YALEMENT C	S FOR MEDICARE & 1 OF DIFFICIENCIES CORRECTION	MEDICAID SERVICES  (X1) PROVIDERUSUPPLITRICLIA  (UENTIPICATION NUMBER;	(X2) MULTII A. DUILDING	PLE CONSTRUCTION	(X3) DATE S COMPLS	URVEY ETEO C
		346509	B. WING	4	11/	17/2012
	OVIDER OR SUPPLIER OD NURSING CENTER	3,0000		reey adores9, city, syate, ziṗ code 116 pee dee road Aberideen, nc 28316		and the state of t
(X4) ID PREFIX TAG	ALI ARCIONAL	Atement of deficiencies Y must be preceded by Pull L90 identifying information)	ID PREFIX .1'AG	PROVIDER'S PLAN OF COM (EACH GORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	8HOOFD HIE	COMPLETION
F 168 SS=C	The facility must info and in writing in a lar understands of his or regulations governing responsibilities during facility must also pronotice (if any) of the \$1919(e)(6) of the Amade prior to or uporesident's stay. Recany amendments to writing.  The facility must info entitled to Medicaid of admission to the resident becomes of items and services if facility services under which the resident in other items and service the amount of charginform each resident in items and service (f)(A) and (B) of this The facility must infeat the time of admission to the resident's stey, facility and of chargincluding any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating any chargunder Medicare or the facility must fur infeating and the	orm each resident before, or ston, and periodically during of services available in the ea for those services, es for services not covered by the facility's per diem rate.	F 150	1. All residents are pot at risk. 2. Resident if 59 is no resident of the facil. 3. When a resident is discharged from the Medicare program depending on whet resident has complement, an McCommunication for presented to the Secretes Director. Or Therapy Communication Form will be preparted to the Secretes Director. Or Therapy Communication for Therapy Director of Minimum Data Set Coordinator 7 days discontinuing serve Therapy and or Modicare Communication for minimum Communication f	onger a lity. due to be  her the eted ough the  OS or  rm will be ocial The MOS inication red by the r the is prior to ices. The IDS inication ne of e discharge ischarge next payer e form is ied by the or the	13/14/12
	legal rights which in	icludes:				(X6) DATE

Any descioncy statement ending with an esterisk (\*) denoted a descioncy which the institution may be excused from correcting providing it is determined that other setaguerde provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the standings stated above are disclosable 90 days other setaguerde provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 14 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 deficiencies are cited, an approved plan of correction is requisite to continued 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.

FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) OATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING

· · · · · ·			A. BUI	LDINO			c
		343508	B. WA	IG	*		7/2012
•	ROVIDER OR SUPPLIER DOD NURSING CENTER		SYREET ADDRESS, CITY, STATE, 2IP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315				
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEPICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IO PREF TAG	1	PROVIDER'S PLAN OF CORRECTI (EACH COARECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.0 8E	(X5) COMPLETION DATE
F 156	for establishing eligible the right to request are 1924(c) which determine the right to request are 1924(c) which determine the resource institutionalization and spouse an equitable scannot be considered toward the cost of the medical care in his or down to Medicaid eligible. A posting of names, a numbers of all pertine groups such as the Sagency, the State lice ombudsman program advocacy network, are unit; and a statement complaint with the State agency concerning remisappropriation of refacility, and non-complaint with the State agency concerning remisappropriation of refacility, and non-complaint with the State agency concerning requirement. The facility must completely and non-complaint of requirements include procedures regarding requirements include provide written inform concerning the right to or surgical treatment.	equirements and procedures lity for Medicaid, including a sessesment under section lines the extent of a couple's at the time of a stributes to the community share of resources which available for payment institutionalized spouse's her process of spending libility levels.  Inderesses, and telephone and State client advocacy tate survey and certification insure office, the State, the protection and at the Medicaid fraud control that the resident may file a late survey and certification sident abuse, neglect, and seldent property in the collance with the advance ts.	F	15	or the Social Services Director 7 days prior to ending Medicare services by either the MDS Coordinator or the Therapy Director. The Liability Notice for Medicare Benefits Non-Coverage form will be prepared by the Social Services Director and mailed to the resident representative or the alert and oriented resident by Certified Return Receipt 5 days in advance of loss of benefits. The Social Services Director will provide the alert and oriented resident with a copy of the Liability Notice for Medicare Benefits Non-Coverage form and discuss with them what their plans are at that time The original Notice for Medicare Benefits Non-Coverage form will be sent certified return receipt. The original will be delivered to the alert and oriented resident by the Activities Department through their mall service program. The Social Services Director will keep a record of when she has received the Communication Form, when		1.2 (14)

