	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 05/16/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/10/2013
				915 PEE DEE ROAD	
KINGSWO	OD NURSING CENTE	R		ABERDEEN, NC 28315	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	
E 001 SS=F			E OC	01	6/3/19
	comply with all app emergency prepare [facility] must estab comprehensive em program that meets section.* The emer	t for Transplant Center] must blicable Federal, State and local edness requirements. The blish and maintain a hergency preparedness is the requirements of this gency preparedness program ot be limited to, the following			
	comply with all app local emergency pr hospital must deve comprehensive em program that meets	482.15:] The hospital must licable Federal, State, and reparedness requirements. The lop and maintain a nergency preparedness s the requirements of this n all-hazards approach.			
	with all applicable I emergency prepare CAH must develop comprehensive em program, utilizing a	5.625:] The CAH must comply Federal, State, and local edness requirements. The and maintain a hergency preparedness in all-hazards approach. NT is not met as evidenced			
	Based on record re facility failed to esta Emergency Prepar failed to complete a based risk assess cooperation and co regional, state and system of tracking residents, develop develop an alternat	eview and staff interviews, the ablish a comprehensive edness (EP) plan. The facility a facility-based/community nent, develop a process for ollaboration with local, tribal, federal EP officials, develop a on-duty staff and sheltered a communication plan, te means of communication, of sharing information and		1. The facility failed to establish a comprehensive Emergency Preparedness Plan. The facility fa complete a facility-based/community-based ris assessment. The Administrator re and updated the emergency plan b on the facility and community-base assessment and communication p utilizing all hazard approach. This completed by 06/03/19 by the	ailed to sk eviewed based ed risk lan

**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.

06/01/2019

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/18/2019 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINCSWO	OD NURSING CENTER			91	15 PEE DEE ROAD		
RINGSWO	OD NORSING CENTER			A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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
E 001	<ul> <li>occupancy, needs and assistance, develop a plan with residents or provide evidence of sit</li> <li>Findings included: <ol> <li>A review of the fact</li> <li>A review of the fact</li> <li>Y revealed the fact</li> <li>Y revealed the fact</li> </ol> </li> <li>a. The EP plan did not population including a of services the facility emergency.</li> <li>b. The EP plan did not for collaboration with l and federal EP official</li> <li>c. The EP plan did not for tracking staff and reder the fact of the fact</li></ul>	on, develop policy and volunteers, develop a formation about the facility's d its ability to provide means of sharing the EP responsible party (RP) and taff training on the EP plan. cility EP plan material on following: The EP plan was d did not include the ot address the resident tt-risk residents and the type could provide in an ot address the procedures local, tribal, regional, state ls. ot address the procedures residents. t address a communication ot address an alternate tion. t address a means of nation for continuity of care. t address policy and	E	001	Administrator. a. The EP plan did not address the resident population including at-risk a the type of services the facility could provide in an emergency. The Administrator will have a list of all residents that have difficulty with communications and how they communicate. The staff will be assig for constant supervision of residents. staff member and or volunteer will be assigned for at risk residents. Diesel generator Red out let plugs Back up water supply Emergency food supply Emergency pharmacy services O2 cylinders b. The EP plan did not address the procedures for collaboration with local tribal, regional state and federal EP officials. The Administrator is address the issue with the Deputy Director of Public Safety EM Division/EMS Divis Moore County to implement proper procedures. Documentation of on-going efforts to communicate with local, tribal, regions state and federal EP offices. Schedu and planned evacuation drill due on 6/26/2019 with local fire, police and E services c. The EP plan did not address the procedures for tracking staff and residents. The administrator will use daily updated resident census sheet che bistic the second is a service of the second is a servic	ned A sing on of al, ed iMS a as a	
	procedures for volunte				checklist/headcount as well as a dail		

Event ID: 6GQD11

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 05/16/2019 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) E 001 Continued From page 2 E 001 on duty sheet. Sheets will be provided h. The EP plan did not establish sharing of for all administrative members. information on the facility's occupancy, needs and Midnight census completed Q midnight by its ability to aid in the event of an emergency. charge nurse to ensure accuracy Daily census is printed and brought to i. The EP plan did not develop a means of morning meeting for interdisciplinary sharing the plan with residents or RP. distribution Nurses/ Med Aides head count post j. The EP plan did not provide evidence of staff emergency or evacuation training on the EP plan. Activities Director to assist with ensuring all staff and residents accounted for An interview was conducted with the during and after emergency Administrator, Maintenance Director and the d. The EP plan did not address a Director of Nursing (DON) on 5/16/19 at 9:45 AM. communication plan. The Administrator The Administrator stated the facility had reviewed and updated the emergency developed an EP plan but was unable to provide plan which coordinates resident care evidence until 5/14/19. The DON stated the EP within the facility, across healthcare plan provided was completed on 5/14/19 and she providers and coordination with state and was aware of the missing components. The local public health department. The Maintenance Director stated he started his administrator ensured that the disaster position in June 2018 and he had no previous manuals included contact information with Long-Term Care experience. The Administrator state and local health departments. The Administrator will have all administrative stated it was possible that the previous Maintenance Director accidently took the EP plan staff contact information made available with him when he left. She stated the facility and updated as needed. As well as any implemented the Disaster Plan during Hurricane repair or city services that is needed. Florence in September of 2018 and sheltered in place. The Administrator stated it was her Updated phone list will be at each Nursing expectation the facility develops and maintains a station to include administrative staff and comprehensive EP plan with annual updates. floor staff as well as ancillary staff (i.e. activities, medical records, dietary and housekeeping ect.) The phone list will be updated on a weekly basis by the staffing coordinator to remove inactive employees as well as include any new employees All hands on deck phone tree to be created by 06/03/2019 to allow for all staff in house during the event of an

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

Event ID:6GQD11

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/18/2019 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 05/16/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	•
100000				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 ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
E 001	Continued From page	23	EO	<ul> <li>emergency or disaster Red outlet charging in co staff charging when appr continued communication</li> <li>e. The EP did not addre means of communication Administrator will initiate communication plan that of choice. The Administr the use of Facebook or T necessary. The Administ Radio station, Red Cross Battery operated radios v local weather and emerg each Nurses station Emergency cell phone ac cell phones by employee f. Plan did not address sharing medical informati of care. The Administrate emergency operation in f red outlets. Emergency g facility to operate to meet staff needs. Medical records personn face sheet and H&amp;P out of during evacuation if poss Nurses will evacuate witt Report will be given to th on duty via phone or in w communication sheet wh transferred to another face emergency or disaster</li> <li>g. Plan did not address procedure for volunteers initiate training upon original</li> </ul>	opriate to ensure n ess an alternate b. The the emergency offer two options ator may initiate witter as trator will contact s, Military, FEMA. with access to ency stations at ccess to personal s a means of ion for continuity or will maintain facility by using generator allows t all residents/ el will remove of live chart sible. n current MAR ird party by nurse rriting via nursing len the patient is cility due to s policy and . The facility will
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID:6G	OD11	Facility ID: 970412	If continuation sheet Page 4 of 74

Event ID:6GQD11

Facility ID: 970412

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FOR	D: 06/18/2019 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	345509	B. WING				C /16/2019
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWOOD NURSING CENTER			91	15 PEE DEE ROAD		
			A	BERDEEN, NC 28315		
PREFIX (EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 001 Continued From page	. 4	E	001	maintain annual emergency preparedness thru policies and procedures to volunteers that is consistent with their expected roles. Administrator and Activity Director w in-service volunteers at next resident/family council meeting. All volunteers that are available to a with evacuation and emergency will contacted by the activities director a assistance requested as soon as po- after disaster or emergency h. The EP plan did not establish s of information on the facility's occup needs and its ability to aid in the eve an emergency. The Administrator w in place a plan to notify other facilitie our occupancy and needs in the eve an evacuation. The Administrator w provide a plan for the residents who need to be evacuated to another fac and what the residents care would b meet their needs. Medical Records Social Worker will call and assist in placement if need for transfer. The members or responsible party will bu notified by telephone. All necessary paperwork and medications will tran with resident. At least one staff mer to transfer with residents if necessary evacuate to another setting. Agreement is in place with St. Josep the pines to assist with residents, ac and facility needs in the event of an emergency or disaster. The Moore County Emergency Resp team will receive a copy of the emer response plan no later than 06/03/20	ssist be nd ssible haring ancy, ent of ill put es of ent of ill may be to and family e family e family e for to ber to of sfer nber ry to obs of cuity	

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Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/18/2019 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345509	B. WING				C /16/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER			91	15 PEE DEE ROAD		
				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
E 001	Continued From page	≥ 5	E	001	Agreement is in place with Meadow w Nursing Facility to take bedbound pat in the event of an emergency or disas i. The EP plan did not develop a mean sharing the plan with residents or RP. The administrator will send a letter our families and implemented through resident council. The administrator will develop and se out letters to resident's RP and family members by 06/03/2019 informing the of the emergency response plan and facilities in place to assist with disaste emergencies j. The EP plan did not provide evid of staff training on the EP plan. The Administrator will in-service all staff a keep a sign –in sheet of attendances well as new hires to be completed up orientation of training to include updat accordingly. Staff will be in serviced on Emergency Response plan by 06/03/2019 2. All residents in the facility have the potential to be affected by the alleged deficient practice. 3. The Administrator updated the emergency plan based on the facility community-based risk assessment ar communication plan utilizing an all-hazards approach. The emergency preparedness plan will be evaluated a updated on an as needed basis and reviewed for compliance at least annu Facility staff will be educated on the updated emergency plan. This will be completed by 06/03/2019.	ients ster ins of it to ind em ers or ence ind as on tes y and id sy and ially.	

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Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: ( FORM A OMB NO. 0	PPROVED
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SUI COMPLET	
		345509	B. WING			C 05/16/	2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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 .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
E 001	Continued From page	96	EC	001			
					b. In-services of staff and volunteers of updated emergency plan policy and procedures, as well as communication plan will be completed by 06/03/2019 b Maintenance Director, Administrator, Director of Nursing, Shift Supervisor an or Nurse Manager.	у	
					<ul> <li>4. The Administrator/Maintenance Director will review, and update emergency plan quarterly and as needed b. QA tool entitled Disaster Plan Check will be reviewed with Department Head weekly for 4 weeks. Monthly x 2 month c. Training will be updated at least annually and as needed; Maintenance Director will include staff documentation Emergency preparedness Plan training a log. This will be completed by 06/03/2019.</li> <li>d. Any issues or trends identified will b addressed by Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will b revised to ensure continued compliance</li> <li>5. The Administrator and Maintenance Director are responsible for implementia and maintaining the acceptable plan of correction. Corrective action completed</li> </ul>	klist s is. n of on e e e.	
F 558 SS=D	CFR(s): 483.10(e)(3)	odations Needs/Preferences	F 5	558	by 06/03/2019.	6/3	3/19
	§483.10(e)(3) The rig services in the facility	ht to reside and receive with reasonable					

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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:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345509	B. WING _				C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER		- I	S	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 PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 558	other residents. This REQUIREMENT by: Based on observation record review, the fact divided plate during m adaptive equipment m (Resident #52) of 1 re accommodation of ne Resident #52 was add diagnosis of Traumati Review of an Occupa and Plan of Treatment to have a divided plat Resident #52's care p indicated he was dep that any adaptive equi and provided. His quarterly Minimur 4/14/19 indicated sev with verbal behaviors for supervision with st and he was coded with	sident needs and hen to do so would or safety of the resident or i is not met as evidenced ns, staff interviews and illity failed to provide a heals for a resident with eeds. This was for 1 esident review for reds. The findings included: mitted on 1/15/18 with a c Brain Injury (TBI). tional Therapy Evaluation t dated 3/2/18 indicated was e with meals. Alan last revised 10/25/18 endent on staff to ensure ipment needed for present n Data Set (MDS) dated ere cognitive impairment . Resident #52 was coded taff set-up for meals only	F 5	558	<ul> <li>F558- Reasonable accommodations Needs/ Preference:</li> <li>1. The facility failed to provide a divide plate during meals for resident #52 with adaptive equipment needs. Resident # physician order was processed on 5/18 by the Director of Nursing and resident #52 began receiving the divided plate of 5/15/19 during meals.</li> <li>2. Other residents in the facility receil adaptive equipment needs for meals he the potential to be affected by the alleg deficient practice. The Registered Dietician (RD) completed an audit on residents requiring adaptive equipment meals on 5/23/2019. Any concerns identified were addressed.No other concerns identified in the facility.</li> <li>3. Licensed Nurses and Occupationa Therapist were re-educated by the Director of Nursing (DON) and Rehabilitation Therapy Manager (RTM regarding the process of writing order of adaptive equipment and processing or to ensure resident will receive adaptive equipment this will be completed by Ju 3, 2019.Any staff with out training will the held at an inactive status and unable to work until in services are completed. T</li> </ul>	n #52 5/19 i on ving ave ed t for al j for der e ne oo	
	Resident #52 was obs	n on 05/13/19 at 12:35 PM, served eating his lunch in ng upright in bed. There			includes all staff on all shifts. Including PRN. 4. Audit Observation via dining adap		

Facility ID: 970412

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 05/16/2019
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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 558	Continued From page was no divided plate		F 558	equipment will be completed by of Nursing (DON), Licensed Nurs	se, Staff
	During another observation on 5/14/19 at 9:20 AM, Resident #52 was observed eating his lunch in his room. He was sitting upright in bed. There was no divided plate in use. During an interview on 5/14/19 at 2:15 PM, the Rehabilitation Director stated Resident #52 was evaluated on 3/2/18 for the use of a divided plate which was indicated. She stated she was unable to provide any evidence of a written order for the divided plate.	is observed eating his lunch sitting upright in bed. There		Development Coordinator, Minim Assessment Coordinator, Activiti Director, Ambassador rounds co by Director of Nursing (DON), Lic Nurse, Staff Development Coord Minimum Data Assessment Coord	es nducted censed inator, rdinator,
		or stated Resident #52 was for the use of a divided plate She stated she was unable		Activities Director weekly x 4 wee monthly x 2 months. Any issues identified will be addressed by th Assurance Performance Improve Committee to include the followin Director of Nursing (DON), Licen Nurse, Staff Development Coord Minimum Data Assessment Coord	or trends e Quality ement ng staff sed inator,
	Medication Aide (MA) Resident #52' medica breakfast on a regula read he was to have a MA #1 stated she was #52 was to be provide	n on 5/15/19 at 8:10 AM, ) #1 was administering ations. He was eating his r plate. His dietary tray ticket a divided plate for meals. s not aware that Resident ed with a divided plate for it was documented on his		Activities Director (QAPI) as the and the plan will be revised to en continued compliance. The Direct Nursing will be responsible for m and reporting data to QAPI team 5. The Director of Nursing, Ref Therapy Manager and Administra responsible for implementing and maintaining the acceptable plan	y arise, isure stor of aintaining nabilitation ator are d of
	During an interview on 5/15/19 at 8:40 AM, the Dietary Manager (DM) stated he received a Diet Requisition Form yesterday that Resident #52 was to have his meals served on a divided plate, but he could not find one prior to the one he received on 5/14/19. The DM stated he updated Resident #52's dietary tray ticket on 5/14/19 to reflect the need for a divided plate and that he should have been served breakfast 5/15/19 on a divided plate this morning.			correction. Corrective action cor by 6/3/2019.	npleted

