

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2018
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345365 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/22/2018 |
| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON | | | STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501 | | |
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| F 656 SS=D | <p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care</p> | F 656 | | 3/18/18 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/16/2018

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.

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| F 656 | <p>Continued From page 1</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, staff interviews and record review, the facility failed to implement care plan interventions of lowering a rod for hanging clothes in the resident closet for 1 of 13 residents (Resident #80) reviewed for accidents.</p> <p>Resident #80 was initially admitted to the facility on 3/10/15. Her most recent admission date was 10/5/17. Her diagnoses include: COPD (chronic obstructive pulmonary disease), difficulty in walking and dependence on supplemental oxygen.</p> <p>Review of resident's most recent MDS (Minimum Data Set), dated 2/5/18 stated that resident requires one-person physical assist for transfers, ambulation, personal hygiene and toilet use. It stated that resident required two personal physical assistance for transfers. The MDS revealed that Resident #80 was assessed as cognitively intact.</p> <p>Review of care plan dated 1/10/18 with a handwritten notation which stated in part: closet-MT (maintenance) to lower rod.</p> <p>An interview of Resident #80 was conducted on 2/20/18 at 11:48 AM. Resident explained her falls happen when she attempts to complete tasks without staff assistance. Resident #80 indicated she believes it takes staff too long to come when she presses her call bell. She reported it happens on all shifts but occurs mostly on 3-11 shift. Resident #80 stated that she has been instructed to wait for staff to come to assist</p> | F 656 | <p>1. The facility failed to implement the care plan intervention of lowering a rod for hanging clothes in closet of resident #80. The Director of Nursing reviewed resident #80 medical record on 2/22/18; the resident had not fallen since 1/10/18. The Regional Nurse spoke with resident #80 on 2/21/18 and the resident desires for the rod in the closet to remain in its current position. The resident will allow staff to assist her with closet needs. The Department Head Interdisciplinary Team received re-education on 2/22/18 by Regional Nurse to complete the maintenance requisition form and give to the Plant Operation Manager/Assistant Plant Operation Manager and/or place in the Maintenance request book to carry out intervention(s).</p> <p>2. Residents in the facility have the potential to be affected by the alleged deficient practice. Resident care plan intervention for falls were reviewed and initiated or implemented by Minimum Data Set Coordinator (MDSC), Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Wound Nurse on 2/22/18. The SDC, MDSC, DON, ADON, Wound Nurse will re-educate Licensed Nurses on implementing care plan interventions and completing maintenance requisition if needed to execute</p> | | |

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| F 656 | <p>Continued From page 2</p> <p>her. She demonstrated she has enough oxygen tubing to use her walker to ambulate to the bathroom without assistance.</p> <p>Review of progress note dated 1/10/18 which read in part: Resident had an unwitnessed fall to her buttocks in her room while attempting to put clothes away. She was transported to the Emergency Department.</p> <p>Review of progress note dated 1/11/18 which read in part: Resident returned from ED (emergency department) with a diagnosis of right 3rd rib fracture.</p> <p>An interview with the MDS Nurse was conducted on 2/21/18 at 4:19 PM regarding the notation on care plan. She explained after Resident #80's fall on 1/10/18 the team re-evaluated the care plan. The team determined since this fall happened at the closet, it was felt it would be safer for resident's closet rod to be moved. This would prevent her from needing to reach up to get things out of her closet.</p> <p>During an interview of Resident #80 was conducted on 2/21/18 at 4:26 PM, she stated that the closet rod had not been moved. Resident #80 indicated she was unaware that the rod was to be moved. She explained it is difficult to get things from her closet and most of the time a nurse will get things for her. Resident #80 was not willing to allow her closet door to be opened during this interview. Similar closets observed had the rod placed in the upper portion of the closet.</p> <p>During an interview with the MDS Nurse on 2/21/18 at 4:28 PM she indicated once work</p> | F 656 | <p>interventions. This will be completed by 3/18/18.</p> <p>3. Audit observations of 5 resident fall care plan interventions will be conducted weekly x 4 weeks, then 3 fall care plan interventions weekly x 2 months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise and the plan will be revised to ensure continued compliance.</p> <p>4. The Director of Nursing and Administrator is responsible for implementing and maintaining the acceptable plan of correction.</p> <p>5. Corrective action completed by 3/18/18.</p> | | |

