met. 3/28/17 A1C be cist a/28/17 A1C be cist # 87 on ing cepted arried cian ctor of tions are Divisional a rders ensure	
					by 4/14/17. Residents with significant weight I noted will be weighed weekly unti is stable. Residents with significar	l weight	

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	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO	D: 04/17/2017 MAPPROVED D: 0938-0391		
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		345509	B. WING				03/2017		
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE				
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (C (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 520	Continued From page	e 146	F	520	loss will be discussed in SOC meeting weekly until weight is stable or it determined resident is "Unavoidable Weight Loss". Food Service Director (CDM) will generate the list of those residents with significant weight loss to weighed weekly. Staff Nurses may con the Food Service Director (CDM) to a to this list resident's they suspect have weight loss. All new admissions and newly identifier residents with weight loss will be communicated with facility Registered Dietician by the Food Service Director (CDM). These residents will also be added to the weekly weight list mainta by the Food Service Director. Restorative Certified Nursing Assistan (RCNA) weigh all residents. They will follow facility policy to weigh all new admissions weekly x4, then monthly unless otherwise indicated by the Restorative Nurse upon review of weig All residents are weighed monthly. Residents with significant weight chan will be weighed weekly at direction of Restorative Nurse or by agreement of SOC Committee (members include: D Staff Development/Restorative Nurse, MDS LPN Coordinator, Treatment Nur Food Service Director, Social Service Director and therapy representative.) All resident's weights were reviewed for significant changes in weight by the Divisional and Facility Registered Dieticians on 3/23/2017 and 4/7/17. Another audit checking for weight loss be done on 4/11/17. Care plans were updated by the Divisional and Facility	o be ntact dd e a ed ined ts ghts. ges the ON, rse, or			

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		MEDICAID SERVICES					M APPROVEI O. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING			03	C 6/03/2017
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER			91	15 PEE DEE ROAD		
				ABERDEEN, NC 28315			
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F 520	Continued From page	e 147	F	520	Registered Dieticians and by the For Service Directors. Facility Registered Dietician will communicate his/her findings to the Administrator and Director of Nursing Weights are monitored weekly by the CDM. Residents with significant weiloss will be reviewed in Standards O (SOC) meeting weekly until weight is stable. Food Service Director will bri- printed copies of weights to SOC me for all members to review. This is an ongoing process to manage significa- weight changes in the facility. All new admissions and newly identi- residents with weight loss will be communicated with Registered Dieti- by the Food Service Director. An audit will be completed by 4/13/1 a nurse manager, of resident's with of for Remeron and supplements to en- they are being given as ordered. Au be completed monthly for three (3) months. The QAPI Committee will review audor results for compliance monthly for the (3) months in the monthly QAPI meet to assure compliance is sustained. V re-evaluate for compliance for comp and if compliance is not met will con- for another three (3) months. The Fo Service Director will bring significant weight change report to QAPI meeting monthly.	g. ght f Care f Care s ng eeting ant fied cian 7, by orders sure dit will lit ree ting Vill liance tinue pod	
	7(02-99) Previous Versions Obs	olete Event ID:51			Resident #39: Upon reviewing of me		Page 148 of 10

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2013 MAPPROVED D. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION (>	(X3) DATE SURVEY COMPLETED C		
		345509	B. WING			03/03/2017		
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KINGSWO	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315			
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F 520	Continued From page	e 148	F	520	record by the Consultant Pharmacist and the Staff Development Coordinator, lab results were found for a general chemisti profile that included liver function results as well. This was completed 10/4/16, therefore no new liver function panel was ordered. A Lipid panel was drawn 3/24/1 and indicated the following results: Cholesterol 134 Normal Rang -199 Triglycerides 177 (H) -149 HDL-Cholesterol 38.4 (L) 40-60 LDL-Calculated 60 -99 VLDL 35 6-40 All residents with cholesterol lowering medications have had a lipid panel performed in the last 12 months or was completed by 4/6/17 as noted by the pharmacist and Staff Development Coordinator. These residents will also have a liver panel performed by 4/13/17 one has not been completed within the last 12 months. All residents receiving cholesterol lowering medications will have a lipid panel and a liver panel performed annually. A file has been developed to alert Unit Managers and Director of Nursing (DON) when labs are due for each resident, which includes those with cholesterol lowering medications so that lipid panels are done annually. Consultant Pharmacist will review medical record of same residents and ensure cholesterol lowering medications	ry 67 e 0 0		