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DEPARTMENT OF HEA CENTERS FOR MEDIC					F	ORM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
		345509	B. WING			05/16/2019
NAME OF PROVIDER OR SUPP		-		STREET ADDRESS, CITY, STATE, ZIP 915 PEE DEE ROAD ABERDEEN, NC 28315	CODE	
PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
have a divided the expectation prescribed an write a physic department. A order should of and give it to a stated that did During an inter Administrator expectation th on a divided p F 604 Right to be Frr SS=D CFR(s): 483.1 §483.10(e) Re The resident H and dignity, in §483.10(e)(1) physical or ch purposes of d required to tre consistent wit §483.12 The resident H neglect, misaj and exploitation includes but is corporal punis any physical of	der on 8 der on 8 d plate w on that w y adapt ian's oru- tian's or	5/14/19 for Resident #52 to with meals. She stated it was when Rehabilitation ive equipment, they should der and give it to the nursing me, the nurse taking off the e a Diet Requisition Form ary department. The DON cur until 5/14/19. n 5/16/19 at 10:40 AM, the DN stated it was their dent #52 receive all meals ordered. Physical Restraints , 483.12(a)(2) and Dignity. ght to be treated with respect : to be free from any restraints imposed for e or convenience, and not esident's medical symptoms, 12(a)(2). right to be free from abuse, tition of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.	F 55			6/3/19

Facility ID: 970412

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TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	LE CONSTRUCTION	(X3) DAT	IO. 0938-039 TE SURVEY MPLETED
			A. BUILDING	3		C
		345509	B. WING		0	5/16/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI	DE	
KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD		
	OD NORONO OENTER			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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 604	Continued From page	e 10	F 60			
1 004						
		e that the resident is free nical restraints imposed for				
		e or convenience and that				
		eat the resident's medical				
	symptoms. When the					
	indicated, the facility	must use the least restrictive				
		ast amount of time and				
		e-evaluation of the need for				
	restraints.	T is not mat as suideneed				
		F is not met as evidenced				
	by: Based on observation	on, record review, Physical		F604- Right to be free from	Physical	
		iew, and staff interview, the		Restraints:	i ilgolodi	
	,	re a physical restraint had a		1. The facility failed to ensu	ure a physical	
	medical symptom to	justify its use and failed to		restraint had a medical symp	otom to justify	
	· · ·	assessment of the need for		its use and failed to complete	•	
		prior to its implementation		assessment of the need for t		
		Resident #4) reviewed for		restraint prior to its implement		
		A pommel cushion (a cushion atural gap between the upper		resident #4. Resident #4 was on 05/29/19 for the least rest		
		d position preventing the		alternative. Upon reassessm		
	-	vard in their chair) was in		05/29/19 by Physical Therap		
		's wheelchair to prevent the		resident continues to require		
	-	out of her wheelchair.		Pommel Cushion. (a cushion	ed designed	
	The findings included	1:		to fill the natural gap between legs when in a seated position		
				the user from sliding forward		
	Resident #4 was adn	nitted to the facility on		This was provided to facilitate	e upright	
		cently readmitted on 10/9/18		trunk posture and to ease mo	•	
	÷	ncluded a history of falling,		Nursing staff initiated a physi		
	difficulty walking, and	d dementia.		for the Pommel Cushion on r		
	Posidont #4 ! a acra	plan included the feetus area		5/16/2019. The facility compl		
		plan included the focus area itiated on 11/17/19) related		updated restraint assessmer 5/16/2019 for resident #4. Th		
		itioning, incontinence, poor		MDS coordinator updated the	•	
	communication/comp			reflect the use of the Pomme		
	unawareness of safe			a restraint on 5/15/2019. The		
		-		Cushion will be used for histo		
						1

Event ID: 6GQD11

Facility ID: 970412

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· /	3	) ´co	MPLETED
			-			С
		345509	B. WING			5/16/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	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 CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 604	Continued From page	e 11	F 60	)4		
		29/19 indicated Resident #4		falls and repeat injury.		
	's cognition was seve	erely impaired. She had no		2. Resident□s that re		
		ection of care. Resident #4		and have a device such		
	-	bendent on 2 or more for bed		cushions, other cushior		
	-	essing, and toileting and		mechanical device, ma		
		ersonal hygiene. She e of 1 for locomotion on/off		attached or adjacent to body have the potential		
	the unit. Resident #4			The Director of Nursing		
		e of motion and she utilized		Supervisors, Licensed		
	a wheelchair.			complete a reassessme		
				accuracy and use wher		
	An incident report dat			than 06/3/2019. No oth		
	Resident #4 fell out o	f her wheelchair.		identified through out th	-	
	Resident #4 ' s care r	plan related to falls was		3. The facility Therap Director of Nursing will		
		ith the intervention of a		and educate staff in the		
	therapy screen for a i	new wheelchair cushion.		as it relates to writing o		
				equipment use for restr		
		rral Screen dated 3/18/19		processing by June 03,		
		4 was referred for a screen		will educate nursing sta		
		ng out of her wheelchair. ducted by Physical Therapist		completion of restraint later than June 03, 201		
		nd indicated a pommel		Nursing will educate sta		
		esigned to fill the natural gap		restraint assessment. A		
	-	gs when in a seated position		not completed mandate		
		om sliding forward in the		06/03/2019 will be unal		
	· · ·	o facilitate upright trunk		requirement is fulfilled.		
	posture and to ease r	nobility.		shifts and PRN staff. So therapy will ensure the		
	The hard copy medic	al record and electronic		option is utilized for any		
		led no physical restraint		4. The Director of Nu		
		on was conducted for the		Rehabilitation Therapy	-	
		s pommel cushion utilized as		review weekly x 4 week	•	
		dditionally, there was no		2 months any devices t		
		if any lesser restrictive		added and ensure appr		
		empted prior to the pommel nented by staff on 3/18/19.		been received, assessr and care plans are in p	-	
		101100 by 51an 011 3/ 10/ 18.		or trends identified will	-	
				the Quality Assurance I	-	

Event ID:6GQD11

Facility ID: 970412

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		MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION	OMB NO. 09 (X3) DATE SUR	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	COMPLETE	
					С	
		345509	B. WING	······	05/16/2	2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP 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 (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE CC	(X5) DMPLETIO DATE
F 604	The quarterly MDS as indicated Resident #4 impaired. Resident #4 dependent on 2 or mo transfers, dressing, a on 1 for personal hyg extensive assistance the unit. Resident #4 impairment with range a wheelchair. She wa restraint (any manual mechanical device, m attached or adjacent the individual cannot restricts freedom of m to one's body) in the daily. An observation was of 12:30 PM and reveale wheelchair with a por The resident 's active 5/13/19, did not have to Resident #4 's por utilized as a physical The care plan for Res 5/14/19 by MDS Nurs area of the utilization physical restraint. Th be in place in Residen intervention was to en positioned correctly w while restrained.	ssessment dated 4/29/19 4 's cognition was severely #4 was assessed as one for bed mobility, nd toileting and dependent iene. She required the of 1 for locomotion on/off had no functional e of motion and she utilized as coded with a physical method or physical or naterial or equipment to the resident's body that remove easily which novement or normal access category of "other" used conducted on 5/13/19 at ed Resident #4 seated in her nmel cushion in place. e care plan was reviewed on a care plan in place related nmel cushion was being restraint. sident #4 was revised on se #1 to include the focus of a pommel cushion as a ne pommel cushion was to nt #4 's wheelchair. The nsure Resident #4 was with proper body alignment	F 60		e (QAPI) as they e revised to iance. Restraint . Record of audit e Director of ented in QAPI by sing, Rehabilitation dministrator are nting and ble plan of	
	Resident #4 were rev	physician ' s orders for riewed on 5/14/19 and s in place for the pommel				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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)	BE	(X5) COMPLETION DATE
F 604	for Resident #4. An interview was con on 5/14/19 at 4:58 PM #4 had a pommel cus wheelchair. She indic was utilized as a phys Resident #4 from slid and falling onto the gr The Nursing Assistan reviewed on 5/15/19 a had a pommel cushio restraint. An interview was con Nursing (DON) on 5/1 stated that prior to the physical restraint, a re assessment/evaluatio order was to be obtain be developed. The DO had a pommel cushio physical restraint for t prevention. She indic was not able to be ref Resident #4. She exp out of her wheelchair explained that on 3/12 again as a result of sl wheelchair, but staff i repeat fall. The DON referred to rehabilitati 3/18/19 to see if there be done to prevent here wheelchair. She repor	ducted with MDS Nurse #1 A. She stated that Resident shion in place on her cated the pommel cushion sical restraint to prevent ing out of her wheelchair round. t (NA) care guide was and indicated Resident #4 n in place as a physical ducted with the Director of 15/19 at 10:30 AM. She e implementation of a estraint on was to be completed, an ned, and a care plan was to ON revealed Resident #4 n that was utilized as a the purpose of fall cated the pommel cushion moved independently by blained that Resident #4 fell on 3/11/19. She further 8/19 Resident #4 almost fell iding forward in her ntervened and prevented a stated that Resident #4 was on for an evaluation on e was something that could er from sliding forward in the orted that PT #1 ovided the pommel cushion	F	604			
	recommended and pr						

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 06/18/2019 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION		X3) DATE S COMPL	SURVEY LETED
		345509	B. WING			C 05/16/2019		
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COE	)E		
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 PREF TAG	x	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	E	(X5) COMPLETION DATE
F 604	pommel cushion and floor that the pommel for Resident #4. She have prompted the m assessment/evaluatio from the physician of required the use of a reported that all new morning meetings that department heads eve She stated that durin 3/19/19, MDS Nurse informed of the new of cushion and this would develop a care plan f pommel cushion utiliz Resident #4 ' s medic the DON and she ver physician ' s order for identification of the m required the use of a restraint assessment restrictive alternative pommel cushion beir also verified that ther for the pommel cushi restraint until 5/14/19 An interview was con 5/15/19 at 10:35 AM. Screen for Resident a She indicated the por implemented to preve forward out of the wh floor. PT #1 revealed she was supposed to pommel cushion and	ritten an order for the informed the nurse on the cushion was implemented indicated that this would urse to complete a restraint on and to obtain justification the medical symptom that physical restraint. The DON orders were reviewed in the at were held with all ery Monday through Friday. g the morning meeting on #1 should have been order for the pommel ld have prompted her to or the use of Resident #4 ' s zed as a physical restraint. cal record was reviewed with ified that there was no the pommel cushion, no redical symptom that physical restraint, and no /evaluation and no lesser attempted prior to the g implemented. The DON e was no care plan in place on utilized as a physical ducted with PT #1 on The 3/18/19 Rehabilitation #4 was reviewed with PT #1.	F	604				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C 16/2019
NAME OF PF	ROVIDER OR SUPPLIER		TREET ADDRESS, CITY, STATE, ZIP CODE				
KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	X       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRIDE						(X5) COMPLETION DATE
F 604 F 623 SS=C	that the pommel cush An interview was com- on 5/15/19 at 10:45 A Resident #4 had a po- utilized as a physical that the pommel cush fall prevention interve from her wheelchair of reported that the pom- Resident #4 's ability wheelchair. She reve was initiated on 3/18/ a care plan for Reside cushion as a physical A follow up interview DON on 5/16/19 at 10 there was a miscomm was the root cause of medical symptom ide assessment/evaluation for the pommel cushion restraint for Resident Notice Requirements CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m	ion was implemented. ducted with MDS Nurse #1 M. She verified that mmel cushion that was restraint. She indicated ion was implemented as a ntion after Resident #4 fell on 3/11/19. MDS Nurse #1 mel cushion restricted to slide forward in her ealed the pommel cushion 19, but she did not develop ent #4 ' s use of the pommel restraint until 5/14/19. was conducted with the 0:40 AM. She reported that nunication with PT #1 that in o order being in place, no ntified, no on, and no care plan in place on utilized as a physical #4. Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The py of the notice to a Office of the State pudsman.		604			6/3/19
	Long-Term Care Omb	oudsman.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/18/2019 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION		SURVEY PLETED
		345509	B. WING				_ 16/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	KINGSWOOD NURSING CENTER				115 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 623	discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility at resident is transferred (ii) Notice must be may before transfer or disc (A) The safety of indiv be endangered under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follow (i) The reason for tran (ii) The location to wh transferred or dischar (iv) A statement of the	ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; nich the resident is	F	623			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/18/2019 APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í				(X3) DATE COMP	SURVEY LETED
		345509	B. WING			_	05/	C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWOOD NURSING CENTER				9	15 PEE DEE ROAD			
				Α	BERDEEN, NC 28315			
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING			(X5) COMPLETION DATE					
F 623	and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailing telephone number of the protection and add developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individu §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice if In the case of facility of the administrator of the written notification print to the State Survey As	er of the entity which ts; and information on how irm and assistance in ind submitting the appeal s (mailing and email) and the Office of the State budsman; / residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act.	F	623				

Facility ID: 970412

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
			A. BUILDING	;		С
		345509	B. WING		0	5/16/2019
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 623	Continued From page	- 1 <b>9</b>	Гер	2		
1 025	-		F 62	3		
		esident representatives, as transfer and adequate				
		dents, as required at §				
	483.70(I).					
		is not met as evidenced				
	by:					
		iew, responsible party (RP),		F623- Notice Requirement befo	ore	
		erviews, the facility failed to		Transfer/Discharge:		
		d/or the resident's RP in reason a resident was		<ol> <li>The facility failed to notify t and or the resident s RP in wri</li> </ol>		
		facility to the hospital for 5		regarding the reason a resident		
		#70, #73 & #185) of 5		discharged from the facility to the		
	-	viewed for hospitalizations.		for resident #58, #81, #70, #73		
				Resident # 185 no longer reside	es in the	
	Findings included:			facility. The responsible party f		
				Resident #58 was notified in wr	•	
		originally admitted to the		discharge that occurred on 11/1		
		he quarterly Minimum Data ent dated 4/17/19 indicated		The responsible party for Resid was notified in writing of the dis		
		d cognitive impairment.		that occurred on 05/05/2019. The	•	
				responsible party for Resident #		
	Review of the Reside	ent #58's nurse's note dated		notified in writing of the discharge		
	11/18/18 at 8:10 AM i	revealed that Resident #58		occurred on 01/02/2019. The R	-	
	was discharged to the	e hospital due to		Party for resident # 73 was noti	fied in	
	-	nd was readmitted back to		writing of the discharge that occ	curred	
	the facility on 11/23/1	8.		03/05/2019 & 03/21/2019. This		
	TI 1 1 1 1 1 1 0 100			completed 05/30/2019. This wa		
		0/18 at 8:50 AM indicated		completed by the Social Worke		
		is discharged to the hospital readmitted back to the facility		2. Residents that reside in the have the potential to be affected	•	
	on 12/31/18.	calination back to the facility		was conducted by the Director		
				Staff Development Coordinator		
	The notes dated 11/2	18/18 and 12/29/18 did not		Supervisor, Licensed Nurses, a		
	indicate that the RP v	vas notified in writing of the		Worker to identify transfers or d		
	reason for the discha			in the last 4 weeks to provide w		
				notice to the responsible party t		
		as interviewed on 5/16/19 at		completed by June 3, 2019. Th	-	
		ited that the facility staff had		20 late discharge notices that w	ere mailed	
	called to notify her the	at the resident was		to resident's RP.		