STATEMENT AND DIAM O	of Depiciencies Correction	(X1) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:	(X2) MI A. 8UIL		CONSTRUCTION	(X3) DATE S	CBTS
		345509	B, Wini	3	and the second s	11	C /17/2012
	OVIDER OR SUPPLIER			915 6	T ADDRESS, CITY. STATE, ZIP COOR PEE DEE ROAD ERDEEN, NC 28315		
(X4) ID PREFIX TAG	(GACH DEFICIENC	TATEMENT OF OFFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PI,AN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULDRE	COMPLETION DATE
F 158	policies to implement applicable State law.  The facility must info name, specially, and physician responsible.  The facility must prorwritten information, a applicants for admiss information about no Medicare and Medicare and Medicare and Medicare for posuch benefits.  This REQUIREMENT by:  Based on observation with residents, family to give advance notice for 1 of 3 residents (focurrent state agency failed to ensure resident of the findings include:  1. On 11/16/12 a receive the Liability Notices of Non-Coverage, it revivas admitted to the findings that on 8/16/12 her Not meeting therapout	scription of the facility's advance directives and advance directives and a many of contacting the se for his or her care.  Ininently display in the facility and provide to residents and sion oral and written who apply for and use aid benefits, and how to revious payments covered by  It is not met as evidenced ons, record review, interviews and staff, the facility failed be of Medicare non-coverage Resident #59); failed to post contact information and lents are knowledgeable lights.	f	156	she sent the Liability is and the date she received the green certified reconnected to the Administrator1 x perfor auditing purposes Administrator will conthe correctness of the and make notes on the of audit findings. This serve as our audit too 4. Social Services Director present audit results Quality Assurance Committee 1 x permeter a months and their quarterly thereafter.  5. The corrected state conformation has been enlarged and posted a level that wheelchair residents can read. The administrator will man calendar for the first is of each month to be to the Administrator will through the building it review all posted.	elves celpt be week The afirm e log will bl. br will to the bonth n bontact at a he rk her Friday the day il walk	19/14/12

	of deficiencies F correction	(DENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	COMPLET	
•		346508	g. WN	G		1	C 1 <b>7/2012</b>
	ROVIDER OR SUPPLIER DOD NURSING CENTER	<u></u>		91	BET ADDRESS, CITY, STATE, ZIP COOG 5 PEE DEE ROAD BERDEEN, NC 28316		
(X4) ID PREFIX TAG	(BACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PACCEDED BY FULL. LSC IDENTIFYING INPORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(XS) COMPLETION OATE
F 156	On 9/24/12, Resident from Administrative is Medicare services with meeting therapeutic on 9/24/12.  The Administrative is 11/16/12 at 4:06 pm. aware of how many or required to give the I responsible parties (in generally the therapeutic goals be attempts to call the funreachable after 2 to certified letter through the resident was alter directly to the resident was alter directly to the resident #59 initially want Resident #59 initially want Resident #59 initially want Resident #59 to recent sudden death thought, he gave the permission to make a #59, who signed the ended.  2. On 11/13/12 at 12 contact information was last revised 02/0 as The Division of Fe outdated phone number 1/25 at 12 contact information of poutdated phone number 1/25 at 12 contact information of Fe outdated phone number 1/25	I #59 received a 2nd notice Staff #5 that her current ould end on 9/24/12 due to goels. She signed the form  Itaff #5 was Interviewed on She stated that she was not days in advance that she was lability notice to residents or RP). She stated that repartment told her 3 to 5 overage ending, due to long met. She stated that she RP and if they are o 3 calls, she sent out a himall. If she was aware that it and oriented, then she went out for a signature.  In she contacted the RP for he expressed that he didn't is be approached due to in their family. After some Administrative Staff #6 direct contact with Resident form, the day after service  It is pm, the state agency was found on a bulletin board e's station. The information or and listed the state agency was found mailing address. Ided for the Complaints	F	156	Information for corrects The Administrator will present the audit result the Quality Assurance Committee 1 x per mon 12 months.  6. The Activity Director has written up a Grievance is concerning Resident #13 missing angels. She call the resident's family member who explained mom is always moving it angels, hiding her angels even giving them away a doesn't remember what did with them. The Activity Director added this information to the completed grievance for and turned it into Social Services 11-27-12. The Activity Director then too blank Grievance form do to resident #13 to explain the facility's process for resolving grievances including searching a resident's room, sometim searching neighboring resident's rooms and talk to staff and family about what could have happened Two days (at 4c the	ts to  oth x  d  Form  3  ed  that  ner  s or  and  t she  vity  m  ok a  own  n	13/10/13