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| F 656 | <p>Continued From page 3</p> <p>orders are written they are placed in the Facility Service Director's box on his door. The MDS Nurse commented she was unsure why the work order had not been completed.</p> <p>An interview with Facility Service Director was conducted on 2/21/18 at 4:29 PM. He stated he was unaware of a work order requesting that the closet rod be moved in Resident #80's closet. The Facility Service Director was unable to locate work order.</p> <p>An interview with the Administrator was conducted on 2/21/18 at 4:38 PM regarding procedure for maintenance requests. She indicated that there are maintenance logs and maintenance request forms on every unit. The Administrator reported it is her expectation that the nurse who completes the care plan also complete a maintenance request.</p> <p>During an interview with Nurse 4 conducted on 2/21/18 at 4:47 PM, she reported she frequently provides care for Resident #80. Nurse 4 stated that she assists resident with ambulation and ensure oxygen tubing does not cause falls. She noted Resident #80 will frequently not wait for staff to assist. Nurse 4 indicated she provides education to resident regarding waiting for assistance prior to ambulating. Nurse 4 advised she did not submit a maintenance request for the closet rod to be moved.</p> <p>During an interview with MDS Nurse on 2/22/18 at 11:17 AM she revealed that she wrote on the care plan to move the closet rod but it was the responsibility of the nurse providing care to complete the maintenance request. She stated that she is unsure of which nurse was present at</p> | F 656 | | | |

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| F 656 | Continued From page 4 the care plan meeting. No documentation could be located with that information. An interview with Director of Nursing was conducted on 2/22/18 at 4:55 PM. She indicated it is her expectation that interventions listed on the care plan would be implemented by staff. | F 656 | | | |
| F 732 SS=C | Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data | F 732 | | 3/18/18 | |

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| F 732 | <p>Continued From page 5</p> <p>available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, facility record reviews and staff interviews, the facility failed to post the daily nurse staffing sheet for 1 of 4 days (2/19/18) of the survey and failed to document accurate information on the daily nurse staffing sheets for 3 of 4 days (2/19/18, 2/20/18 and 2/21/18) of the survey.</p> <p>Findings included:</p> <p>On 2/19/18 at 9:00 am, an observation was made that the facility daily staffing sheet was not posted.</p> <p>On 2/19/18 at 1:15 PM, another observation was made of the facility daily staff posting. The daily nurse staffing sheet was posted on the counter in the front lobby of the facility. The nurse staffing sheet had the date recorded as 2/19/18. The sheet had the census listed as 81. The staffing sheet was complete for all three shifts and included the numbers of licensed and unlicensed staff and the hours worked. The entries of number of actual hours worked and staffing totals did not have any corrections or changes. The actual hours worked information was transposed with the staffing total columns. The sheet was dated 2/19/18.</p> | F 732 | <p>1)The facility failed to post daily nursing staffing sheet and failed to document accurate information on the daily posted staffing sheet. On 02/19/2018 facility failed to post the daily nursing staffing sheet. On 02/19/2018, 02/20/2018 and 02/21/2018 the facility failed to post accurate information on the posted daily nursing staffing sheet. Inaccurate information consisted of incorrect census numbers, corrections not being made when schedule changes occurred, actual hours worked information was transposed with the staffing totals.</p> <p>2)Residents in the facility have the potential to be affected by the alleged deficient practice. Regional Nurse initiated re-education with nurse secretary, department heads and licensed nurses regarding the importance of posting daily nursing staffing sheet and accuracy of information recorded. Re-education will be completed by 03/18/18.</p> <p>3)Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Secretary and/or Licensed Nurse will review the daily nursing staffing sheet</p> | | |