Facility ID: 970412

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	S FOR MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		D. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		Сом	PLETED
		345509	B. WING			C / <b>16/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05	/10/2019
KINGSWO	OOD 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 623	Continued From page	e 19	F 623	3		
	<ul> <li>discharged to the hos received any letter or notify her of the reaso</li> <li>Unit Manager (UM) # 5/15/19 at 2:03 PM.</li> <li>were supposed to cal phone when a resider hospital. She added letter or notice to the writing of the reason for the Director of Nursir on 5/15/19 at 2:50 PM was not aware of the notify the resident and reason for the dischar expected the regulation notification.</li> <li>2. Resident #81 was a facility on 4/17/19. The Set (MDS) assessme that Resident #81's nurse revealed that Resider the the set of the the set of the the set of the the the the the the set of the set of the set of the set of the the set of the set of</li></ul>	spital but she had not notice from the facility to on for the hospitalization. 1 was interviewed on The UM stated that nurses I the RP of the resident by nt was discharged to the that she had never sent a RP to notify him/her in for the discharge. ng (DON) was interviewed A. The DON stated that she regulation that facility had to d or RP in writing of the rge. She reported that she on to be followed for the he admission Minimum Data nt dated 4/28/19 indicated ognition was intact. 's note dated 5/5/19 nt #81 was admitted to the e in mental status and was e facility on 5/9/19. The		<ol> <li>The Director of Nursing on 5 provided education and training the Social worker to provide written notification of transfer to another discharge to the hospital to the responsible party.</li> <li>Social Worker or Nursing St will review all transfers and disch weekly during clinical morning me weekly x 4 weeks to ensure written notification has been provided to responsible party. Any issues or identified will be addressed by the Assurance Performance Improve Committee (QAPI) as they arise, plan will be revised to ensure cor compliance. The Social Worker were responsible for ensuring that all discharges RP received written me Discharge Audit tool. The Social will be responsible for maintainin tool and bringing it to QAPI mont 5. The Administrator and Direct Nursing are responsible for imple and maintaining the acceptable pr correction. Corrective action com by 6/3/2019.</li> </ol>	o the facility or upervisor arges eeting en the trends e Quality ment and the ntinued vill be otice via Worker g audit hly. tor of ementing plan of	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345509	B. WING				C /16/2019
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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	<ul> <li>were supposed to not discharge to the hosp had never informed the writing of the reason of the Director of Nursin on 5/15/19 at 2:50 PM was not aware of the notify the resident and reason for the dischart expected the regulation notification.</li> <li>3. Resident #70 was of facility on 5/22/17. The Set (MDS) assessme that Resident #70 had impairment.</li> <li>Resident #70's nurse AM revealed that Resident the hospital due to un readmitted back to the revealed that Resider hospital due to shorth readmitted back to the The nurse's note date revealed that Resider hospital due to shorth readmitted back to the The 1/2/9 and 3/22/19 the resident or the RF the reason for the dis Resident #70 was inter 10:55 AM. Resident #70 was inter 10:55 AM. Resident #70 was inter the the the the the the the the the the</li></ul>	1 was interviewed on The UM stated that nurses tify the resident before the ital. She added that she he resident or the RP in for the discharge. In (DON) was interviewed A. The DON stated that she regulation that facility had to d or RP in writing of the rge. She reported that she on to be followed for the be annual Minimum Data Int dated 5/8/19 indicated d moderate cognitive I's note dated 1/2/19 at 7:00 sident #70 was discharged to rresponsiveness and was e facility on 1/5/19. ed 3/22/19 at 9:00 AM ht #70 was sent to the less of breath and was	F	623	3		

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		ID HUMAN SERVICES				FORM	APPROVED
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			
		345509	B. WING				C 16/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OD NURSING CENTER				915 PEE DEE ROAD		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 623	Continued From page	<u>م</u>	E F	623	3		
	writing of the reason f			020			
	Unit Manager (UM) #	1 was interviewed on					
	5/15/19 at 2:03 PM.	The UM stated that nurses					
		ify the resident before the ital. She added that she					
	had never informed th	ne resident or the RP in					
	writing of the reason f	for the discharge.					
		ng (DON) was interviewed					
		<ol> <li>The DON stated that she regulation that facility had to</li> </ol>					
	notify the resident and	d or RP in writing of the					
		rge. She reported that she on to be followed for the					
	notification.						
		admitted to the facility on					
	2/21/19 with diagnose Syndrome.	es that included Down ' s					
	The admission Minim	um Data Set (MDS)					
	assessment dated 2/2 #73 ' s cognition was	28/19 indicated Resident severely impaired.					
	A medical record revi	ew revealed Resident #73					
	was transferred to the	e hospital on 3/5/19					
		) and 3/21/19 (readmitted as no documentation that a					
	written notice of hosp	ital discharge was provided					
	to Resident #73 ' s Re	esponsible Party (RP).					
		M, Unit Manager (UM) #1					
	was interviewed. She	e stated that the RP was					
		pital. She reported that a					
		nmary was not given and/or #1 stated that she was not					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/18/2019 / APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			_		C 16/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	KINGSWOOD 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 PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	aware of the regulation had to notify the RP in the hospital discharge On 5/16/19 at 10:40 A (DON) was interviewed that she was not awa indicated the facility h of the reason for the H DON reported that she for notification to be for 5. Resident #185 was 12/11/18 with diagnos with behavioral distur The admission Minim assessment dated 12 #185 's cognition was A medical record revie was transferred to the readmitted to the facil no documentation that discharge was provid Responsible Party (R On 5/15/19 at 2:05 PI was interviewed. She notified by phone whe discharge to the hos written discharge sum sent to the RP. UM a aware of the regulation had to notify the RP in the hospital discharge	on that indicated the facility in writing of the reason for e. AM, the Director of Nursing ed. The DON also stated re of the regulation that had to notify the RP in writing nospital discharge. The e expected the regulation bollowed. a admitted to the facility on ses that included dementia bance. um Data Set (MDS) /18/18 indicated Resident s severely impaired. ew revealed Resident #185 e hospital on 3/12/19 and lity on 3/25/19. There was at a written notice of hospital ed to Resident #185 ' s P). M, Unit Manager (UM) #1 e stated that the RP was en a resident was spital. She reported that a immary was not given and/or #1 stated that she was not on that indicated the facility in writing of the reason for	F	623				

			0.00		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED
					С
		345509	B. WING		05/16/2019
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	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIC
F 623	that she was not awa indicated the facility h of the reason for the h	ed. The DON also stated re of the regulation that nad to notify the RP in writing hospital discharge. The ne expected the regulation	F 62	3	
F 641 SS=E	Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy		F 64	1	6/3/19
	The assessment mus resident's status.	is not met as evidenced			
	Based on record revi interview, the facility f Data Set (MDS) asse areas of medications and #81), active diagu #41), physical restrain falls (Residents #4 an	iew, observation, and staff failed to code the Minimum issment accurately in the (Residents #36, #41, #56, noses (Residents #36 and nts (Residents #4 and #23), nd #81), and gender of 20 residents reviewed.		<ul> <li>F641- Accuracy of Assessments:</li> <li>1. The facility failed to code the MI assessment accurately in the followin areas: medication for resident #36, a #56 and #81</li> <li>Active diagnosis for resident #36 and Physical restraint for resident #4 and Falls for resident #4 and #81</li> <li>Gender for resident #75</li> </ul>	ng #41, d #41
	1/14/17 and most rec	admitted to the facility on ently readmitted on 10/9/18 ncluded a history of falling,		MDS coordinator corrected accuracy assessments in the area of medicati as it relates to resident #36, #41, #50 #81 as of 05/16/2019. MDS coordina corrected accuracy of assessment in area of active diagnosis as it relates	ons 6 and ator 1 the to
	indicated Resident #4 due to increased slidi This screen was conc indicated a pommel c to fill the natural gap I when in a seated pos	rral Screen dated 3/18/19 4 was referred for a screen ng out of her wheelchair. ducted on 3/18/19 and sushion (a cushion designed between the upper legs ition preventing the user in the chair) was provided to		resident #36 and #41 as of 05/16/20 MDS coordinator corrected accuracy assessments in the area of physical restraints as it relates to resident #4 #23 as of 05/16/2019. MDS coordina corrected accuracy of assessment a relates to falls for resident #4 and #8 of 05/16/2019. MDS coordinator corr accuracy of assessments in the area	y of and ator s it s1 as rected

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			0.00		OMB NO. 0938	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345509	B. WING		05/16/201	9
NAME OF P	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 DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION (X: E ACTION SHOULD BE COMPL D TO THE APPROPRIATE DAT CIENCY)	ETIO
F 641	Continued From page	e 24	F 64	11		
	's cognition was seve coded with a physical method or physical or material or equipmen resident's body that th easily which restricts normal access to one "other" used daily wh	m Data Set (MDS) 29/19 indicated Resident #4 erely impaired. She was I restraint (any manual		gender as it relates to 05/16/2019. The corre transmitted and submi 2. Other residents in potential to be affected audit was conducted of in the areas of medica diagnosis, physical res gender on 05/15-16/20 coordinator. No other of the facility. MDS coord opposite one another. will not audit their own 3. MDS education re coding as stated in Re Instrument manual an	ctions were tted 05/17/2019. the facility have the d by the deficit. An on MDS for accuracy tion, active straint, falls and 019 by the MDS concerns found for dinators will audit MDS coordinators assessments. elated to accuracy of esident Assessment	
	12:30 PM and revealed	conducted on 5/13/19 at ed Resident #4 seated in her nmel cushion in place.		from resident chart to l Director of Nursing wit no later than 06/03/20 4. MDS Coordinator	be completed by the h MDS coordinators 19.	
	on 5/14/19 at 4:58 PM #4 had a pommel cus wheelchair. She indic was utilized as a phys Resident #4 from slid and falling onto the gr	cated the pommel cushion sical restraint to prevent ing out of her wheelchair round.		Nursing will randomly MDS weekly x4 week; audit 5 completed MD months to verify accur MDS sections as it rela active diagnosis, phys and gender. Any issue identified will be addre	then randomly S monthly x2 acy of coding for ates to medications, ical restraints, falls as or trends assed by the Quality	
	reviewed on 5/15/19 a had a pommel cushic restraint. A phone interview wa	t (NA) care guide was and indicated Resident #4 on in place as a physical is conducted with MDS		Assurance Performance Committee (QAPI) as plan will be revised to compliance. The Unit I Director of Nursing wil utilization of Assessme	they arise, and the ensure continued Managers and I be responsible for	
	MDS for Resident #4 physical restraint in the daily when in bed was	at 11:40 AM. The 4/29/19 that indicated she had a ne category of "other" utilized s reviewed with MDS Nurse n MDS Nurse #1 and the NA		and bringing it to QAP 5. The Administrator Nursing are responsib and maintaining the ac correction. Corrective	and Director of le for implementing cceptable plan of	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				_ 16/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	pommel cushion in he physical restraint was #2. MDS Nurse #2 re Resident #4 was code physical restraints. S #4 's pommel cushio as a physical restrain was utilized daily whe bed or in chair. An interview was con Nursing on 5/16/19 at that she expected the accurately. 1b. Resident #4 was 1/14/17 and most rec with diagnoses that in difficulty walking, and An incident report dat Resident #4 had a fal fracture. The quarterly MDS as indicated Resident #4 impaired. She was co previous MDS assess Nurse #2 coded Resident the area of falls. A phone interview wa Nurse #2 on 5/15/19 is stated that she review coded the MDS for fa had not reviewed inci MDS for Resident #4	ted Resident #4 had a er wheelchair utilized as a serviewed with MDS Nurse evealed the 4/29/19 MDS for ed inaccurately in the area of the reported that Resident in should have been coded t in the category of "other" en Resident #4 was out of ducted with the Director of t 10:40 AM. She indicated e MDS to be coded admitted to the facility on ently readmitted on 10/9/18 ncluded a history of falling, dementia.	F	641	by 6/3/2019.		

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	-	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				U /16/2019
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 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 641	<ul> <li>was reviewed with MI report and nursing no indicated Resident #4 nasal fracture was rev MDS Nurse #2 reveal Resident #4 was code falls. She reported th the 3/11/19 nursing m #4 had a fall with maj</li> <li>An interview was con Nursing on 5/16/19 at that she expected the accurately.</li> <li>2a. Resident #36 was 11/30/18 with diagnos</li> <li>A physician 's order f 11/30/18 indicated Xa 0.5 milligrams (mg) th (PRN) for anxiety/agit</li> <li>The March 2019 Med Record (MAR) indicate administered PRN Xa and 3/5/19) from 3/1/7</li> <li>The quarterly Minimu assessment dated 3/7 's cognition was seve coded with no antiany 7-day MDS look back 3/7/19). MDS Nurse for Resident #36 in th An interview was con PM with MDS Nurse in</li> </ul>	DS Nurse #2. The incident the dated 3/11/19 that 4 had a fall that resulted in a viewed with MDS Nurse #2. led the 4/29/19 MDS for ed inaccurately in the area of that she must have missed ote that indicated Resident or injury. ducted with the Director of t 10:40 AM. She indicated e MDS to be coded as admitted to the facility on ses that included anxiety. for Resident #36 dated anax (antianxiety medication) mee times daily as needed tation. lication Administration ted Resident #36 was anax on 2 of 7 days (3/4/19 19 through 3/7/19.	F	641			

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	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY			
AND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING						
		345509	B. WING				C 16/2019			
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 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 641	antianxiety medication Nurse #1. The March PRN Xanax was adm 3/4/19 and 3/5/19 was #1. MDS Nurse #1 re Resident #36 was coo of medications. She s coded this MDS to ind medication was receiv An interview was com Nursing on 5/16/19 at that she expected the accurately. 2b. Resident #36 was 11/30/18 with diagnos depression. A physician ' s order f 11/30/18 indicated Cy medication) 60 milligr for depression. A physician ' s order f 11/30/18 indicated Xa 0.5 mg three times da anxiety/agitation. The March 2019 Med Record (MAR) indicat administered routine 0 7 of 7 days from 3/1/1 Xanax for anxiety/agit and 3/5/19) from 3/1/1 The quarterly Minimu assessment dated 3/1	n was reviewed with MDS a 2019 MAR that indicated inistered to Resident #36 on a reviewed with MDS Nurse evealed the 3/7/19 MDS for ded in accurately in the area tated that she should have dicate that antianxiety ved on 2 of 7 days. ducted with the Director of to 10:40 AM. She indicated MDS to be coded as admitted to the facility on ses that included anxiety and for Resident #36 dated mbalta (antidepressant ams (mg) once daily at bed for Resident #36 dated unax (antianxiety medication) aily as needed (PRN) for ication Administration ted Resident #36 was Cymbalta for depression on 19 through 3/7/19 and PRN tation on 2 of 7 days (3/4/19 19 through 3/7/19.	F	641						