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/BUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND REAN OF CORRECTION A. BUILDING C B. WNG 11/17/2012 345509 STREET ADDRESS, CITY, STATE, ZIP GODE NAME OF PROVIDER OR SUPPLIER 816 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID JEACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAĠ TAG DEFICIENCY 12/14/12 Administrator visited with F 156 F 156 Continued From page 4 resident #13 and noticed that the angels were back in On 11/13/12 at 5:00 pm, during a family interview resident's room. for a newly admitted resident, the daughter 7. The Administrator ininquired where she could find the state agency serviced the Activity Director Information in the event; she needed to contact the agency. She was given the location of the and the Social Services bulletin board and informed that the information Director on the importance would be updated by the facility later in the week. of discussing residents rights and the location of the On 11/14/12 at 11:30 am, the state contact facility Survey Results during information from 2007 remained on the bulletin each resident Council board. Meeting. The Social Services The Administrative Staff #1 was contacted on Director is responsible for 11/14/12 at 11:37 am. She stated that she was presenting at least 2 ultimately responsible for monitoring the state resident rights for discussion resources board for accuracy, but was unaware that their form was not current. She removed the and the location of the old information and shared that she would make facility Survey Results during sure that the form was updated, printed larger each meeting. During the and lowered to eye level for residents who may sit Resident Council Meeting for In wheelchairs, On 11/15/16 at 4:30 pm, the December, all Resident bulletin board listed current state contact Rights were discussed. The information. Social Services Olrector will On 11/17/12 at 3:40 pm, the Administrative Staff track which resident rights #8 was interviewed. She stated that she have been discussed each facilitated the monthly resident council meetings month to assure that all and did not discuss in the meetings, how a resident rights have been resident could contact the state agency if there discussed throughout the were concerns. She also acknowledged that she did not know the name of the state agency that year. regulated nursing homes but would inquire with 8. The Activity Director will other staff if a resident inquired. Include a description of the council's discussion of the 3. On 11/17/12 at 3:30 pm, an Interview was held resident's right and which with the Resident Council President, Resident

#13. She stated that she had lived at the facility

PRINTED: 12/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDEN'TIFICATION NUMBER: COMPLETED A. BUILDING Ċ 8. WING 345509 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (BACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE YAG TAG DEFICIENCY) F 156 Continued From page 5 F 156 12/14/12 ones were discussed in the for many years and in the past, the Social Worker minutes of the resident would attend their meetings and discuss resident council meeting. This will be rights, but that hadn't happen for a long time. She presented to the Quality stated that at their monthly resident council Assurance Committee 1 x meetings, no one reviewed Resident Rights. monthly x 12 months. Resident #13 reported that she alorted staff recently that she had some missing property, and although her room was searched, nothing else happened. She commented that she was unclear what the expectations should be, after reporting stolen property. The Administrative Staff #6 was interviewed on 11/17/12 at 3:35 pm. She stated that she had been involved with the Resident Council meetings for two years and does not discuss resident rights at the moetings. She also shared, that the social worker does not attend the meetings to present resident rights to the residents in attendance. F 159 F 159 483.10(c)(2)-(5) FACILITY MANAGEMENT OF F159 PERSONAL FUNDS SS≃B 1. All residents are potentially 12/14/10 at risk. Upon written authorization of a resident, the After the Resident Trust Fund facility must hold, safeguard, manage, and Account was reconciled, the account for the personal funds of the resident interest was calculated for all deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. residents with resident trust funds. Our Business Office The facility must deposit any resident's personal Manager has a program that funds in excess of \$50 in an interest bearing automatically calculates the account (or accounts) that is separate from any of interest once the information the facility's operating accounts, and that credits all interest earned on resident's funds to that in entered by the Business account. (In pooled accounts, there must be a Office Manager. The Interest separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest

