NT OF HEALTH AND HUMAN SERVICES			*A" FORM			
F ISOLATED DEFICIENCIES WHICH CAUSE H ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER # 345509	MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	DATE SURVEY 20MPLETE: 12/1/2011			
VIDER OR SUPPLIER	915 PEE DEE ROAD	ATE, ZIP CODE				
JD NORSING CENTER						
A resident has the right to receive notice be	fore the resident's room or					
Based on record review, staff and resident i (Resident #69, Resident #90) of a new room	nterviews, the facility land namate. The findings included on 12/21/2009. A quarter	erly Minimum Data Set (MDS)				
On 11/29/2011 at 10:18 AM, Resident #69 stated she was not notified when she got a new roommate. She stated she came back from lunch and her roommate was already moved in. No one from the facility introduced her to her new roommate.						
On 12/1/11 at 8:42 AM, Administrative state before we move that resident to another rollet them know that they are going to get at they did not always let them know when the documented in the social worker notes but 2. Resident # 90 was admitted to the facilithat Resident # 90 was cognitively intact.	om. Generally, if it was a roommate prior to the new ney were getting a new/ at was not documented even ity on 04/28/201. A quart	resident coming to the room. However, to the roommate. It also would be ty time.  erly MDS dated 10/31/2011 indicated				
roommate.  A review of Resident #90's medical record roommate.  On 12/1/11 at 8:42 AM, Administrative st before we move that resident to another rollet them know that they are going to get at they did not always let them know when the state of the rooted worker notes but the second worker notes are second workers.	d revealed no documentation of the facility report. Generally, if it was roommate prior to the neathey were getting a new/art was not documented ever	on regarding notification of a new otified the family/resident if oriented an alert and oriented resident, the facility we resident coming to the room. However, nother roommate. It also would be cry time. She further indicated she was not				
	F ISOLATED DEFICIENCIES WHICH CAUSE H ONLY A POTENTIAL FOR MINIMAL HARM NFS VIDER OR SUPPLIER DD NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIE  483.15(e)(2) RIGHT TO NOTICE BEFORD A resident has the right to receive notice be This REQUIREMENT is not met as eviden Based on record review, staff and resident i (Resident #69, Resident #90) of a new room 1. Resident #69 was admitted to the facility assessment dated 10/14/2011 indicated that On 11/29/2011 at 10:18 AM, Resident #69 stated she came back from lunch and her re introduced her to her new roommate.  A review of Resident #69's medical record roommate.  On 12/1/11 at 8:42 AM, Administrative sta before we move that resident to another ro let them know that they are going to get a they did not always let them know when the documented in the social worker notes but 2. Resident # 90 was admitted to the facil that Resident # 90 was cognitively intact.  On 11/29/2011 at 9:36 AM, Resident # 90 roommate.  A review of Resident #90's medical record roommate.  A review of Resident #90's medical record roommate.  On 12/1/11 at 8:42 AM, Administrative s before we move that resident to another re let them know that they are going to get a they did not always let them know when the documented in the social worker notes but  1. Resident # 90 was cognitively intact.  On 11/29/2011 at 9:36 AM, Resident # 90 roommate.  On 12/1/11 at 8:42 AM, Administrative s before we move that resident to another re let them know that they are going to get a they did not always let them know when the documented to another re let them know that they are going to get a they did not always let them know on the re let them know that they are going to get a they did not always let them know on the re let them know that they are going to get a they did not always let them know on the re let them know that they are going to get a they did not always let them know on the second record rec	PROVIDER # 345509  PROVIDER # 345509  PROVIDER BY STREET ADDRESS, CITY, ST 915 PEE DEE ROAD ABERDEEN, NC  SUMMARY STATEMENT OF DEFICIENCIES  483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE OF A resident has the right to receive notice before the resident's room of the resident #69, Resident #90) of a new roommate. The findings inclusions assessment dated 10/14/2011 indicated that Resident #69 was cognitively introduced her to her new roommate.  A review of Resident #69's medical record revealed no documentation to the roommate.  A review of Resident #69's medical record revealed no documentation to the roommate.  On 12/1/11 at 8:42 AM, Administrative staff #4 stated the facility not the new that they are going to get a roommate prior to the new they did not always let them know when they were getting a new/ are documented in the social worker notes but was not documented ever that Resident #90 was cognitively intact.  On 11/29/2011 at 9:36 AM, Resident #90 indicated he was not notificated that Resident #90 was admitted to the facility on 04/28/201. A quart that Resident #90 was admitted to the facility on 04/28/201. A quart that Resident #90 was admitted to the facility on 04/28/201. A quart that Resident #90 was cognitively intact.  On 11/29/2011 at 9:36 AM, Resident #90 indicated he was not notificated them know that they are going to get a roommate prior to the new they did not always let them know when they were getting a new/ are documented.  A review of Resident #90's medical record revealed no documentation to mommate.  A review of Resident #90's medical record revealed no documentation of the new that resident to another room. Generally, if it was a let them know that they are going to get a roommate prior to the new they did not always let them know when they were getting a new/ are they did not always let them know when they were getting a new/ are they did not always let them know when they were getting a new/ are they did not always let them know when they were getting a new/ are they did not alwa	PROVIDER # MULTIPLE CONSTRUCTION  FISOLATED DEFICIENCIES WHICH CAUSE HONLY A POTENTIAL FOR MINIMAL HARM NES  SUMMARY STATEMENT OF DEFICIENCIES  483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.  This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to notify two (2) of two (2) residents (Resident #69) Resident #90) of a new roommate. The findings included:  1. Resident #69 was admitted to the facility on 12/21/2009. A quarterly Minimum Data Set (MDS) assessment dated 10/14/2011 indicated that Resident # 69 was cognitively intact.  On 11/29/2011 at 10:18 AM, Resident #69 stated she was not notified when she got a new roommate. She stated she came back from lunch and her roommate was already moved in. No one from the facility introduced her to her new roommate.  A review of Resident #69's medical record revealed no documentation regarding notification of a new roommate.  On 12/1/11 at 8:42 AM, Administrative staff #4 stated the facility notified the family/resident if oriented before we move that resident to another room. Generally, if it was an alert and oriented resident, the facility let them know that they are going to get a roommate prior to the new resident coming to the room. However, they did not always let them know when they were getting a new/ another roommate. It also would be documented in the social worker notes but was not documented every time.  2. Resident # 90 was admitted to the facility on 04/28/201. A quarterly MDS dated 10/31/2011 indicated that Resident # 90 was cognitively intact.  On 11/29/2011 at 9:36 AM, Resident # 90 indicated he was not notified when he was getting a new roommate.  A review of Resident #90's medical record revealed no documentation regarding notification of a new roommate.			

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

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CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 2 / 2012	(X3) DATE SURVEY COMPLETED
AND FLAN OF CONTROLLOR		l "		C 12/01/2011
NAME OF PROVIDER OR SUPPLIER	345509		T ADDRESS, CITY, STATE, ZIP CODE	12/01/2011
KINGSWOOD NURSING CENT	ER	1	PEE DEE ROAD ERDEEN, NC 28315	
(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 000 INITIAL COMME	NTS /5/2012 to correct F 274-	F 000	This plan of correction shall be construed as an admissi	on of
-resident number	changed to #9 from #5. 0), 483.10(b)(1) NOTICE OF 5, SERVICES, CHARGES	F 156	fault nor agreement with the findings of non-compliance	1
The facility must and in writing in a understands of h	inform the resident both orally a language that the resident is or her rights and all rules and		The plan of correction is provided pursuant of Fede	
responsibilities d facility must also notice (if any) of	regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under		requirements which required acceptable plan of correct a condition of continued	1 1
made prior to or resident's stay. I any amendments	e Act. Such notification must be upon admission and during the Receipt of such information, and s to it, must be acknowledged in		certification.	
writing.  The facility must	inform each resident who is aid benefits, in writing, at the time		483.10- F156	livat
of admission to t resident become items and servic facility services t which the reside	to the nursing facility or, when the omes eligible for Medicaid of the risk for this issue.  Privices that are included in nursing ces under the State plan and for sident may not be charged; those and reason for denial		risk for this issue.  2. All Denial Letters will be completed to include the da and reason for denial.	te of Services
and for which the the amount of ch inform each resi the items and se (i)(A) and (B) of	e resident may be charged, and narges for those services; and dent when changes are made to ervices specified in paragraphs (5) this section.		3. Social Services will mail De Letters to residents' RP, cert mail with return receipt, or the resident if he/she is thei RP, as well as verbally inforn	give to r own ning
at the time of ad the resident's st facility and of ch	inform each resident before, or imission, and periodically during ay, of services available in the targes for those services, targes for services not covered		RP. Denial Letters will be se days prior to their Last Date Coverage.	of

administration

1-11-2012

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.

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
AND PLAN OF	CORRECTION			3	12/0	01/2011
	OVIDER OR SUPPLIER	345509		STREET ADDRESS, CITY, STATE, ZIP COE 915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	VEYOR DESIGN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCE)	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 156	A description of the personal funds, und section;  A description of the for establishing elig the right to request 1924(c) which dete non-exempt resour institutionalization a spouse an equitable cannot be consider toward the cost of medical care in his down to Medicaid and the cost of medical care in his down to Medicaid and the cost of medical care in his down to Medicaid and the cost of the complete of all perturbations and the complete of the computation of actility, and a statement complaint with the agency concerning misappropriation of facility, and non-concerning the right of the concerning the right of surgical treatments included the concerning the right of the concerning the right or surgical treatments.	manner of protecting der paragraph (c) of this  requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which red available for payment the institutionalized spouse's or her process of spending eligibility levels.  a, addresses, and telephone inent State client advocacy e State survey and certification dicensure office, the State am, the protection and and the Medicaid fraud control ent that the resident may file a State survey and certification g resident abuse, neglect, and of resident property in the compliance with the advance	F	4. Social Services will responsible for the coall Denial letters inclureason for termination Services is also responsible of Medicare Medicare Medicare Medicare Medicare Meeting will be review Medicare Meeting will be monthly QA meeting the log weekly x4, may represent the log weekly x4.	mpletion of ding the n. Social nsible for ter in on the Non-Coverage s a copy of all wed in the reekly.  will review nonthly x3, and te Medicare addressed in	Social Services Administra 12 7

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			- LIOTEUCTION	(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION	A. BUII			
		345509	B. WN			12/01/2011
MANE OF PE	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					PEE DEE ROAD RDEEN, NC 28315	
KINGSWO	OOD NURSING CENTER		10	ADE	DROVIDER'S PLAN OF CORR	RECTION (X5) COMPLETION
(X4) ID PREFIX TAG	THE PROPERTY OF THE PROPERTY O	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	1	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE
F 156	includes a written de policies to implement applicable State law.  The facility must informate, specialty, and physician responsib.  The facility must prowritten information, applicants for admis information about he Medicare and Medicare and Medicare refunds for such benefits.  This REQUIREMENT by:  Based on record refacility failed to issue Medicare benefits (Resident # 92) an notice more than 2 benefits for 2 of 3 states for 2 of 3 state	escription of the facility's at advance directives and a transfer	F	156		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	<del>-  </del>		E CONSTRUCTION	(X3) DATE SUF	RVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		345509	B. WN	G	·	12/0	1/2011
NAME OF PR	OVIDER OR SUPPLIER			91	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER				BERDEEN, NC 28315	STION	(X5)
(X4) ID PREFIX TAG		FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ix ∣	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	)ULD B⊨	COMPLETION DATE
F 156	Continued From page On 11/30/11 at 9:45 stated that she spok She shared that she reason why the the form, however in the because she would  2. Resident #51 was 5/26/11. On 11/30/1 conducted which re MDS (Minimum Dat Notice of Medicare recorded that she le representative payer Resident #51 would 6/13/11 because he on page 2 of the nereceiver to "Please have received this."  The notice also have been on the effective and that I may app my Quality Improvate than noon of date of this notice,  On 11/30/11 at 9:0 interviewed. She secondinate the No Non-Coverage un Worker took over recalled calling the songless but die songless but di	am, Administrative Staff #4 te to Resident #92 in person. It doesn't always write a coverage was denied on the case of Resident #92 it was not participate in therapy. It a record review was vealed that on 6/8/11, the ta Set) nurse prepared a Non-Coverage. On the form, it off a phone message for the te (RP) and relayed that the denied coverage on the condition had improved. It was left blank. It was left blank blank because she did not know that it	F	156			

	S FOR WEDICARL &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION	(X3) DATE SU	
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING	COMPLET	ΕU
		345509	B. WNG		12/0	1/2011
	OVIDER OR SUPPLIER  OD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 915 PEE DEE ROAD ABERDEEN, NC 28315	DDE	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 156	Continued From pag	e 4	F1	56		
	facility. On 11/30/11 conducted which rev MDS (Minimum Data Notice of Medicare N recorded that she sp payee (RP) and relay denied coverage on	ealed that on 7/25/11, the Set) nurse prepared a Ion-Coverage. On the form, it oke with the representative yed that Resident #84 was 7/24/11 because her red and that she would be				
F 159 SS=B	interviewed. She state coordinate the distrike Medicare Non-Cover Worker took over the shared that her expendification to be dorned day of coverage. Rerecalled that she had calls to the RP befor on 7/25/11. She state aware that Resident an assisted living behim a copy of the nonot know that it was 483.10(c)(2)-(5) FAC PERSONAL FUNDS Upon written authorifacility must hold, sate account for the perside paragraphs (c)(3)-(8) The facility must depart of the coordinate of the coor	cution of the Notices of rage letters until the Social task in September. She ectations was for the refive days prior to the last garding Resident #84, she distempted several phone is successfully reaching him red that the RP was already #84 would be transferred to diste by mail, because she did a required action.  CILITY MANAGEMENT OF Security and considered in coliity, as specified in of this section.	F	159 F 159 See n pag	prease lext	
	The facility must dep funds in excess of \$	oosit any resident's personal 50 in an interest bearing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,,,,		345509			12/01/2011
	VIDER OR SUPPLIER  D NURSING CENTER		9	REET ADDRESS, CITY, STATE, ZIP CODE 015 PEE DEE ROAD ABERDEEN, NC 28315	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
attless Times of the second of	the facility's operating all interest earned on account. (In pooled a separate accounting)  The facility must main funds that do not excounting account, interestly cash fund.  The facility must estable that assures a full an accounting, according accounting principles funds entrusted to the behalf.  The system must prevent funds with factory person other the individual finance through quarterly state the resident or his or the facility must noting the facility must noting the facility must noting the factory of the facility must not section 1611(a)(3)(B) amount in the account resident's other reaches the SSI resource limit for resident may lose elimit for resident may lose elimits for resident may l	that is separate from any of g accounts, and that credits resident's funds to that accounts, there must be a for each resident's personal eed \$50 in a non-interest rest-bearing account, or ablish and maintain a system d complete and separate g to generally accepted s, of each resident's personal e facility on the resident's acclude any commingling of accility funds or with the funds than another resident.  It is record must be available tements and on request to her legal representative.  If y each resident that receives the amount in the saches \$200 less than the rone person, specified in of the Act; and that, if the int, in addition to the value of conexempt resources, ource limit for one person, the gibility for Medicaid or SSI.	F 159	1. All residents are potential risk. 2. Residents #6 and #29 have given the most recent month statement for their respective funds. Completed 12-29-2011 3. Audit conducted to determine are any other alert and oriented residents that should receive their statement. Completed 1-06-2012 For it identified, the Trust Fund statement for December was presented to them by the BC Completed 1-06-2012 The is responsible for mailing out personally presenting all Resimplements. 4. Monthly Trust Fund statements. 4. Monthly Trust Fund statements. 4. Monthly Trust Fund statements. 5. Alert and oriented residence will continue to be mailed to residents RP monthly by the BOM. 5. Alert and oriented residence be requested to sign a seconfor their personal file. 6. Program results will be reviewed by Administrator 1 month. 7. Results will be presented meeting quarterly for 1 year.	e been ally e trust  BOM  mine if  d  hose  Some Service  BOM  1-10-12  BOM  1-10-12  BOM  Adm  1-10-11  Adm  1-10-11  Adm  1-10-11  Adm  1-10-11  BOM  Reach  BOM  BOM  BOM  BOM  BOM  BOM  BOM  BO

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
	•	345509	B. WNG	·	12/0	1/2011
	ROVIDER OR SUPPLIER DOD NURSING CENTER		9	REET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 159	by: Based on record revinterviews, the facility financial bank statem sampled residents (Rwith resident trust funcognitively intact and decision-making. The 1. Resident #6 was a 4/29/2009. A quarter dated 10/26/2011 indicognitively intact.  On 11/29/2011 at 9:2 had a resident trust for receive any statement asked how much more facility would tell him.  On 12/1/2011 at 10:4 5 stated she provided responsible parties (Fand oriented resident requested one. She residents a receipt with from their account.  2. Resident # 29 was 12/20/2009. A quarter indicated Resident #2 A review of Resident #2 A review of Resident #2 On 12/20/2009.  On 11/29/2011 at 2:00	few, resident and staff failed to issue quarterly ents to two (2) of three esident #6, Resident #29) d accounts who were independent in e findings included: dmitted to the facility on ly Minimum Data Set (MDS) icated Resident #6 was  6 AM, Resident #6 stated he unds account but did not lts. Resident #6 stated if he ney was in his account, the	F 159			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SUI COMPLET	
		345509	B. WNG		12/0	1/2011
NAME OF PP	OVIDER OR SUPPLIER	340009	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 120	.,
	OD NURSING CENTER		91	5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 159	receive a bank stater	nent. She indicated that the how much was in the	F 159			
F 226 SS=B	5 stated she provider responsible parties (I and oriented residen requested one. She residents a receipt w from their account. 483.13(c) DEVELOP		F 226	F226 1. The referred to 3 emplo	oyees'	
	policies and procedu mistreatment, negled	elop and implement written res that prohibit st, and abuse of residents n of resident property.	-	licenses and or certification verified, retrieved and place their files. Completed 12-Conducted an audit of all collicensed and certified emp	ced in 29-2011 current loyees	
	by: Based on policy revireview and staff inter			for verification. Completed 29-2011 The SDC is response verifying all licenses/certification of all new perspective employed. A Pre-Employment/Pre Orientation Checklist will in the specific process.	nsible for ication ployees e.	50e 12-21-11
	The facility's Administraction out a history of a mistreatment of residence of little out out, by a court of least out out of least out out of least out out out out out out out out out ou	strative Policies and creening, dated 3/11/2004 d, "It is the policy of this ial employees be screened to	Faa	attached to all perspective employees applications an forwarded to the DON.  3. The Pre-Employment/I Orientation Checklist will be completed and verified by DON and SDC prior to Orie	d Pre- pe both the ntation.	2-24-11 2000 12-29-11