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If continuation sheet Page 149 of 160

STATE SUMMORE OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBERE       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DATE SUMMEY COMPLETED B         NAME OF PROVIDER OR SUPPLIER       345599       B. WING       (C) 03/03/2017         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       915 PEE DEE ROAD ABERDEEN, NC 28315       (C) 03/03/2017         PMUE IN PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST & PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S TAN OF CORRECTION SHOULD DE (EACH OERRECTIVE ADTRON SHOULD DE (EACH OERRECTIVE ADTRON SHOULD DE CROSS-REFERENCED AD DEFICIENCY)       COMPLETE DEFICIENCY         F 520       Continued From page 149       F 520       F 520       Continued From page 149       F 520         I have been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs present or needed. Consultant Pharmacist will review medical record of residents the holesterol lowering medications to ensure this class of medications to ensure this class of medications the been monitored as evidenced by all results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monthly review. All new admission and re-admissions will be reviewed of cholesterol lowering medications cordered will be reviewed to ensure the DON and Unit Manager/ Staff Development Coordinator. Current residents with new cholesterol lowering medications or are reviewed in Morning Meeting by the DON and/or Assistant Director of Nursing and/or the Staff D		-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391	
JAME OF PROVIDER OF SUPPLIER         STREET ADDRESS, CITY, STATE, 2IP CODE         933/03/2017           KINGSWOOD NURSING CENTER         STREET ADDRESS, CITY, STATE, 2IP CODE         935 PEEE DEE ROAD ABERDEEN, NC 28315         93/03/2017           (04) ID FREEK         SUMMARY STATEMENT OF DEFICIENCES. (EACH OFFICIENCY MUST BE PRECIDEND BY FULL TAG         ID PREFX (EACH OFFICIENCY MUST BE PRECIDEND BY FULL REQULATORY OR LSC. DENTIFYING INFORMATION)         ID PREFX TAG         PREFX (CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY         0000 DEFICIENCY           F 520         Continued From page 149         F 520         Inave been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all residents with cholesterol lowering medications, monitoring dosages and labs present or needed.         Inave been monitored as of medications to ensure this class of medications have been monitored as evidenced by lab results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monitoring by the DON and/or Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol lowering medications ordered will be reviewed for cholesterol lowering medication monitoring by the DON and/or Assistant Director of Nursing and the IDN to upcoming labs when orders are reviewed in Morning Meeting by the DON and Unit Manager/ Staff Development Coordinator. The QAPI Development Coordinator.							
NAME OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 23315       (V4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSD DENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFIERE CORRECTIVE ACTION SHOULD BE DEFICIENCY     CONSTRUCTIVE ACTION SHOULD BE DEFICIENCY     CONSTRUCTIVE ACTION SHOULD BE CROSS-REFIERE CORRECTIVE ACTION SHOULD BE DEFICIENCY     CONSTRUCTIVE ACTION SHOULD BE D			345509	B. WING			
KINGSWOOD NURSING CENTER         ABERDEEN, NC 28315           (Pa) ID PREFIX TAG         SUMMARY STATEMENT OF DEPICIENCIES (ECH OPERCIENCY MUST EPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDERS PLAN OF CORRECTION (ECH OPERCENTW ANT IN SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION DEFICIENCY           F 520         Continued From page 149         F 520         have been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs present or needed. Consultant Pharmacist will review medical record of residents with cholesterol lowering medications have been monitored as evidenced by lab results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monitoring by the DON and/or Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol lowering medications or dered will be reviewed of cholesterol lowering medication monitoring by the DON and/or Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol lowering medications ordered will be reviewed of cholesterol lowering medications ordered will be reviewed of cholesterol lowering medications ordered will be reviewed of cholesterol lowering medications ordered will be reviewed of cholesterol lowering medications ordered will be reviewed of cholesterol lower	NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