amounts were calculated and posted to the appropriate

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	2012
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315  ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
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DEFICIENCY	(X6) COMPLETION DATE
bearing account, interest-bearing account, or potty cash fund.  The facility must establish and maintain a system that assures a full and complete and separate accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.  The system must preclude any comminging of resident funds with facility funds or with the funds of any person other than another resident.  The individual financial record must be available through quenterly statements and on request to the resident or his or her legal representative.  The facility must notify each resident that receives Modicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident may lose eligibility for Medicaid or SSI.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview, the facility failed to apply monthly interest since March, 2012 to 3 of 3 sampled residents (Resident # 6, #33 and #124 had the Interest posted to their accounts and then checks were processed for the full amount owed. Checks for residents #6, #33 and #124 were mailed out to the appropriate parties by the Business Office Manager.  3. Each month after the Resident Trust Fund Account will be posted to their accounts. This process should be completed by the Business Office Manager by the 10 <sup>th</sup> of each month.  4. Each week the Business Office Manager will run a surmany report of the Resident Trust Fund Accounts showing individual balances and the total balance for all accounts. This surmany will be presented to the Administrator to audit for monthly interest posted to their accounts. This surmany will be presented to the Administrator to audit for monthly interest posted in the surface of the full amount owed. Checks for residents #6, #33 and #124 were mailed out to the langer of the full amount owed. Checks for residents were provided to t	a щ(13

Statement of deficiencies And-Plan of Correction		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED	
		345509	345509 B. WNG		44/	C
	ROVIDER OR SUPPLIER	R	s	TREET ADDRESS, CITY, STATE, ZIP COD 918 PEE DEE ROAD ABERDEEN, NC 28315		17/2012
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCE) TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETION DATE
TREATMENT WITH THE REAL PROPERTY OF THE PROPER	resident trust fund a Resident #124 had \$140,30 and receive \$0.12 on 2/29/12, w \$2,281.12.  The Administrative 3 11/16/12 at 9:50 am hired into her position was still receiving or office procedures.  She confirmed that is since 2/29/12 becauted it and post it frommented that she corportrate trainer to interest payments to account.	ecord review was conducted of account files. It revealed that an account balance of ed her last interest payment of hen her balance was  Staff # 6 was interviewed on some shared that she was an during February, 2012 and ingoing training for business interest have been suspended se she didn't know how to for the residents. She is was still waiting for her is give her direction on posting the resident trust fund cord review was conducted of ecount files. It revealed that	F 15		y bond ry will strator's Manager alts to	13/14/13
t de la decembration de la company de la com	her initial deposit on The Administrative S 11/16/12 at 9:50 am. hired into her position	of received any interest since 7/19/12.  taff # 6 was interviewed on She shared that she was of during February, 2012 and going training for business				
	She confirmed that in since 2/29/12 becaus divide it and post it fo	nterest have been suspended se she didn't know how to or the residents, She was still waiting for her				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING C B, WNG 346508 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES iD (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REQULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEPICIENCY · # 159 Continued From page 8 F 159 corportrate trainer to give her direction on posting interest payments to the resident trust fund account. 3. On 11/15/12, a record review was conducted of resident trust fund accounts. It revealed that Resident #6 had an account balance of \$778.00 and had not received any interest since her initial deposit on 10/4/12. The Administrative Staff # 6 was interviewed on 11/16/12 at 9:50 am. She shared that she was hired into her position during February, 2012 and was still receiving ongoing training for business office procedures. She confirmed that interest have been suspended since 2/29/12 because she didn't know how to divide it and post it for the residents. She commented that she was still waiting for her corportrate trainer to give her direction on posting Interest payments to the resident trust fund account. F 160 483,10(c)(6) CONVEYANCE OF PERSONAL F 160 F160 FUNDS UPON DEATH SS≖B 1. All residents are potentially 12/14/12 at risk. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey 2. Each month after the within 30 days the resident's funds, and a final Resident Trust Fund Account accounting of those funds, to the individual or is reconciled, the interest is probate jurisdiction administering the resident's calculated for all residents estate. with resident trust funds by the Business Office Manager. This REQUIREMENT is not met as evidenced The calculated interest amounts are posted to the

Based on record review and staff interviews, the facility failed to convey funds for 2 of 3 expired