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		
	345509	B. WING		12/	01/2011
ROVIDER OR SUPPLIER		915	PEE DEE ROAD		·
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
entered into the State concerning abuse, mi Procedure: "A verifical certification status, incregistry will be obtained disciplinary action was 1. Nurse #3 was hired Practical Nurse. On 1 conducted of Nurse # revealed that at the till evidence that her lice the pre-hire screening North Carolina Board	e Nurse Aides Registry istreatment or neglect."  ation of the current license or cluding the Nurses Aide ed to include whether any is been taken against them."  d on 10/26/11 as a Licensed 12/1/11, a review was 43's personnel file. It me of her hire, there was no ense was verified, as part of g. A document from the of Nursing, dated 11/30/11	F 226	certification and the Crir Background Check will b to the Pre-Employment/Pre-Or Checklist and it will be fi employees permanent e file. 5. A Log of all new hires maintained by the SDC. will monitor weekly x4, i x3, and quarterly therea results will be presented	minal rientation iled in the employee s will be The SDC monthly ifter. The	500 12-24-11 500 12-04-11
was interviewed. She who normally conduct screening was on a le unavailable for intervireason why the licens of hire.  2. Nurse #4 was hired Nurse. On 12/1/11, a Nurse #4's personnel time of her hire, there license was verified a screening. A document Board of Nursing, date with a license expiration 12/1/11 at 10:50 a was interviewed. She	shared that the employee sted the pre-employment eave of absence and iew. She did not know the se was verified after the date of on 9/29/11 as a Registered review was conducted of lile. It revealed that at the e was no evidence that her as part of the pre-hire ent from the North Carolina ted 11/30/11 was in her file, ion date of 7/13/2012.				
)	CONIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From page entered into the State concerning abuse, mi  Procedure: "A verificate retification status, incregistry will be obtained disciplinary action wandered of Nurse #3 was hired Practical Nurse. On a conducted of Nurse #7 revealed that at the time vidence that her lice the pre-hire screening North Carolina Board was in her file, with a 1/31/2013.  On 12/1/11 at 10:50 at was interviewed. She who normally conducted screening was on a let unavailable for interviewed in the control of hire.  2. Nurse #4 was hired Nurse. On 12/1/11, a Nurse #4's personnel time of her hire, there license was verified a screening. A document Board of Nursing, date with a license expiration on 12/1/11 at 10:50 at was interviewed. She	OD NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8 entered into the State Nurse Aides Registry concerning abuse, mistreatment or neglect."  Procedure: "A verification of the current license or certification status, including the Nurses Aide registry will be obtained to include whether any disciplinary action was been taken against them."  1. Nurse #3 was hired on 10/26/11 as a Licensed Practical Nurse. On 12/1/11, a review was conducted of Nurse #3's personnel file. It revealed that at the time of her hire, there was no evidence that her license was verified, as part of the pre-hire screening. A document from the North Carolina Board of Nursing, dated 11/30/11 was in her file, with a license expiration date of 1/31/2013.  On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed. She shared that the employee who normally conducted the pre-employment screening was on a leave of absence and unavailable for interview. She did not know the reason why the license was verified after the date	OVIDER OR SUPPLIER  ON NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8 entered into the State Nurse Aides Registry concerning abuse, mistreatment or neglect."  Procedure: "A verification of the current license or certification status, including the Nurses Aide registry will be obtained to include whether any disciplinary action was been taken against them."  1. Nurse #3 was hired on 10/28/11 as a Licensed Practical Nurse. On 12/1/11, a review was conducted of Nurse #3's personnel file. It revealed that at the time of her hire, there was no evidence that her license was verified, as part of the pre-hire screening. A document from the North Carolina Board of Nursing, dated 11/30/11 was in her file, with a license expiration date of 1/31/2013.  On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed. She shared that the employee who normally conducted the pre-employment screening was on a leave of absence and unavailable for interview. She did not know the reason why the license was verified after the date of hire.  2. Nurse #4 was hired on 9/29/11 as a Registered Nurse. On 12/1/11, a review was conducted of Nurse #4's personnel file. It revealed that at the time of her hire, there was no evidence that her license was verified as part of the pre-hire screening. A document from the North Carolina Board of Nursing, dated 11/30/11 was in her file, with a license expiration date of 7/13/2012.  On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed. She shared that the employee	OVIDER OR SUPPLIER  OD NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8 entered into the State Nurse Aides Registry concerning abuse, mistreatment or neglect."  Procedure: "A verification of the current license or certification status, including the Nurses Aide registry will be obtained to include whether any disciplinary action was been taken against them."  1. Nurse #3 was hired on 10/28/11 as a Licensed Practical Nurse. On 12/1/11, a review was conducted of Nurse #3's personnel file. It revealed that at the time of her hire, there was no evidence that her license was verified, as part of the pre-hire screening. A document from the North Carolina Board of Nursing, dated 11/30/11 was in her file, with a license expiration date of 1/31/2013.  On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed. She shared that the employee with a license expiration date of 7/13/2012.  On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed as part of the pre-hire screening, A document from the North Carolina Board of Nursing, dated 11/30/11 was in her file, with a license expiration date of 7/13/2012.  On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed. She shared that the employee  1	OVIDER OR SUPPLIER  345509  OVIDER OR SUPPLIER  DI NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES  GEACH DEFICIENCY USES OF PROVIDERS PLAN OF CORRECTION  GEACH CORRECTION

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345509	B. WNG	<u> </u>	12/0	1/2011
	ROVIDER OR SUPPLIER		9	REET ADDRESS, CITY, STATE, ZIP CODE 115 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	reason why the licens of hire. On 12/1/11 at 1:10 pr	eave of absence and lew. She did not know the se was verified after the date m, Administrative Staff#1	F 226			
	records contained in a department and found for Nurse #4's license 3. Nurse Aide #1 was 12/1/11, a review was #1's personnel file. It her hire, there was no certification was verifi screening. A docume	ied, as part of the pre-hire nt from the North Carolina r, dated 10/31/11 was in her				
F 253 SS=B	was interviewed. She who normally conduct screening was on a le unavailable for intervi reason why the certifidate of hire.  483.15(h)(2) HOUSE MAINTENANCE SER	iew. She did not know the ication was verified after the KEEPING & RVICES ide housekeeping and a necessary to maintain a	F 253	Fa53= See new		
		is not met as evidenced		P 000		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SU COMPLE	
		345509	B. WNG		12/0	01/2011
	OVIDER OR SUPPLIER  OD NURSING CENTER		915	T ADDRESS, CITY, STATE, ZIP CODE PEE DEE ROAD ERDEEN, NC 28315		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	Based on observation facility had closet door in disrepair on four (4 than 2/3 of resident resident resident resident resident rooms in the which was not listed) resident rooms where listed as real bad, 25 bad and 18 where the 210 was listed under was one room where been repaired alread rooms that did not in 215 and Room 216), rooms with furniture condition was 63 per of rooms with real bafacings was 94 perce with very bad or bad 100 hall (out of 14 ro (out of 16 rooms), 1 rooms) and 9 were on Room 407 was not listed in 247 revealed 34 rooms the closet doors and rooms with closed do time. Damage including areas of veneer back from the door/dof veneer barely han	n and resident interviews the ors and dresser drawer fronts of four (4) halls and more coms. Findings included:  written document titled Room ated 7/20/11, revealed there facility (excluding room 407 and of these there were 10 at the furniture facings were where they were listed as any were listed as fair (Room both bad and fair). There the furniture facings had by (Room 103) and two dicate any damage (Room The total percentage of facings in real bad or bad cent. The total percentage d, bad or fair furniture facings were on the furniture facings were	F 253	funiture in need of repair completed by maintenance logged on the Maintenance Furniture Audit. Complete 23-2011  2. Maintenance Staff will refinishing all furniture, locompletion date for each Furniture Repair Complete 3. Furniture will be checked daily rounds by the depart heads and other key personal theads and other key personal theads and other heads and other heads and located at each nurses stare Department Heads were in serviced on this program to Administrator. Completed 2011 Anticipated complete furniture is 01-31-2012  4. Maintenance will complete furniture. Rooms #101,102,103,104,105,106 8,109,110,111,112,113,114 2,203,204,205,206,207,206 02,306, 307,and308 have be completed. Completed 1-	twill be the and the ce and the c	
FORM ONE OF	ez(02.00) Provious Versions Of		411 Facil	ity ID: 970412	If continuation sh	eet Page 11 of 72

STATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING	·		12/01/2011	
	OVIDER OR SUPPLIER			91	ET ADDRESS, CITY, STATE, ZIP CODE 5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	CACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 253	the particle board be kick plate for the closd damaged and/or the fronts had damaged  On 12/1/11 at 11 AM Administrative Staff aware of the state of and dresser drawer problem in almost effacility. She indicated drawer/door fronts from months and that replacing one set per complex of a months one room's closet and the stated that more but he did not know provided the inventor Furniture Facings of 483.20(b)(1) COMPASSESSMENTS  The facility must conduct a comprehensive, a reproducible assess functional capacity.  A facility must make assessment of a reresident assessment of a reresident assessment by the State. The allest the following:	neath. In several rooms the set and/or dresser was also bedside table drawer/door veneer also.  I, interview with #3 revealed that she was if disrepair of the closet doors fronts and that it was a very resident room in the ted that one set of ad been replaced in the last it her plan was to start in month.  If with Administrative Staff #6 and during that time replaced and drawer fronts (Room 103). It would be replaced in future when. In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room atted 7/20/11 (See above). In addition, he only he completed titled Room attended to the room attended		253	Anticipated completion of rooms#210,211,212,213,21 16,303,307,401,402,403,40 06,408,409,410,411,412,41 15,416,417 and 418 will be 2012.  5. Audits will be monitore the Administrator weekly x monthly x3, and quarterly thereafter.  6. Results of audits will be presented to the QA Comm x each month x 12 months.	4,405,4 3,414,4 1-31- d by 4,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		12/01/2011
	OVIDER OR SUPPLIER OD NURSING CENTER		915 P	ADDRESS, CITY, STATE, ZIP CODE SEE DEE ROAD RDEEN, NC 28315	
(X4) ID PREFIX TAG	ÆACH DESICIENO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 272	Continence; Disease diagnosis at Dental and nutritions Skin conditions; Activity pursuit; Medications; Special treatments at Discharge potential; Documentation of suthe additional assess areas triggered by the Data Set (MDS); and Documentation of particular polyments of particular polyments for particular polyments of particular polyments for 4 (6) of 4 sampled residual polyments for 4 (6) of 4 sampled re	patterns; ping; and structural problems; and health conditions; al status; and procedures; animary information regarding sment performed on the care he completion of the Minimum of articipation in assessment.  IT is not met as evidenced view, and staff interview, the less residents regarding are return to community on their nimum Data Set) residents # 92, #85, #114 & # dents. The findings include: a admitted to the facility on olde diagnoses including Left	F 272	1. All residents are potentially risk. 2. All identified residents (#92,#85,#114,#6) section Q of their MDS was corrected. Completed 12-29-2012 3. The facility's MDS Coordinated the software compated inform them of the problem. The problem was corrected 11 2011. All in-house MDS will be audited by the MDS/Care Plan Coordinator and Social Service. Completed 1-13-2012. 4. Each upcoming MDS will be reviewed for completion of Set Q in the daily Administrative. Nurse meeting. Administrative nurses are DON, ADON, SDC, I and Clinical Coordinator. 6. Results of monitoring will presented 1 x month x 12 monto QA Committee.	# 05   12-21-11   12-2

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD  ABERDEEN, NC 28315  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD  ABERDEEN, NC 28315  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DATE COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DATE (ABOUT COMPLETED  (X5) DATE (ABOUT COMPLETED  (X6) COMPLETED  (X7) DATE (ABOUT COMPLETED  (X8) DATE (ABOUT COMPLETED  (X8) DATE (ABOUT COMPLETED  (X8) DATE (ABOUT COMPLETED  (X9) DATE (ABOUT COMPLETED  (X1) DATE (ABOUT COMPLETED  (X2) DATE (ABOUT COMPLETED  (X3) DATE (ABOUT COMPLETED  (X4) DATE (ABOUT COMPLETED  (X4) DATE (ABOUT COMPLETED  (X5) DATE (ABOUT COMPLETED  (X6) DATE (ABOUT C		O FOR MEDICARE &	MEDICAID SERVICES	-			OND NO	
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  KINGSWOOD NURSING CENTER  B. WNG  STREET ADDRESS, CITY, STATE, ZIP CODE  915 PEE DEE ROAD  ABERDEEN, NC 28315  PROVIDER'S PLAN OF CORRECTION  COMPLETING	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1				
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  KINGSWOOD NURSING CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315  PROVIDER'S PLAN OF CORRECTION COMPLETING	AND PLAN OF	CORRECTION	DEITH IS MISSISSIAN			—		
NAME OF PROVIDER OR SUPPLIER  915 PEE DEE ROAD  ABERDEEN, NC 28315  PROVIDER'S PLAN OF CORRECTION (X5)  COMPLETING ACTION SHOULD BE  COMPLETING ACTION SHOULD BE			345509	B. WIN	IG		12/01/2011	
KINGSWOOD NURSING CENTER  ABERDEEN, NC 28315  PROVIDER'S PLAN OF CORRECTION (X5) COMPLETING ACTION SHOULD BE COMPLETING ACTION SHOULD BE	NAME OF PR	ROVIDER OR SUPPLIER						
PROVIDER'S PLAN OF CORRECTION (X5)  CHANADY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETI	KINGSWO	OOD NURSING CENTER			1			
CHAMARY STATEMENT OF DEFICIENCIES I COMPECTIVE ACTION SHOULD BE	KINGONG			in		I PROVIDER'S PLAN OF CORRE	CTION	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  (EACH CORRECTIVE ACTION OF IOSE O	PREFIX	(CACH OFFICIENT	Y MUST BE PRECEDED BY FULL	PRE	-IX	CROSS-REFERENCED TO THE APP	PROPRIATE	DATE
F 272 Conlinued From page 13 assessment dated 09/13/11 indicated that Resident #92's cognitive status was intact. The section of the MDS for the discharge plan and return to community was blank.  The social worker's notes dated 09/01/11 revealed that the resident was admitted for short term rehab (rehabilitation) and to return home where she resides with her daughter. The resident is to receive PT (Physical Therapy)/CT (Occupational Therapy). The plan is to return home once goals are met. The notes dated 09/15/11 indicated that the resident would like to go home and is discussing a day with her daughter. Discussed home health options which resident states she has had. Resident also states her daughter generally cares for her at home.  On 11/30/11 at 8:40 AM, the MDS Nurse was interviewed. She stated that the social worker was responsible in completing the section regarding discharge plan and the return to community.  On 11/30/11 at 8:45 AM, the social worker was interviewed. She stated that she was not completing the section under discharge plan and return to community because the computer would not accept any response. She further stated that the facility had a lot of MDS assessments rejected from the state because of incomplete information. She also indicated that it has something to do with the software the facility was using.  2. Resident #85 was admitted to the facility on 3/16/10, then readmitted on 9/1/11 with multiple	F 272	assessment dated 0 Resident #92's cogn section of the MDS of return to community  The social worker's revealed that the resterm rehab (rehability where she resides worker's resident is to receive (Occupational There home once goals ar 09/15/11 indicated of go home and is disc daughter. Discusse resident states she her daughter generation  On 11/30/11 at 8:40 interviewed. She s was responsible in regarding discharge community.  On 11/30/11 at 8:40 interviewed. She s completing the sec return to communit not accept any resi the facility had a lo rejected from the s information. She a something to do wi using.	9/13/11 indicated that itive status was intact. The for the discharge plan and was blank.  notes dated 09/01/11 sident was admitted for short tation) and to return home with her daughter. The e PT (Physical Therapy)/OT apy). The plan is to return re met. The notes dated that the resident would like to cussing a day with her ed home health options which has had. Resident also states ally cares for her at home.  O AM, the MDS Nurse was tated that the social worker completing the section e plan and the return to  S AM, the social worker was stated that she was not tion under discharge plan and by because the computer would ponse. She further stated that t of MDS assessments tate because of incomplete also indicated that it has ith the software the facility was		272			

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WIN	G		12/01	/2011
	OVIDER OR SUPPLIER			91	EET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	disease. The admiss 09/13/11 indicated the status was impaired. the discharge plan ablank.  On 11/30/11 at 8:40 interviewed. She state was responsible in coregarding discharge community.  On 11/30/11 at 8:45 interviewed. She state completing the section return to community not accept any responsible facility had a lot rejected from the state information. She also	seizures and Alzheimer's sion MDS assessment dated at Resident #85's cognitive. The section of the MDS for and return to community was.  AM, the MDS Nurse was atted that the social worker completing the section plan and the return to.  AM, the social worker was atted that she was not con under discharge plan and because the computer would be assessments atted that it has at the software the facility was.	E	272			
	5/31/01, then readm diagnoses including diabetes mellitus II. dated 2/3/11 indicate cognitive status was MDS for the dischar community was blar On 11/30/11 at 8:40 interviewed. She st was responsible in o	admitted to the facility on itted on 5/31/11 with multiple spinal cord Injury and The annual MDS assessment ed that Resident #6's intact. The section of the ge plan and return to the lak.  AM, the MDS Nurse was ated that the social worker completing the section plan and the return to					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SUE COMPLET	
	345509	B. WING		12/0	1/2011
OVIDER OR SUPPLIER OD NURSING CENTER		9	15 PEE DEE ROAD		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
community.  On 11/30/11 at 8:45 / interviewed. She star completing the section return to community the not accept any responsible facility had a lot on rejected from the state information. She also something to do with using.	AM, the social worker was ted that she was not n under discharge plan and because the computer would nse. She further stated that f MDS assessments e because of incomplete o indicated that it has the software the facility was	F 272			
10/28/2011 and disch Diagnoses included: failure to thrive and g disease.  The Admission Minim 11/4/11 indicated resimpairment. Residen with locomotion on the with bed mobility, transsistance was requiunit, dressing, persor The section of the MI and return to the common 11/30/2011 at 8:4 interviewed. She starwas responsible for cregarding discharge promunity.	harged home 11/11/11. Hypertension, Diabetes, astroesophageal reflux  from Data Set (MDS) dated ident had mild cognitive at required limited assistance e unit, extensive assistance hasfers, and toilet use. Total red with locomotion off the hall hygiene and bathing. DS for the discharge plan hamunity was blank.  5 AM, the MDS nurse was ted that the social worker completing the section blan and the return to the				
	CONIDER OR SUPPLIER  SUMMARY ST.  (EACH DEFICIENC REGULATORY OR IS  Continued From page community.  On 11/30/11 at 8:45 / interviewed. She state completing the section return to community is not accept any responthe facility had a lot or rejected from the state information. She also something to do with using.  4. Resident # 114 was 10/28/2011 and discharded: failure to thrive and grid disease.  The Admission Minim 11/4/11 indicated resimpairment. Residen with locomotion on the with bed mobility, transistance was required unit, dressing, person The section of the MI and return to the community.  On 11/30/2011 at 8:4 interviewed. She state was responsible for coregarding discharge prommunity.  On 11/30/2011 at 8:4 interviewed. She state was responsible for coregarding discharge prommunity.	OVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15 community.  On 11/30/11 at 8:45 AM, the social worker was interviewed. She stated that she was not completing the section under discharge plan and return to community because the computer would not accept any response. She further stated that the facility had a lot of MDS assessments rejected from the state because of incomplete information. She also indicated that it has something to do with the software the facility was using.  4. Resident # 114 was admitted to the facility was using.  4. Resident # 114 was admitted to the facility was using.  The Admission Minimum Data Set (MDS) dated 11/4/11 indicated resident had mild cognitive impairment. Resident required limited assistance with locomotion on the unit, extensive assistance with locomotion on the unit, extensive assistance with locomotion of the MDS for the discharge plan and return to the community was blank.  On 11/30/2011 at 8:45 AM, the MDS nurse was interviewed. She stated that the social worker was responsible for completing the section regarding discharge plan and the return to the	OVIDER OR SUPPLIER OD NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  Community.  On 11/30/11 at 8:45 AM, the social worker was interviewed. She stated that she was not completing the section under discharge plan and return to community because the computer would not accept any response. She further stated that the facility had a lot of MDS assessments rejected from the state because of incomplete information. She also indicated that it has something to do with the software the facility was using.  4. Resident # 114 was admitted to the facility 10/28/2011 and discharged home 11/11/11. Diagnoses included: Hypertension, Diabetes, failure to thrive and gastroesophageal reflux disease.  The Admission Minimum Data Set (MDS) dated 11/4/11 indicated resident had mild cognitive impairment. Resident required limited assistance with bed mobility, transfers, and tollet use. Total assistance was required with locomotion off the unit, dressing, personal hygiene and bathing. The section of the MDS for the discharge plan and return to the community was blank.  On 11/30/2011 at 8:45 AM, the MDS nurse was interviewed. She stated that the social worker was responsible for completing the section regarding discharge plan and the return to the community.  On 11/30/2011 at 8:45 AM, Administrative staff	OVIDER OR SUPPLIER  OD NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  community.  On 11/30/11 at 8:45 AM, the social worker was interviewed. She slated that it has something to thrive and gastroesophageal reflux disease.  The Admission Minimum Data Set (MDS) dated 11/4/11 indicated resident had mild cognitive impairment. Resident required limited assistance with locomotion on the unit, extensive assistance with locomotion on the unit, extensive assistance with locomotion on the unit, extensive assistance with locomotion of the unit, dressing, personal hygiene and bathing.  The section of the MDS for the discharge plan and return to completing the sex required with locomotion off the unit, dressing, personal hygiene and bathing. The section of the MDS for the discharge plan and return to the community.  On 11/30/2011 at 8:45 AM, the MDS nurse was interviewed. She slated that the social worker was responsible for completing the section regarding discharge plan and the return to the community.  On 11/30/2011 at 8:45 AM, Administrative staff	OVIDER OR SUPPLIER  345509  OVIDER OR SUPPLIER  OD NURSING CENTER  SUMMAY STATEMENT OF DEFICIENCES (SAN DEFICIENCE) (SAN DEFICIENCE) (SAN DEFICIENCY MUST BE PRECEDED BY FUIL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  community.  On 11/30/11 at 8:45 AM, the social worker was interviewed. She slated that she was not completing the section under discharge plan and return to community because the computer would not accept any response. She further stated that the facility had a lot of MDS assessments rejected from the slate because of incomplete information. She also indicated that it has something to do with the software the facility was using.  4. Resident # 114 was admitted to the facility 10/28/2011 and discharged home 11/11/11. Diagnoses included: Hypertension, Diabetes, failure to thrive and gastroesophageal reflux disease.  The Admission Minimum Data Set (MDS) dated 11/4/11 indicated resident had mild cognitive impairment. Resident required limited assistance with locomotion on the unit, extensive assistance with locomotion on the unit, extensive assistance with locomotion on the unit, extensive assistance with locomotion of the unit, dressing, personal hygiene and bathing. The section of the MDS for the discharge plan and return to the community.  On 11/30/2011 at 8:45 AM, Atm MDS nurse was interviewed. She stated that the social worker was responsible for completing the section regarding discharge plan and the return to the community.  On 11/30/2011 at 8:45 AM, Administrative staff