Ords JD PREERX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         Open COUNT (CONSTRUCTION OF CORRECTION (CONSTRUCTION OF CORRECTION CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         Open COUNT (CONSTRUCTION (CONSTRUCTION OF CORRECTION (CONSTRUCTION OF CONSTRUCTION (CONSTRUCTION OF CONSTRUCTION (CONSTRUCTION (CONSTRUCTION OF CONSTRUCTION (CONSTRUCTION (CONSTRUCT	KINGSWO	OD NURSING CENTER					
PREERX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREEX TAG       CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION INFO         F 520       Continued From page 149       F 520       have been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs present or needed. Consultant Pharmacist will review medical record of residents with cholesterol lowering medications to ensure this class of medications have been monitored as evidenced by lab results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monthy review. All new admission and re-admissions will be reviewed for cholesterol lowering medication monitoring by the DON and/or Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol lowering medications ordered will be reviewed to ensure lab monitoring is in place. They will be added to the file that alerts Unit Managers and the DON and Unit Manager? Staff Development Coordinator. The OAPI Committee will review Consultant Pharmacist report brought by					,		
have been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs present or needed. Consultant Pharmacist will review medical record of residents with cholesterol lowering medications to ensure this class of medications to ensure this class of medications have been monitored as evidenced by lab results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monthly review. All new admission and re-admissions will be reviewed for cholesterol lowering medication monitoring by the DON and/or Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol lowering medications ordered will be reviewed to ensure lab monitoring is in place. They will be added to the file that alerts Unit Managers and the DON to upcoming labs when orders are reviewed in Morning Meeting by the DON and Unit Manager/ Staff Development Coordinator. The QAPI Committee will review Consultant Pharmacist report brought by	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACT           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO T			
the Consultant Pharmacist or DON for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. For F333: Resident #81, Coumadin is being	F 520	Continued From page	e 149	F 520	<ul> <li>have been monitored. Consultant Pharmacist visited on 3/27 &amp; 3/28 reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs press needed.</li> <li>Consultant Pharmacist will review record of residents with cholesteror lowering medications to ensure th of medications have been monitor evidenced by lab results. This was on 3/27 &amp; 3/28/17. He will continu part of his routine monthly review.</li> <li>All new admission and re-admissi be reviewed for cholesterol lowerin medication monitoring by the DON Assistant Director of Nursing and/ Staff Development Coordinator.</li> <li>Current residents with new choless lowering medications ordered will reviewed to ensure lab monitoring place. They will be added to the fil alerts Unit Managers and the DON upcoming labs when orders are re- in Morning Meeting by the DON a Manager/ Staff Development Coor The QAPI Committee will review Consultant Pharmacist report broot the Consultant Pharmacist or DON compliance monthly for three (3) r in the monthly QAPI meeting to as compliance is not met will continu- another three (3) months. For F333: Resident #81, Coumadin is being</li> </ul>	eent or medical ol is class red as s done e this as ons will ng N and/or or the terol be i is in le that N to eviewed nd Unit rdinator. ught by N for months ssure valuate d if e for	
administered as ordered. Review was done by the Director of Nursing (DON)							