PRINTED: 12/04/2012
FORM APPROVED
OMB NO, 0938-0391

IPLE CONSTRUCTION (X3) DATE SURVEY

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDEWSUPPLIERICLIA IDEMNAICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
,	į	345509	8. WA	IG	- Ad	11/	C 17/2012	
	ROVIDER OR SUPPLIER DOD NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  916 PEE OEE ROAD  ABERDEEN, NC 28315					
(X1) IÜ PREFIX TAĞ	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	10 PREF YAG		Provider's Plan of Corre (Each Corrective action sh Cross-referenced to The App Deficiency)	OULD BE	(KS) ODMPLETION OATE	
F 160	residents (Residents a days of their deaths.)  The findings include:  1. On 11/15/12, a recin the business office, Staff #6. It revealed the admitted to the facility 6/6/12. At the time of \$3534.24 in her reside the finding and the resident three additionability payments from death, leaving a balanthere was also a \$10 cebla service.  The Administrative Staff/1/15/12 at 9:30 am, \$11/15/12 at 9:30 am, \$11/15/12 at 9:31 am and the clerk of contact the clerk of contact the service of the clerk of contact the service of the clerk of contact the clerk of	ord review was conducted along with Administrative that Resident #124 was fron 10/5/10 and expired on the death, she had ent trust fund account.  I showing transactions from the trust fund account, after her trust account, after her account with the facility on all personal medical in the trust account, after her account for June aff #8 was interviewed on the stated that Resident in her account because she arsonal medical liability out account, then send her	F.	180	appropriate accounts be Business Office Manage Residents #6, #33 and #had the interest posted their accounts and their accounts and their accounts and their accounts were processed the full amount owed. Checks for residents #6 and #124were mailed to appropriate parties by the Business Office Manager will run account summary report the Resident Trust Fund Accounts showing indivibalances for all account This summary will be presented to the administrator weekly. It administrator will use the tool to audit the month interest postings, refund deceased residents and verify that the account the does not exceed our Sur Bond amount. During the weekly audit the need for a refund to deceased resident is for the paperwork, etc. need.	for  124 to  for  133 the he r. an t of  dual s.  The his ly ls for to otal rety , if	S  11  13	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/04/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B, WNG 345509 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE KINGSWOOD NURSING CENTER 815 PEE DEE ROAD ABERDEEN, NC 28315 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X3) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 161 Continued From page 11 F 161 F161 12/14/12 The facility must purchase a surety bond, or 1. All residents with Resident otherwise provide assurance satisfactory to the Trust Funds are potentially at Secretary, to assure the security of all personal funds of residents deposited with the facility. A Surety Bond for \$70,000,00 was received by the This REQUIREMENT is not met as evidenced Administrator. Each week the Business Based on record review and staff interviews, the Office Manager will run a facility failed to provide sufficient coverage for the summary of the Resident resident trust fund account. Trust Fund accounts showing The findings include: individual balances and the total balance for all resident On 11/15/12, a record review was conducted in accounts. The summary will the business office, regarding the resident trust fund accounts. The Administrative Staff #6 was be presented to the interviewed at 9:30 am and esked to produce a Administrator weekly. The copy of the surety bond. Administrator will use this tool to audit and monitor The surely bond was reviewed and revealed that monthly interest postings, it was in effect from 1/15/12 to 1/15/13, and refunds for deceased protected the resident trust fund account up to \$40,000. residents and to verify that the account total does not The Administrative Staff #6 produced a balance exceed our Surety Bond report, dated 11/15/12, representing all funds in amount. the resident trust fund account, which totaled 4. The Business Office Manager \$68,014.36. She acknowledged that she hadn't will present the audit results deducted payments yet for the personal medical liablifies, which would reduce the balance. to the Quality Assurance Committee 1 x per month for On 11/15/12 at 9:45 am, the Administrative Staff 12 months. #1 was informed that the surety bond had insufficient coverage for the resident trust fund account. She stated that she would contact the corporate office and make sure that the bond was

increased.

VAID LIVE OF CORRECTION		ERVSUPPLIER/CLIA CATION NUMBER:	1	JULIPLE CONSTRUCTION	(X3) DATE S COMPL	
			A. OUILI	the state of the s		
		345509	B. WNG		4.4	C 47/2042
NAME OF PROVIDER OR SU	G CENTER			STREET ADDRESS, CITY, STATE, ZIP OC 815 PEE DEE ROAD ABERDEEN, NC 28318		17/2012
PREFIX (EAC)	UMMARY STATEMENT OF D 1 DEFICIENCY MUST BE PRE LATORY OR LSC IDENTIFYIN	CEOED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T ORFICIENC	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
On 11/16/1 #1 produce corporate o been Increa resident tru \$27,271.04 483.10(g)(1 READILY A A resident h the most rec Federal or S correction in The facility r examination accessible to their evallab  This REQUIL by: Based on re interviews, th residents we of the state of The findings On 11/15/12 reviewed from 2012. The no the location of oriented resid reflected that	REMENT is not met as cord review, resident a ne facility failed to ensu- re knowledgeable about turvey results.	rom the at the bond had alance of the on lowered to osted.  RESULTS -  the results of ly conducted by y plan of the facility.  available for accereadily cost a notice of sevidenced and staff are that but the location discussion of alert and are minutes.	F 16	5167	ctor spoke I and I and I and I collity Survey I, Ir in- Ity Director Vices Inportance Its rights If the Its at each	10/14/12