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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 COMF	E SURVEY PLETED
		345509	B. WING				C / <b>16/2019</b>
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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	anxiety. MDS Nurse Resident #36 in the a An interview was con PM with MDS Nurse Resident #36 that ind of anxiety or depressi Nurse #1. The March routine Cymbalta was #36 on 7 of 7 days fro was reviewed with MI 2019 MAR that indica anxiety/agitation was #36 on 2 of 7 days (3 3/1/19 through 3/7/19 Nurse #1. MDS Nurse MDS for Resident #30 the area of active diag should have coded th Resident #36 ' s activ anxiety and depression An interview was con Nursing on 5/16/19 at that she expected the accurately. 3a. Resident #41 was 12/17/18 with diagnos s disease, depression The March 2019 Med Record (MAR) from 3 indicated Resident #4 Klonopin (antianxiety	diagnoses of depression or #1 coded the 3/7/19 for rea of active diagnoses. ducted on 5/15/19 at 2:50 #1. The 3/7/19 MDS for icated no active diagnoses on was reviewed with MDS a 2019 MAR that indicated a administered to Resident om 3/1/19 through 3/7/19 DS Nurse #1. The March ted PRN Xanax for administered to Resident /4/19 and 3/5/19) from was reviewed with MDS e #1 revealed the 3/7/19 6 was coded in accurately in gnoses. She stated that she is MDS to indicate that e diagnoses included on. ducted with the Director of a 10:40 AM. She indicated a MDS to be coded a admitted to the facility on ses that included Alzheimer ' h, and anxiety. iication Administration /22/19 through 3/28/19 11 was administered medication) 1 milligram of 7 days and no injections.	F	641			

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) D	DATE SURVEY COMPLETED
		345509	B. WING			HOULD BE COMPLETI	
NAME OF P	ROVIDER OR SUPPLIER		•		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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETION
F 641	assessment dated 3/2 #41 's cognition was Resident #41 was coo 7 days and antianxiet MDS Nurse #1 coded Resident #41 in the a An interview was con on 5/15/19 at 4:35 PM Resident #41 that ind injection on 1 of 7 day medication swas review MDS Nurse #1. The 3/22/19 through 3/28/ #41 received Klonopit injections was review MDS Nurse #1 reveal resident #41 was cod of medications. She coded this MDS to ind received antianxiety r on 7 of 7 days and ha An interview was con Nursing on 5/16/19 at that she expected the accurately. 3b. Resident #41 was 12/17/18 with diagnos A physician 's order f 2/21/19 indicated Klon medication) 1 milligra diagnosis of anxiety. The March 2019 Med Record (MAR) indicated	28/19 indicated Resident severely impaired. ded with an injection on 1 of y medication on 1 on 7 days. I the 3/28/19 MDS for rea of medications. ducted with MDS Nurse #1 A. The 3/28/19 MDS for icated she received an ys and antianxiety days was reviewed with March 2019 MAR from '19 that indicated Resident n on 7 of 7 days and no ed with MDS Nurse #1. led that the 3/28/19 MDS for ed inaccurately in the area stated that she should have dicate that Resident #41 nedications were received ad received no injections. ducted with the Director of t 10:40 AM. She indicated e MDS to be coded as admitted to the facility on ses that included anxiety. for Resident #41 dated nopin (antianxiety m (mg) once daily for a	F	641			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345509	B. WING				/16/2019
NAME OF PF	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	<ul> <li>#41 's cognition was received antianxiety r review period. Residu active diagnosis of ar the 3/28/19 MDS for Factive diagnoses.</li> <li>An interview was con on 5/15/19 at 4:35 PM Resident #41 that ind had not included anxi Nurse #1. The 2/21/1 Resident #41 's Klon anxiety was reviewed March 2019 MAR tha was administered Kloo ordered was reviewed March 2019 MAR tha was administered Kloo ordered was reviewed Nurse #1 revealed the #41 was coded inacc? She stated this MDS active diagnosis of ar An interview was con Nursing on 5/16/19 at that she expected the accurately.</li> <li>4. Resident #23 was 12/24/12 with diagnos with behavioral distur The quarterly Minimu assessment dated 2/2 #23 's cognition was</li> </ul>	m Data Set (MDS) 28/19 indicated Resident severely impaired. She nedication during the MDS ent #41 was coded with no fixiety. MDS Nurse #1 coded Resident #41 in the area of ducted with MDS Nurse #1 A. The 3/28/19 MDS for icated her active diagnoses ety was reviewed with MDS 19 physician ' s order for opin 1 mg once daily for with MDS Nurse #1. The t indicated Resident #41 nopin 1 mg once daily as d with MDS Nurse #1. MDS e 3/28/18 MDS for Resident urately for active diagnoses. should have included the twice for Resident #41. ducted with the Director of t 10:40 AM. She indicated e MDS to be coded admitted to the facility on ses that included dementia bance and Parkinson ' s. m Data Set (MDS) 28/19 indicated Resident moderately impaired.	F	641			
		ded with a physical restraint					

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	-	D HUMAN SERVICES				FORM	: 06/18/2019 APPROVED
STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	LETED
		345509	B. WING		-	( 05/ <sup>,</sup>	C 16/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET 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 BI ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 641	in the category of "oth MDS Nurse #1 coded MDS in the area of ph An observation was c her room on 5/15/19 a was asleep on a wing An observation was c a common area of the on 5/15/19 at 3:30 PM walking independently walker. An interview was con- on 5/15/19 at 1:18 PM that the winged mattree restraint for Resident MDS was coded inacc physical restraints. M that the winged mattree Resident #23, but tha Resident #23 's move prevented her from ge further explained that get in and out of bed if winged mattress in pla 2/28/19 MDS should if physical restraints we An interview was com- Nursing on 5/16/19 at that she expected the accurately. 5a. Resident #81 was 4/17/19 with multiple of congestive heart failu	her" used daily when in bed. Resident #23 ' s 2/28/19 hysical restraints. onducted of Resident #23 in at 1:15 PM. Resident #23 ed mattress. onducted of Resident #23 in a secured memory care unit A. Resident #23 was y with the assistance of a ducted with MDS Nurse #1 A. MDS Nurse #1 reported ess was not a physical #23 and that the 2/28/19 curately in the area of ADS Nurse #1 explained ess was in place for t it had not restricted ement and it had not etting out of bed. She Resident #23 was able to independently with the ace. She stated that the have indicated that no re used for Resident #23. ducted with the Director of t 10:40 AM. She indicated MDS to be coded	F 641				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C	
		345509	B. WING				5/16/2019	
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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 641	medication, antidepre antianxiety medication opioid medication dur Resident #81 had phy (4/17/19) for Risperda anxiety, Trazodone for Torsemide for CHF ar pain. The April 2019 Medic Records (MARs) reve received Risperdal, V Torsemide and Oxycc assessment period (A On 5/15/19 at 2:45 Pt interviewed. She revi and the April 2019 M/ Resident #81 had ord antipsychotic, antidep and opioid medication period. MDS Nurse # MDS assessment dat that these medication accurately. She repo completed the admiss she only worked part On 5/15/19 at 3:56 Pt interviewed by phone she didn't understand admission MDS asse antipsychotic, antianx	um Data Set (MDS) 28/19 indicated that receive an antipsychotic ssant medication, n, diuretic medication and ing the assessment period. vsician orders on admission al for psychosis, Valium for or depressive disorder, nd oxycodone for chronic ation Administration ealed that Resident #81 had alium, Trazodone, odone during the april 22-April 28, 2019). M, MDS Nurse #1 was ewed the physician's orders ARs and acknowledged that ers and had received oressant, antianxiety, diuretic ns during the assessment e1 reviewed the admission ed 4/28/19 and indicated s were not coded rted that MDS Nurse #2 sion MDS assessment and time at the facility. M, MDS Nurse #2 was . MDS Nurse #2 stated that why she coded the	F	641				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE	
		345509	B. WING_				C 16/2019
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 PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	2 33	F	641			
	(DON) was interviewe	M, the Director of Nursing ed. She stated that she ssessments to be coded					
	4/17/19 with multiple congestive heart failu chronic pain, depress The admission Minim assessment dated 4/2	re (CHF), anxiety disorder, ive disorder and psychosis. um Data Set (MDS) 28/19 indicated that tion was intact and he had					
	dated 4/26/19 at 6:25	note and incident report PM revealed that Resident on the floor in front of the					
	interviewed. She rev and acknowledged th on 4/26/19. She indic	M, MDS Nurse #1 was iewed the incident reports at Resident #81 had a fall cated that the admission red 4/28/19 was coded					
	(DON) was interviewe	M, the Director of Nursing ed. She stated that she ssessments to be coded					
	4/2/19 with multiple d	. ,					

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/18/2019 MAPPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	LETED
		345509	B. WING		_		C 16/2019
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 B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	medication for 7 days period. Review of Resident # revealed that he had anticoagulant medica (MAR) for April 2019 had not received an a during the assessmen On 5/16/19 at 10:17 <i>A</i> interviewed. She revi and the MAR for April that Resident #56 had received an anticoagu assessment period. On 5/16/19 at 10:43 <i>A</i> (DON) was interviewed expected the MDS as accurately. 6b. Resident #56 was 4/2/19 from another fa displaced fracture fem for closed fracture, ar A review of Resident # Data Set (MDS) dated resident was rarely or usually understands of moderately impaired for The resident required for all transfers and to	eived an anticoagulant during the assessment 56's physician's orders no order for an tion. tion Administration Record revealed that Resident #56 inticoagulant medication nt period (April 7-13, 2019). AM, MDS Nurse #1 was iewed the physician's orders 2019 and acknowledged d no order and had not ulant medication during the AM, the Director of Nursing ed. She stated that she issessments to be coded a admitted to the facility on acility with diagnoses of nur neck, initial encounter	F 64				

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	MENT OF HEALTH AN S FOR MEDICARE & I	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	
		345509	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
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 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 641	meals. The active dia fracture of femur neck fracture, and repeated A review of Resident t 4/2/19 revealed a foct on prior fall with injury documented depressi medication identified. A review of Resident to orders dated 5/1/19 d antidepressant medic On 5/15/19 at 3:00 pr conducted of the MDS Resident #56 ' s admi was incorrectly coded medication for 7 days On 5/15/19 at 3:10 pr conducted with the Di she expected the MD 7. Resident #75 was a diagnosis of Dementia Review of Resident # Minimum Data Set (M his gender as female. During an interview of Nurse #1 stated it was reason she incorrectly gender as female was paperwork referred to	gnoses were displaced c encounter for closed d falls. #56 ' s care plan dated on us for falls and injury based 7. There was no ion or psychotropic #56 ' s current physician id not reveal an order for ation. In an interview was S Nurse #1 who stated that ission MDS dated 4/13/19 I for antidepressant and would be corrected. In an interview was rector of Nursing who stated S to be coded accurately. admitted on 4/8/19 with a a. 75 admission section A IDS) dated 4/21/19 indicated In 5/15/19 at 2:50 PM, MDS is a mistake and the likely y coded Resident #75 is because his hospital him as "she". She stated have been coded as male	F	641			

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		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVE D. 0938-039	
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		345509	B. WING			C /16/2019	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
			9	15 PEE DEE ROAD			
KINGSWC	OOD NURSING CENTER		4	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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 641	Continued From page	e 36	F 641				
	Administrator and Dir	n 5/16/19 at 10:40 AM, the ector of Nursing stated it that Resident #75's MDS be his gender as male.					
F 656 SS=E		Comprehensive Care Plan	F 656			6/3/19	
	implement a compreh care plan for each res- resident rights set for §483.10(c)(3), that im- objectives and timefra- medical, nursing, and needs that are identif assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483 (ii) Any services that a under §483.24, §483. provided due to the re- under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF	ames to meet a resident's I mental and psychosocial ied in the comprehensive nprehensive care plan must J - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)-					

Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345509	B. WING				C 16/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
				9	15 PEE DEE ROAD		
KINGSWC	OOD NURSING CENTER			A	ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	<ul> <li>(B) The resident's prefuture discharge. Fact whether the resident's community was assess local contact agencies entities, for this purpod (C) Discharge plans in plan, as appropriate, if requirements set forth section.</li> <li>This REQUIREMENT by:</li> <li>Based on record revision interview, the facility fin the areas of restrain psychotropic medicate side rails (Resident #81), pain of #81), and contracture sampled residents revision in the section.</li> <li>Tia. Resident #81 was 4/17/19 with multiple back pain, lumbar race post-surgery, malignar anxiety disorder, depring sychotic, antianx medications since adu 4/17/19.</li> </ul>	ference and potential for ilities must document a desire to return to the seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced ew, observation and staff ailed to develop a care pan ints (Resident #4), ions (Residents #36 & 81), 56), urinary catheter management (Resident (Resident #57) for 5 of 20 viewed. admitted to the facility on diagnoses including low liculopathy status int neoplasm of the prostate, ressive disorder and an's orders and Medication ds (MARs) revealed that ers and had received an iety and antidepressant mission to the facility on	F	656	<ul> <li>F656- Development/ Implementation Comprehensive Care Plan:</li> <li>The facility failed to develop a care plans in the following areas: Restraints resident #4</li> <li>Psychotropic medications Resident #3 and #81</li> <li>Side rails resident #56</li> <li>Urinary catheters resident #81</li> <li>Pain management resident #81</li> <li>Contractures resident #57</li> <li>The MDS coordinator updated the care plans for resident #4 as it relates to restraints 05/16/2019, resident #36 and #81 as it relates to psychotropic medications 05/16/2019, resident #56 it relates to side rails 05/16/2019, resident #81 as it relates to urinary catheters 05/16/2019, resident #81 as it relates to pain management 05/16/2019 and Resident #57 as it relates to contractur on 05/16/2019.</li> <li>Other residents in the facility have potential to be affected by this alleged deficient practice. An audit of care plan in the areas of restrains, psychotropic meds, side rails, urinary catheters, pain</li> </ul>	6 d as lent o res the is	

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 05/16/2019 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 656 Continued From page 38 F 656 Diazepam (an antianxiety medication), Duloxetine management and contractures was (an antidepressant medication), Risperdal (an completed by the MDS coordinator antipsychotic medication) and Trazodone (an 05/16/2019. Any concerns identified were antidepressant medication). The assessment addressed. No other issues identified in indicated that the resident needed a care plan for the facility. psychotropic medications to ensure the resident Education with MDS coordinators by 3. suffers little to no side effects related to the Director of Nursing as it relates to medication use and to provide the highest guality developing and implementation of a of life for this resident. The CAAs indicated to patient specific care plan will be proceed to care plan for the use of the completed no later than June 3, 2019. The Unit Managers and or Director of psychotropic medication. 4. Nursing will randomly audit 5 care plans Resident #81's care plan developed on 4/29/19 per week x 4 weeks then randomly audit 5 was reviewed. There were only 2 care plans care plans monthly x 2 months on developed, a care plan for falls and for nutrition. residents who have restraints, There was no care plan developed for the use of psychotropic medications, side rails, the psychotropic medications. urinary catheters, pain management and contractures to ensure accuracy and On 5/15/19 at 2:45 PM. MDS Nurse #1 was execution/ utilization of care plans. Any interviewed. She stated that residents on issues or trends identified will be psychotropic medication should have a care plan addressed by the Quality Assurance developed for the use of psychotropic medication. Performance Improvement Committee She reviewed the care plan for Resident #81 and (QAPI) as they arise, and the plan will be acknowledged that there was no care plan revised to ensure continued compliance. developed for the use of the psychotropic MDS coordinator will be responsible for medications. maintaining and performing Care Plan audit opposite of one another as MDS On 5/15/19 at 3:05 PM, the Director of Nursing cannot audit self. MDS coordinators will (DON) was interviewed. The DON stated that be responsible for bringing information to QAPI monthly. she expected a care plan developed for residents receiving psychotropic medications. The Administrator and Director of 5. Nursing are responsible for implementing and maintaining the acceptable plan of 1b. Resident #81 was admitted to the facility on correction. Corrective action completed 4/17/19 with multiple diagnoses including low by 6/3/2019. back pain, lumbar radiculopathy status post-surgery, malignant neoplasm of the prostate, anxiety disorder, depressive disorder and psychosis.