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		345509	B. WIN	.G		C - 12/01/2011	
	OVIDER OR SUPPLIER		•	9-	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 274 SS=B	community.  On 11/30/2011 at 8:4:#4 was interviewed. completing the section return to the community would not accept any stated that the facility assessments rejected incomplete information had something to do facility was using.  483.20(b)(2)(ii) COMINITER SIGNIFICANTA facility must conduct assessment of a resident's physical or purpose of this section means a major declinate resident's status that itself without further in implementing standar interventions, that has one area of the resider requires interdisciplinate requires interdisciplinate plan, or both.)  This REQUIREMENT by:  Based on record revisacility failed to completatus MDS assessments of a second resident of the resider requires interdisciplinate plan, or both.)	5 AM, Administrative staff She stated she was not in under discharge plan and ity because the computer response. She further had a lot of MDS I from the stated because of in. She also indicated that it with the software that the PREHENSIVE ASSESS I CHANGE  It a comprehensive then within 14 days after the should have determined, significant change in the mental condition. (For in, a significant change e or improvement in the will not normally resolve intervention by staff or by d disease-related clinical is an impact on more than ent's health status, and ary review or revision of the  Is not met as evidenced ew and staff interview, the ete a significant change in ent for 2 (Residents #45 & #		272	F274  1. All residents are potentially a risk. 2. Significant change assessme were completed for residents # and #9. Completed 1-06-2012 3. All in-house residents MDS w assessed for possible need for Significant Change Assessments a committee consisting of the N Coordinator, Rehab Director, Sc Services and DON. Completed 30-2011 Significant Change Assessments were completed for those determined to need one. Completed 1-06-2012 The MD Nurse was in-serviced on the Plan of Care for residents #4 and #9 the Plan of Correction. Completed 12-20-2011	nts 145 vere s by MDS ocial 12- or S an and	AND PRESTORY OF THE PROPERTY O

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	<del></del> -	
		345509			12/01/2011
KINGSWO (X4) ID	OVIDER OR SUPPLIER  OD NURSING CENTER  SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	9	REET ADDRESS, CITY, STATE, ZIP CODE  115 PEE DEE ROAD  ABERDEEN, NC 28315  PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	OULD BE   COMPLETION
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
F 274	Alzheimer's Disease assessment dated 0. Resident #45 had m problems and neede person physical assistoilet use and person Minimum Data Set a indicated that Resid decision making pro assistance with one mobility, dressing, to hygiene.  Based on the annua quarterly MDS assed declined in 4 areas living), bed mobility, personal hygiene from extensive assistance.  On 12/01/11 at 1:23 interviewed. She sident of compare the current assessment Nurse further reveas scheduled to have completes the quarther resident was trichange.	The annual MDS 8/12/11 indicated that emory and decision making and limited assistance with one st with bed mobility, dressing, nal hygiene. The quarterly assessment dated 11/11/11 ent #45 had memory and blems and needed extensive person assist with bed bilet use and personal  Al MDS assessment and the assment, Resident #45 had of ADLs (activities of daily dressing, toilet use and born limited assistance to e.  B PM, the MDS Nurse was atted that she understood that (decline or improvement) in d trigger a significant change int. She also stated that she e last assessment with the te for any changes. The MDS and and and the MDS and and and the MDS	F 274	4. All future Quarterly assessments will be compare the residents previous Annua assessment to identify any al decline and/or improvement would trigger a significant ch assessment.  5. If a significant change is required, the Quarterly MDS be changed to a Significant C MDS.  6. Residents who trigger for Significant change MDS will discussed in daily Administra Nurse meeting.  7. Monthly Log of residents requiring a Significant Chang will be presented 1 x month the QA Committee x 12 mor The DON is responsible for monitoring this program.	reas of that ange MDS  will Change  a be ative 12-31-11  ge MDS ly to
	facility on 07/03/06	s originally admitted to the with multiple diagnoses sion, Anxiety, Chronic Kidney			

PRINTED: 12/13/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				T		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mī A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLET		
		345509	B. WIN	G		12/0	1/2011	
NAME OF PE	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OOD NURSING CENTER		915 PEE DEE ROAD					
MINGOIT				LAI	BERDEEN, NC 28315		0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 274	Disease, and Osteop assessment indicated cognitive status was independent with amb supervision with amb assessment also indisupervision with bath assessment dated 09 Resident #5 had mod ambulation in roccur during entire 7	orosis. The annual MDS If that Resident #5's Intact and she was bulation in room and needed ulation in corridor. The cated that she needed ing. The quarterly MDS I/08/11 indicated that lerate cognitive impairment om and in corridor did not days. The assessment she needed extensive	F	274				
F 278 SS=B	areas, ambulation and On 12/01/11 at 1:23 interviewed. She state 3 or more changes (continued on the compare the current assessment of the current assessment of the resident was trigger change.  483.20(g) - (j) ASSES ACCURACY/COORD	ent #5 had declined in 2 d bathing.  PM, the MDS Nurse was ted that she understood that decline or improvement) in trigger a significant change is. She also stated that she last assessment with the for any changes. The MDS and that when a resident was quarterly assessment, she enly assessment even though gered for a significant.  SSMENT DINATION/CERTIFIED at accurately reflect the must conduct or coordinate	F	278	F278-18	renez	J	
	assessment also indi supervision with bath assessment dated 05 Resident #5 had more and ambulation in rococcur during entire 7 further indicated that assistance with bathi Based on the annual assessments, Reside areas, ambulation and On 12/01/11 at 1:23 interviewed. She sta 3 or more changes (c ADL functions would in status assessment did not compare the current assessment Nurse further reveals scheduled to have a completes the quartet the resident was triggen than the resident was triggen assessment must be assessment assessment must be assessment assessment must be assessment a	cated that she needed ing. The quarterly MDS 1/08/11 indicated that lerate cognitive impairment om and in corridor did not days. The assessment she needed extensive ng.  and quarterly MDS ent #5 had declined in 2 d bathing.  PM, the MDS Nurse was ted that she understood that decline or improvement) in trigger a significant change is. She also stated that she last assessment with the for any changes. The MDS and that when a resident was quarterly assessment, she enly assessment even though gered for a significant  SSMENT DINATION/CERTIFIED est accurately reflect the must conduct or coordinate	F	278	F278-18	·e reg		

Facility ID; 970412

Event ID:XCC411

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	ATEMENT OF DEFICIENCIES (X1) PROVIDENCE IDENTIFICATION NUMBER:		A. BUILDING			
		345509	B. WNG		12/01/2011	
	OVIDER OR SUPPLIER  OD NURSING CENTER		915	T ADDRESS, CITY, STATE, ZIP CODE PEE DEE ROAD ERDEEN, NC 28315		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	F 278	DEFICIENCY)		
F 278	Continued From pag participation of healt	n professionals.		1. All residents are potentially risk.		
	A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the			<ol> <li>Residents #90 and #45 MDS coding errors were corrected 1 29-2011. Residents #90, #45, #</li> </ol>	2-	
assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who			#9, #51, #75, #85, #92, #93, #1 #114 MDS signatures were corrected 12-29-2011. All in-h			
	willfully and knowing false statement in a	Medicaid, an individual who ly certifies a material and resident assessment is ney penalty of not more than		residents MDS will be audited time of next scheduled MDS are any errors corrected. These M	at nd	
	\$1,000 for each ass willfully and knowing to certify a material	essment; or an individual who <sub>l</sub> ly causes another individual and false statement in a		will be added to MDS log to sh corrections completed and dat All annual admission and	ow	
	resident assessmen penalty of not more assessment.	t is subject to a civil money than \$5,000 for each		significant change assessment completed as of 9-1-2011 pull and signatures completed. 1-3	ed 1-3-12	
	Clinical disagreeme material and false s	nt does not constitute a tatement.		2012 3.MDS nurse will visit daily wit	th 405	
	hv:	This REQUIREMENT is not met as evidenced by:		residents who are in MDS look back period to assist in assessment.	12-36	
	and staff interview, assess one (2) of e (Resident # 90) for	Based on observation, medical record review and staff interview, the facility failed to accurately assess one (2) of eleven (11) sampled residents (Resident # 90) for speech and (Resident #45) for		<ol> <li>After completion of MDS, I coordinator will review assess for accuracy.</li> </ol>		
	antipsychotic medication and failed to complete RN signature for Care Area Assessment and care planning for eleven (11) of thirteen (13) sampled residents (Resident #6, #9, #45, #51, #75, #85, #90, # 92, #93, #111 and # 114). The findings included:			5. MDS Coordinator will bring completed MDS to the daily Department Head meeting fo completion of all signatures.	19-3	
	1a. Resident #90 w	as admitted to the facility				

CENTERS FOR MEDICARE & MEDICALD SERVICES  (XX) PROMISERS PROPER  345599  NAME OF PROWDER OR SUPPLIER  (XXI) SUMMARY STATEMENT OF GERGENOUS STREET ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION OR SUPPLIER  (XXI) SUMMARY STATEMENT OF GERGENOUS STREET ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION SHOULD STREET ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION SHOULD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION SHOULD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION SHOULD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION SHOULD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION SHOULD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION SHOULD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD  ABERDEEN, NO 2815  PROVIDERS NAME OF CORRECTION SHOULD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD STREET ROAD STATE ADDRESS, CITY, STATE, 2IP CODE 915 PEOCES ROAD STREET, 2IP CODE 915	DEPART	MEINT OF THEMETICADE &	MEDICAID SERVICES				OMB NO. 0930-0031	
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  COULD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST SEE PRECEDED BY FLIZ. (EACH DEFICIENCY DEFICIENCY)  F 278 Continued From page 20 4/28/12010. Cumulative diagnoses included: Cerebrovascular accident with hemiplegia and Aphasia.  An Annual Minimum Data Set (MDS) assessment dated 5/22/2011 indicated resident had clear speech, was understood and understands. Resident #80 Communication board to express hirmself and answer questions during the interview.  A Social work note dated 8/2/11 indicated Resident #90. Resident #90. Resident #90. Resident #90. By the following separation of the MDS for 5/2/2011 and stated that it was incorrect information regarding speech clarity and that Resident #90 was understood. She stated she had no idea why she had documented it that way and it was a mistake. She knew Resident #90 was admitted to the facility 4/28/2010. Cumulative diagnoses included: Cerebrovascular accident with hemiplegia and	STATEMENT C	F DEFICIENCIES	/X1) PROVIDER/SUPPLIER/CLIA	1 .			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  CASH DEACHS WINDS WINDS STATEMENT OF DEFICIENCIES (EACH DEACHSING MUST BE FRECEDED BY FULL TAG  FEET ADDRESS, CITY, STATE, ZIP CODE 916 PEED EDE ROAD ABERDEEN, NC 28315  PROVIDER'S FLAN OF CORRECTION (EACH OCKRETCH AND STON SHOULD BE (EACH OCKRETCH AND SHOULD BE (EACH OCKRETCH A	AND PLAN OF	CORRECTION				·	12/01/2011	
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SUMMARY STATEMENT OF DEFICIENCIES   PREPRY   RESULATORY OR LSC IDENTIFYING INFORMATION)   PREPRY   RESULATORY OR LSC IDENTIFYING INFORMATION   PROPRY INFORMATION   PROP					91	15 PEE DEE ROAD		
## Continued From page 20 ## Continued From page 20 ## Corebrovascular accident with hemiplegia and Aphasia.  An Annual Minimum Data Set (MDS) assessment dated 5/2/2011 indicated resident had clear speech, was understood and understands. Resident was alert and oriented. Communication did not trigger on the MDS.  On 11/29/2011 at 9:36 AM., an interview was conducted with Resident #90. Resident #90 and a communication be express himself and answer questions during the interview.  A Social work note dated 8/2/11 indicated Resident #90 expressed himself with gestures, garbled works and sound board.  An Activity progress note dated 10/31/11 revealed that Resident #90 could not speak.  On 11/30/11 at 9:45 AM., the MDS nurse reviewed the MDS for 52/2011 and stated that it was incorrect information regarding speech clarify and that Resident #90 was understood. She stated she had no idea why she had documented it that way and il was a mistake. She knew Resident #90 was admitted to the facility 4/28/2010. Cumulative diagnoses included: Cerebrovascular accident with hemiplegia and	KINGSWO	OD NURSING CENTER			A		<del></del>	
Aphasia.  An Annual Minimum Data Set (MDS) assessment dated 5/2/2011 indicated resident had clear speech, was understood and understands. Resident was alert and oriented. Communication did not trigger on the MDS.  On 11/29/2011 at 9:36 AM., an interview was conducted with Resident #90. Resident #90 used gestures, sounds and a communication board to express himself and answer questions during the interview.  A Social work note dated 8/2/11 indicated Resident #90 expressed himself with gestures, garbled words and sound board.  An Activity progress note dated 10/31/11 revealed that Resident #90 was understood. She stated she had no idea why she had documented it that way and it was a mistake. She knew Resident #90 did not talk.  1b. Resident #90 was admitted to the facility 4/28/2010. Cumulative diagnoses included: Cerebrovascular accident with hemiplegia and	PREFIX	ACTION DECICIONO	V MITST BE PRECEDED BY FULL	PRE	ΪX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLO BE	COMPLETION
An Annual Minimum Data Set (MDS) assessment dated 5/2/2011 was reviewed. No signature was	F 278	4/28/2010. Cumulatic Cerebrovascular accompliance.  An Annual Minimum dated 5/2/2011 indices peech, was underson Resident was alert and did not trigger on the Conducted with Resignatures, sounds an express himself and interview.  A Social work note on Resident #90 express himself and interview.  A Social work note on Resident #90 express himself and interview.  An Activity progress that Resident #90 conducted words and see that Resident #90 condu	Data Set (MDS) assessment ated resident had clear tood and understands. Indicated a communication at MDS.  36 AM., an interview was ident #90. Resident #90 used id a communication board to answer questions during the dated 8/2/11 indicated is sed himself with gestures, sound board.  5 AM., the MDS nurse for 5/2/2011 and stated that it nation regarding speech clarity 190 was understood. She idea why she had documented as a mistake. She knew of talk.  The idea is a communication board to a sea a different to the facility at a different with hemiplegia and in Data Set (MDS) assessment.	F	278	completion and all Annual an Significant Change MDS and I admissions in the areas of VE the MDS Coordinator will sign VC1 section.  7. All MDS will be logged on MDS log and checked for account and signatures daily in Daily Administrative Nurse meeting. The DON is responsible for monitoring this program. The Log will be reviewed 1 x mor 12 months in the QA Comm	athly x	MDS