PRINTED: 12/04/2012 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAYE SURVEY ANP AN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING C B. WNG 345509 11/17/2012 NAME OF PROVIOUR OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 016 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG YAG CROSS-REFERENCED TO THE APPROPRIATE OATE DEFICIENCY F 167 Continued From page 13 F 167 12/14/12 4. The Administrator will each month review the meeting On 11/17/12 at 3:30 pm, Resident #13 was minutes to determine if interviewed about the monthly resident council these issues are being meetings. She stated that attended regularly and discussed each month. that she was aware of the kind of the information that was contained in a survey results book but 5. The Activity Director will she did not know where the book was located in include in the meeting the facility. minutes a description of the council's discussion of these On 11/17/12 at 3:40 pm, the Administrative Staff #8 was interviewed. She shared that she had Issues and present to the been in her position for two years and facilitated Quality Assurance the monthly resident council minutes. She stated Committee 1 x monthly x 12 that she does not review the location of the state months. survey results book with the residents attending the council meetings, <u>F 226</u> F 226 483, 13(c) DEVELOP/IMPLMENT F 226 1. All residents are potentially at 12/14/12 SS=E ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written 2. NA #9 sent home on 11/15/12. policies and procedures that prohibit Fingerprints obtained and mistreatment, neglect, and abuse of residents and misappropriation of resident property. resubmitted to North Carolina State Bureau of Investigation for National Criminal Background This REQUIREMENT is not met as evidenced Check on 11/16/12. Employee #9 bγ: has not returned to work at this Based on document review and staff Interview time and will be allowed to return the facility failed to obtain a national criminal background check for 1 of 1 staff (NA #9) known to work as soon as National to reside out of state, and failed to determine if a Criminal Background Check results national criminal background check was required returned with no issues identified. prior to employment for 5 of 5 staff (NA # 5, NA #6, NA #7, NA #8, NA #10): 3. NA # 5, #6, #7, #8, and #10 all had completed 5 year address The findings included:

history completed on 11/16/12.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERICLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY "In of Correction IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 345509 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 913 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE YAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCYL 12/14/12 4. All new applicants will F 226 Conlinued From page 14 F 226 complete a S year address history 1. Review of the facility document dated as modified 5/4/09 and titled "Administrative Policies with application by Staffing and Procedures Background Checks" revealed Coordinator "At present this state law requires only State 5. Director of Nursing or Assistant Wide background check for all employees working in a Long Term Care facility." There was Director of Nursing when conducting also a hand written note that read "5 yrs or < Interview will go over each (years or less) in State must obtain fingerprint cards, for federal check". applicant's addresses for the last 5 years to confirm address history Review of the employee file for NA #9 revealed upon interview of each the current residence address on her application was an out of state address (South Carolina). perspective employee. There was no information in her employee file to 6. Any perspective employee who Indicate she had lived in the State of North meets the criteria for requiring a Carolina for the 5 years prior to hire at the facility. National check will be given a Interview with Administrative Staff #7 on 11/15/12 fingerprint card and application at 11 AM revealed she was aware that State law will be held until card is returned. required a national criminal background check for any new employee that had not resided in North Fingerprint card will then be sent Carolina for the five years prior to the date of hire off for Background check by and acknowledged NA #7's South Carolina Staffing Coordinator address Indicated a national background check should have been done. She stated that she 7. No one will be hired until recalled NA #7 submitting finger print cards prior acceptable Criminal Background to hire but she did not know what had happened Check is received and approved by to it and did not have the results of the national background check. She indicated that NA #7 the Administrator. would not work further shifts until a national 8. Human Resources will audit background criminal history check was completed. applications and Criminal Background Information sent to 2. Review of the facility document dated as State Bureau of Investigation and modified 5/4/09 and titled 'Administrative Policies and Procedures Background Checks" report findings in Quality revealed " At present this state law requires only Assurance Meeting. Audits will be