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| F 732 | <p>Continued From page 6</p> <p>An observation was made of the daily nurse staffing sheet at 5:00am on 2/20/18. The sheet posted was the same sheet that was posted on 2/19/18. No revisions in the staffing numbers or census had been made to the document.</p> <p>On 2/20/18 at 7:30 am, a facility staff member provided a copy of the daily staff posting sheet. The resident census had been corrected from 82 to 81. The entries of number of actual hours worked and staffing totals did not have any corrections or changes. The actual hours worked information was transposed with the information required in the staffing total columns. The sheet was dated 2/20/18.</p> <p>On 2/20/18 at 8:30 am, review of the facility matrix revealed a resident had expired on 2/19/18. The daily nurse staffing sheet for 2/19/18 did not reflect a census change and was recorded as 81.</p> <p>On 2/21/18 at 8:00 am, an observation was made of the facility daily staff posting sheet. The resident census was listed as 81. The entries of number of actual hours worked and staffing totals did not have any corrections or changes. The actual hours worked information was transposed with the information required in the staffing total columns. The sheet was dated 2/21/18.</p> <p>During an interview with the Nursing Secretary (hereafter referred to as NS) at 10:55 am, on 2/22/18, she stated she was the person responsible for completing and posting the daily staff posting sheet. The NS stated that she was unaware of either the requirement to update staff changes as the events occur during the day or the that the daily staff posting had to be available</p> | F 732 | <p>daily to ensure posting is displayed and accurate per regulation. Also will ensure daily posting staffing sheet will be posted daily and will update as schedule changes occur. This will be audited four times per week for one month then three times a week for one month and then two times per week for one month. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise and the plan will be revised to ensure continued compliance.</p> <p>4)The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction.</p> <p>5)Corrective action completed by 03/18/2018</p> | | |

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| F 732 | Continued From page 7 at the beginning of the shift. The NS stated that the updates of the staffing and census takes place during "stand up meetings at 9:15 in the mornings the following day". During the interview, the Nurse Secretary provided corrected copies of the daily staff posting sheets. The sheets provided had been revised to include both the census changes and to reflect any staff call outs with the accurate numbers worked. The NS indicated she would make sure the staffing sheets posted in the future will be revised at the beginning of each shift to ensure accuracy. An interview with the DON (Director of Nursing), on 2/22/18 at 4:15 PM, revealed that call outs are taken by the nurses and "all nurses know to make corrections" on the daily staff posting. During an interview with the administrator at 4:20 PM on 2/22/18, the administrator stated that she was unaware of either the requirement to post the daily staffing sheets by the beginning of each shift or that changes need to be updated to show current staff and/or census changes. The administrator stated, "I thought it was daily until she (the NS) told me earlier today." | F 732 | | | |
| F 760 SS=D | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, resident and family interviews, staff interviews, record review and physician interview, the facility failed to ensure that residents were administered the correct | F 760 | 1)The facility failed to ensure the resident was administered the correct medications and failed to monitor for adverse effects afterwards, resulting in resident #10 | 3/18/18 | |

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| F 760 | <p>Continued From page 8</p> <p>medications and failed to monitor for adverse effects afterwards, resulting in a resident receiving thirteen incorrect medications for 1 of 5 residents (Resident # 10) reviewed for medication administration.</p> <p>Findings included:</p> <p>Resident #10 was admitted to the facility on 9/27/16 with diagnoses that included Multiple Sclerosis and Hypertension. His most recent MDS (Minimum Data Set), dated 12/26/17, indicated that he was assessed as cognitively intact.</p> <p>An interview with a family member on 2/19/18 at 10:00 AM indicated she was notified that the patient was given the wrong medication on 2/16/18. She expressed concern regarding the error.</p> <p>An interview with Resident #10 was conducted on 2/19/18 at 10:42 AM. He stated the nurse came to his room on Friday night and woke him up. He reported Nurse 1 gave him medications and a shot. Resident #10 commented he had experienced a headache since the medication administration. He reported he attempted to tell the nurse that he did not receive medications at night. Resident #10 indicated the nurse continued administering the medications. He concluded by stating that he complied with her request to take the medication.</p> <p>Review of event report dated 2/17/18 which read in part: Following medications given in error: Lantus insulin 40 units, Januvia 100 mg (milligrams), Dilatin 200 mg, Levetiracetam 1000 mg, Gabapentin 100 mg, Simvastatin 20 mg,</p> | F 760 | <p>receiving thirteen incorrect medications on 2/16/18. Licensed Nurse #1 was re-educated by the Director of Nursing 2/17/18 on The Medication Administration Rights. Director of Nursing on 2/19/18 re-educated Nurse #2 and #3 on resident monitoring.</p> <p>2)Residents in the facility having the potential to be affected by the alleged deficient practice. 2/16/18 ADON completed interviews and observations of residents on unit one hundred and found no negative outcomes. Re-education of Licensed Nurses on the appropriate policy and procedure to include the medication administration rights and Medication competencies to include all shifts by the Staff Development Coordinator (SDC), Director of Nursing (DON) and Assistant Director of Nursing (ADON). This re-education will be completed by 3/18/18. Remaining nurses will have re-education and competencies completed on first scheduled shift.</p> <p>3)Medication Competency Observations Audits will be conducted 6 observations x 1 week, 10 per week x 3 weeks, 5 per week x 4 weeks, and then 2 per week x 4 weeks. If any concerns with medication competency observations identified, immediate education will be provided and the Director of Nursing will be notified immediately. All data will be summarized and presented to the facility Quality Assurance Performance Improvement meeting monthly x 3 months by the Director of Nursing or Staff Development</p> | | |