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

Facility ID: 970412

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PRECEDED BY FULL	A. BUILDING	LE CONSTRUCTION	-	(X3) DATE COMPI	LETED
DEFICIENCIES PRECEDED BY FULL					
PRECEDED BY FULL			ATE, ZIP CODE		16/2019
PRECEDED BY FULL		915 PEE DEE ROAD	,		
PRECEDED BY FULL		ABERDEEN, NC 28315			
,	PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
	F 65	6			
-					
s at risk for ary catheter, a and history of sease. The resident needed a welling urinary was clean, dry eakdown due to as of infection de the highest the assessment an to address the lling catheter. oped on 4/29/19 y 2 care plans and for nutrition. ped for the use of lurse #1 was sidents with uld have a care the care plan for ed that there was indwelling urinary ector of Nursing iON stated that					
	the facility with a theter. As) dated 4/28/19 s at risk for ary catheter, a and history of sease. The resident needed a welling urinary was clean, dry reakdown due to ns of infection de the highest The assessment an to address the elling catheter. oped on 4/29/19 y 2 care plans and for nutrition. ped for the use of	YING INFORMATION)       TAG         F 65         the facility with a theter.         VAS) dated 4/28/19         s at risk for any catheter, a and history of sease. The resident needed a welling urinary was clean, dry reakdown due to the so finfection de the highest. The assessment an to address the elling catheter.         oped on 4/29/19         y 2 care plans and for nutrition. ped for the use of         Aurse #1 was esidents with uld have a care the care plan for ed that there was indwelling urinary         ector of Nursing DON stated that	PRECEDED BY FULL YING INFORMATION)	PRECEDED BY FULL YING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  F 656  F 656 F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656  F 656 F 656  F 656  F 656 F 656 F 656 F 656 F 656 F 656 F 656 F 656 F 656 F 656 F 656 F 656 F 656 F 656 F 65	PRECEDED BY FULL YING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 656  F 656  the facility with a theter.  As) dated 4/28/19 is at risk for and history of sease. The resident needed a welling urinary was clean, dry reakdown due to ns of infection de the highest The assessment an to address the elling catheter.  oped on 4/29/19 y 2 care plans and for nutrition. ped for the use of Hurse #1 was isidents with uld have a care the care plan for ad that there was indwelling urinary

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
			A. BOILDI	NG _			C
		345509	B. WING				16/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OD NURSING CENTER				15 PEE DEE ROAD		
				A	ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	2 40	F6	656			
	1c. Resident #81 was 4/17/19 with multiple back pain, lumbar rad	admitted to the facility on diagnoses including low liculopathy status Int neoplasm of the prostate,					
	Resident #81 was add order for oxycodone f	mitted with a physician's or chronic pain.					
	revealed that Resider oxycodone for pain. T indicated that Resider for pain to ensure the	ment (CAAs) dated 4/28/19 at #81 was receiving he assessment further at #81 needed a care plan resident was comfortable byide the highest quality of					
	was reviewed. There	lan developed on 4/29/19 were only 2 care plans n for falls and for nutrition. an developed for pain					
	interviewed. She stat medication should ha pain management. S	M, MDS Nurse #1 was ted that residents on pain ve a care plan developed for he reviewed the care plan acknowledged that there eloped for pain					
	(DON) was interviewe	M, the Director of Nursing ed. The DON stated that plan developed for residents ations.					
	2a. Resident #57 was	admitted to the facility on					

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345509	B. WING				C / <b>16/2019</b>
NAME OF PI	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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	<ul> <li>(MDS) assessment da Resident #57 had imp impairment in ROM o lower extremities.</li> <li>Resident #57's care p reviewed and there w to prevent further dec</li> <li>On 5/15/19 at 2:45 PP interviewed. She stat contracture should ha She reviewed the care acknowledged that th developed for the har</li> <li>On 5/15/19 at 3:05 PP (DON) was interviewed she expected a care p with contracture</li> <li>2b. Resident #57 was 11/16/12 with multiple dementia. The quarte (MDS) assessment da Resident #57 had imp used side rails as a re Resident #57's care p reviewed. The care p</li> </ul>	e diagnoses including erly Minimum Data Set ated 4/17/19 indicated that paired cognition and had n one side of upper and blan dated 4/17/19 was as no care plan developed line of the hand contracture. M, MDS Nurse #1 was ted that residents with ave a care plan developed. e plan for Resident #57 and ere was no care plan nd contractures. M, the Director of Nursing ed. The DON stated that plan developed for residents admitted to the facility on e diagnoses including erly Minimum Data Set ated 4/17/19 indicated that paired cognition and had not	F	656	5		
	Resident #57 had a p 2/26/18 for low bed w	hysician's order dated ith no side rails.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345509	B. WING				C / <b>16/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	2 42	F	656	5		
		M and on 5/14/19 at 3:50 s observed in bed. The bed oth sides of the bed.					
	#1 was interviewed. #57 had a physician of She stated that Resid resident and all hospi them. The UM indica	M, the Unit Manager (UM) She verified that Resident order for no side rails in bed. Tent #57 was a hospice ce beds have side rails in ted that she would get the ve the side rails in resident's					
	(DON) was interviewe she expected residen rails to have no side r 3. Resident #4 was a 1/14/17 and most rec	dmitted to the facility on ently readmitted on 10/9/18 icluded a history of falling,					
	indicated Resident #4 due to increased slidi This screen was conc (PT) #1 on 3/18/19 ar cushion (a cushion de between the upper les preventing the user fr	rral Screen dated 3/18/19 was referred for a screen ng out of her wheelchair. ducted by Physical Therapist nd indicated a pommel esigned to fill the natural gap gs when in a seated position om sliding forward in the o facilitate upright trunk nobility.					
	indicated Resident #4 impaired. Resident # dependent on 2 or mo						

Facility ID: 970412

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				_ 16/2019
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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	on 1 for personal hyg extensive assistance the unit. Resident #4 impairment with range a wheelchair. She war restraint (any manual mechanical device, m attached or adjacent of the individual cannot restricts freedom of m to one's body) in the of daily. An observation was of 12:30 PM and reveale wheelchair with a por The resident 's active 5/13/19, did not have to Resident #4 's por utilized as a physical The care plan for Res 5/14/19 by MDS Nurs area of the utilization physical restraint. Th be in place in Residen intervention was to en positioned correctly w while restrained. An interview was con on 5/14/19 at 4:58 PM #4 had a pommel cus wheelchair. She indio was utilized as a physical and the physical as a physical and the physical customer and the statement of the table of the table of the table of the positioned correctly w	iene. She required the of 1 for locomotion on/off had no functional e of motion and she utilized s coded with a physical method or physical or vaterial or equipment to the resident's body that remove easily which novement or normal access category of "other" used onducted on 5/13/19 at ed Resident #4 seated in her nmel cushion in place. e care plan was reviewed on a care plan in place related nmel cushion was being restraint. sident #4 was revised on e #1 to include the focus of a pommel cushion as a e pommel cushion was to nt #4 ' s wheelchair. The nsure Resident #4 was rith proper body alignment ducted with MDS Nurse #1 A. She stated that Resident hion in place on her cated the pommel cushion sical restraint to prevent ing out of her wheelchair	F	656	6		

Facility ID: 970412

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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:	, <i>,</i>		CONSTRUCTION	(X3) DATE	
		345509	B. WING _				C / <b>16/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 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	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	The Nursing Assistan reviewed on 5/15/19 a had a pommel cushio restraint. An interview was con 5/15/19 at 10:35 AM. Screen for Resident # She indicated the por implemented to preve forward out of the who floor. An interview was con on 5/15/19 at 10:45 A Resident #4 had a po utilized as a physical that the pommel cush fall prevention interve from her wheelchair of reported that the pommel 3/18/19, but she had for Resident #4 's usia a physical restraint un An interview was con Nursing on 5/16/19 at that Resident #4 had utilized as a physical she expected a care puse 4. Resident #36 was a	t (NA) care guide was and indicated Resident #4 in in place as a physical ducted with PT #1 on The 3/18/19 Rehabilitation #4 was reviewed with PT #1. inmel cushion was ent Resident #4 from sliding eelchair and falling onto the ducted with MDS Nurse #1 M. She stated that immel cushion that was restraint. She indicated ion was implemented as a intion after Resident #4 fell on 3/11/19. MDS Nurse #1 imel cushion restricted to slide forward in her ne resident was unable to cushion independently. She cushion was initiated on not developed a care plan e of the pommel cushion as intil 5/14/19. ducted with the Director of t 10:40 AM. She verified a pommel cushion that was restraint. She indicated that plan to be in place for the	F 6	556			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/18/2019 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			( 05/ <sup>-</sup>	) 16/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
KINGSWO	OD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	1		
(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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page anxiety, and depressi		F 65	6			
	's cognition was seve	7/19 indicated Resident #36 erely impaired. She received tion and antidepressant					
	conducted on 5/15/19 was on routine Seroq medication) 12.5 millio routine Cymbalta (ant mg at bed, and as new	grams (mg) twice daily, idepressant medication) 60					
		e care plan was reviewed led no care plan was in notropic medications.					
	PM with MDS Nurse # physician 's orders the medication, antidepre- antianxiety medication Nurse #1. The active care plan was place m psychotropic medication MDS Nurse #1. MDS was an error and that been developed related utilization of psychotrom	opic medications.					
	Nursing on 5/16/19 at that she expected a c address the use of ps	ducted with the Director of t 10:40 AM. She indicated are plan to be in place to sychotropic medication. admitted to the facility on					

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						FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				_ 16/2019
	OF CORRECTION       IDENTIFICATION NUMBER:       A. B.         345509       B. W         PROVIDER OR SUPPLIER         VOOD NURSING CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         6       Continued From page 46 4/2/19 from another facility with diagnoses of displaced fracture femur neck, initial encounter for closed fracture, and repeated falls.         A review of Resident #56 's Admission Minimum Data Set (MDS) dated 4/13/19 revealed the resident was rarely or never understood and usually understands others. Cognition was moderately impaired for decision making skills. The resident required total dependence of 2 staff for all transfers and toileting, of one for bathing and dressing, and set up with supervision for meals. The active diagnoses were displaced fracture of femur neck encounter for closed fracture, and repeated falls. The resident had no fall since admission to the facility.         A review of Resident #56 's care plan dated 4/2/19 revealed a focus for falls and injury based on prior fall with injury. There was no goal or intervention for use of bilateral, padded, half side rails documented.         A review of Resident #56 's Bed Rail Evaluation Form dated 4/2/19 completed by the Unit Manager revealed "no rails indicated."         A review of Resident #56 's Physical Restrain Review Form dated 4/2/19 completed by the Unit Manager revealed "no restraints warranted."         On 5/15/19 at 1:10 pm Resident #56 was observed to be residing in his bed with bilateral half, padded side rails.       On 5/15/19 at 2:30 pm an interview was </td <td></td> <td></td> <td>STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315</td> <td></td> <td></td>			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	<ul> <li>4/2/19 from another fadisplaced fracture fem for closed fracture, and a review of Resident is Data Set (MDS) dated resident was rarely or usually understands of moderately impaired for all transfers and to and dressing, and set meals. The active dia fracture of femur neck fracture, and repeated fall since admission to A review of Resident 4/2/19 revealed a foct on prior fall with injury intervention for use of rails documented.</li> <li>A review of Resident Form dated 4/2/19 co Manager revealed "not on 5/15/19 at 1:10 pr observed to be residint half, padded side rails On 5/15/19 at 2:30 pr conducted with Reside side and surroundings"</li> </ul>	acility with diagnoses of hur neck, initial encounter ad repeated falls. #56 ' s Admission Minimum d 4/13/19 revealed the "never understood and others. Cognition was for decision making skills. total dependence of 2 staff oileting, of one for bathing t up with supervision for gnoses were displaced & encounter for closed d falls. The resident had no o the facility. #56 ' s care plan dated us for falls and injury based 7. There was no goal or f bilateral, padded, half side #56 ' s Bed Rail Evaluation mpleted by the Unit o rails indicated." #56 ' s Physical Restrain /2/19 completed by the Unit o restraints warranted." m Resident #56 was ng in his bed with bilateral 5.	F	65			

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 06/18/2019 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			_		C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, 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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 657 SS=D	that he wanted them the he turned. The reside to sleep in a queen sist this bed and wanted the verbalized no concerr On 5/15/19 at 3:00 pm conducted with MDS I Resident #56 did not I rails and she was not were added. The MD the resident should has care plan for side rails On 5/15/19 at 3:10 pm conducted with the Di who stated that when he did not have the sin needed to be updated obtained for side rails the side rail as an ena staff to evaluate for side care plan for use. Care Plan Timing and CFR(s): 483.21(b)(2)( §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an inti includes but is not lim (A) The attending phy	because he held them when ent commented that he used ze bed and had rolled out of he side rails. The resident ns. In an interview was Nurse #1 who stated have a care plan for side aware when the side rails VS Coordinator stated that ave had an evaluation and s. In an interview was rector of Nursing (DON) Resident #56 was admitted de rails. The care plan d and an order would be . The resident was using abler. The DON expected de rail use and develop a I Revision (i)-(iii) ensive Care Plans orehensive care plan must of days after completion of ssessment. rerdisciplinary team, that ited to rsician. e with responsibility for the		656				6/3/19