State Wide background check for all employees

DEPAR	TMENT OF HEALTH A	ND HUMAN SERVICES					'ED: 12/04/2012 RM APPROVED
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4 40 BMAN	ROVIDER OR SUPPLIER		<del></del>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	11	/17/2012
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	working in a Long Terrwas also a hand writted (years or less) in State cards, for federal check or Review of the employee the facility member at the facility member at the facility member and was in address history for the listed. Also there was whether or not NA #5 r for less than 5 years proposed for a facility of the last law required background check for a not resided in North Caprior to the date of hire. The employee file for Nationalist information that indicate recent hires had resided past 5 years of not. Shobtain this information to the provide a 5 year address of 11/16/12 at 9 AM Acceptated that NA #5 had address history and had Carolina for the past 5 year of not address history and had Carolina for the past 5 year of not address history and had Carolina for the past 5 year of 11/16/12 at 3:30 PM	m Care facility." There in note that read "5 yrs or ate must obtain fingerprint k".  oyee file for NA #5, a by revealed the staff dread was listed on North Carolina but no previous 5 years was no information to indicate esided in North Carolina for to the date of hire.  Interview with revealed she was aware a national criminal any new employee that had rolina for the five years. She acknowledged that A #6 did not have any ed whether or not these d in North Carolina for the e stated that she would by asking them each to s history.  Iministrative Staff #7 I completed a five year I all resided in North ears.  during interview with the acknowledged that by ddress prior to hire the owing whether or not et the State criteria for	F .	226	done weekly x4 weeks, mont 3months, and quarterly there and reviewed by the Director Nursing in monthly Quality Assurance meeting.	after	13/14/12

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STA LUMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S COMPLU	URVEY
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F 226	Continued From pag	•	F	226	)	
	recent hire at the face member's current application and was address history for the listed. Also there we whether or not NA fill for less than 5 years. On 11/15/12 at 11 And Administrative Staff that State lew require background check for resided in North prior to the date of the employee file for information that indirecent hires had respect to years of not, obtain this information provide a 5 year address history and Carolina for the past c. Review of the employee file for the past c. Review of the employee file for the past c. Review of the employee file for the past c. Review of the employee file for the past c. Review of the employee file for the past c. Review of the employee file for the past c. Review of the employee file for the past c. Also there we whether or not NA file	#7 revealed she was aware and a national criminal or any new employee that had Carolina for the five years afre. She acknowledged that r NA #8 did not have any cated whether or not these ided in North Carolina for the She stated that she would on by asking them each to dress history.  M Administrative Staff #7 had completed a five year had all resided in North to years.  Inployee file for NA #7, a cility revealed the staff address was listed on in North Carolina but no he previous 5 years was as no information to indicate if resided in North Carolina a prior to the date of hire.				ol Press 12 of 52

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 ERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEPICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C 11/17/2012 B. WING . 345509 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 016 PER DEE ROAD ABERDEEN, NC 28315 KINGSWOOD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH CORRECTIVE ACTION SHOULD BE OATE PREFIX (X4) (O (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX YAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAO F 226 Continued From page 17 F 228 Administrative Staff #7 revealed she was awere that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years prior to the date of hire. She acknowledged that the employee file for NA #7 did not have any Information that indicated whether or not these recent hires had resided in North Carolina for the past 5 years of not. She stated that she would obtain this information by asking them each to provide a 5 year address history. On 11/16/12 at 9 AM Administrative Steff #7 reported that NA #7 had completed a five year address history and had all roulded in North Carolina for the past 5 years. On 11/16/12 at 3:30 PM during interview with Administrative Staff #2 she acknowledged that by only asking for current address prior to hire the facilly has no way of knowing whether or not potential employees most the Stale criteria for having a national criminal background check. d. Review of the employee file for NA #8, a recent hire at the facility revealed the staff member 's current address was listed on application and was in North Carolina but no address history for the previous 5 years was listed. Also there was no information to indicate whether or not NA #8 resided in North Carolina for less than 5 years prior to the date of hire. On 11/15/12 at 11 AM interview with Administrative Staff #7 revealed she was aware that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 C. ERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XX) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF OFFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION C 11/17/2012 B. WNO \_ 345500 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 916 PEG DER ROAD ABERDEEN, NC 28316 KINGSWOOD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES LEACH CORRECTIVE ACTION SHOULD BE PREFIX Cross referenced to the appropriate (BACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) 10 REGULATORY OR LSC IDENTIFYING INFORMATION) YAG PREFIX DEFICIENCY) TAG F 226 Conlinued From page 18 F 226 prior to the date of hire. She acknowledged that the employee file for NA #8 did not have any information that indicated whether or not these recent hires had resided in North Carolina for the past 5 years of not. She stated that she would obtain this information by asking them each to provide a 5 year address history. On 11/16/12 at 9 AM Administrative Staff #7 reported that NA #8 had completed a five year address history and had all resided in North Carolina for the past 5 years. On 11/16/12 at 3:30 PM during interview with Administrative Staff #2 she acknowledged that by only asking for current address prior to hire the facility has no way of knowing whether or not potential employees meet the State criteria for having a national criminal background check. e. Review of the employee file for NA #10, a recent hire at the facility revealed the staff member's current address was listed on application and was in North Carolina but no address history for the previous 5 years was listed. Also there was no information to indicate whether or not NA #10 resided in North Carolina for less than 5 years prior to the date of hire. On 11/15/12 at 11 AM Interview with Administrative Staff #7 revealed she was aware that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years prior to the date of hire. She acknowledged that the employee ille for NA #10 did not have any Information that indicated whether or not these recent hires had resided in North Caroline for the