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING  12/01/2011  NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 916 PEE DEE ROAD ABERDEEN, NC 28315  (X4) ID PREFIX FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FEATT TAG  Continued From page 21 noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).  On 11/30/2011 at 9:45 AM., the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.  On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility them those areas needed	DE: 700	A CAD MEDICADE &	MEDICAID SERVICES					. 0936-0331
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (Care Area Assessment) process (VB1) and signature of person completed and signed on any assessments.    Continued From Page 21 (VC1).   Continued F			CYAN PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  SIMMARY STATEMENT OF DEFICIENCIES  (X4) ID PREFIX TAG  F 278  Continued From page 21 noted at signature of person completing the care plan (VC1).  On 11/30/2011 at 9:45 AM., the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.  On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility	AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMIT RETER	
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 278  Continued From page 21 noted at signature of person completing the care plan (VC1).  On 11/30/2011 at 9:45 AM., the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.  On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility				B. WIN	iG	<del></del>	12/01/2011	
KINGSWOOD NURSING CENTER  (X4) ID PREFIX TAG  F 278  Continued From page 21 noted at signature of person completing the care plan (VC1).  On 11/30/2011 at 9:45 AM., the MDS nurse stated that VB1 and vignature of an any assessments.  On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility			345509				120	1/2011
KINGSWOOD NURSING CENTER  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 278  Continued From page 21 noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).  On 11/30/2011 at 9:45 AM., the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.  On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility	NAME OF PR	ROVIDER OR SUPPLIER						
(X4) ID PREFIX TAG    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)      F 278								
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 278  Continued From page 21 noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).  On 11/30/2011 at 9:45 AM., the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.  On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility	KINGSWU			<del></del>	┷		CTION	
noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).  On 11/30/2011 at 9:45 AM., the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.  On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility	PREFIX	I CACH DESIGNED	Y MIJST BE PRECEDED BY FULL	PREF	ΉX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	
to be completed and signed.  2. Resident #93 was admitted to the facility 4/29/2010. Cumulative diagnoses included: Advanced Multiple Sclerosis, Osteomyelitis and Osteoporosis.  An Annual MDS dated 5/6/2011 was reviewed. No signature was noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).  On 11/30/11 at 9:45 AM, the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.  On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility consultant had not told them those areas needed to be completed and signed.	F 278	noted at signature of (Care Area Assessm signature of person of (VC1).  On 11/30/2011 at 9: stated that VB1 and completed and signature of person of (VC1).  On 11/30/11 at 1:45 stated she did not ke areas. The Administ consultant had not to be completed and 2. Resident #93 was 4/29/2010. Cumula Advanced Multiple State Osteoporosis.  An Annual MDS dai No signature was n coordinator for CAA process (VB1) and completing the care on 11/30/11 at 9:45 that VB1 and VC1 is signed on any asset on 11/30/11 at 1:45 stated she did not be areas. The Administ consultant had not	RN coordinator for CAA hent) process (VB1) and completing the care plan  45 AM., the MDS nurse VC1 had never been ed on any assessments.  PM., Administrative staff #1 how she needed to sign those trator also said the facility old them those areas needed d signed.  Is admitted to the facility tive diagnoses included: Sclerosis, Osteomyelitis and  ted 5/6/2011 was reviewed. oted at signature of RN (Care Area Assessment) signature of person e plan (VC1).  5 AM, the MDS nurse stated had never been completed and	F	278			

CENTERS	FOR MEDICARE &	MEDICAID SERVICES			- CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER		LDING			
		345509	B. WIN	IG		12/01/2011	
		340009		QTRI	EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER			915 PEE DEE ROAD			
KINGSWO	OD NURSING CENTER			A	BERDEEN, NC 28315		
		THE DESIGNATION OF DE	1D	1	PROVIDER'S PLAN OF CORRECT	CTION (X5) COMPLETION	
(X4) ID PREFIX	CANLINEGICIENIC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	PRE	īX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	00000	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	120	,	DEFICIENCY)		
				-		/ 1	
E 070	Continued From pag	o 22	F	278		/ 1	
F 278	Continued From pag	as admitted to the facility					
	9/27/2011. Cumulat	ive diagnoses included:					
	Coronary Artery Dise	ease, Hypertension,					
	Congestive Heart Fa	illure and Diabetes.					
	A - Admission MDS	dated 11/2/11 was reviewed.				/	
	No eignature was no	oted at signature of RN					
	coordinator for CAA	(Care Area Assessment)				/	
	process (VB1) and s	signature of person	ŧ.		\ /		
	completing the care	plan (VC1).					
	On 44/20/44 of 0:45	AM, the MDS nurse stated					
	that VB1 and VC1 h	ad never been completed and					
	signed on any asses	ssments.			\ \ \		
		DIA Administrative staff #1					
	On 11/30/11 at 1:45	PM, Administrative staff #1 now she needed to sign those	-				
	stated she did not k	strator also said the facility	ĺ				
	consultant had not t	old them those areas needed					
	to be completed and	d signed.				\	
		·					
	A Resident # 114 \	was admitted to the facility					
-	10/28/2011. Diagn	oses included: Hypertension,	ĺ				
	Diabetes, Failure to	thrive and Gastroesophageal				\	
	Reflux Disease.						
	An Admission MDS	dated 11/4/11 was reviewed.				\	
	No signature was f	oted at signature of RN	Ì				
	coordinator for CA	A (Care Area Assessment)	ŀ				
	process (VB1) and	signature of person					
	completing the care	e pian (VC1).			//	Y	
	On 11/30/11 at 9:4	5 AM, the MDS nurse stated			(	lack	
	that VB1 and VC1	had never been completed and				\	
	signed on any asse	essments.					
	0 4410044 -14-4	E DM Administrative staff #1					
	On 11/30/11 at 1:4	5 PM, Administrative staff #1				vi vi vi vi vi vi vi phont Pogo 23 of 72	

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES				T	0936-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP! LDING	LE CONSTRUCTION	(X3) DATE SUR! COMPLETE	
		245500			-	12/01	/2011
		345509			TID DODE	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			1	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	L L	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 278	stated she did not kn areas. The Administration consultant had not to to be completed and 5a. Resident #75 was 01/29/09 with multiple Alzheimer's Disease assessment dated 17 Resident #75 had may problems and was or antidepressant medical Review of Resident # that she was on Risp at bedtime twice a way on 12/01/11 at 1:34 interviewed. She state why she did not code medication for the use 15b. Resident # 75 was Review of the annual 02/03/11 revealed the Area Assessment (Cosigned by an RN (Refor CAA Process and care plan.  On 12/01/11 at 1:23 interviewed. She state Care Area Assessment signed since she state 15c.	ow she needed to sign those rator also said the facility ld them those areas needed signed. In admitted to the facility on e diagnoses including. The quarterly MDS 1/01/11 indicated that emory and decision making an antianxiety and cations.  If 5's medications revealed herdal 0.25 mgs (milligrams) eek starting 08/19/11  PM, the MDS Nurse was atted that she did not know the antipsychotic se of Risperdal.  If MDS assessment dated hat the section under Care eAA) Summary was not egistered Nurse) coordinator of the person completing the PM, the MDS Nurse was ted that the section under care eAA) Summary has not been under Summary has not been under downking as an MDS dithat she did not know that	F	278			
							]

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SUR	
STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(AT) PROVIDERSOFFEIEWOLDA IDENTIFICATION NUMBER:	1 '	LDING		COMPLET	ED
		345509	B. WIN	G		12/0	1/2011
	OVIDER OR SUPPLIER			91	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	·	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE .	(X5) COMPLETION DATE
F 278	6. Resident #51 was 05/26/11. Review of assessment dated 06 section under Care A Summary was not sig Nurse) coordinator for person completing the On 12/01/11 at 1:23 interviewed. She state Care Area Assessment signed since she state 05/26/11 at 1:23 interviewed.	admitted to the facility on the admission MDS 6/03/11 revealed that the area Assessment (CAA) gned by an RN (Registered or CAA Process and the are care plan.  PM, the MDS Nurse was ted that the section under ent Summary has not been rted working as an MDS d that she did not know that	F	278			
	09/01/11. Review of assessment dated 09 section under Care A Summary was not sinurse) coordinator for person completing the On 12/01/11 at 1:23 interviewed. She stated Care Area Assessments signed since she stated on the coordinate of the coordin	9/13/11 revealed that the Area Assessment (CAA) gned by an RN (Registered or CAA Process and the					And the state of t
	8. Resident #5 was a facility on 07/03/06. assessment dated 0 section under Care of Summary was not si			_			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345509	B. WNG		12/0	1/2011
NAME OF PROVIDER OR SUPPLIER KINGSWOOD NURSING CENTE	R	9	REET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD ABERDEEN, NC 28315		
CEACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
interviewed. She st Care Area Assess signed since she st Nurse. She indicat this section needed  9. Resident #45 wa 08/02/10. Review of assessment dated section under Care Summary was not so Nurse) coordinator person completing  On 12/01/11 at 1:21 interviewed. She st Care Area Assess signed since she st Nurse. She indicat this section needed 10. Resident #85 w 9/1/11. Cumulative Alzheimer's diseas  An Admission MDS No signature was r coordinator for CA/ process (VB1) and completing the care  On 11/30/11 at 9:4	the care plan.  3 PM, the MDS Nurse was ated that the section under nent Summary has not been rarted working as an MDS ed that she did not know that it to be signed.  It is admitted to the facility on of the annual MDS 08/12/11 revealed that the Area Assessment (CAA) signed by an RN (Registered for CAA Process and the the care plan.  3 PM, the MDS Nurse was ated that the section under ment Summary has not been tarted working as an MDS ed that she did not know that it to be signed.  It is admitted to the facility ediagnoses included:  It is admitted to the	F 278			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 278	stated she did not kno areas. The Administr	PM, Administrative staff #1 ow she needed to sign those ator also said the facility d them those areas needed	F 2	78			
,	5/31/11. Cumulative of	admitted to the facility fiagnoses included: spinal ic bladder and diabetes					
	signature was noted a	Care Area Assessment) gnature of person		X			
		M, the MDS nurse stated d never been completed and ments.					
	stated she did not kno areas. The Administra	PM, Administrative staff #1 ow she needed to sign those ator also said the facility d them those areas needed signed.				)	
	483.20(d), 483.20(k)( COMPREHENSIVE C	1) DEVELOP	F 2	79 F 279-	- Sll		
	A facility must use the to develop, review and comprehensive plan of		10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -	next f	)as		
	plan for each resident objectives and timetal	lop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial					

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) ML	ILTIPLE C	ONSTRUCTION	(X3) DATE SUR COMPLETE	
ATEMENT ( ND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING			
		345509	B. WN			12/01/2011	
AME OF PR	OVIDER OR SUPPLIER		:	915 P	ADDRESS, CITY, STATE, ZIP CODE EE DEE ROAD		
KINGSWO	OD NURSING CENTER		•	ABE	RDEEN, NC 28315		~F)
(X4) ID PREFIX TAG	CHARLE DECIDIONS	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TD R⊨	(X5) COMPLETION DATE
F 279	Continued From page needs that are identically assessment.  The care plan must to be furnished to at highest practicable psychosocial well-be §483.25; and any see be required under § due to the resident's §483.10, including the under §483.10(b)(4).  This REQUIREMENT by:  Based on record refacility failed to revice 3 (Residents #45, # residents. The find 1. Resident # 45 who 08/02/10 with multically allowed that Residential that Residents and price falls dated 11/1 approaches included ambulation, non shape floors free of within reach and keep floors floors floors floors floors floors floors floors	describe the services that are tain or maintain the resident's physical, mental, and ging as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment.	F	279	1. All residents are potential risk 2. The care plans for resident #45, #67 and #59 were revise and corrected. Completed 2011 All in-house resident Plans Are being reviewed ar revised through the following procedures. 3. All Administrative Nurse meet daily to review new Norders, any falls or incident resident issues from the proday. 4. Any revisions to resident Plans will be made by the fourse at this time. 5. Care Plans will be brough Standards of Care meeting and updated by the MDS for easy access and review nurses, CNA's, and MD's a needed. 7. The DON is responsible monitoring this program using the Admin Nurses for monitoring the Admin Nurses for monitoring the Admin Nurses for easy access and review nurses, CNA's, and MD's a needed. 7. The DON is responsible monitoring the Admin Nurses form and during the Administrative Nurses made and the Administrative Nurses made and the QA Comes and monitoring the QA Com	nts ewed 12-02- Care nd ng s will AD es, any evious t Care MDS ght to g weekly Nurse. together s station v by as e for daily Meeting eeting. g will be nmittee 1	MOS AND CONTROL OF STATE OF ST

DEPARIM	IENT OF HEALTH AN	(D) (OARD OED) (ICES					, 0000 0001
CENTERS	FOR MEDICARE & I	MEDICAID SERVICES	(X2) MI	ULTIPLE	CONSTRUCTION	(X3) DATE SUR COMPLETI	RVEY ED
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TAND PLAN OF	JOHNEO HOLL		l l			12/0	1/2011
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MANE OF BRI	OVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
					5 PEE DEE ROAD BERDEEN, NC 28315		
KINGSWO	OD NURSING CENTER			AE	PROVIDER'S PLAN OF CORRECT	TION	(X5)
OV D ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREF		CACH CORRECTIVE ACTION SHO	OFO RE	COMPLETION DATE
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TAG	NCOOD (1011)						
				. 070		/	
F 279	Continued From pag	e 28		279			
	floor and the RFA (re	estraint free alarm in bed) did		1		/	
	not cound. The infel	vention was to check non		1		/	
	for malfunction. This	s intervention (RFA) was not plan approaches for falls. On		1		/	
	14bo 11/20/11 at 2:45	PM. the report indicated that					
	Decident #45 fell fro	m the bed. The metalicin			\	/	
	was to monitor the r	esident in the common area			\ \ \	/	
	butho staff This in	tervention was not added to	1	İ	\ /		
	the core plan approx	aches for talls. On 11/20/11			\ /		
	at 7:30 PM, the repo	ort revealed that Resident #45 The interventions were RFA in			\ /		
	who aloboic and PT	(Physical Therapy) to evaluate			I X		
	and treat. These in	terventions were not added to					
	the care plan.				/ \		
	1	man o Lane Numo uras			/ \	\	
	On 12/01/11 at 1:23	B PM, the MDS Nurse was ated that every morning the					
	interviewed. She st	members have a stand up					
	meeting and they fa	alked about falls. She			/		
İ	a almoulodged that	Resident #45 had several lans			/		
	but she did not go	pack and revised the care plan	ļ		/	\	
	for follo	as admitted 3/26/07 and had			/	\	
	Annoide existences	ses that included hypertension,			/	\	
	I demontic Parkings	un , e disease atto nebiession:				\	
	The questorly Minit	mum Data Set (MDS) daled				'	\
	o io indicated st	ie was codnitively illibalied and					
1	had an injury fall (I	not a major injury) since her last			/		X
	quarterly assessm	ent.					
1	Poviou of the Inci	dent/Accident report dated					
	04644 at 3:15 PM	A revealed "Resident noted on					
}	Appr haside hed ly	ing on her back with her leet on					
	the wall and head	pointed to toot of ped.					
	roport indicated R	esident #59 sustaineu a 1					
1	centimeter abrasic	on on her back from the fall. to prevent reoccurrence was "	1				
	The action taken	personal bed alarm to sound	1				
1	shorten string on	helaniai neg alemin to access	1				

DEPARTM	IENT OF HEALTH AN	ID I IDIAN AL OFICE					. 0000 333
ENTERS	FOR MEDICARE &	MEDICAID SERVICES	1000.10	TIDI	E CONSTRUCTION	(X3) DATE SUR	
ATEMENT O	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL			COMPLET	
D   Little		345509	B. WIN	G		12/0	1/2011
				STRE	ET ADDRESS, CITY, STATE, ZIP CODE	-	
	OVIDER OR SUPPLIER				5 PEE DEE ROAD BERDEEN, NC 28315		
INGSWO	OD NURSING CENTER			┸—-	PROVIDER'S BLAN OF CORRE	CTION	(X5) COMPLETION
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F 279	Continued From pagalarm sooner. "This to the care plan.  The Falls Investigated dated 9/17/11 reveal bed prior to the fall. checked off. Under to PT/OT (Physical Therapy) was check intervention was not related to cognisately, poor judger osteoperosis, demorated to being on and remeron were were: remind residually wheelchair, remind RFA (restraint free keep personal item bed to increase multiple of the Inci 11/13/11 at 1:10 For floor in bathroom. "The Falls Investigated 11/14/11 residually in the Falls Investigated 11/14/11 residually in the Investigated 11/14/11 residually in the Falls Investigated 11/14/11 residually in the Investigated	s intervention was not added ion Overview Plan of Action iled the resident had been in No corrective actions were the referrals section, referral Therapy/Occupational ked and dated 9/19/11. This t added to the care plan.  plan for Resident #59 last revealed she was at risk for nitive impairment, impaired ment, poor hearing, entia, arthritis, Parkinsons and fall risk medications (seroquel listed). The approaches listed dent to use assistive device, I resident to ask for assistance, e alarm) to bed, RFA to chair, ms within reach, ½ rails when in obility.  dent/Accident report dated on. States she was trying to go me report indicated Resident ed from the fall. There was me section regarding steps taken		7279			
	the deaths referre	ls section, referral to PT/OT y/Occupational Therapy) was					
Į.	, ,				Sacility ID: 970412	If continuation	sheet Page 30

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					1,0000 000.
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING	LE CONSTRUCTION	(X3) DATE SUF	
		345509	B. WI	IG		12/0	1/2011
	OVIDER OR SUPPLIER			91	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		·
KINGSHO	OD HOROMO OZMIZIO		<del>,</del>	I A		TION	(X5)
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ix	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
F 279	was not added to the	1/14/11. This intervention	F	279		/	
	11/27/11 at 4:30 PM Assistant) was pushi (bathroom) when rsd out of w/c (wheelcha right side. " The rep was not injured from prevent reoccurrence to use call bell for as was not added to the	revealed "CNA (Nursing ng rsdt (resident) out of BR t slammed forward and fell ir) landing on floor on her ort indicated Resident #59 the fall. The action taken to e was "reiterate to resident sistance." This intervention approach to "remind"					
	dated 11/28/11 rever pushed in her wheel No corrective actions the referrals section, Therapy/Occupation dated 11/28/11. This to the care plan.  2. Resident #67 was facility 1/2/2009. Sh facility 8/3/2011 follo	on Overview Plan of Action aled the resident was being chair by an NA when she fell. It is were checked off. Under referral to PT/OT (Physical al Therapy) was checked and is intervention was not added as originally admitted to the e was readmitted to the owing an overnight					
	Alzheimer's Disease Anemia.  An Admission Minim 8/10/2011 indicated short term and long with poor decision-n assistance was requ	nulative diagnoses included: Hypertension, Diabetes and num Data Set (MDS) dated Resident # 67 displayed term memory impairment naking abilities. Extensive lired with bed mobility, bathing, toileting and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		12/01/201	11
	ROVIDER OR SUPPLIER OOD NURSING CENTER		9	REET ADDRESS, CITY, STATE, ZIP CODE 015 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COM	(X5) APLETION DATE
F 279	personal hygiene.  A physician's progres indicated Resident #6 bleeding (5/27/2011 a ranged from 9.2-9.7. religious beliefs, refus 8/1/2011 stated that I has dropped to 7.4 as A physician' progress indicated that Reside outpatient colonoscop rectal bleeding. A recolonoscopy. Family chemotherapy or radii A Care Plan dated 8/resident's bleeding, reand/or comfort care in On 12/1/11 at 10:00 // reviewed the medical did not find a care plar resident's religious procancer or a care plan On 12/1/2011 at 1:13 care plan meetings a stated she made chall updated the care plar the staff had a standuland discussed any chemotherapy or radio. She would the did not know why the	s notes dated 6/29/11 67 had two episodes of rectal and 6/15/2011). Hemoglobin Resident #67, because of sed blood transfusions 6 progress note dated Resident #67' hemoglobin of 7/29/2011. 6 note dated 8/4/2011 6 note dated 8/4/2011 6 note dated 8/4/2011 6 for no surgery, ation therapy. 6 for no surgery, ation therapy. 6 for no surgery ation therapy at the surgery ation therapy. 6 for no surgery ation therapy at the surgery ation therapy at the surgery at the surg	F 279			