Event ID:6GQD11

Facility ID: 970412

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FUR MEDICARE & I					M APPROVED 0. 0938-039
DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
	345509	B. WING		0	C 5/16/2019
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
			915 PEE DEE ROAD		
DD NURSING CENTER			ABERDEEN, NC 28315		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
<ul> <li>(D) A member of food</li> <li>(E) To the extent practice the resident and the medical record if the pand their resident reprint practicable for the resident's care plan.</li> <li>(F) Other appropriate disciplines as determined and their resident by the disciplines as determined assessments.</li> <li>(F) Other appropriate and revite an after each assessments.</li> <li>This REQUIREMENT by:</li> <li>Based on record revite the areas of code state restraints (Resident # reviewed.</li> <li>The findings included:</li> <li>1. Resident #73 was a recently readmitted or that included Down 's a physician 's order or that included Down 's a physician 's order or a cognition was the care plan for Resident #73 had a further and the set plan for R</li></ul>	and nutrition services staff. tricable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined a development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the quarterly review T is not met as evidenced ew, observation, and staff failed to revise care plans in tus (#73) and physical 23) for 2 of 20 residents : admitted 2/21/19 and most n 3/28/19 with diagnoses a Syndrome. dated 2/21/19 indicated ull code status. um Data Set (MDS) 28/19 indicated Resident severely impaired. sident #73 included the	F 6	<ul> <li>F657- Care Plan Timing and</li> <li>The facility failed to revise in the area of code status on r as well as physical restraint for #23</li> <li>The facility MDS coordinator of care plan for resident #73 as i code status as of 05/16/2019.</li> <li>MDS coordinator updated the for resident #23 as it relates to restraints on 05/16/2019.</li> <li>Other residents in the face potential to be affected by this practice as it relates to care p with code status and restraints facility implemented code statt restraint audit 5/16/2019. This completed to ensure all code restraints are correct as well a correctly on the order. No other</li> </ul>	e care plans resident #73 or resident corrected the it relates to The facility care plan o physical cility have the deficient lan revision s. The us and s was status and as reflected er concerns	
	•			ted by the	
	DVIDER OR SUPPLIER SUMMARY STJ (EACH DEFICIENC) REGULATORY OR I Continued From page (D) A member of food (E) To the extent prace the resident and the r An explanation must if medical record if the p and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determined or as requested by th (iii)Reviewed and revi- team after each assession comprehensive and quassessments. This REQUIREMENT by: Based on record revi- interview, the facility for the areas of code stati- restraints (Resident # reviewed. The findings included 1. Resident #73 was a recently readmitted out that included Down 's A physician 's order of Resident #73 had a fu- The admission Minimined assessment dated 2/2 #73 's cognition was The care plan for Resi- focus area of full code	345509         DVIDER OR SUPPLIER         DUNURSING CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 48         (D) A member of food and nutrition services staff.         (E) To the extent practicable, the participation of the resident and the resident's representative(s).         An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.         (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.         (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.         This REQUIREMENT is not met as evidenced by:         Based on record review, observation, and staff interview, the facility failed to revise care plans in the areas of code status (#73) and physical restraints (Resident #23) for 2 of 20 residents	A BUILDIN         345509         DVIDER OR SUPPLIER         DD NURSING CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 48         (D) A member of food and nutrition services staff.         (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.         (F) Other appropriate staff or professionals in disciplines as determined by the resident's meeds or as requested by the resident.         (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.         This REQUIREMENT is not met as evidenced by:         Based on record review, observation, and staff interview, the facility failed to revise care plans in the areas of code status (#73) and physical restraints (Resident #23) for 2 of 20 residents reviewed.         The findings included:         1. Resident #73 was admitted 2/21/19 and most recently readmitted on 3/28/19 with diagnoses that included Down 's Syndrome.         A physician 's order dated 2/21/19 indicated Resident #73 had a full code status.         The admission Minimum Data Set (MDS) assessment dated 2/28/19 indicated Resident #73 's cognition was severely impaired.	345509     B. WING       SUDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP COD 915 PEE DEE ROAD ABERDEEN, NC 28315       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WE BE PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREDET ROAD ABERDEEN, NC 28315       Continued From page 48 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident's care plan.     F 657       (F) Other appropriate staff or professionals in disciplines as determined by the resident. imilipReviewed and revised by the interdisciplinary team after each assessment. Inite areas of code status (#73) and physical restraints (Resident #23) for 2 of 20 residents reviewed.     F657- Care Plan Timing and 1. The facility failed to revise as well as physical restraint for #23 The facility MDS coordinator of care plan for resident #23 as it relates to care plan for resident #23 as it relates to restraints (Resident #23) for 2 of 20 residents reviewed.       1. Resident #73 was admitted 2/21/19 and most recently readmitted on 3/28/19 with diagnoses that included Down 's Syndrome.     F657- Care Plan Timing and 1. The facility MDS coordinator of care plan for resident #23 as it relates to code status as of 05/16/2019. MDS coordinator updated the for resident #73 had a full code status.       The admission Minimum Data Set (MDS) assessment dated 2/28/19 indicated Resident #73 is clogent #73 included the focus area of full code status (mitiated on 73' 's cognition was severely impaired.	NULLINKS         Op           OWDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, 2IP CODE           95 PUNRSING CENTER         STREET ADDRESS, CITY, STATE, 2IP CODE           96 NURSING CENTER         95 PEE DEE ROAD ABERDEEN, NC 23315           SKIMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY WIST BE PRECEDED BY FULL REQULATORY OR LSC DENTIFYING INFORMATION)         PREFIX TAG           Continued From page 48 (D) A member of food and nutrition services staff.         Prefix (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident resident and their resident's needs or as requested by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:         F657- Care Plan Timing and Revision: 1. The facility failed to revise care plans in the areas of code status (#73) and physical restraints (Resident #73) and physical restraints (Resident #73) or of 20 20 residents reviewed.         F657- Care Plan Timing and Revision: 1. The facility MDS coordinator corrected the care opin for resident #73 as well as physical restraint for resident #23           The findings included:         1. Resident #73 was admitted 2/21/19 and most recently readmitted on 3/28/19 with diagnoses that included Down 's Syndrome.         2. Other resident #73 as it relates to code status as of 05/16/2019. The facility MDS coordinator updated the care plan for resident #73 as it relates to care plan for resident #73 as it relates to core plan for resident #73 as it relates to coreaplan the assessment dated 2/28/19 indicated Resident

Facility ID: 970412

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/18/2019 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345509	B. WING				C / <b>16/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, 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 LSC IDENTIFYING INFORMATION)	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 657	<ul> <li>revised on 3/5/19 by</li> <li>A physician 's order Resident #73 had a construction Not Resuscitate (DNR)</li> <li>An interview was comon 5/15/19 at 1:50 Phreviewed new physic morning meeting that through Friday. The provide the status was changed from 5/19 hat indicated status was changed from full constructed when Reside changed from full constructed that she misses revise Resident #73 'An interview was com Nursing (DON) on 5/1 indicated that she expression of the resident.</li> <li>2. Resident #23 was 12/24/12 with diagno with behavioral disturt The quarterly Minimutassessment dated 2/1 #23 's cognition was</li> </ul>	MDS Nurse #1. dated 3/28/19 indicated change in code status to Do R). ducted with MDS Nurse #1 M. She stated that she ian ' s orders during the t was held every Monday obysician ' s order dated d Resident #73 ' s code from a full code to a DNR DS Nurse #1. The care plan ent #73 was a full code was Nurse #1. MDS Nurse #1 e plan should have been nt #73 ' s code status de to DNR on 3/28/19. She ed this and she was going to ' s care plan. ducted with the Director of 16/19 at 10:40 AM. She pected care plans to be a to reflect the current status admitted to the facility on ses that included dementia 'bance and Parkinson ' s.	F	657	<ol> <li>Education with the MDS coordina and review of care plan revision will be completed by the Director of Nursing te ensure care plan timing and revision is done with in a timely manner. This will completed no later than June 3, 2019</li> <li>The facility MDS coordinator will update care plans on all admission and readmissions and use code status/restraint audit tool 1x per week months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and or plan will be revised to ensure continue compliance. MDS coordinators will be responsible for bringing information to QAPI monthly.</li> <li>The Administrator and Director of Nursing are responsible for implement and maintaining the acceptable plan of correction. Corrective action complete by 6/3/2019.</li> </ol>	e so s l be d x 2 d t the ed	

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/18/2019 APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING					C 16/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				9	915 PEE DEE ROAD			
KINGSWO	OOD 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 PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 657	functional impairment she utilized a walker. Resident #23 ' s activ on 5/15/19. This care area for the utilization physical restraint. Th on 8/6/18. An observation was c her room on 5/15/19 a was asleep on a wing An observation was c a common area of the on 5/15/19 at 3:30 PM walking independently walker. An interview was com and the Director of Nu 1:18 PM. Resident #2 indicated the winged physical restraint was #1 and the DON. The winged mattress was Resident #23 and tha revised. The DON ex mattress was in place had not restricted Res it had not prevented h She further explained to get in and out of be winged mattress in place had not restricted Res it had not prevented h She further explained to get in and out of be winged mattress in place had not restricted Res it had not prevented h She further explained to get in and out of be winged mattress in place had not prevented h She further explained to get in and out of be	<ul> <li>Resident #23 had no</li> <li>with range of motion and</li> <li>e care plan was reviewed</li> <li>e plan included the focus</li> <li>of a winged mattress as a</li> <li>is focus area was initiated</li> <li>conducted of Resident #23 in</li> <li>at 1:15 PM. Resident #23</li> <li>ied mattress.</li> <li>conducted of Resident #23 in</li> <li>e secured memory care unit</li> <li>A. Resident #23 was</li> <li>y with the assistance of a</li> </ul> ducted with MDS Nurse #1 <ul> <li>ursing (DON) on 5/15/19 at</li> <li>23 's care plan that</li> <li>mattress was utilized as a</li> <li>reviewed with MDS Nurse</li> <li>ey both reported that the</li> <li>not a physical restraint for</li> <li>t the care plan needed to be</li> <li>cplained that the winged</li> <li>e for Resident #23, but that it</li> <li>sident #23 's movement and</li> <li>for Resident #23 was able</li> <li>ad independently with the</li> </ul>	F	657				

Facility ID: 970412

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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:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345509	B. WING			/16/2019
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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	Resident #23. A follow up interview DON on 5/16/19 at 10 expected care plans t	e 51 was conducted with the 0:40 AM. She indicated she o be reviewed and revised ne current status of the	F 6	57		
F 688 SS=D	Increase/Prevent Dec CFR(s): 483.25(c)(1)- §483.25(c) Mobility. §483.25(c)(1) The fac resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoida §483.25(c)(2) A resid motion receives appro- services to increase re prevent further decreas §483.25(c)(3) A resid receives appropriate a assistance to maintain the maximum practica reduction in mobility is This REQUIREMENT by:	cility must ensure that a ne facility without limited not experience reduction in as the resident's clinical es that a reduction in range ble; and ent with limited range of	F 6	F688- Increase/Prevent Decreas	se in	6/3/19
	interview, the facility f prevent further decrea	ailed to provide care to ase in range of motion for 1 ampled residents reviewed		<ul> <li>F688- Increase/Prevent Decrease</li> <li>ROM/Mobility:</li> <li>1. The facility failed to provide of prevent further decrease in range motion for resident #57.</li> <li>The facility requested therapy sci 05/16/2019 for resident #57 for b hand contractures.</li> </ul>	care to e of reen	

Event ID:6GQD11

Facility ID: 970412

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						0.0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMF	SURVEY
			A. BUILDING	G		С
		345509	B. WING			
	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZI		16/2019
	NOVIDEIX OIX 3011 EIEIX			915 PEE DEE ROAD	CODE	
KINGSWO	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 ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 688	Continued From page	52	F 68	00		
1 000	1 0		FO		o facility have the	
	11/16/12 with multiple	mitted to the facility on		2. Other residents in the potential to be affected b		
	-	ension. The quarterly		practice related to ROM/	•	
		IDS) assessment dated		wide audit was complete		
		t Resident #57 had impaired		to ensure residents with		
		pairment in ROM on one		currently using splints an	id have been	
	side of upper and low			screened by therapy. Thi		
	assessment further in	ndicated that the resident		by the Director of Nursing	g and the	
	was receiving hospic	e care.		Activities Director. No oth	ner issues	
				identified.		
		plan dated 4/17/19 was		3. The facility Director		
		as no care plan developed		Therapy Manager will pro		
	to prevent further dec	line in ROM of both hands.		with nursing and therapy		
	On 4/4/10 a robab (r	ehabilitation) referral screen		process of screening and to residents as well as ho		
	-	rsing due to bilateral hand		communication to ensure		
	contractures.			receive contracture care		
	contractareo.			manner by June 3, 2019		
	On 4/11/19, Resident	#57 was seen by the		have not completed man	-	
		ysician note revealed that		06/03/2019 will be unable		
	Resident #57's hands	s were contracted.		requirement is fulfilled. T	his includes all	
	On 5/13/19 at 0:15 Al	M, on 5/14/19 at 2:20 PM		shifts and PRN staff. 4. This will be audited	by the Director of	
		60 AM, Resident #57 was		Nursing and or Nurse Su		
		both hands in fist position.		random audit of 5 resider		
		to prevent further decrease		contractures per week x		
	in ROM noted on bot			randomly audit of 5 resid		
				contractures monthly x 2	months. Any	
		M, Nursing Aide (NA) # 3,		issues or trends identified		
	-	#57, was interviewed. She		addressed by the Quality		
		know if the resident was		Performance Improveme		
		e or not. The NA reported		(QAPI) as they arise, and		
		on splint or ROM exercise,		revised to ensure continu		
		as responsible for the nt and the provision of the		compliance.The director responsible for maintaini		
	exercise.			and bringing it to QAPI.		
				5. The Administrator ar	nd Director of	
	On 5/15/19 at 8:54 A	M, Nurse #2, assigned to		Nursing are responsible		
		terviewed. She stated that		and maintaining the acce		

Facility ID: 970412

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/18/2019 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			( 05/'	C 16/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	E, 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 CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 688	or not. She added that splint/brace, the restor for the application. On 5/15/19 at 8:55 AM interviewed. She stat not on their work load splint application. On 5/15/19 at 10:21 A (DON) was interviewed 4/4/19, Resident #57 screening due to bilat therapy department re hospice. The Restora responsible for restora role and failed to refer On 5/15/19 at 10:30 A interviewed. She stat referral from nursing to bilateral hand contract hospice resident so sit to get an approval fro resident however she nursing nor hospice a On 5/15/19 at 11:33 A was interviewed. She working at the facility development coordina Restorative Nurse. S the referral from thera hospice however she hospice.	resident was on splint/brace at if the resident was on rative aide was responsible M, Restorative Aide #1 was red that Resident #57 was for ROM exercise nor for M, the Director of Nursing ed. She stated that on was referred to therapy for eral hand contractures. The eferred the resident to ative Nurse who was ative nursing was new to her r Resident #57 to hospice. M, the Rehab Director was red that she had received a to screen Resident #57 for ture. Resident #57 was a he sent a referral to hospice m hospice to treat the never heard back from fter the referral. M, the Restorative Nurse stated that she started in March 2019 as staff ator (SDC) and as a he stated that she received apy to refer Resident #57 to might have missed to call	F 688	correction. Correctiv by 6/3/2019.	re action completed	3	
		AM, the DON was again N stated that she expected					

					OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345509	B. WING		05/16/2019
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 688	Continued From page	e 54	F 688	3	
	the staff to provide ca				
		t further decline in ROM.			
F 689		ards/Supervision/Devices	F 689	9	6/3/19
SS=D	CFR(s): 483.25(d)(1)	(2)			
	§483.25(d) Accidents	i.			
	The facility must ensu	ure that -			
		sident environment remains			
	as free of accident ha	azards as is possible; and			
	\$483.25(d)(2)Each re	sident receives adequate			
		stance devices to prevent			
	accidents.				
	This REQUIREMENT	is not met as evidenced			
	by:				
		ns, resident and staff		F689- Free of Accident	
		I review, the facility failed to		Hazards/Supervision/Devices:	
		garettes and lighter as nt #14) of 2 residents		1. The facility failed to secure a resident s cigarettes and lighter as	
		oking. The findings included:		ordered for resident #14. The facility	
		oking. The mange meladea.		implemented a dual person check for	
	Review of the facility	s undated policy titled		smoking materials when resident is in t	bed
		n some instances smoking		and smoking material not in use as of	
	restrictions may be ne	ecessary because of safety		05/27/2019. Resident was Re- Evaluate	ed
		The restrictions should be		05/29/2019 and has been deemed safe	2
	noted in the resident	care plan.		and appropriate to carry tobacco produ	
				and smoking material during any hours	
		mitted on 1/12/18 with		out of bed. The facility implemented	d
	Accident and hemiple	s of Cerebral Vascular		supervised smoking audit for supervise smokers in the facility to ensure that the	
		yuu.		is no smoking material at the bedside of	
	Review of a physiciar	n order dated 5/23/18 read		on resident's person when not in use.	
		ing material (cigarettes and		was started 05/20/2019.	
	lighter) were to be sto	ored on the medication cart		2. Other residents that smoke have a	L
	at all times.			potential to be affected by this deficient	
				practice as it relates to unsecured	
		erly Minimum Data Set		smoking material. Supervised smokers	
	(MDS) stated 2/10/19	undicated she was	1	were checked for contraband 5/17/201	4