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| F 760 | <p>Continued From page 9</p> <p>Donepezil HCL 10 mg, Fioricet 50/300/40mg, Finasteride 5 mg, Tamsulosin HCl 0.4 mg, Ranitidine 150 mg, Senna laxative 8.6 mg, and Miralax powder 3350 17 grams.</p> <p>Review of a statement from Nurse 1 dated 2/20/18 which read in part: received his roommate's PO (by mouth) medications as well as 40 units of Lantus. The Medical Doctor (MD) was notified and orders were given to perform Accuchecks (glucose monitoring) every hour for 24 hours.</p> <p>Review of progress notes for 2/17/18-2/18/18 documented blood sugar checks at 1:45 AM, 2:45 AM, 3:45 AM, 9:20 AM and 11:35 PM. There was no record of any additional blood glucose readings.</p> <p>An interview was conducted with the facility medical director on 2/21/18 at 2:52 PM. He stated he ordered blood glucose monitoring every hour for 24 hours. He reported he felt that Resident #10 could be managed appropriately in the facility and decided the resident did not need to be transferred to the Emergency Department. The Medical Director indicated he did not feel that Resident #10 had suffered any harm from this incident.</p> <p>An interview was conducted with Nurse 1 on 2/22/18 at 3:24 PM. She stated that she changed the divider card on the medication cart. Nurse 1 indicated she must have switched the medications when she replaced the divider card. She reported Resident #10's room is set up differently from the other rooms in the facility. Nurse 1 explained in the other rooms the A beds were at the window and the B beds were by the</p> | F 760 | <p>Coordinator. Any issues and trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance.</p> <p>4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of Correction.</p> <p>5. Corrective action completed by 3/18/18.</p> | | |

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| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON | | | STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501 | | |
| (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) | (X5) COMPLETION DATE | |
| F 760 | <p>Continued From page 10</p> <p>door. Resident #10's room was set up with the A bed at the door and the B bed by the window. She reported the facility medical director was contacted and he ordered blood sugar checks hourly for 24 hours. Nurse 1 stated she checked Resident #10's blood sugar three times and documented the results in the chart. She indicated she did not recall Resident #10 informing her he did not take medications at night.</p> <p>An interview was conducted with Nurse 2 on 2/22/18 at 3:31 PM. She stated she checked and documented Resident #10's blood sugar one time during her shift. Nurse 2 indicated she was told by Nurse 1 that Resident #10 had blood sugar checks ordered hourly. Nurse 2 revealed she monitored Resident #10 frequently throughout the day but failed to do the hourly blood sugar monitoring. She continued, stating had she been concerned about the resident she would have contacted his doctor.</p> <p>An interview was conducted with Nurse 3 on 2/22/18 at 4:06 PM. She stated she was advised of the order for blood glucose monitoring hourly for Resident #10. She reported she checked his blood sugar three times during her shift. Nurse 3 commented she documented one blood sugar check in the electronic medical record. She added the other two blood sugar checks done during her shift were documented on a paper located inside the medication cart. Nurse 3 indicated she has been unable to locate that paper.</p> <p>An interview the Director of Nursing was conducted 2/22/18 at 3:55 PM. She stated it is her expectation that residents would be given the</p> | F 760 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 760 | Continued From page 11 correct medication and the doctor's orders would be followed. Observations of medication administration were conducted on 2/20/18 at 5:07 AM and 2/21/18 at 3:45 PM with no issues noted. | F 760 | | | |