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	ROVIDER OR SUPPLIER			915	ET ADDRESS, CITY, STATE, ZIP CODE 5 PEE DEE ROAD 5 BERDEEN, NC 28315	G	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	religious preferences comfort measures. 483.20(k)(3)(i) SERVI PROFESSIONAL STATH The services provided must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must meet professional must must must must must must must must	and diagnosis of cancer or ICES PROVIDED MEET ANDARDS If or arranged by the facility all standards of quality.  Is not met as evidenced ew and staff interview, the doctor's orders for 4 #45 & #100) of 10 sampled as include:  admitted to the facility on diagnoses including The annual MDS #12/11 indicated that mory and decision making the orders dated 09/21/11 the theory and decision making the orders dated 09/21/11 the theory and decision making the orders dated 09/21/11 argic and constipated. Add wel movement) on protocol and Administration Record) are was transcribed to the R and was administered 2011. On the October and	F	279	F281  1. All residents are potentially risk  2. MD orders have been clarificand corrected on the MARs for residents #92, #75, #45, #100. Completed 12-29-2011 All inhouse resident medical records be audited through the following procedures.  3. A selected Nurse from each Hwill be assigned at the end of earmonth for checking of new MAR for the upcoming month. These same nurses will do MAR checks every month.  4. First check of new MAR's will done using the chart and going back thru 3 months of MD order to ensure accuracy.  5. The second check on all New MAR' will be done using the resident's current MAR.  6. The selected nurses will be trained on the new MAR check procedure. Completed 12-26-20.	will ag Hall ach k's be s	DON 12-28-11 DON 12-28-11 DON 12-28-11 DON 12-28-11
	November, 2011 MAR	s, Amiliza was not					'

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CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X1) PROVIDER/SUPPLIER/CLIA  (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SUR COMPLETE		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING			
		345509	B. WIN	IG	<u> </u>	12/0	1/2011
	and the state of t			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER				15 PEE DEE ROAD		
KINGSW	OOD NURSING CENTER			A	BERDEEN, NC 28315		(75)
(X4) ID PREFIX TAG	CANTI DEGICIENO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Continued From page transcribed and there the resident.  On 12/01/11 at 11:10 interviewed. Nurse is stated that Amitiza wo October and Novem nurses had checked last month's MARs at Amitiza.  On 12/01/11 at 12:0 was interviewed. She problems with the number of the MARs.  2. Resident # 100 wo 09/20/10. Review of 09/06/11 revealed at ointment ½ inch to 109/07/11, there was discontinue Lacrillub ointment to both eye.  The MARs were revitanscribed to the Control of 12/01/11 at 11:10 on 12/01/	e 33 efore was not administered to  O AM, Nurse #1 was #1 reviewed the chart and ras not transcribed to the ber MARs. She stated that 2 the new MARs against the and missed the order for  E PM, administrative staff #1 ne stated that she had urses checking the MARs. had new nurses now to check  as admitted to the facility on if the telephone orders dated doctor's order for Lacrilube ooth eyes for dry eyes. On is a new doctor's order to be and to start Artificial Tears es for dry eyes.  viewed. Lacrilube was october, November and ARs and was administered in nber, 2011.  10 AM, Nurse #1 was		281	7. MD orders will be revied daily Admin Nurses meeting then checked to ensure all were transcribed to the Martan Tark's for accuracy.  8. The Clinical Care Coording responsible for the monitor when labs are drawn and are in charts. All facility ping of labs drawn will be placed Scheduling Notebook unting results come in to ensure labs have been obtained.  9. Clinical Coordinator will pink copies against return results daily to ensure all results are received. The Care Coordinator is responsible and specific and initial that of the monitor and initial that of the monit	wed in and and and and and and and and and an	Climed Cord  Climed Cord  Climed Cord  Climed Cord  Climed Cord  C
	stated that Lacrilub October and Nover	#1 reviewed the chart and e was transcribed to the nber, 2011 MARs. She stated checking the new MARs nth's MARs and missed the e the Lacrilube.			presented to the QA Co x month x12 months.		neet Page 34 of 7

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	(20) 14	H TIO	LE CONSTRUCTION	(X3) DATE SURVEY	<b>′</b>	
STATEMENT OF	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI			COMPLETED		
		345509	B. WIN	G		12/01/2	011	
	OVIDER OR SUPPLIER			91	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315			
	<u></u>	TOT DEPOSITIONS	ID	_	PROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETION	
(X4) ID PREFIX TAG	CACH DESIGNA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE { S	DATE	
F 281	-		F	281				
	was interviewed. Shoroblems with the nu	5 PM, administrative staff #1 ie stated that she had irses checking the MARs at i. She stated that she had sheck the MARs.						
	01/29/09. Review of November, 2011 rev	s admitted to the facility on the physician's orders for realed an order for Risperdal twice a week on Friday and Dementia with Depressive						
	Risperdal was trans twice a week (Friday initialed by the nurse 2011, Risperdal was admi 2011, Risperdal was a week (Friday and the nurses daily from 2011 indicating that The October, 2011 initials for 10/15 (Sa 10/28 (Friday) indic administered. The revealed that Rispe given twice a week was initialed by the	iewed. In September, 2011, cribed to the MAR to be given and Saturday) but was es daily indicating that nistered daily. In October, a transcribed to be given twice Saturday) but was initialed by m October 3 thru October 7, it was administered daily. MAR also had no nurse's aturday), 10/21 (Friday) and ating that Risperdal was not November, 2011 MAR rdal was transcribed to be on Friday and Saturday but it nurses from 11/1 thru 11/5 is administered daily.						
	interviewed. She s	50 AM, Nurse #1 was tated that the nurses checking of the month should have ays the medications are trent.					.)	

PRINTED: 12/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLET	
		345509	B. WING	3	12/0	1/2011
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 915 PEE DEE ROAD ABERDEEN, NC 28315	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 281	was interviewed. She problems with the nur the end of the month. new nurses now to chindicated that she expense order before givin 4. Resident #92 was	PM, administrative staff #1 e stated that she had rses checking the MARs at . She stated that she had neck the MARs. She also pected the nurses to read g the medications.	F 2	:81		
	femoral fracture. The assessment dated 09 Resident #92's cognit Review of the telephodoctor's order dated (erythrocyte sediment blood count) and PT( (partial thromboplasti The doctor's progress revealed " pt.(patient but now some increase knee and thigh. Left k versus overlap cellulit Review of the laborat	n/13/11 indicated that tive status was intact.  one orders revealed a 11/16/11 for ESR tation rate), CBC (complete prothrombin time)/PTT in time).  Is notes dated 11/16/11 or time the in swelling/erythema of the costeoarthritis flare tis".				
	ESR and PT/PTT we the results in the char report.  On 12/01/11 at 12:05 #1 stated that the lab completed for ESR, C drawn on 11/17/11.	re drawn on 11/17/11 with It but there was no CBC  PM, the administrative staff				

Event ID: XCC411

TEMENT OF	FOR MEDICARE & I DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	12/01/2011	
D PLAN OF C	ORREGION	345509	i				
AME OF PRO	IVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 915 PEE DEE ROAD	, ZIP CODE		
UNGSWO	OD NURSING CENTER			ABERDEEN, NC 28315	PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECT	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	COMPLETION DATE	
			F:	281			
F 281	Continued From pag	je 36					
	the CBC. She state	d that she would have it	ļ.				
E 000	drawn today.	ARE/SERVICES FOR	F	309 <u>F309</u>	IIΑ		
F 309 SS=D	THE PERSON NAMED DE	EING		1. Resident #4	5All	APOPUL	
JU-D	1			residents are p	otentially at risk.	Mr. Wy	
	land the necess	receive and the facility must ary care and services to attain		2. Ali abnorma	al lab results will be	(3)	
	l or mointain the high	lest bracticable hilly sickly		faxed to the IV	10 40 y	t t	
	i i a and noveho	eacial Well-Delliq. 10		placed to MD.	eport to the Clinical	MOOS S	
	accordance with the	e comprehensive assessment		3. Nurse will	ny abnormal labs	136 Tr	
	and plan of care.			Coordinator a	ese results will be	13	
				placed on the	Supervisors	,	
		NT is not met as evidenced		placed on the	well as the report		
				cheet for tha	t hall.	TO ST	
	by: Based on record r	eview and staff interview, the		A JENAD is h	as not responded to	3	
	t- with following to ma	ke a follow up can with the		call regarding	g abnormal labs by the	0	
	attending physicial	n regarding the abnormal (Resident # 45) of 10 sampled	1	end of that s	hift, the nurse is to		
	haiting	to a delay in Changing in		notify the N	ursing		
	course of treatmer	nt or plan of care. The finding		Supervisor/(	Clinical Coordinator.	~0°	
	includes:			5 The Nurs	ing Supervisor/Clinical	100	
	Desident # 45 wes	s admitted to the facility on		Coordinator	should immediately	dx.	
	na roard a with mul	linia diadnoses iliviuullis		notify the D	ON	1300	
	Discordor	The disarterly (IVIDO) IVIII III Comment		6. The DON	I will follow up and	1900	
	Data Cot access	nent dated 11/11/11 indicated had memory and decision		notify the A	dministrator		
	that Resident #45 making problems	nad momory said services		immediate	ly. The Administrator		
	1			uill attemr	of to contact MD as well.	TOT	
	Review of the phy	ysician's orders for November,	-	if Administ	rator cannot locate MD	12-0	
	hoodsalod the	at Resident #45 was on Dilantin milliliter) by mouth twice a day at		then a call	will be made to the		
	1	turnanta rayaalad a	_   ,-	2/9-56	then e		
1	Review of the lat	ooratory reports revealed a 25.6 ( normal 10-20) dated	12		001	Ì	

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		
		345509	B. WING_		12/0	1/2011
KINGSWC (X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		915 PEE DEE ROAD ABERDEEN, NC 28315  PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AP	ORRECTION (X5) IN SHOULD BE COMPLETION	
TAG	REGULATORTOR	LOO IDESTIFICATION OF THE COLUMN CO.		DEFICIENCY)	<u> </u>	<u> </u>
F 309	11/18/11. The report physician or Nurse P they had been review  The nurse's notes daread " lab (laborator of 25.6. Notified MD awaiting new order " Further review of the 19 and November 20 to indicate that a follom MD regarding the ab  The MARs for Novem On November 19 and nurse's initials for 8 / indicating that Dilantin Resident #45.  On 11/30/11 at 2:35 interviewed. She state on duty when the lab abnormal Dilantin level had called the MD's MD will call back. SI faxed the laboratory indicated that she left had not returned her had informed the nur follow up call to MD. she came back to wo resident was lethargishe called the MD to Dilantin level.	twas not initialed by the ractitioner to indicate that yed.  ted 11/18/11 at 12 Noon y) called with Ditantin level (medical doctor) of results, nurse's notes for November of 2011, there were no notes ow up call was made with the normal Dilantin level.  There were reviewed. If November 20, there were on and 4 PM doses on was administered to the rel. She indicated that she oratory called for the rel. She indicated that she had report to MD. Nurse #1 twork at 3 PM and the MD call. She indicated that she ree on 3-11 shift to make a She further revealed that ork on 11/21/11. The cand had been falling, so get an order for a stat	F 30	facility Medical Director for and direction.  7. Any high levels of meds held until MD can be reach as Nursing staff was in-se procedure by SDC. Comple 29-2011  9. Clinical Coordinator will labs to the daily Admin Numeeting for review.  10. Results of Lab review documented on Admin Numeeting Form. Monitoric will be presented to the Committee 1 x month x 1 ongoing.	will be hed. rviced on eted 12- I bring all urse will be urses ng results QA	Appropriate Contraction of the C
·	had ordered to hold	11/21/11 was 22.1, the MD the Dilantin for 24 hours and on 11/22/11. The Dilantin				

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WNG 12/01/2011 345509 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 F 309 Continued From page 38 level on 11/22/11 was 25.1. The MD ordered to give Dilantin infatabs 100 mgs every 12 hours. On 12/01/11 at 2:55 PM, the administrative staff #1 was interviewed. She stated that her expectation was for the nurses to keep calling the doctor until he calls back and to hold the medication (Dilantin). She stated that the facility had no policy on notification of MD of abnormal lab reports. She also stated that she had investigated this incident and found out that the nurse on the 7-3 shift had reported the abnormal Dilantin level to the nurse on 3-11 shift and the nurse on the 3-11 shift failed to inform the nurse on 11-7 shift and to hold the Dilantin. Administrative staff #1 revealed that the nurse on 11-7 shift was no longer employed by the facility. On 12/01/11 at 3:22 PM, Nurse #2 (nurse on 3-11 shift) was interviewed. She stated that she was aware of the abnormal Dilantin level and withheld the 4 PM dose of Dilantin on 11/18/11. She indicated that she could not remember if she had followed up the call to the MD office. She also indicated that if she did not document it on the nurse's notes she might have not called. Nurse #2 indicated that she had informed the nurse on 11-7 shift about the abnormal Dilantin level. F 323 483,25(h) FREE OF ACCIDENT F 323 HAZARDS/SUPERVISION/DEVICES SS=D The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

CENTERS TATEMENT OF	F DEFICIENCIES	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
MD L Dat of		345509	B. WIN				01/2011	
	OVIDER OR SUPPLIER			9	REET ADDRESS, CITY, STATE, ZIP CODI	Ē		
KINGSWO	OD NURSING CENTER			_/	ABERDEEN, NC 28315		(X5)	
(X4) ID PREFIX TAG	are accidicate	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE	
F 323			F	323	again. The string on he shortened so it would	er alarm was alarm		
	This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and document review, the facility failed to evaluate risks and implement interventions to prevent falls for one 1 (Resident #59) of 3 sampled residents with fall risk and failed to				sooner and she was m room closer to the nur for closer observation #77 reevaluated. Resi acute episode which is resolved. Current into	ses station . Resident dent had s now	12-29-11 400m	
	sampled residents with fall risk and falled to maintain electrical equipment in safe operating condition for one 1 (Resident #77) of 1 sampled resident. Findings include:			are appropriate. He h further falls. 2. Nurses were in-sei	as had no	729-11		
	cumulative diagnos dementia, Parkinso The quarterly Minin	es that included hypertension, n's disease and depression. num Data Set (MDS) dated e was cognitively impaired and ot a major injury) since her last			to complete incident including intervention further falls. The in-s done by the SDC. Co	ns to prevent ervice was mpleted 12-		
	quarterly assessment Review of the Incid 9/16/11 at 3:15 PM	lent/Accident report dated I revealed " Resident noted on ling on her back with her feet on pointed to foot of bed. " The			3. All incident repor brought to Daily Adr meeting and Departmenting for review evaluation. The AD	nin Nurse <sub>Iment</sub> Head and	12-29	
	report indicated Recentimeter abrasio	esident #59 sustained a 1 in on her back from the fall. o prevent reoccurrence was " personal bed alarm to sound			responsible for veriinterventions were 4. Any new interve	fying that initiated. ntions will be	A De-	
	The Falls Investigation Overview Plan of Action dated 9/17/11 revealed the resident had been in bed prior to the fall. The safety device checked off as having been in place was a personal alarm. There was no documentation of whether it had alarmed when she fell. Low bed mat and half side rails were not checked. No possible causes		Andrew Market and the state of		5. Accident Incides reviewed by the AE weekly x4, monthly quarterly there aft results will be press Committee month	nt Log will be DON and DON y x3, and er. Monitoring ented to the QA	ADOR-	

CENTER	S FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPI	E CONSTRUCTION	(X3) DATE SU COMPLET	RVEY IED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING			
		345509	B. WN			12/0	01/2011
	OVIDER OR SUPPLIER		915 PEE DEE ROAD				
KINGSWO	OOD NURSING CENTER			A	BERDEEN, NC 28315	TION	(X5)
(X4) ID PREFIX TAG	ALL DECICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	iX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLÉTION DATE
F 323	for the incident were actions were checked section, referral to F. Therapy/Occupation dated 9/19/11.  Review of the care updated on 11/8/11 adverse reactions to (seroquel, remeron one of the approach medications for advalso indicated Resirelated to cognitive poor judgement, podementia, arthritis, being on fall risk moremeron were listed. Review of the Incidental 11/13/11 at 1:10 P on floor in bathroom. The Falls Investigated 11/14/11 related to 11/14/11 related	checked off. No corrective and off. Under the referrals of off. Under the referrals of off. Under the referrals of the control	F	323	6. All resident rooms will be monitored daily on Administrator any potential safety had 7. Any problems noted will reported to Maintenance at the Administrator on Department on the maintenance logs and nurses station.  8. A log of all identified provided by maintenance and the Maintenance Log at each in station.  9. Administrator will revieweekly x4, monthly x3, and quarterly thereafter.  10. Potential Hazards and issues will be addressed in QA meeting.	rounds cards.  I be ind to rtment r noted t each oblems ce on the nurses ew log d	All grant 12 Start 12

DEPARTM	IENT OF HEALTH AN	ID HUMAN SERVICES				1. 0938-0391
CENTERS	FOR MEDICARE &	MEDICAID SERVICES	(X2) MUI	TIPLE CONSTRUCTION	(X3) DATE SUF	RVEY
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		, Ooka Carr	
AND PLAN OF	CORRECTION	(DEITH IS)	A. BUILD	<del>-</del>		
		345509	B. WNG		12/0	1/2011
		345509		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
NAME OF PRO	OVIDER OR SUPPLIER		'	915 PEE DEE ROAD		ĺ
			.	ABERDEEN, NC 28315		
KINGSWO	OD NURSING CENTER			DROVIDER'S PLAN C	OF CORRECTION	(X5) COMPLETION
0/4)/D	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	WACH CORRECTIVE A	CTION SHOULD BE	DATE
PREFIX	(A4) ID (EACH DESIGNER MUST BE PRECEDED BY TOLE		TAG	CROSS-REFERENCED IN	NCY)	
TAG	REGULATORY OF					
					)	1
	o Erom nac	no 41	F3	323		
F 323	Continued From pag	the incident were checked				
	possible causes for	ctions were checked off.			/	
	Limited the referrals	section, referral to P1701			/	
	(Physical Therapy/C	occupational Inerapy) was	1		/	1
1	checked and dated	11/14/11.			/	
	İ				/	
	Review of the Incide	ent/Accident report dated			/	
	A A INTIMA OF AIRN DR	A revealed " UNA UNDIDING			/	
	Assistant) was push	ning rsdt (resident) out of BR dt slammed forward and fell				
	(bathroom) when rs	air) landing on floor on her				
	Thora	work indicated Kealderii maa			/	1
	I not injured from	n the fall. The action taken to			/	
	i roogcurren	re was " reliefate to residerit		`	\	
	boll for s	registance." The restuerit s			X	
	21 -1 -1 - mo utoro pre	seant on the torni. Hitle was	•		/ \	
	has further health as	ssessment documented and				1
	was a resident see	n by a physician " was he attached statement from				
	checked "no".	7/11 read " I was pushing			\	
-	( of recident)	from hathroom to net beu.	1	/	\	
	all a landed to make	as if she nassed out. One is in			\	
	out of her chair on	to the floor on her right side."			\	ļ
				1		
	The Falls Investiga	ation Overview Plan of Action			\	
		reside the resident was poins	Ì	/	\	
	pushed in her whe	checked off as having been in			\	
1	LILLE WAS A DATE!	mal alarm. NO possible causes			\	
	for the incident Wi	ere checked off. No confective		/	\	
	actions were chec	ked off. Under the releitals			_ \	
1	the enforced to	VPT/OT (Physica)			· \	1
	The area of Occupation	ional Therapy) Was Cricked and		/	'	\
	1-4-41/20/11	There was no mulcallon that the				\
-	are had boon ack	ed to demonstrate now the		1/		
	incident occurred	to determine if issues requiring		\ <u></u>		V
-	reeducation were	involved. There was no eresident's medications or				7
	indication that the	s regiment o modifications			if and involve	sheet Page 42 of 7
- 1	1			Facility ID: 970412	it commination	J.,JOI3-

PRINTED: 12/13/2011 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 12/01/2011 B. WNG 345509 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 915 PEE DEE ROAD ABERDEEN, NC 28315 KINGSWOOD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE 1Đ SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 323 Continued From page 42 F 323 health status had been reviewed in relation to the fall or the NA's written statement that the resident " looked as if she passed out " . Interview with the Administrative Staff #7 on 12/1/11 at 1:30 PM revealed physical therapy was already working with Resident #59 when she fell on 9/16/11 and had been continuing to work with her so the referrals to PT/OT were not adding, or contributing, anything new that PT wasn't already working on with the resident. During interview with Administrative Staff #1 and #3 on 12/1/11 at 4 PM they indicated that reminding a cognitively impaired resident to use the call bell was not a sufficient intervention to prevent falls on its own; and that it did not make sense in a situation where the staff member had been pushing the resident in a wheelchair when the fall occurred. They both also indicated that a more thorough investigation of the resident's falls should have been conducted so appropriate interventions could be put in place. 2. Resident #77 was admitted on 9/8/11 with diagnoses including Alzheimer's disease and Diabetes. The Admission MDS dated 9/14/11 revealed Resident #77 was moderately cognitively impaired and independent in locomotion, walking, transferring, eating and toileting but required limited assistance for dressing and hygiene. Resident #77 was on contact isolation throughout the survey.