Facility ID: 970412

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CENTER STATEMENT ( AND PLAN OF NAME OF PI	S FOR MEDICARE & I DE DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DOD NURSING CENTER SUMMARY ST/	ATEMENT OF DEFICIENCIES	· /	NG ST 91 AI	CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE <b>5 PEE DEE ROAD</b> <b>BERDEEN, NC 28315</b> PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	FORM OMB NC (X3) DATE COMP ( 05/	LETED
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 689	was coded as having side of her upper extra Review of Resident # dated 2/10/19 indicate were to be stored by f when not in use. This nurse who completed Review of Resident # 3/20/19 read she was smoking materials in Smoking material was medication cart. Review of April 2019 Record (MAR) indicate shift were documentin #14's smoking materia were to be stored on the times. Review of the facility's Tobacco Use form dat the facility was to stor and lighter. Review of Resident # dated 5/11/19 did not restrictions related to or lighter. This form v Review of May 2019 I 5/14/19 indicated first documenting validations smoking material (cig.	exhibited no behaviors. She physical limitations to one emities. 14's Tobacco Assessment ed her cigarettes and lighter the nursing department form was not signed by the the form. 14's care plan last revised on a allowed to keep her her purse during the day. s to secure on the Medication Administration red first, second and third ng validation that Resident als (cigarettes and lighter) the medication cart at all s Tobacco/Smokeless ted revised 4/2/19 indicated re Resident #14's cigarettes 14's Tobacco Assessment indicate any smoking the storage of her cigarettes vas signed by Nurse #1. MAR from 5/1/19 through , second and third shift were	F	589	<ul> <li>and no other concerns were identified. This was completed by the Director of Nursing and was implemented on only supervised smoking residents.</li> <li>The Licensed Nursing staff and Medication Aides will be educated by Director of Nursing, Staff Development Coordinator, Unit Manager or shift Supervisor on importance of following supervised smoking guidelines to ensufire and patient safety. This will occur relater than June 3, 2019. Any staff that have not completed mandatory training 06/03/2019 will be unable to work until requirement is fulfilled. This includes all shifts and PRN staff.</li> <li>The Department Heads and or licensed Nurses will complete random audits on supervised smokers once a week during environmental rounds x 4 weeks then monthly 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 revised to ensure continued complianc A supervised smoking audit will be completed by the Director of Nursing are responsible for implementi and maintaining the acceptable plan of correction. Corrective action complete by 6/3/2019.</li> </ul>	re o I by I be e. nd	

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	-	D HUMAN SERVICES				FORM	MAPPROVED
STATEMENT OF I	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
AND PLAN OF CO	JRRECHON	IDENTIFICATION NOMBER.	A. BUILDI	ING	3		C
		345509	B. WING				
NAME OF PRO	VIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWOOI	D 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
D3wobcskno Das DRauA Co DRrhh C	243 PM Resident #14 wheelchair in her roor f her wheelchair was ag was unzipped and igarettes. Resident # he did not have a light ept her lighter until show o visible evidence of bserved on her cloth During an observation gain at 11:30 AM, Ref moking in the design During an observation Resident #14 was in the resident Council Me nzipped on the right visible to smoke. During an observation Resident #14 was observation Resident and it was porting an observation Resident #14 was observation Resident and it was porting an observation Aution Aide (MA) art for Somerset hall	<ul> <li>and interview on 5/13/19 at 4 was sitting in her</li> <li>n. Observed in the right side a gray zipper top bag. The d visible was a red pack of 214 zipped the bag stating ther. She said the nurse he went outside. There was a shes or cigarette burns ing.</li> <li>a on 5/14/19 at 9:30 AM and esident #14 was outside ated smoking area.</li> <li>a on 5/14/19 at 2:35 PM, he main dining room during eeting with her gray bag side of her wheelchair. An existence was visible.</li> <li><i>M</i>, Resident #14 went back</li> <li><i>M</i> on 5/14/19 at 3:50 PM, served in the Rehabilitation ch. She had her gray bag in was unzipped. Visible were</li> </ul>	F	68			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				_ 16/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Resident #14's smoki in the medication carf #14's room with MA # table was the gray ba of cigarettes visible in was asleep and did n sheet was covering h MA #1 stated the norn shift nurse or MA lock smoking items around bed. She stated MA # 5/14/19 and she relie on third shift. MA #1 Resident #14 had posi items because she st most of day. MA #1 c not supposed to have concerns with noncor rules. In an observation on Resident #14's door v asleep in bed. Visible bedside table with the sticking out of the bag In an observation on Resident #14 was in f She was in possessio unzipped. There was red pack of cigarettes During an interview o stated she removed F and lighter and stored cart. She stated mana	ng items were not secured . On entry to Resident 1, observed on the bedside g unzipped with a red pack uside the bag. Resident #14 ot arouse of request. The er head. mal process was the second ted up Resident #14's d 8:00 PM when she went to to were Nurse #1 this morning stated during the day, session of her smoking ays outside in smoking area onfirmed Resident #14 was her smoking items due to npliance with the smoking 5/15/19 at 9:25 AM, was open, and she was still was the gray bag still on the e red pack of cigarette visible g. 5/15/19 at 1:20 PM, the main dining room eating. on of the gray bag that was no visible evidence of the	F	689			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/18/2019 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING					C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	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 PREF TAG		(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 689	cart when not in use.	e 58 i items on the medication n 5/15/19 at 3:20 PM, MA #2	F	689				
	last evening and they area till about 11:00 F Resident #14 came in television room. MA # #14 was not up that la her cigarettes and ligh after she went to bed. allowed Resident #14 lighter during the day time outside smoking. cigarettes and lighter the medication cart af	should have been locked on fter she went to bed t at 11:00 PM and confirmed						
	PM, Nurse #1 confirm last night. She stated already in the bed wh she only verified Resi lighter were secured of before she signed off she signed off on the night. Nurse #1 confir Resident #14 medicat AM and she did not n sitting on her bedside inside. Regarding the Assessment dated 5/ any smoking restriction her cigarettes or lighted	terview on 5/15/19 at 3:25 ned she worked third shift normally Resident #14 was ien she arrived at work, and ident #14's cigarettes and on the medication cart on the MAR. She confirmed MAR for third shift last med she administered tions this morning at 6:00 otice the gray bag unzipped table with her cigarettes incomplete Tobacco 11/19 that did not indicate ons related to the storage of er, she stated it was an have indicated her ordered						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 16/2019
NAME OF PI	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				115 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 689	Continued From page restrictions. Nurse #1 be more observant in	stated she would have to	F	689			
F 690 SS=D	Administrator and DC expectation that Resid lighter were to be sec when they were not in secured on the medic	dent #14's cigarettes and ured on the medication cart n use during the day and ation cart once she went to eturned to her until she was to smoke. inence, Catheter, UTI	F	690			6/3/19
	admission receives se maintain continence u condition is or becom not possible to mainta	cility must ensure that ient of bladder and bowel on ervices and assistance to inless his or her clinical es such that continence is ain.					
	ensure that- (i) A resident who entrindwelling catheter is resident's clinical con- catheterization was no (ii) A resident who entrindwelling catheter or is assessed for remov- as possible unless the	on the resident's sement, the facility must ers the facility without an not catheterized unless the dition demonstrates that eccessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary;					

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/18/20 APPROVE 0. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY IPLETED
		345509	B. WING		05	C 5/16/2019
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER			915 PEE DEE ROAD		
	OD NOROINO OENTER			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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 690	Continued From page	e 60	F 69			
	receives appropriate	treatment and services to infections and to restore				
	§483.25(e)(3) For a r incontinence, based of					
	ensure that a residen	ssment, the facility must it who is incontinent of bowel treatment and services to				
	restore as much norn possible.					
		iew and staff interview, the		F690- Bowel/Bladder Incontine	ence	
	culture report that rec	up on a positive urinary quired antibiotic treatment for on for 1 (Resident #56) of 1		Catheter, UTI: 1. The facility failed to follow positive urinary culture report the		
	residents reviewed for Findings included:	or urinary tract infection.		antibiotic treatment for a urinar infection for resident #56. The t spoke with the doctor for reside	facility	
		mitted to the facility on acility with diagnoses of		implemented secondary contact lab results should the doctor no	t regarding	
	cystitis and history of (UTI).	urinary tract infections		accessible via primary phone n This was established 05/16/20 secondary point of contact will	19. The	
	Data Set (MDS) date	#56 ' s Admission Minimum d 4/13/19 revealed the		Medical Director as well as and physician working in Kingswoo	other d.	
	usually understands	r never understood and others. Cognition was for decision making skills.		2. Other residents have the p be affected by the deficient pra relates to potential delay in trea	ctice as it	
	Resident #56 require for all transfers and to	d total dependence of 2 staff pileting, of one for bathing		active Urinary Tract Infections. Director of Nursing, Unit Manag	The ger and or	
		t up with supervision for agnoses were cystitis and		Shift Supervisor will audit the p weeks Urinary Culture Reports completed by 06/03/19. No issu identified.	this will be	
		#56 ' s care plan dated sus at risk for urinary tract		<ol> <li>The staff education will be by the Director of Nursing to ind education to reflect procedure of</li> </ol>	clude	

Facility ID: 970412

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3		
		345509	B. WING		0	C 5/16/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 690	Continued From page	9 61	F 69	0		
	Resident #56 had a p which revealed obtain culture. A review of Resident dated 5/2/19 revealed organism Enterococc antibiotics for treatme On 5/6/19 Resident # Tetracycline each day (physician order). On 5/15/19 at 4:00 pr conducted with Unit M she was aware of Re urinalysis on 4/29/18 UM #1 stated that she culture from the lab o had a UTI. UM #1 sta resident's physician a and was unable to lea the culture. UM #1 sta Medical Director and physician returned to order the antibiotic fo that since the Reside status on 4/28/19 for	hysician order dated 4/29/19 n urine for urinalysis and #56 ' s lab report results d urine culture positive for us faecalis (A). Susceptible ent were provided. 56 ' s physician ordered r for 10 days for UTI n an interview was Manager (UM) #1 who stated		<ul> <li>which include a lab audit tool June 3, 2019. Any staff that completed mandatory training 06/03/2019 will be unable to requirement is fulfilled. This is shifts and PRN staff.</li> <li>A lab tool will be implement Unit Managers on labs and communication tracking no lad June 3, 2019. Nursing Manage implement procedure for a por culture requiring further treats include Primary Physician is times minimum on the day of the primary physician is not a Medical Director will be conta further orders based on cultur sensitivity. Also, if the Medica the Primary Doctor a differen the facility will be contacted in that he/she is not available w manner. This will be implement staff education to reflect proof change no later than June 3, tool will be implemented by th Manager on labs and commu- tracking no later than June 3, will be completed weekly x 4 monthly x 2 months. Any iss identified will be addressed b</li> </ul>	have not g by work until ncludes all hented by the ater than gement will positive urinary ment to contacted 2 f resulting. If available, the acted to give ire and al Director is it doctor in in the event with in a timely ented with cedure 2019. A lab he Unit unication , 2019. This weeks then ues or trends	
	the Medical Director v physician was not ava	ailable.		Assurance Performance Imp Committee (QAPI) as they ar plan will be revised to ensure compliance. The Unit Manag	rise, and the e continued ers will	
	she expected the stat positive urine culture	n an interview was irector of Nursing who stated ff to contact the physician for when reported from the lab ne physician returned to the		<ul> <li>perform audits and bring resumentality.</li> <li>5. The Administrator and D Nursing are responsible for ir and maintaining the acceptation</li> </ul>	irector of mplementing	

Facility ID: 970412

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		ND HUMAN SERVICES MEDICAID SERVICES	•			RM APPROVE O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY
		345509	B. WING		C 05/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OD NURSING CENTER			15 PEE DEE ROAD 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 690	Continued From page	e 62	F 690			
	facility. If the attending physician was not available, the Medical Director should be contacted.			correction. Corrective action com by 6/3/2019.	npleted	
F 700 SS=D		-(4)	F 700			6/3/19
	The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.					
	bed rails with the res	v the risks and benefits of ident or resident btain informed consent prior				
		e that the bed's dimensions le resident's size and weight.				
	and maintaining bed	d specifications for installing				
	interview, the facility before use (Resident side rails for a reside requiring side rails (R	iew, observation, and staff failed to evaluate side rails is #56 and #57) and used nt who was assessed as not Resident #4) for 3 of 7 or restraints. Findings		F700- Bedrails: 1. The facility failed to evaluate before use on resident #56 and # used side rails for a resident who assessed as not requiring side ra resident #4. The facility reviewed and updated assessment on resident #56 and	57 and was ills for d side rail	

Event ID:6GQD11

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		345509	B. WING		0	C 5/16/2019
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE,		
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	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 700	Continued From page	e 63	F 70	00		
	1. Resident #56 was 4/2/19 from another fa displaced fracture fer for closed fracture, ar A review of Resident Data Set (MDS) date resident was rarely or usually understands of moderately impaired The resident required for all transfers and to and dressing, and set meals. The active dia fracture of femur neck fracture, and repeated A review of Resident 4/2/19 revealed a foc on prior fall with injury	admitted to the facility on acility with diagnoses of nur neck, initial encounter nd repeated falls. #56 's Admission Minimum d 4/13/19 revealed the r never understood and others. Cognition was for decision making skills. I total dependence of 2 staff pileting, of one for bathing t up with supervision for gnoses were displaced k encounter for closed		of 05/16/2019 to reflect was completed by Unit facility removed the ra- as of 05/15/2019. This the Unit Manager. 2. Other residents ha be affected by this defi- relates to improper sid rail assessment will be residents that have sid Manager. This will be 6/3/19. Any concerns addressed. No other c 3. Education with Lid will be completed rega completing and assess later than June 3, 2019 Managers, Staff Devel or MDS. Any staff that mandatory training by unable to work until re- fulfilled. This includes	t Manager. The ils from resident #4 is was completed by ave the potential to icient practice as it le rail use. A side completed on de rails by the Unit completed by identified will be concerns identified. censed Nursing staff urding properly sing side rails no 9 by DON, Unit lopment Coordinator have not completed 06/03/2019 will be quirement is	
	A review of Resident orders revealed there use. A review of Resident Form dated 4/2/19 co Manager revealed "no A review of Resident Review Form dated 4 Manager revealed "no	5 rails indicated." #56 ' s Physical Restrain /2/19 completed by the Unit o restraints warranted."		<ul> <li>staff.</li> <li>An audit of 10 be completed weekly x 4 monthly x 2 months to of side rails. This will b Unit manager. Any iss identified will be addree Assurance Performanc Committee (QAPI) as plan will be revised to compliance. A bedrail completed by the Unit brought to QAPI month</li> </ul>	d rails will be weeks then 5 ensure proper use be completed by the sues or trends essed by the Quality ce Improvement they arise, and the ensure continued audit will be Manager and	
	On 5/15/19 at 1:10 pr observed to be residin half, padded side rails	ng in his bed with bilateral		Manager. 5. The Administrator Nursing are responsib and maintaining the ac	le for implementing	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	· · ·	E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		345509	B. WING		0	C 5/16/2019	
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE		, 10,2010	
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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 700	On 5/15/19 at 2:30 pr conducted with Resid self and surroundings was aware of his side indicate that he wante them when he turned that he used to sleep rolled out of this bed. The resident verbalized On 5/15/19 at 3:00 pr conducted with the M Resident #56 did not rails and she was not were added. The MD the resident should ha care plan for side rails On 5/15/19 at 3:10 pr conducted with the Di who stated that when he did not have the si needed to be updated obtained for the side r side rails as an enable to evaluate for side rails 2. Resident #57 was a 11/16/12 with multiple dementia and hyperte Minimum Data Set (N 4/17/19 indicated that cognition, was depen- transfer and was non	n an interview was lent #56 who was oriented to 5. The resident indicated he e rails and was able to ed them because he held . The resident commented in a queen size bed and had He wanted the side rails. ed no concerns. n an interview was DS Nurse #1 who stated have a care plan for side aware when the side rails DS Coordinator stated that ave had an evaluation and s. n an interview was irrector of Nursing (DON) Resident #56 was admitted ide rails. The care plan d and an order would be rails. The resident used er. The DON expected staff ail use and develop a care indicated. admitted to the facility on e diagnoses including ension. The quarterly IDS) assessment dated t Resident #57 had impaired dent with bed mobility,	F 700		ompleted by		