Event ID: 5IT011

Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345509	B. WING		03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	
KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD	
				ABERDEEN, NC 28315	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETION IE APPROPRIATE DATE
F 520	Continued From page	e 150	F 52		e Medication R) and current ders have ey are current lone by the nd Nurse n R) and current been does is being as done by the nd Nurse n R) and current g administered e by the DON an's order on ders have rrent and by the DON an's order on been does is being as done by the n current and by the DON an's order on been does is being as done by the n box order on been does is being as done by the nysician's as of March 6, on importance n medications ance the tely by

Event ID: 5IT011

Facility ID: 970412

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			C	
		345509	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER		•	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 151	F	520	been placed in resident's MAR to ensumedications are documented as giver coming and off going staff nurse will s that documentation is complete at each change of shift. The Coumadin Audit tracking tool was initiated on December 22, 2016 to mo Coumadin administration as ordered in response to the medication error cited December 19, 2016. This tool is maintained by the DON. 11pm to 7am and 7pm -7am nurses w be in-serviced on completing chart che each evening by 4/14/2017 by the Nur Consultant or the Corporate Clinical Nurse. All nurses will be in-serviced on the correct procedure in transcribing physician orders by 4/14/2017. MARs for the upcoming month will be double checked by administrative nurse against current monthly MARs. Narcotic Audit sheet for each resident been placed in resident's MAR will be reviewed daily Monday through Friday 11p-7a Charge Nurse, Narcotic Audit Sheets for Saturday and Sunday will b included with the audit done on Monda for one month then weekly for one mor weekly x 2 for one month. Charge nur will give completed audits with summa to the DON weekly on Fridays. a. The Coumadin Audit tracking tool monitored by the Director of Nurse da Monday through Friday. Orders and changes received Saturday and Sund will be updated to the log on Monday. orders initiating and change or new or will be transcribed by the staff nurse	a. On ign ign ch initor n on ill ecks rse has r by be ay, onth, se ary is ily ay Any	

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Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWO	OOD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 520	Continued From page	2 152	F 520	receiving order to include correct transcription to the MAR and lab requested completed as needed. An audit of all residents receiving Coumadin will be completed to verify medication errors by 4/13/17. The QAPI Committee will review resu the Narcotic Audit and the Coumadin for compliance monthly for three (3) months in the monthly QAPI meeting assure compliance is sustained. Will re-evaluate for compliance for compl and if compliance is not met will cont for another three (3) months. Audits of be brought to the QAPI Committee meeting by the DON. For F354: The facility is using the services of a registered nurse for at least eight (8) consecutive hours seven days a wee The Administrator will receive the sta sheet for the next day with the name the RN providing RN coverage. The Administrator will then give the sheet the Human Resource Director (HR). will verify that the RN named did prov hours of coverage on the assigned d checking Time Tender. An audit will be completed daily to re the required registered nurse covera Audit will be done daily by Human Resources or Administrator by review time tender and comparing with the s sign in sheet. Nursing schedule is currently managed by the Director of Nursing (DON) with the Staff	ults of Audit to iance inue will ek. fffing of t to HR vide 8 ay by flect ge. ving staff

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Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C	
		345509	B. WING				03/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER			-	15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	÷ 153	F	520	Development Coordinator. They review staffing daily for each shift to ensure tha there is eight (8) hour coverage by an R An audit will be completed daily to reflect the required registered nurse coverage H Human Resources, Administrator and/o Director of Nursing (DON) daily for four weeks, bi-weekly for one month, and monthly for one month. The QAPI Committee will review results the Registered Nurse Audit for complian monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Audit will be brought to the QAPI Committee by Human Resource Director. For F428: Resident #39: Upon reviewing of medic record by the Consultant Pharmacist an the Staff Development Coordinator, lab results were found for a general chemisis profile that included liver function results as well. This was completed 10/4/16, therefore no new liver function panel wa ordered. A Lipid panel was drawn 3/24/ and indicated the following results: Cholesterol 134 Normal Rang -199 Triglycerides 177 (H) -149 HDL-Cholesterol 38.4 (L) 40-60 LDL-Calculated 60 -99	N. tt by r of ice e cal d try s r 17	