On 12/1/11 at 8:30 AM, the resident was observed in his room sitting in his wheelchair. The air-conditioning and heating unit on the far wall of his room, under the window, was observed

DEPART		MEDICAID SERVICES					0000 000
STATEMENT (	OF DEFICIENCIES	LY1V PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPL	E CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY ED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII		<del></del>		
		345509	B. WIN	G		12/01	1/2011
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
	OD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315		
KINGSWC			ID	<del></del>	BROWDER'S PLAN OF CORRECT	TION	(X5) COMPLETION
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F 323	to be unplugged from The outlet cover was windowsill. Beside the containing what apper The electrical outlet and burnt looking. The electrical outlet and burnt looking. Interview with reside revealed he did not room uncomfortable there was a problem wore out. "  Interview with Admit on 12/1/11, at 9 AM requisitions or report Resident #77's room the room and recall recently, after the period He stated that while unplugged the aircoand discovered the said that he had into power supply cord the outlet cover was the room. He went having to order a new that the materials. He metalling unit was new the room and recall inform anyone that heating unit was new the room and recall the materials. He materials and the materials are the time at the said that was new that was damage.	the electrical wall outlet. If off and sitting on the the outlet cover was a box the early to be a new outlet. In the wall was blackened the plug-in end of the powering from the air-conditioning to blackened and burnt.  In the wall was blackened the plug-in end of the powering from the air-conditioning to blackened and burnt.  In the wall was asked if the with the unit he said " it with the unit he said " it with the unit he said " it with the unit he said " it with the unit he said " it with the was painting repair in the was painting the revious resident moved out. The head been painting it revious resident moved out. The head head to fix the outlet and at that time, which was why soff and the new outlet was in the onto add that he ended up the word for the unit and he to do the repair until he had be said the room had been and that since then, Resident with #6 added that he did not the air-conditioning and of working or that the electrical and and the room should not be seed. He further added that the	F	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SUR COMPLETO	
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	OVIDER OR SUPPLIER		915	T ADDRESS, CITY, STATE, ZIP CODE PEE DEE ROAD ERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	power supply cord had and he would fix both Interview with Admin at 9:10 AM revealed transferred into Room On 12/1/11 at 10 AM provided by Admin #cord had been ordered On 12/1/11 at 10:30 was interviewed and been aware of any pair-conditioning and outlet in Resident #7 that this was a comfort a potential safety had it was her expectation such hazards and the admitted to a room wair-conditioning and electrical outlet or potential safety had admitted to a room wair-conditioning and electrical outlet or potential safety had all the safety had	ad probably arrived by now a items immediately.  istrative Staff #2 on 12/1/11 Resident #77 was an #103 on 11/22/11.  review of the invoice 6 revealed the power supply ed on 11/18/11.  AM Administrative Staff #3 indicated that she had not roblems with the heating unit or the electrical 7's room. She indicated out issue for the resident and exard. She further stated that in that she be informed of at residents would not be with a non functioning heating unit, or a damaged	F 323			
F 329 SS=D	power supply cord in have been repaired. 483.25(I) DRUG REC	Room 103 was observed to GIMEN IS FREE FROM	F 329	F329  1. All residents are pote	ntially at	
	unnecessary drugs. drug when used in e duplicate therapy); o without adequate mo indications for its use adverse consequence	regimen must be free from An unnecessary drug is any xcessive dose (including r for excessive duration; or onitoring; or without adequate e; or in the presence of ces which indicate the dose r discontinued; or any		2. All residents with psy medications will be iden Identified residents' beh were added to behavior monitoring sheets. Com 2-2011	tified. aviors pleted 12-	12-2-11

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I BUT OF		245509	B. WNG	•	1	2/01/2011
	OVIDER OR SUPPLIER	345509		TREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION		(X5) COMPLETION DATE
F 329	Based on a compreh resident, the facility resident, the facility rewho have not used a given these drugs ur therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventices			3. All residents with psychoactive medications will have a Behavior Monitor sheet completed with target behaviors identified monthly with the end of the month MARs audit.  4. Nurses will be in-serviced on how to complete Behavior Monitor Sheets by SDC. Completed 12-29-2011  5. Nurses assigned to complete monthly checks on New MAR's will be in-serviced on how to fill out Behavior Monitor Sheets with Target Behaviors identified. The		12-24-11 12-24-11 12-24-11
	by: Based on record refacility failed to monitoring sheets for anothering sheets for and/or antianxiety minclude:  1. Resident #92 was 09/01/11 with multip Psychosis. The address	T is not met as evidenced view and staff interview, the liter the behaviors or to get behaviors on the behavior of 4 (Residents # 92, #9, #75 and residents on antipsychotic medications. The findings admitted to the facility on ole diagnoses including mission MDS assessment		SDC provided the traini Completed 12-26-2011 6. Behavior Monitor Sh audited each night by t shift for completion. 7. Audits will be review DON or her designee de discussed in monthly O	ng. eets will be he night ved by the aily and	13-34-11 13-34-11
	Review of the physical control	cated that Resident #92's s intact. cian's orders for November, Resident #92 was on at bedtime for Psychosis.				

FORM APPROVED OMB NO. 0938-0391

PRINTED: 12/13/2011

DEPART	MENT OF REALTHA	ALEDIAND CEDVICES					7, 0000 500.
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
STATEMENT C	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	LDING			1
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KINGSWO	OD NURSING CENTER			^	BERDEEN, NC 28315  PROVIDER'S PLAN OF CORRE	CTION	(X5)
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F 329			F	329			
	On 11/30/11 at 2:35 interviewed. She state behavior monitoring resident's behaviors	ted that the facility had a form used to document				/	
	Resident #92 had n	oring forms were reviewed. o behavior monitoring form for aber, 2011. The October and conitoring forms had no viors listed.					
	interviewed. She s why Resident #92 I form for November the behavior monitor behaviors listed an	to AM, Nurse #1 was tated that she did not know had no behavior monitoring , 2011. She further stated that bring forms should have target d the nurses checking the f the month were responsible behaviors on the forms.					
	#1 was interviewed behaviors should be monitoring forms. in-serviced the nur monitoring form be over of nurses later would schedule ar	05 PM, the administrative staff d. She stated that target be listed on each behavior She stated that she had uses on the use of the behavior efore but there was a big turn ly. She indicated that she in-service for all the nurses avior monitoring forms.					
	facility on 07/03/0 including Anxiety.	as originally admitted to the 6 with multiple diagnoses The quarterly MDS 1 09/08/11 indicated that moderate cognitive impairment.	And the second s				about Page A7 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					COMPLETED	
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	OVIDER OR SUPPLIER  OD NURSING CENTE	R		REET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
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F 329	Review of the phys 2011 revealed that 0.25 mgs at bedtim On 11/30/11 at 2:3 interviewed. She st behavior monitoring resident's behavior The behavior monit Resident #9 had not the month of Noves September, 2011 r behaviors listed.  On 12/01/11 at 11: interviewed. She swhy Resident #9 h for November, 201 behavior monitorin behaviors listed an MARs at the end of for writing the target On 12/01/11 at 12: #1 was interviewed behaviors should the monitoring forms. in-serviced the nur monitoring form be	ician's order for November, Resident #9 was on Xanax he for Anxiety. 5 PM, Nurse #1 was tated that the facility had a g form used to document	F 32			
	regarding the beha	in-service for all the nurses avior monitoring forms.  as admitted to the facility on iple diagnoses including				

CENTERS FOR MEDICARE & MEDICAID SERVICES						OWR MO	0930-0391
	S FOR MEDICARE & DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPL	E CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY D
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING			
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	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315		
KINGSITO		OF DESIGNATES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECT	TION	(X5) COMPLETION
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F 329	Alzheimer's Disease assessment dated 1: Resident #75 had me problems.  Review of the physic 2011 revealed That Risperdal 0.25 mgs Friday and Saturday Depressive features  On 11/30/11 at 2:35 interviewed. She stabehavior monitoring resident's behaviors  The behavior monitor Resident #75 had not the month of Novem September, 2011 m behaviors listed.  On 12/1/11 at 11:10 interviewed. She stabehaviors listed and MARs at the end of for writing the targe	The quarterly MDS 1/01/11 indicated that emory and decision making sian's orders for November, Resident #75 was on at bedtime twice a week on for Senile Dementia with  PM, Nurse #1 was sted that the facility had a form used to document  oring forms were reviewed. The behavior monitoring form for aber, 2011. The October and conitoring forms had no target  AM, Nurse #1 was ated that she did not know and no behavior monitoring 2011. She further stated that oring forms should have target of the nurses checking the the month were responsible t behaviors on the forms.	F	329			
	#1 was interviewed behaviors should be monitoring forms. Sin-serviced the nurse monitoring form be	D5 PM, the administrative staff . She stated that target e listed on each behavior She stated that she had ses on the use of the behavior fore but there was a big turn y. She indicated that she					and Proper 40 of 7
		Event ID: YCC	2444	5	acility ID: 970412	f continuation sh	eet Page 49 of 72

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345509	B. WING		12/0	1/2011
	ROVIDER OR SUPPLIER		9.	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		
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F 329	would schedule an in- regarding the behavior  4. Resident #37 was a 9/4/07 with diagnoses anxiety; depression wideation; and vascula The annual MDS assindicated that Reside cognitively impaired.  Review of the physici resident was on seron week and ativan 0.5 r  On 11/30/11 at 2:35 Finterviewed. She state behavior monitoring for resident's behaviors.  The behavior monitor The November and Cativan and seroquel histed.  On 12/1/11 at 10 AM, and stated that target and she did not know reviewed the forms an appeared to be writing their initials on a shift having any behaviors she had been taught documented as they behaviors should be I Nurse #5 also indicate.	eservice for all the nurses or monitoring forms.  admitted to the facility on a including hypertension; with history of suicidal or dementia with delusions. The sessment dated 8/27/11 and #37 was moderately  an's orders revealed the quel 12.5 mg 4 times per mg twice a day.  PM, Nurse #1 was and that the facility had a form used to document and no target behaviors  Nurse #5 was interviewed behaviors should be listed why they were not. She and noted that some staff g a zero in the form and when the resident was not. She went on to add that that behaviors were to be occurred and that target listed to be able to do that.	F 329			

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED
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OVIDER OR SUPPLIER  OD NURSING CENTER	L	s	TREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE COMPLETION
Continued From page On 12/01/11 at 12:05 #1 was interviewed. behaviors should be monitoring forms. Si in-serviced the nurse monitoring form befo over of nurses lately, would schedule an ir regarding the behavi 483.25(n) INFLUENZ IMMUNIZATIONS  The facility must dev that ensure that — (i) Before offering the each resident, or the representative receiv benefits and potential immunization; (ii) Each resident is of immunization Octobe annually, unless the contraindicated or th immunized during th (iii) The resident or th representative has th immunization; and (iv) The resident's m documentation that if following: (A) That the resider representative was p the benefits and pote immunization; and (B) That the resider	e 50  5 PM, the administrative staff She stated that target listed on each behavior ne stated that she had so on the use of the behavior re but there was a big turn She indicated that she n-service for all the nurses or monitoring forms. ZA AND PNEUMOCOCCAL  elop policies and procedures e influenza immunization, resident's legal res education regarding the al side effects of the  offered an influenza er 1 through March 31 immunization is medically e resident has already been is time period; he resident's legal ne opportunity to refuse edical record includes ndicates, at a minimum, the int or resident's legal provided education regarding ential side effects of influenza  ant either received the		F334  1. All residents are potential risk 2. Facility Policy for Influent administration has been up to include that each resider or Responsible Party will reseducation prior to administ of Vaccine. Completed 12-2011 The ADON is responsion providing the information of Vaccine.  3. Each resident and/or RP are consent form that includes acknowledgement of education benefits and side effects of Vaccine during their admission meeting and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration of the Vaccine during their admission provides and prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to administration prior to admi	za dated at and ceive ration 02- ble for rior to  will sign s tion of the Flu ion  ADON
influenza immunizat	ion or did not receive the		F334 CONtin	ulci
	OVIDER OR SUPPLIER  OD NURSING CENTER  SUMMARY ST (EACH DEFICIENCY REGULATORY OR  Continued From page  On 12/01/11 at 12:05 #1 was interviewed. behaviors should be monitoring forms. St in-serviced the nurse monitoring form befo over of nurses lately, would schedule an ir regarding the behavidas.25(n) INFLUENZ IMMUNIZATIONS  The facility must develow that ensure that— (i) Before offering the each resident, or the representative receive benefits and potential immunization; (ii) Each resident is contraindicated or the immunization; (iii) The resident or the representative has the contraindicated or the immunization; and (iv) The resident or the representative was the benefits and potential immunization; and (iv) That the resident influenza immunization; and (iv) T	OVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 50  On 12/01/11 at 12:05 PM, the administrative staff #1 was interviewed. She stated that target behaviors should be listed on each behavior monitoring forms. She stated that she had in-serviced the nurses on the use of the behavior monitoring form before but there was a big turn over of nurses lately. She indicated that she would schedule an in-service for all the nurses regarding the behavior monitoring forms.  483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that —  (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;  (ii) Each resident is offered an influenza immunization october 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;  (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and  (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:  (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza following:	OVIDER OR SUPPLIER  OD NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 50  On 12/01/11 at 12:05 PM, the administrative staff #1 was interviewed. She stated that target behaviors should be listed on each behavior monitoring forms. She stated that she had in-serviced the nurses on the use of the behavior monitoring form before but there was a big turn over of nurses lately. She indicated that she would schedule an in-service for all the nurses regarding the behavior monitoring forms.  483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that — (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (iv) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (iv) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (iv) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and	OVIDER OR SUPPLIER  345509  STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28316  PROVIDERS PLAN OF CORRECT  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IS O IDENTIFYING INFORMATION)  Continued From page 50  On 12/01/11 at 12:05 PM, the administrative staff #1 was interviewed. She stated that target behaviors should be listed on each behavior monitoring form before but there was a big turn over of nurses lately. She indicated that she would schedule an in-service for all the nurses regarding the behavior monitoring forms. 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policles and procedures that ensure that - (0) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the Immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (iv) The resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (iv) The resident either received the influenza immunization or did not receive the

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURY COMPLETE	/EY D
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•	ALVON DEGICIENC	TATEMENT OF DEFICIENCIES	915 F	PEC DEE ROAD  RDEEN, NC 28315  PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APPR	ULD BE 1	(X6) COMPLETION DATE
F 334	Continued From page contraindications or The facility must devithat ensure that— (i) Before offering the immunization, each legal representative the benefits and potential potential immunization; (ii) Each resident is immunization, unless medically contraindical ready been immunization; and (iv) The resident or representative has the immunization; and (iv) The resident's indocumentation that following:  (A) That the resident representative was the benefits and popneumococcal immunization or (v) As an alternative and practitioner reconstruction or the pneumococcal immunization, unless the immunization, unless the pneumococcal immunication or (v) As an alternative and practitioner reconstruction or the pneumococcal immunication, unless the pneumo	refusal.  relop policies and procedures  resident, or the resident's receives education regarding rential side effects of the  offered a pneumococcal s the immunization is cated or the resident has nized; the resident's legal he opportunity to refuse  redical record includes indicated, at a minimum, the  rent or resident's legal provided education regarding tential side effects of unization; and rent either received the reminization or did not receive immunization due to medical refusal.  re, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F 334	4. A log will be maintained of Flu Vaccines administered to include residents name, date education, a copy of educat material used for that year, consent signed, and date valued administered. The ADON is responsible for maintaining log.  5. Flu Vaccine Log will be responsible for maintaining log.  6. Progress of Vaccine administration and Log will reviewed in monthly QA.  7. All nurses will be in-serve this procedure. Completed 2011	e of ion date occine the eviewed be iced on 12-29-	4000 12-01-11 12-00-11 12-00-11 12-00-11
			C411 For	#lity ID: 970412	If continuation she	et Page 52 of 72

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14.1.00111			1		PROVIDER'S PLAN OF CORRECT	TION	(X5)
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F 334	This REQUIREMEN' by: Based on record reversal facility failed to provide the providential summunization before 5 (Residents # 45, # sampled residents.  The facility's policy a Vaccination (undate read in part " Resident " Resident part " Resident provided prior to the vaccine.  1. Resident # 45 was 08/02/10 with multipe Alzheimer's Disease Minimum Data Set a indicated that Reside decision making provided to the Immunitation of the immunitation of the immunitation of the immunitation of the immunitation of the Immunitatio	view and staff interview, the de education regarding the al side effects of the influenza offering the immunization to 99, #59, #85 & # 55) of 5 The findings include:  and procedure for Influenza d) was reviewed. The policy dents are protected from the ceiving the vaccine annually "indicate that education will be offering of the influenza diagnoses including e. The quarterly (MDS) assessment dated 11/11/11 lent #45 had memory and oblems.  Inization Record revealed that eceived Influenza Vaccine on as no evidence in the chart rding benefits and potential enza immunization was dent/RP (responsible party) exation.  O PM, the administrative staff is She stated that the resident ave been educated of vaccine prior to offering. She the education was not		334			

		MEDICAID SERVICES	(X2) M	II TIPI	E CONSTRUCTION	(X3) DATE SUR	VEY
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII			COMPLETE	9
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KINGSWO				<u> </u>	PROVIDER'S PLAN OF CORRECT	TON	(X5)
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F 334	Continued From pag	e 53	F	334			
	staff#2 stated that th	AM, the administrative e education and the consent pneumococcal vaccines during admission and not					
	o1/31/11. The quarindicated that Resid decision making pro Review of the Immu Resident #99 had re 11/15/11. There was that education regal side effects of influence provided to the resident and the control of the resident and the control of the resident and the control of the resident and the control of the resident and the control of the resident and the control of the resident and the control of the resident and the control of the resident and the control of the resident and the control of the resident and the control of th	nization Record revealed that eceived Influenza Vaccine on as no evidence in the chart rding benefits and potential enza immunization was dent/RP (responsible party)					
	#2 was interviewed or the RP should he risk/benefits of the acknowledged that documented in the	PM, the administrative staff She stated that the resident ave been educated of vaccine prior to offering. She the education was not resident's records.					
	#2 stated that the	5 AM, the administrative staff aducation and the consent for aneumococcal vaccines were ring admission and not yearly.					
	09/01/11. The adr	as admitted to the facility on nission MDS assessment dent # 85 had memory and				\	

STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPL	E CONSTRUCTION .	(X3) DATE SURV	EY EY
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		ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETION
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F 334	Review of the Immur Resident #85 had re 10/18/11. There was that education regard side effects of influent provided to the resid prior to the immunization. On 11/30/11 at 4:50 #2 was interviewed. or the RP should have risk/benefits of the vacknowledged that the documented in the residence of the residence of the vacknowledged that the education of the resident was and progiven to the RP duri	nization Record revealed that ceived Influenza Vaccine on a no evidence in the chart ding benefits and potential max immunization was tent/RP (responsible party) ation.  PM, the administrative staff She stated that the resident we been educated of accine prior to offering. She he education was not	F	334			
	revealed that Resid impairment.	ent #59 had severe cognitive					
	Resident #59 had re 11/11/11. There wa that education regal side effects of influe	inization Record revealed that eceived Influenza Vaccine on as no evidence in the chart rding benefits and potential enza immunization was dent/RP (responsible party) zation.					
:	On 11/30/11 at 4:5	OPM, the administrative staff					

STATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345509	B. WN	G		12/01	/2011
	OVIDER OR SUPPLIER			91	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		
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F 334	#2 was interviewed. or the RP should have risk/benefits of the value acknowledged that it documented in the result of the influence and programment of the RP during 5. Resident # 55 was 11/20/06. The annual	She stated that the resident re been educated of accine prior to offering. She ne education was not	F	334			
	Resident #55 had re 10/13/11. There wa that education regar side effects of influe	nization Record revealed that ceived Influenza Vaccine on s no evidence in the chart ding benefits and potential nza immunization was lent/RP (responsible party) ation.					
	#2 was interviewed. or the RP should ha risk/benefits of the v acknowledged that i documented in the r	PM, the administrative staff She stated that the resident ve been educated of accine prior to offering. She the education was not esident's records.  AM, the administrative staff ducation and the consent for				\	
	the influenza and pr	neumococcal vaccines were ng admission and not yearly.	-				

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	
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	OVIDER OR SUPPLIER OD NURSING CENTER		915	T ADDRESS, CITY, STATE, ZIP COD PEE DEE ROAD ERDEEN, NC 28315	ÞĖ	
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 356 SS=C	INFORMATION  The facility must post a daily basis: o Facility name. o The current date. o The total number at by the following categunlicensed nursing stresident care per shift.  Registered nurses (as - Registered nurses) - Certified nurses or Resident census.  The facility must post specified above on a of each shift. Data more of each shift.	the following information on the actual hours worked gories of licensed and aff directly responsible for t: es. cal nurses or licensed defined under State law). aides.  If the nurse staffing data daily basis at the beginning just be posted as follows: format. e readily accessible to	F 356	F356  1. Staffing information posted outside of the Daily Staff 2. Staffing Coordinator Coordinator, Administrand all Nursing Supervibeen in-serviced on the how to complete and a The SDC provided the i Completed 12-29-2011 3. Staffing Sheets will I completed at the begin each shift with the applinformation by the shift Supervisor.  4. Staffing Sheets will I maintained in the DON 5. Copies of Staffing Sherovided to Administration monitoring purposes de Administrator will proving results of the QA Committee e on-going.	con's office fing Sheet.  r, Clinical rative Staff, disors have the form and adjust daily. In-servicing. The fire of the control of the contr	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		· 345509	B. WING		12/0	1/2011
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(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 356	required.  The findings include On 11/29/11 at 4:00 of daily nursing ass 11/27/11 to determited form did not containt shift and it did not recertified nurse aided number of staff wornumber of working aides, who were be staff working hours.  On 11/29/11 at 4:45 #1 was interviewed normally completed would not be availated. On 11/30/11 at 9:25 #3 was interviewed daily staffing assign incorrectly. She shat the information on the staff, upon her reabsence. 483.60(c) DRUG REIRREGULAR, ACT	opm, a review was conducted ignments from 11/13/11 to ine sufficient staffing. The in resident census updates per ecord the working hours for is II. There were errors with the king, which skewed the actual hours per discipline. Nurse ing oriented were listed under in the staff who the form was on leave and ble for interview.  If am, the Administrative Staff is the wasn't aware that the ment had been completed a willingness, to correct the form and would in-service eturn from a leave of	F 356	See		
	pharmacist.  The pharmacist must the attending physical	st report any irregularities to eports must be acted upon.		pag	TO THE COLUMN TO	

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	
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F 428	Continued From page	<del>s</del> 58	F 428	F428  1. All residents are pote risk. Residents #45,75,10 orders were clarified 12/	00,9,92	Deach
	by: Based on record rev facility's pharmacist for irregularities to the at Director of Nursing for 100, # 9 & #92) of 10 findings include:	tending physician or the or 5 (Residents # 45, # 75, # sampled residents. The admitted to the facility on e diagnoses including		2. Pharmacy Manager w contacted by DON and ir citation. Date12-19-201 3. Consultant Pharmacis complete and thorough residents and their recor Completed 12-29-2011 4. Pharmacist will meet each month at the conclusion visit to review docum findings for the month.	vas informed of  1 ist did a audit of all rds. with DON usion of nented	Da 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
	assessment dated 08 Resident #45 had me problems.  Review of the telephorevealed that Residen			responsible for monitori Consulting Pharmacists of review and documentation audits are performed month MA 5. Results of Pharmacists review will be discussed	ing the monthly on. Chart onthly with AR audit. s monthly	12000
	were reviewed. Amit September, 2011 MA from 09/21 thru 09/31 November, 2011 MA	on Administration Record) iza was transcribed to the R and was administered 1, 2011. On the October and Rs, Amitiza was not fore was not administered to		meeting monthly.		
	and revealed that the	men review) were reviewed pharmacist had reviewed n 10/13/11 and 11/17/11. ntion of irregularities				

DEPARTI	MENT OF HEALTHY	MEDICAID SERVICES					. 0930-0331
	F DEFICIENCIES	IX1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPI	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI				
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MANS OF DR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
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KINGSWO	OD NURSING CENTER		T :	ــــــــــــــــــــــــــــــــــــــ	BROWNER'S PLAN OF CORRE	CTION	(X5)
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F 428	Continued From pag regarding the Amitiza On 12/01/11 at 11:50 interviewed. He state remember the recomduring his drug regin but he indicated that recommendations.  Copies of the pharm the attending physic and November, 201 no recommendation irregularities for Res Amitiza.  2. Resident # 100 w 09/20/10 with multip Alzheimer's Disease assessment dated Resident #100 had problems.  Review of the telep revealed a doctor's inch to both eyes for there was a new do Lacrilube and to staboth eyes for dry experience.	e 59 a.  O AM, the pharmacist was ed that he could not mendation he had made men reviews for Resident #45 the DON had copies of his facist's recommendations to lian and/or DON for October 1 were reviewed. There were so report of drug sident #45 regarding the  vas admitted to the facility on ble diagnoses including e. The quarterly MDS 08/05/11 indicated that memory and decision making thone orders dated 09/06/11 order for Lacrilube ointment ½ or dry eyes. On 09/07/11, bottor's order to discontinue art Artificial Tears ointment to yes.	F	428			
	transcribed to the	viewed. Lacrilube was October and November, 2011 ministered in October and					
					Facility ID: 970412	if continuation sl	neet Page 60 of 7

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MEDICAID SERVICES  MAD PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FERN OF		345509	B. WIN	3		12/01	/2011
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F 428	On 12/01/11 at 11:14 interviewed. Nurse stated that Lacrilube to the October and it stated that 2 nurses MARs against the lathe order to discontii.  The DRRs (drug regand revealed that the resident's chart. The notes did not margarding the Lacril.  On 12/01/11 at 11:5 interviewed. He state remember the recoduring his drug regil. #100 but he indicated his recommendation.  Copies of the phant the attending physicand November, 20 no recommendation irregularities for Reflection.  3a. Resident #75 in O1/29/09 with multiple assessment dated assessment dated Resident #75 had problems.	O AM, Nurse # 1 was #1 reviewed the chart and was incorrectly transcribed November, 2011 MARs. She were checking the new st month's MARs and missed nue the Lacrilube.  Jimen review) were reviewed e pharmacist had reviewed on 10/13/11 and 11/16/11. Jention of irregularities ube.  JO AM, the pharmacist was ted that he could not mmendation he had made men reviews for Resident ed that the DON had copies of	F	428			

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2011 revealed That Resident #75 was on Risperdal 0.25 mgs at bedtime twice a week on Friday and Saturday for Senile Dementia with Depressive features.  The MARs were reviewed. In September, 2011, Risperdal was transcribed to the MAR to be given twice a week (Friday and Saturday) but was initiated by the nurses daily including that Risperdal was administered daily. In October, 2011, Risperdal was transcribed to be given twice a week (Friday and Saturday) but was initiated by the nurses daily including that Risperdal was investigated by the nurses daily from October 3 thru October, 2011 nidicating that it was administered daily. The October, 2011 midicating that it was administered daily. The October, 2011 MAR also had no nurse's initiate for 10/15 (Saturday), 10/21 (Friday) and 10/28 (Friday) indicating that Risperdal was not administered. The November, 2011 MAR revealed that Risperdal was transcribed to be given twice a week on Friday and Saturday but it was initiated by the nurses from 11/1 thru 11/5 Indicating that it was administered daily.  The DRRs (drug regimen review) were reviewed and revealed that the pharmacist had reviewed the resident's chart on 9/14/11, 10/13/11 and 11/16/11. The notes did not mention of irregulatities regarding the Risperdal.  On 12/01/11 at 11:50 AM, the pharmacist was interviewed. He stated that he could not remember the recommendation he had made during his drug regimen reviews for Resident #75 but he indicated that the DON had copies of his recommendations.  Copies of the pharmacist's recommendations to the attenting physician and/or DON for October	PREFIX		NV MILET BE DRECEDED DI LVEN	PRE	FIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOOFD RE	
Copies of the pharmacist's recommendations to		2011 revealed That Risperdal 0.25 mgs Friday and Saturday Depressive features. The MARs were revealed was transtwice a week (Friday and the nurses daily frozont indicating that The October, 2011 initials for 10/15 (S 10/28 (Friday) indicating that Risperdal tha	Resident #75 was on at bedtime twice a week on y for Senile Dementia with s.  viewed. In September, 2011, scribed to the MAR to be given by and Saturday) but was sees daily indicating that inistered daily. In October, as transcribed to be given twice it Saturday) but was initiated by sm October 3 thru October 7, at it was administered daily.  MAR also had no nurse's aturday), 10/21 (Friday) and cating that Risperdal was not in November, 2011 MAR erdal was transcribed to be at on Friday and Saturday but it is enurses from 11/1 thru 11/5 as administered daily.  Regimen review) were reviewed the pharmacist had reviewed the pharmacist had reviewed the pharmacist had reviewed the pharmacist had reviewed the gimen reviews for Resident #75 that the DON had copies of his		: 428			
		Copies of the pho	armacist's recommendations to /sician and/or DON for October					short Dogg 82 C

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F 428	no recommendation:	1 were reviewed. There were	F	428			
	01/29/09 with multip	as admitted to the facility on ble diagnoses including e. The quarterly MDS 11/01/11 indicated that nemory and decision making					
	2011 revealed That	ician's orders for November, t Resident #75 was on s at bedtime twice a week on by for Senile Dementia with s.	A THE PROPERTY OF THE PROPERTY				
	interviewed She s	5 PM, Nurse #1 was tated that the facility had a g form used to document rs.					
	Resident #75 had the month of Nove September, 2011 behaviors listed.	itoring forms were reviewed. no behavior monitoring form for ember, 2011. The October and monitoring forms had no target					
	and revealed that	egimen review) were reviewed the pharmacist had reviewed rt on 9/14/11, 10/13/11 and					
	Copies of the pha	nmacist's recommendations to sician and/or DON for				sheet Page 63	

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F 428	reviewed There we	and November, 2011 were re no recommendations or s for Resident #75 regarding	F	428			
	interviewed. He stated remember the record during his drug regile but he indicated that recommendations.	O AM, the pharmacist was ed that he could not nmendation he had made men reviews for Resident #75 t the DON had copies of his The pharmacist also I not look at the behavior nuch during his visits.				/	
	#1 was interviewed behaviors should be monitoring forms. In-serviced the nur- monitoring form be over of nurses late	D5 PM, the administrative staff. She stated that target elisted on each behavior. She stated that she had ses on the use of the behavior fore but there was a big turn y. She indicated that she in-service for all the nurses vior monitoring forms.					
	facility on 07/03/06 including Anxiety. assessment dated Resident #9 had n	s originally admitted to the with multiple diagnoses. The quarterly MDS 09/08/11 indicated that noderate cognitive impairment. sician's order for November, it Resident #9 was on Xanax me for Anxiety.					

CENTERS	SEOR MEDICARE &	MEDICAID SERVICES				(X3) DATE SUI	RVEY
TATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	COMPLETED	
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F 428	Continued From pag	e 64	F	428		/	
	On 11/30/11 at 2:35 interviewed. She sta behavior monitoring resident's behaviors	ted that the facility had a form used to document					
	Resident #9 had no	oring forms were reviewed. behavior monitoring form for iber, 2011. The October and onitoring forms had no target					
	and revealed that the	gimen review) were reviewed ne pharmacist had reviewed on 9/14/11, 10/13/11 and					
	the attending physics September, October There w	nacist's recommendations to cian and/or DON for or and November, 2011 were ere no recommendations or es for Resident #9 regarding ehaviors.				\	
	interviewed. He staremember the recoduring his drug regular but he indicated the recommendations.	50 AM, the pharmacist was ated that he could not ommendation he had made limen reviews for Resident #9 at the DON had copies of his The pharmacist also id not look at the behavior much during his visits.					
	00/04/44 with mul	as admitted to the facility on tiple diagnoses including dmission MDS assessment	And the second s				

CENTERS FOR MEDICARE & MEDICAID SERVICES							. 0936-0391
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MIND L DVI OI	COMMEDITOR	0.45500				12/01	/2011
	OVIDER OR SUPPLIER  OD NURSING CENTER	345509	<b>i</b>	91	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	dated 09/13/11 indicated cognitive status was  Review of the physica 2011 revealed that R Seroquel 100 mgs at On 11/30/11 at 2:35 interviewed. She state behavior monitoring resident's behaviors.  The behavior monitoring resident #92 had not the month of Novem September, 2011 monitoring september, 2011 monitoring resident #92 had not the month of Novem September, 2011 monitoristed.  The DRRs (drug regional revealed that the resident's chart of the resident #92 had not the resident's chart of the phaviors listed.  On 12/1/11 at 11:10 interviewed. She stated why Resident #92 had form for November, the behavior monitor target behavior listed MARs at the end of of writing the target.  Copies of the pharm the attending physical september, Octobe reviewed. There we	ated that Resident #92's intact.  ian's orders for November, esident #92 was on bedtime for Psychosis.  PM, Nurse #1 was ted that the facility had a form used to document  ring forms were reviewed.  behavior monitoring form for ber, 2011. The October and onitoring forms had no target  imen review) were reviewed to pharmacist had reviewed to no 10/13/11 and 11/16/11.  AM, Nurse #1 was ted that she did not know and no behavior monitoring 2011. She further stated that ring forms should have a did and the nurses checking the the month were responsible behaviors on the forms.  The acist's recommendations to the sian and/or DON for a rand November, 2011 were the rere no recommendations or the for Resident #92 regarding	F	428			

INDEXENCE CORRECTION  INDEXENDED CORRECTION			MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  SIAMMARY STATEMENT OF DEFIDENCES  GRAND DEFICIENCY MUST BE PRECORDED BY FULL PRICE TAO   CONTINUED THE STATEMENT OF DEFIDENCES  GRAND DEFICIENCY MUST BE PRECORDED BY FULL PRICE TAO   CONTINUED THE STATEMENT OF DEFIDENCES  F 428  Continued From page 66  On 12/01/11 at 11:50 AM, the pharmacist was interviewed. He stated that he could not remember the recommendation he had made during his drug regiment of which the power of the pharmacist was indicated that the DON had copies of his recommendations. The pharmacist also indicated that his DON had copies of his recommendations. The pharmacist also indicated that his DON had copies of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records or receipt and detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically records or receipt and detail to enable and accurate reconciliation, and determines that drug records are with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and permit only authorized personnel to have access to the keys.  The facilit	STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[ ·		COMPLETED
SUMMARY STATEMENT OF DEFICIENCES   PROPERTY AND OF CORRECTION SHOULD BE GRACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IS DISCHIPTIVING REFORMATION)   PROPERTY REGULATORY OR IS DISCHIPTIVING REFORMATION)   PROPERTY REGULATORY OR IS DISCHIPTIVING REFORMATION)   PROPERTY REGULATORY OR IS DISCHIPTIVING REFORMATION)   PROPERTY REGULATORY OR IS DISCHIPTIVING REFORMATION)   PROPERTY REGULATORY OR IS DISCHIPTIVING REFORMATION)   PROPERTY REGULATORY OR IS DISCHIPTIVING REFORMATION   PROPERTY REGULATORY OR IS DISCHIPTIVING REFORMATION)   PROPERTY REGULATORY OR IS DISCHIPTIVING REFORMATION   PROPERTY REGULATORY OR INTERPRECED ROTORY REGULATORY OR INTERPRECED ROTORY REGULATORY OR INTERPRECED ROTORY REGULATORY OR INTERPRECED ROTORY REGULATOR			345509			12/01/2011
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F428   Continued From page 66   Continued From page 67 of Fast 7	KINGSWO					CTION (X6)
P 4.28 Continued From page Co.  On 12/01/11 at 11/150 AM, the pharmacist was interviewed. He stated that he could not semember the recommendation he had made during his drug regimen reviews for Resident #92 but he indicated that the DDN had copies of his recommendations. The pharmacist also indicated that he did not look at the behavior monitoring sheets much during his visits.  F 431 SS=D  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of recipit and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance wilk State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature conirols, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	PREFIX	CAOU DESIGNA	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	OULD BE COMPLETION
during his drug regimen reviews for Resident #92 but he indicated that the DON had copies of his recommendations. The pharmacist also indicated that he did not look at the behavior monitoring sheets much during his visits.  F 431 SS=D  F 431 LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconcilitation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 428	On 12/01/11 at 11:5	O AM, the pharmacist was ed that he could not	F 428		
Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to  and monthly thereafter in QA.  If continuation sheet Page 67 of 7		remember the recorduring his drug regine but he indicated that recommendations. Indicated that he did monitoring sheets in 483.60(b), (d), (e) ELABEL/STORE DR  The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliate records are in orde controlled drugs is reconciled.  Drugs and biologic labeled in accordant professional principal propriate access instructions, and the applicable.  In accordance with facility must store to locked compartment controls, and permit have access to the controlled drugs list controlled drugs l	nmendation he had made men reviews for Resident #92 It the DON had copies of his The pharmacist also I not look at the behavior much during his visits. IRUG RECORDS, UGS & BIOLOGICALS  Inploy or obtain the services of ist who establishes a system It and disposition of all sufficient detail to enable an ion; and determines that drug or and that an account of all maintained and periodically  als used in the facility must be note with currently accepted bles, and include the cory and cautionary the expiration date when  I State and Federal laws, the fall drugs and biologicals in ints under proper temperature it only authorized personnel to the keys.  I story and separately locked, and compartments for storage of sted in Schedule II of the	F 431	1. All expired medications removed from Medication 1. Room on 11/31/11. 2. Central Supply will check stock medications in medic room weekly to rotate stock remove any medications at expire. 3. Medication carts will be twice weekly by night nurse check for any medications thave expired or close to explain the expired or within 14 days of expiration will be removed destroyed or returned to plas required. 5. DON and or her designed a second audit on medication and medication room weekly medication storage Quantity. 6. All audits will be recorded the Medication Storage Quantity. 7. Results of the audit will	storage  call ation k and rout to  audited es to chat biration  ve f and harmacy e will do on carts cly. ed on  be
Event ID: XCC411 Facility ID: 970412		Comprehensive D Control Act of 197	6 and other drugs subject to		and monthly thereafter in (	QA.  If continuation sheet Page 67 of 7:

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	T		- CONCEDUCTION	(X3) DATE SUR	VEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LDING	LE CONSTRUCTION	COMPLETED	
		345509	B. WI	IG		12/0	1/2011
	OVIDER OR SUPPLIER			91	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		
			<u> </u>	Ь	PROVIDER'S PLAN OF CORRECT	TION	(X5)
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F 431	nackage drug distribi	e 67 the facility uses single unit ution systems in which the nimal and a missing dose can	F	431			
	by: Based on observation facility failed to disca	r is not met as evidenced on and staff interview the rd expired medications from edication rooms. Findings					
	200 hall was observed cupboard the following medications were observed to the following medications were observed to the following medications were observed to the following the following the following the following solutions are spiration date of containers of vitaming 10/11), folic acid 800 (unopened with an emucinex 600mg 20 the refrigerator the following follo	served: calcium oyster shell in an unopened 100 tablet date 1/11), two unopened liphate 200 mg (expiration 11), Vitamin E 400 IU 100 soft gels (unopened with 10/11), three 100 tablet B 100 mg (all expired on					
F 441	12/1/11 at 4 PM, she expectation that me for and free of expire	ministrative Staff #1 on e indicated it was her dication rooms were checked ed medications. CONTROL, PREVENT		F 441	1 See next pag		

CENTERS	CENTERS FOR MEDICARE & MEDICAID SERVICES		0/01/11	u TIDI E (	CONSTRUCTION	(X3) DATE SURVEY	
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUIL		OONO MOONO.	COMPLETE	D
AD PERIO	OOMCEONON	345509				12/01	/2011
	OVIDER OR SUPPLIER			915	T ADDRESS, CITY, STATE, ZIP CODE PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			ARE	PROVIDER'S PLAN OF CORRECT	TON	(X5)
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F 441 SS=D	SPREAD, LINENS  The facility must esta Infection Control Prosafe, sanitary and coto help prevent the dof disease and infection Control The facility must est Program under which (1) Investigates, cor in the facility;  (2) Decides what proshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spreadisolate the resident (2) The facility must communicable disease from direct contact direct contact will treat the contact direct contact will treat the spreadisolate the resident (3) The facility must hands after each direct contact will treat contact will treat contact direct contact will treat	ablish and maintain an agram designed to provide a comfortable environment and development and transmission ation.  Program ablish an Infection Control the it - atrols, and prevents infections coedures, such as isolation, an individual resident; and ord of incidents and corrective fections.  ad of Infection to Control Program esident needs isolation to of infection, the facility must asse or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	I.	441	1. All residents are potential risk. 2. All current nurses includir night and weekend nurses we ducated on the process for disinfection of glucometers is SDC Completed 12-03-2013. All new nurses will be train on the procedure for disinfe of glucometers in orientatio SDC will provide the in-ser training. 4. Each medication cart will glucometers. 5. Glucometers will be sanit between each use ,using Swipes to wipe down glucom and then being wrapped in wipe for 2 minutes per manufacturers instructions 6. DON or her designee will random audits of nurses had them demonstrate the promand explain how often to dimachines 2 x each month. 7. Results of audits will be reviewed by DON or design biweekly x4 and then mon Monitoring results will be presented in QA meeting 1 month x 6 months.	ng vere by the 1 ined ction n. The vice have 2 tized ani- neter Sani- I do aving cedure isinfect	State of the state

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WNG	· · · · · · · · · · · · · · · · · · ·	12/0	1/2011
	OVIDER OR SUPPLIER  OD NURSING CENTER	2	915 F	FADDRESS, CITY, STATE, ZIP CODE PEE DEE ROAD RDEEN, NC 28315		
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	Continued From particles of the document review, of failed to properly distinctuded:  Review of the document review, of failed to properly distinctuded:  Review of the document review, of failed to properly distinctuded:  Review of the document review, of failed to properly distinctuded:  Review of the document review, of failed to properly distinctuded:  Review of the document review of the meter or use Stani-Cloth® HB Geometrical review of the document review of the document review of the document review of the document review of the document review of the document review of the document review of disinfect the use of disinfect bacteria, fungi, virus	ge 69  IT is not met as evidenced ion, staff interview and ne (1) of three (3) nurses sinfect a glucometer. Findings  ment titled 'Glucometer eaning/Disinfecting ed) revealed, in part, for the the facility, "Disinfecting er and bleach (or bleach wipe), wel and thoroughly wipe down uper Sani-Cloth® & ermicidal disposable wipes."  ment titled 'ng Glucometers' (dated 'Administrative Policies & ded by the facility read, in part:	F 441			
	surfaces after each manufacturer direct dampened with EP Agency) registered On 11/30/11 at 4:2 using the glucomet Resident #12. She	to use following the tion or wipe with a cloth A (Environmental Protection detergent/disinfectant."  5 PM Nurse #6 was observed ter to test the blood sugar of e used a lancet to obtain a drop t strip that was inserted into				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SUI COMPLET	
		345509	B. WNG		12/0	1/2011
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F 441	wiped the opening inserted with an a the room, dispose and lancet (in the the glucometer inserted with an asteries and lancet (in the the glucometer inserted with an asteries and lancet (in the glucometer inserted with a syabs, a lancet, a medication cup ar Resident #92. She from the medication cup ar Resident #92's reasked to stop for a supplies on top or On 11/30/11 at 4: and was asked if forgotten to do be blood glucose. Near the glucometer with a syabs, a lancet, a medication cup ar Resident #92's reasked to stop for a supplies on top or On 11/30/11 at 4: and was asked if forgotten anything were any special to clean the glucometer with an asteries and with an a she was in Reside On 11/30/11 at 4:	where the test strip was loohol swab. She then exited dof the test strip, alcohol swab sharps container) and placed side the medication cart. Nurse ident #12 the required insulin rosed of the syringe in the Throughout the process she required and performed hand d.  36 Nurse #6 was observed ations into a medication cup for the test strip, along with alcohol a cup of water and the test strip, along with alcohol a cup of water and the then she moved towards from. At that time Nurse #6 was a moment. She then placed the the medication cart.  38 Nurse #6 was interviewed there was something she had fore testing Resident #92's surse #6 did not think she had g. When she was asked if there wipes she was supposed to use meter between uses, she said tree and she had been taught in at the glucometer could be icohol swab; like she did when	F 441			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WIN	G	· · · · · · · · · · · · · · · · · · ·	12/0	1/2011
	ROVIDER OR SUPPLIER  DOD NURSING CENTER			9	REET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		
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F 441	revealed that Admin # the glucometers using medication carts. She taught in staff orientat The instructions on the by Admin #2 and indication cleaned needed minutes. Admin #2 pr #6 regarding the clear expectation that gluco each use. Nurse #6 sthe glucometer as inside the facility was in the prequirements for disintheir licensed nurses,	t2 expected staff to clean the sani wipes on the e also stated that this was ion and annual updates. e sani-wipes were reviewed exated the item that was d to remain wet for 5 rovided education to Nurse ning technique and emeters were cleaned after stated that she would clean	F	441			

This plan of correction shall not JAN 1 3 2012 RINTED: 12/19/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES be construed as an admission ИВ NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES ) DATE SURVEY (XI) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE C STATEMENT OF DEFICIENCIES COMPLETED of fault nor agreement with IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 17X79 the findings of noncompliance. B. WING 12/15/2011 345509 STREET A NAME OF PROVIDER OR SUPPLIER BIS PEThe plan of correction is pro-KINGSWOOD NURSING CENTER ABERI vided pursuant of Federal (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ۱E (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREPIX PRÉFIX DATE ATE Requirements which require REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG an acceptable plan of cor-K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 rection as a condition of SS=E One hour fire rated construction (with 1/4 hour fire-rated doors) or an approved autometic fire continued certification. extinguishing system in accordance with 8.4.1 K 029 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from 1. The kitchen dry stoother spaces by smoke resisting partitions and rage door was fixed doors. Doors are self-closing and non-rated or immediately. field-applied protective plates that do not exceed 48 inches from the bottom of the door are 2. All residents are at permitted. 19.3.2.1 risk for potential harm. 3. Maintenance Supervisor will perform a weekly documented audit of all This STANDARD is not met as evidenced by: facility doors Ix week Surveyor: 27871 Based on observations and staff Interview at for 1 month and approximately 8:30 am onward, the following then 1 x month through items were noncompliant, specific findings out year. include: kitchen dry storage room door failed to close and latch for smoke tight seal. 4. Each documented audit will be reviewed by the 42 CFR 483,70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 038 administrator., K 038 Results of audits will be SS≒E Exit access is arranged so that exits are readily presented at each QA accessible at all times in accordance with section Martenenel Supervisor 1/20/2012 meeting for review and 7.1. 19.2.1 recommendations. KO38-Nex+ Va This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at

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

Ca)

(X8) DATE

TITLE

program participation.

LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE

This plan of correction shall not VINTED: 12/19/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES be construed as an admission **JB NO. 0938-0391** CENTERS FOR MEDICARE & MEDICAID SERVICES ) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE & STATEMENT OF DEFICIENCIES COMPLETED of fault nor agreement with IDENTIFICATION NUMBER: AND PLAN OF CORRECTION ... A BUILDING B. WING \_ the findings of noncompliance. 12/15/2011 345509 STREET A NAME OF PROVIDER OR SUPPLIER 815 PEIThe plan of correction is pro-KINGSWOOD NURSING CENTER **ABERI** vided pursuant of Federal (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 3E PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE ATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Requirements which require TAG an acceptable plan of cor-K 029 NFPA 101 LIFE SAPETY CODE STANDARD K 029 rection as a condition of SS=E One hour fire rated construction (with % hour fire-rated doors) or an approved autometic fire continued certification. extinguishing system in accordance with 8.4.1 K 029 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from 1. The kitchen dry stoother spaces by smoke resisting partitions and rage door was fixed doors. Doors are self-closing and non-rated or immediately. field-applied protective plates that do not exceed 48 inches from the bottom of the door are 2. All residents are at permitted. 19.3.2.1 risk for potential harm. 3. Maintenance Supervisor will perform a weekly documented audit of all This STANDARD is not met as evidenced by: facility doors 1x week Surveyor: 27871 Based on observations and staff interview at for 1 month and approximately 8;30 am onward, the following then 1 x month through items were noncompliant, specific findings include: kitchen dry storage room door failed to out year. close and latch for smoke tight seal. Each documented audit will be reviewed by the 42 CFR 483.70(a) K 038 NFPA 101 LIFE SAFETY CODE STANDARD administrator... K 038 SS≒E 5. Results of audits will be Exit access is arranged so that exits are readily presented at each QA accessible at all times in accordance with section 19,2.1 meeting for review and 7.1. recommendations. This STANDARD is not met as evidenced by: K038-NEX Surveyor: 27871 Based on observations and staff interview at ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other entergended provide aufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 80 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 disclosuble 14 days following the date those documents are made available to the facility. It deficiencies are clied, an approved plan of correction is requisite to continued program participation.

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		& WEDIGAID SERVICES	OVEN MILL TIP	LE CONSTRUCTION	COMPLETED
STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	01 - MAIN BUILDING 01	COMPLETED
		345509			12/15/2011
	NOVIDER OR SUPPLIER	•	91	EET ADDRESS, CITY, STATE, ZIP CODE 5 PEE DEE ROAD BERDEEN, NC 28315	STRON KS
(X4) ID PREFIX TAG		NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JULD BE 1 TYPE TO 1
K 038 K 047 SS=F	items were noncor include: there was system component alarm panel for the unit.  42 CFR 483.70(a) NFPA 101 LIFE S. Exit and directions	am onward, the following inpliant, specific findings not a wiring diagram and its location map adjacent to fire expecial locking in Special care.  AFETY CODE STANDARD in signs are displayed in ection 7.10 with continuous erved by the emergency lighting	K 038	K 038  1. All residents are at risk for potential har 2. The company that originally installed the Special Unit locking system has been contacted.  3. The wiring diagram systems component map will be provide	nm. ne and d to
K 051 SS≔F	Surveyor: 27871 Based on observa approximately 8:3 items were nonco include: kitchen d signs displayed w  42 CFR 483.70(a NFPA 101 LIFE S  A fire alarm syste devices or equipr NFPA 72, National effective warning Activation of the offential systems are the systems extinguishing systems are the systems are the systems.	ations and staff interview at 0 am onward, the following mpliant, specific findings id not have Exit or directional ith continuous illumination.	K 061	the facility by the copany that originally stall the special lock system and then placed adjacent to the fire panel.  4. The administrator was monitor the process completion.  5. Results will be reported to the QA Committed.	in- king aced alarm  vill ss for Supers for Adm. ee.  1/20/2012

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	Taratar		E CONSTRUCTION	(X3) DATE SI	JRVEY
WO DROVE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		345509	B. WIN				5/2011
NAME OF PROVIDER OR SUPPLIER KINGSWOOD NURSING CENTER			J	91	EET ADDRESS, CITY, STATE, ZIP COD 6 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			HODED RE	COMPLETION DATE
K 038	approximately 8:30 items were noncor include: there was	age 1 am onward, the following npliant, specific findings not a wiring diagram and ts location map adjacent to fire a special locking in Special care	K	038	K038 Previou	s gaze	
K 047 SS≒F	Exit and directions	AFETY CODE STANDARD  It signs are displayed in ection 7.10 with continuous erved by the emergency lighting	К	047	<ol> <li>All residents are risk for potential l</li> <li>The 2 required Ex Directional signs to immediately order</li> <li>A certified electric</li> </ol>	narm. it or were .red. ' cian	
K 051 SS=F	Surveyor: 27871 Based on observe approximately 8:3 items were nonco include: kitchen disigns displayed w 42 CFR 483.70(a) NFPA 101 LIFE S A fire alarm syste devices or equipm NFPA 72, National effective warning Activation of the communal fire alarm extinguishing systems steening as	ltions and staff interview at 0 am onward, the following mpliant, specific findings d not have Exit or directional ith continuous illumination.		051	was contacted an Exit or directional were installed in a quired locations.  4. Maintenance Sup or designee will p Administrator wit documented mor all Exit signs 1 x p  5. Results of monito be presented to 0 mittee each monit	signs re- ervisor rovide h a litor of er month. ring will IA Com- th.	

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	T		N E CONCEDIOTION	(X3) DATE SU	RVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		T OF DEFICIENCIES (X1) PROVIDENSUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			TED .	
		345509			12/18	15/2011		
	ROVIDER OR SUPPLIER	TER :		91	EET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	•		
(X4) ID PREFIX TAG	SUMMARY STA	AYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(XS) COMPLETION DATE	
K 051	nurse's stations. Freath of egress, Elets are available power is provided, maintained in accords of mainter. There is remote as	age 2 Pull stations are located in the actronic or written records of A reliable second source of Fire alarm systems are ordance with NFPA 72 and hance are kept readily available innunciation of the fire alarm oved central station. 19.3,4,	K 051		1. All residents are at risk for potential harm. 2. Fire Alarm Company (Diebold) was again contacted and 2 more back up batteries were brought to the facility and installed. 3. After another 24 hrs. for new batteries to charge, the alarm system was tested with positive results.	<ol> <li>All residents are at risk for potential harm.</li> <li>Fire Alarm Company (Diebold) was again contacted and 2 more back up batteries were brought to the facility and installed.</li> <li>After another 24 hrs. for new batteries to charge, the alarm system was tested with positive results.</li> </ol>		
	Surveyor: 27871 Based on observa approximately 8:3 items were nonco	is not met as evidenced by: tions and staff interview at 0 am onward, the following mpliant, specific findings filed to activity when tested on			4. Maintenance Supervise designee will test alarm 1 x per month for 3 m and then quarterly the 5. Results will be present the QA Committee mo	n system onths	Mantenand Supervisor	
K 056 SS⇒E	If there is an autor installed in accord for the Installation provide complete building. The systaccordance with Napection, Testin Water-Based Fire	natic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the tem is properly maintained in IFPA 25, Standard for the g, and Maintenance of Protection Systems. It is fully a is a reliable, adequate water		056	Kosh vext	Daye.		

PRINTED: 12/19/2011 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION . IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	PLE CONSTRUCTION  5 01 - MAIN BUILDING 01	COMPLETED	
	345509				12/15/20	)11
	ROVIDER OR SUPPLIER DOD NURSING CEN	TER	91	EET ADDRESS, CITY, STATE, ZIP COI IS PEE DEE ROAD BERDEEN, NC 28315 PROVIDER'S PLAN OF COF		IX-81
(X4) ID PREFIX TAG	パスペクリ わせごうしほんご	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE 1 VV	(X9) MPLETION DATE
K 058	systems are equip switches, which ar	inued From page 3 ly for the system. Required sprinkler ly for the system. Required sprinkler ly for the system. Required sprinkler ly flow and tamper ly fire alarm system. 19,3,5		<ol> <li>All residents are a risk for potential h</li> <li>Sunland Fire Prote has been contacte have the paperwo that our test of ob</li> </ol>	arm. ection d. They rk show- estruct-	
	Surveyor; 27871 Based on observa approximately 8;3 items were nonco include; facility ha test of obstruction valves were not si			tion is not due und but we have sched It to occur before 3. Both the accelerat and the obstruction be completed bef 4. Results of tests with sented to the QA	duled 1/20/2012. ted valves on test will ore 1/20/2012. Sill be pre-	laigteac upervis ofzola
K 069 SS≃F	Cooking facilities with 9.2.3. 19.3  This STANDARD Surveyor: 27871 Based on observe approximately 8:3 Items were nonconnected in acconnected	AFETY CODE STANDARD are protected in accordance	K 069	1. All residents are risk for potential 2. The deep fat fry moved so that I located under the system. 3. Sunland Fire Properties been contacted. 4. All components system will be seen to a hydrostatic test prior to 1/2. 5. Results of tests presented to Question in the system will be seen to a hydrostatic test prior to 1/2.	of the ubjected pressure	nteac. enisol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPI A, BUILDING	LE CONSTRUCTION  01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED			
	345509	B, WING		12/1	5/2011		
	ROVIDER OR SUPPLIER 1. 1.		ET ADDRESS, CITY, STATE, ZIP COO S PEE DEE ROAD	E			
KINGSW	OOD NURSING CENTER	AE	BERDEEN, 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
K 069	Continued From page 4 exceeding 12 years. 42 CFR 483.70(a)	K 069		/  :			