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/18/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING		_	05/	C 16/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, 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	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	<ul> <li>was low bed with no s 2/26/18).</li> <li>A bed rail/assist bar e completed on 5/4/19. the reason for the used 0n 5/13/19 at 3:20 Pf PM, Resident #57 wa had ¼ side rails on both on 5/14/19 at 3:51 Pf Resident #57, was interested the side rails were use from falling.</li> <li>On 5/14/19 at 3:52 Pf Resident #57, was interested to a single of the side rails were use from falling out of 0n 5/15/19 at 8:38 Af Resident #57, was interested the side rails were and She added that the signer and She added that the signer from falling.</li> <li>On 5/15/19 at 9:31 Af (DON) was interviewed she expected the bed form completed to incore of the side rails. The #57 was not suppose bed as ordered.</li> </ul>	of the care plan interventions side rails (added on evaluation form was partially The form did not indicate e of the side rail. M, and on 5/14/19 at 3:50 s observed in bed. The bed oth sides of the bed. M, NA #4, assigned to terviewed. She stated that ed to prevent Resident #57 M, Nurse # 3, assigned to terviewed. The Nurse stated e used to prevent Resident f bed. M, NA #3, assigned to terviewed. She stated that ally dependent for bed she was non - ambulatory. de rails were used to ag out of bed. M, the Director of Nursing ed. The DON stated that rail/assist bar evaluation shude the reason for the use DON reported that Resident d to have side rails in her	F 700				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMF	LETED
		345509	B. WING				C 16/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
				9	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)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORTORT		IAG		DEFICIENCY)		
F 700	Continued From page	9 66	F	700			
	residents with an orde	er for no side rails to have					
	no side rails in their b	ed. She also indicated that					
		valuated for use of the side					
	-	son for the use of the side					
		the side rails in their bed.					
		dmitted to the facility on ently readmitted on 10/9/18					
		icluded a history of falling,					
	difficulty walking, and						
	The quarterly Minimu	m Data Set (MDS)					
		29/19 indicated Resident #4					
		erely impaired. Resident #4					
	was assessed as dep	endent on 2 or more for bed					
	mobility and transfers	i.					
	A Bed Rail/Assist Bar	Evaluation dated 4/29/19					
	indicated Resident #4	was assessed as not					
	needing side rails.						
	An observation was c	onducted of Resident #4 on					
		Resident #4 was asleep in					
		quarter side rails in place.					
		ducted with the Director of					
	- · ·	15/19 at 11:30 AM. The Bed					
		ation dated 4/29/19 that					
		was assessed as not					
	-	s reviewed with the DON. ion of Resident #4 in bed					
		side rails in place was					
		N. She revealed that					
		supposed to have any side					
		that Resident #4 previously					
	was on a different uni	t in a different bed. She					
		when Resident #4 was					
		memory care unit (3/15/19)					
	the bed she was mov						
	bilateral quarter rails	in place. The DON revealed					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/18/2019 APPROVED ). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		345509	B. WING				C 16/2019
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE	E, 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	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)	(X5) COMPLETION DATE	
F 700 F 730 SS=D	were mistakenly in pla reported that this error today (5/15/19). A follow up interview of DON on 5/16/19 at 10 was her expectation the for a resident who was side rails. She addition residents were moved different beds, that the checked to ensure side for residents that had and determined to hav usage. Nurse Aide Peform Re CFR(s): 483.35(d)(7) §483.35(d)(7) Regula The facility must comp of every nurse aide at months, and must pro- education based on the reviews. In-service tra- requirements of §483. This REQUIREMENT by: Based on record revis facility failed to ensure (NA) reviewed for stat Dementia training. Th NA #1's date of hire w #1's education/In-servise	ied that these side rails ace for Resident #4. She r was going to be corrected was conducted with the 0:40 AM. She stated that it hat side rails not be utilized is assessed with no need for onally indicated that when d to different rooms with e new bed needed to be le rails were only in place been thoroughly evaluated we a need for side rail eview-12 hr/yr In-Service r in-service education. Dete a performance review cleast once every 12 ovide regular in-service he outcome of these aining must comply with the .95(g). is not met as evidenced ew and staff interview, the e 2 of 5 Nursing Assistants ffing, received annual	F 700	F730- Nurse Aide Pe 12hr/yr in service: 1. The facility failed assistants reviewed for annual dementia train implemented session Alzheimer and demer 05/27/2019. This was	erform Review- to ensure 2 nursin or staffing received ing. The facility 1 of 12 for annual itia training as of implemented by t	ng d	6/3/19
	NA #2's date of hire w	as 7/9/14. Review of NA		Activities Director and Development Coordin			

Event ID: 6GQD11

Facility ID: 970412

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		345509	B. WING		C 05/16/2019
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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 730	<ul> <li>#2's education/In-ser last Dementia training</li> <li>During an interview of Staff Development Correcently to the position confirmed she was an training was required works weekends and (prn) and that was like missed.</li> <li>During an interview of Administrator and Direcently</li> </ul>	vices records indicated her g was in September 2017. In 5/16/19 at 9:47 AM, the oordinator (SDC) stated she on of SDC March 2019. She ware that annual Dementia . The SDC stated NA #1 only NA #2 worked as needed ely the reason they were on 5/16/19 at 10:40 AM, the rector of Nursing stated it that all employed aides	F 73	<ol> <li>Other residents in the facility har potential to be affected by this deficie practice as it relates to knowledge de regarding dementia and Alzheimer's Annual training was implemented 05/27/2019. An audit of staff that hav received 12 hours/yr was completed 05/16/2019. Any concerns identified be addressed. This was implemented The Activities Director and the Staff Development Coordinator. No other issues identified.</li> <li>The Activities Director and Staff Development coordinator will provide educational hour 2 times a month un hours of dementia training is comple active employees. The education will continue through December 2019. Th facility will provide 8 hours of dement training for new hires on start date an provide the opportunity for 4 addition hours until 1st annual evaluation. Th facility has posted a list of dates and for mandatory dementia/ Alzheimer through December 2019 at various locations through out the building as 05/27/2019.</li> <li>This will be monitored q month &gt; months and as necessary. Any issue trends identified will be addressed by Quality Assurance Performance Improvement Committee (QAPI) as t arise, and the plan will be revised to ensure continued compliance. This v audited with Educational Audit and monitored by Staff Development and Activities Director. This will be broug QAPI by the Staff Development</li> </ol>	ent eficit /e on will d by e 1 til 12 te by he tia nd ial e times of c 3 es or y the hey vill be

Event ID:6GQD11

Facility ID: 970412

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	-	ND HUMAN SERVICES MEDICAID SERVICES				PRINTED: 06/18/2019 FORM APPROVED OMB NO. 0938-0391		
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COMF	E SURVEY PLETED	
		345509	B. WING _				C / <b>16/2019</b>	
NAME OF PI	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 PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 730			5. The Administrator and Direct Nursing are responsible for imple and maintaining the acceptable correction. Corrective action correction		5. The Administrator and Director of Nursing are responsible for implementir and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019.	•		
F 867 SS=D	CFR(s): 483.75(g)(2)	(ii)	F٤	867			6/3/19	
	assurance committee (ii) Develop and imple action to correct idem This REQUIREMENT by: Based on observatio interview, the facility's Committee (QA) faile and monitor intervent into to place following survey dated 3/1/18. deficiencies in the are Assessments at F641 Minimum Data Set (M medications, diagnos on 3/1/18 and Develo Comprehensive Care developing a care pla previously cited 3/1/1 This citation is cross	83.75(g) Quality assessment and assurance. 83.75(g)(2) The quality assessment and surance committee must: Develop and implement appropriate plans of tion to correct identified quality deficiencies; is REQUIREMENT is not met as evidenced ased on observations, record review and staff erview, the facility's Quality Assurance mmittee (QA) failed to maintain procedures d monitor interventions that the committee put to to place following the annual recertification rvey dated 3/1/18. This was for two recited ficiencies in the areas of Accuracy of sessments at F641-not accurately coding the nimum Data Set (MDS) in the areas of edications, diagnosis and falls previously cited 3/1/18 and Develop/Implement mprehensive Care Plan at F656-not veloping a care plan for a urinary catheter eviously cited 3/1/18. The findings included: is citation is cross referenced to:			F867- QAPI/QAA: 1. The facility failed to maintain procedures and monitor interventions th the committee put into place following th annual recertification survey date 03/01/2018. This was for 2 recited deficiencies in the area of Accuracy of assessments and Develop/Implement Comprehensive Care Plans. The facility implemented immediate correction in the areas recited to reflect correction on 05/15-16/2019 for the accuracy of assessments and the development and implementation of comprehensive care plans. This was completed by the MDS coordinator 2. Other residents have the potential be affected by this deficient practice as	to		
	staff interview, the fac Minimum Data Set (M	d review, observation, and cility failed to code the /IDS) assessment accurately ations (Residents #36, #41,			<ul><li>relates to Accuracy of assessment and Comprehensive Care Plans.</li><li>3. MDS coordinators will be in service re-educated regarding Accuracy of</li></ul>	ed		

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		с	
		345509	B. WING		05/16/2019	
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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 867	Continued From page	e 70	F 867			
	and #41), physical rea #23), falls (Residents (Resident #75) for 7 of F656-Based on recor- staff interview, the fac pan in the areas of re psychotropic medicat side rails (Resident # (Resident #81), pain f #81), and contracture sampled residents real In an interview on 5/1	management (Resident (Resident #57) for 5 of 20 viewed. 6/19 at 10:10 AM, the		assessments and Care Plans by th Director of Nursing by June 3, 2019 4. The MDS coordinators that co sections on the MDS. They will me review recited areas at each month QAPI review x 3 months. The facili utilize all team members that comp sections on the MDS to review, mo and make suggestions to prevent f recitations. Any issues or trends id will be addressed by the Quality Assurance Performance Improvem Committee (QAPI) as they arise, a plan will be revised to ensure conti compliance. Audit tool for accurac care plans will be completed by the Manager. The Unit Manager will m	9. mplete et and hly ty will blete ponitor further entified nent nd the nued y and e Unit aintain	
F 880 SS=D	stated they hired a parapparently was not prassessments. The DC systems were implem areas that needed to system failed. The DC December 2018 and nursing department. Infection Prevention & CFR(s): 483.80 (a)(1)	(2)(4)(e)(f) ntrol blish and maintain an ınd control program	F 880	all audits and present the to QAPI. 5. The Administrator and Directo Nursing are responsible for implem and maintaining the acceptable pla correction. Corrective action comp by 6/3/2019	r of nenting an of	
	comfortable environm	nent and to help prevent the nsmission of communicable				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				_ 16/2019
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	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 880	and control program ( a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services un- arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicab infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran to be followed to prev (iv)When and how isco resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possili circumstances. (v) The circumstances	blish an infection prevention IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of se or infections should be esmission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable cin lesions from direct	F	88			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING			05/	C 16/2019
NAME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B					(X5) COMPLETION DATE	
F 880	by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on record revi interview, the facility f precautions during bloc contaminated sharp in container during bloc 1 resident 's observe #71). Findings includ Resident #71 's quart dated 2/14/19 revealer resident was depende living except meals. long-term use of insul Resident #71 was re- 3/20/19 with the diagr insulin. Resident #71 had a m	he disease; and procedures to be followed rect resident contact. Im for recording incidents incility's IPCP and the en by the facility. Ite, store, process, and to prevent the spread of riew. In a nanual review of its r program, as necessary. T is not met as evidenced ew, observation, and staff failed to use universal bod retrieval by disposal of a n a non-approved sharps d glucose monitoring for 1 of d for finger stick (Resident ed: terly Minimum Data Set ed an intact cognition. The ent for all activities of daily The active diagnosis was in. admitted to the facility on nosis long term use of	F 8	880	<ul> <li>F880- Infection control and prevention</li> <li>The facility failed to use universal precautions during blood retrieval by disposal of a contaminated sharp in a r approved sharps container during blood glucose monitoring. There were no adverse effects for resident # 71. Nurs #2 received re-education on 5/15/19 by the Staff Development Coordinator regarding proper disposal of sharps into the appropriate sharps ⊂ container and regular garbage, re-education of univer precaution, contamination, removing the glucometer from the plastic bag that house the glucometer prior to entry into resident s room.</li> <li>Other residents that have blood retrieval have the potential to be affected by this deficient practice as it relates to contamination and infection control. Th were no concerns identified from other</li> </ul>	non d se / o not rsal ie o a ed j ere	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 06/18/2019 FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345509		345509	B. WING			C 05/16/2019	
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP COD	E.		
KINGSWOOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315				
				-		0.75	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION E DATE	
F 880	Continued From page 73		F 880				
	Continued From page 73 On 5/15/19 at 11:30 am an observation was done of Nurse #2 who used a disposable finger stick sharp for blood retrieval and glucose evaluation. After Nurse #2 used the sharp for blood retrieval, the nurse placed the contaminated sharp on the multiuse (more than one resident) plastic bag that housed the glucometer and discarded the contaminated sharp in the regular garbage on the medication cart. There was an available sharps container (regulated sharps disposal) on the medication cart. On 5/15/19 at 11:33 am an interview was conducted with Nurse #2 who stated she was ready to start her next finger stick for blood glucose evaluation. Nurse #2 was asked to stop for interview. Nurse #2 agreed that she placed a dirty finger stick sharp on the multiuse plastic bag and discarded the used sharp in the regular garbage. Nurse #2 added that she should have placed the contaminated sharp in the sharps container as required by the facility and should not have placed the sharp on the multiuse bag. On 5/16/19 at 11:00 am an interview was conducted with the Director of Nursing (DON) who stated she expected staff to follow universal precautions at all times and to place sharps items in the sharps containers as required.			<ul> <li>F 880</li> <li>residents that received a fingerstick. The Staff Development Coordinator implemented random monitoring of CBG during environmental rounds as well as while on the halls. This was started 05/26/2019.</li> <li>3. The Staff Development Coordinator initiated re-education with Licensed Nurses and Medication Aides for policy and procedure to check blood sugars. This included disposing of sharps into proper receptacle after obtaining blood sample, universal precaution, removing glucometer from plastic bag prior to entering the residents. This included on 06/3/19. Any staff that have not completed mandatory training by 06/03/2019 will be unable to work until requirement is fulfilled. This includes all shifts and PRN staff.</li> <li>4. Staff Development Coordinator will randomly audit 3 blood glucose checks weekly x4 weeks then monthly x2 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. The Staff Development Coordinator will implement Glucose/Sharps audit tool and be responsible to bring it QAPI weekly.</li> <li>5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by (6/3/2019)</li> </ul>		r ve ve is. d	

Event ID: 6GQD11

Facility ID: 970412

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