Facility ID: 970412

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345509	B. WING		03/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWC	OOD NURSING CENTER		-	915 PEE DEE ROAD ABERDEEN, NC 28315	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 520	Continued From page	2 154	F 520	VLDL 35	6-40
				All residents with cholesterol lowering medications have had a lipid panel performed in the last 12 months or y completed by 4/6/17 as noted by the pharmacist and Staff Development Coordinator. These residents will a have a liver panel performed by 4/1 one has not been completed within last 12 months. All residents receiving cholesterol lowering medications will have a lipi panel and a liver panel performed annually. A file has been developed alert Unit Managers and Director of Nursing (DON) when labs are due file each resident, which includes those cholesterol lowering medications so lipid and liver panels are done annu Consultant Pharmacist will review medical record of same residents at ensure cholesterol lowering medications, monitoring dosages and labs presen needed. Consultant Pharmacist will review n record of residents with cholesterol lowering medications, monitoring dosages and labs presen needed. Consultant Pharmacist will review n record of residents with cholesterol lowering medications to ensure this of medications have been monitored evidenced by lab results. This was on 3/27 & 3/28/17. He will continue part of his routine monthly review. All new admission and re-admission be reviewed for cholesterol lowering medication monitoring by the DON a	was e lso 3/17 if the id to id to or e with o that ially. nd tions 7. He nt or nedical class d as done this as ns will

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345509	B. WING				03/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
KINGSWC	OOD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 520	Continued From page	e 155	F	520	Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesteror lowering medications ordered will be reviewed to ensure lab monitoring is in place. They will be added to the file the alerts Unit Managers and the DON to upcoming labs when orders are review in Morning Meeting by the DON and U Manager/ Staff Development Coordina The QAPI Committee will review Consultant Pharmacist report brought the Consultant Pharmacist or DON for compliance monthly for three (3) mon- in the monthly QAPI meeting to assur compliance is sustained. Will re-evalue for compliance for compliance and if compliance is not met will continue for another three (3) months. For F514: Resident #72 physician orders have be reviewed to ensure pain medications ordered are current and accurate. Rev was done by the DON of MAR and cu- physician's order on 3/6/17. Resident #72 MAR and narcotic count sheet have been reviewed to ensure consistency in documentation. Review was done by the DON of MAR and cu- physician's order on 3/6/17. #125 was discharged on 2/21/17. Clo chart review was done 4/6/17 by Clini Nurse Consultant. Physician orders, M and nurses' notes were reviewed. Resident reported medication as order Resident reported medication effective Resident #125 narcotic count sheets I	I nat wed Jnit ator. by ths e ate r veen view rrent t v rrent sed cal MAR ired. e.		

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Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/17/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		2) MULTIPLE CONSTRUCTION BUILDING		SURVEY PLETED
		345509	B. WING		C 03/03/2017		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
KINGSWO	KINGSWOOD NURSING CENTER			91			
				AE	BERDEEN, NC 28315		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	e 156	F 5	20	been reviewed to ensure consistency is documentation. It was accurate. Resident #72 physician orders for Ativ have been reviewed to ensure ordered are current and accurate Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #72 MAR and narcotic count sheet have been reviewed to ensure consistency in documentation. Review was done by the DON of MAR and cur physician's order on 3/6/17. Resident #87's Ativan is being administered as ordered Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's physician orders have been reviewed to ensure current and accurate. Review was done by the DO of MAR and current physician's order of 3/6/17. Resident #87's MARs have been reviewed to ensure current does is bei given as ordered. Review was done by DON of MAR and current physician's order on 3/6/17. Resident #87's is accurate as of Marcl 2017 as reviewed by the DON. The Director of Nursing (DON) or Staft Development Coordinator has reviewed all residents' narcotics MAR comparing resident's narcotic sheet to documentation. Review will be comple by 4/13/17. All nurses will be in-serviced on the importance of documenting narcotic administration in the MAR and	an I V Trent N Dn M Dn M Dn J T A J G J TO	
					maintaining an accurate narcotic coun Pharmacy Nurse Representative, DON	•	

Event ID: 5IT011

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/17/2017 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345509	B. WING	B. WING			03/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWOOD NURSING CENTER					15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	2 157	F	520	and Nurse Consultants. In-service will complete on 4/12/2017. A Narcotic Audit Sheet for each applicable resident will be placed in residents MAR to ensure accuracy of documentation of narcotic medications given as ordered. Director of Nursing or Unit Manager wi monitor a minimum of 15 narcotic cour sheets and compare with MAR weekly 4 (4) weeks, twice a month for 1 mon and then one time a month for one mo to ensure consistency of documentation The QAPI Committee will review of MA Narcotic monitoring for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evalua for compliance for compliance and if compliance is not met will continue for another three (3) months. Audit results be brought to QAPI Committee meetin by the DON F520 Alliant QIO was contacted by the Administrator on 3/30/17 to request assistance and was told someone wou get back with her. On 4/4/17, the Administrator again called asking for assistance. In the afternoon of 4/4/17, Donna Cohen, Task Manager for the C Ms. Cohen, sent the Administrator an email stating she was "connecting us" Melody Brown, "who heads up the nurs home work" for their organization. The email was copied to Melody Brown. A: 4/13/17, Ms. Brown still had not contacted	II for th, nth n. NR ate will g IId NO, to sing s of	

Event ID: 5IT011

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/17/2017 APPROVED ). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509		(X1) PROVIDER/SUPPLIER/CLIA	` '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED C 03/03/2017		
		B. WING						
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,		
KINGSWO	KINGSWOOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN ( PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T DEFICIE		ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE		
F 520	Continued From page	e 158	F	520	us. On 4/17/17, another email was set to Ms. Cohen stating Ms. Brown had r contacted us and could she herself, as us. Voicemails were also left on Ms. Cohen's cell phone and office phone of 4/17/17 @ 10:00am. On 4/17/17 at 11:11am, Melody Brown replied by em requesting information on what the face needs assistance with. Hand in Hand training will be added to 2017 in-service calendar by second quarter of 2017. The plans of correction for all cited deficiencies, including F tags 279, 282 309, 315, 323, 325, 329 and 514 will b placed into the QAPI program as action plans. To monitor compliance, all aud will be turned in to the facility Administrator to review for completion timeliness. All action plans related to cited tags will remain in QAPI until QA Committee determines compliance has been sustained, but at a minimum of s months. The QAPI Committee will inco but not be limited to, the Administrator Director of Nursing, Staff Developmen Coordinator/Restorative Nurse, Dietar Manager, the Wound Care Nurse, MD Coordinator, Business Office Manager Infection Control Nurse, Maintenance Director and the Medical Director. The QAPI program will involve collectif data, tracking and trending and monito of the cited deficiencies and measures/indicators. The QAPI Committee will set goals/benchmarks/thresholds and iden gaps and opportunities. Cited deficiencies and any facility identified	not ssist on hail cility o our 2, be on its and the PI s six clude the it y S s, r, ng pring		

Event ID: 5IT011

Facility ID: 970412

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ER/CLIA (X2) MUL		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY DMPLETED	
		345509	B. WING				C 03/03/2017	
NAME OF PROVIDER OR S	SUPPLIER	l	1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
KINGSWOOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315				
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 520 Continued	From page	e 159	F	520	areas of concern that have a direct on resident well-being, will be giver priority for improvement. Collected will be used to drive decisions of th Committee. Going forward, the QAPI program w focus on topics that are meaningful address the needs of residents and e.g. infection control issues, incider accidents, pressure injuries, etc. T Committee will charter PIP teams for areas requiring in depth analysis ar practice root cause analysis to get root of problems. The QAPI Comm will plan, implement, measure, mor and document changes using syste analysis and systemic action to add identified problems. Moving forwar QAPI Committee will focus on organizational processes and syste review and act upon opportunities f improvement as identified above. Committee will incorporate best pra modalities such as Root Cause Ana flowcharts, fishbone diagrams, PDS and/or other tools as indicated by individual projects. Corporate staff will visit the facility a 3 days a month. This will include th Administrative Consultant and/or Corporate MDS Nurse. The facility Administrator will send in a weekly to regional with an update of compl on each citation.	vill and staff, its and he or its and he or its and he or ittee ittee ittor, ematic dress d, the ems for or The actice alysis, SA at least he report		

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