PRINTED: 12/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA JENT OF DEFICIENCIES COMPLETED ANU PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 8. WNG \_\_\_ 345500 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 916 PER DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NO 28316 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) IO (CACH CORRECTIVE ACTION SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉPIX DYTE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSG IDENTIFYING INFORMATION) YAG TAG DEFICIENCY) F 226 F 226 Continued From page 19 past 5 years of not. She stated that she would obtain this information by asking them each to provide a 5 year address history. On 11/16/12 at 9 AM Administrative Staff #7 reported that NA #10 had completed a five year address history and had all resided in North Carolina for the past 5 years. On 11/16/12 at 3:30 PM during interview with Administrative Staff #2 she acknowledged that by only asking for current address prior to hire the facility has no way of knowing whether or not potential employees meet the State criteria for having a nellonal criminal background check. £278 F 278 F 278 483,20(g) ~ (I) ASSESSMENT 12/14/12 ACCURACY/COORDINATION/CERTIFIED 1. All residents are potentially at \$S≂B risk. The assessment must accurately reflect the 2. MDS assessments for residents resident's status. H4, #24, I/30, I/36, I/37, and I/41 A registered nurse must conduct or coordinate corrected and resubmitted by the each assessment with the appropriate Minimum Data Set Coordinator. participation of health professionals. 3. All Minimum Data Set A registered nurse must sign and certify that the Assessments audited by Minimum assessment is completed. Data Set Coordinator, Director of Each Individual who completes a portion of the Nursing, Assistant Director of assessment must sign and certify the accuracy of Nursing, and Clinical Care that portion of the essessment. Coordinator using Minimum Data Under Medicare and Medicaid, an Individual who Set Audit tool. Inaccuracles

willfully and knowingly certifies a material and

subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual

false statement in a resident assessment le

Coordinator.

corrected by Minimum Data Set

	MENT OF DEFIDIENCIES (X1) PROVIDEIVSUPPLIEUCLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING		COMPLETED				
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	to certify a material ar resident assessment in penalty of not more the assessment.  Clinical disagreement material and false state that the color of the certification of the ce	and false etatement in a subject to a civil money an \$5,000 for each does not constitute a sement.  Is not met as evidenced at loacurately code (IDS's) for 8 (Residents #4, 6 #41) of 27 residents. The coadmitted to the facility on unstageable pressure to left heat ulcer was at the right continued. The ear Progress Report!  12, 10/25/12 and 10/31/12, and 10/31/12, and 10/31/12 and 10/31/12, and 10/31/12 at 3:34 PM, indicated she coded the skin/Wound QI Log", a weekly by the treatment, Administrative Staff #4 and QI Log dated 10/31/12 was listed as having a		278	4. Minimum Data Set Coordinurse in-serviced by the Di of Nursing on proper codin restraints versus enablers. 5. Treatment nurse in-serv Director of Nursing on proper staging of wounds and how complete the weekly woun report and documentation. 6. Social Services Coordina serviced on proper coding of Minimum Data Set assessment behaviors by Director of Nursing review of nurses a for documentation in look be period. 7. Audit of 30% of Minimum Data assessments completed eveek up to 5 Minimum Data assessments per week will be weekly x4 weeks, then mon months, then quarterly by the of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Clinical Care	rector g of liced by per to d tor In- of t for lirsing notes pack Data each Set done thly x3	13/14/12

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ANGEL AN OF CORPECTION (X2) MULTIPLE CONSTRUCT ANGEL AND OF CORPECTION

	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SI COMPLE	
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KINGSWO	ROVIDER OR SUPPLIER  DOD NURSING CENTER  SUMMARY ST	ATEMENT OF DEFICIENCIES	918	EY AODRESS, CITY, STATE, ZIP CODG PEE ORE ROAD ERDEEN, NC 28316 PROVIDER'S PLAN OF CORRE	and American September 2000 and a september 2000 an	(×5)
(X4) ID PREFIX TAG	(each deficienc	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
F 2.78	Treatment Nurse Indicand Resident #37's probeen listed as unstage Log.  During an Interview or Administrative Staff #1 log to reflect what was Weekly Pressure Ulco added that the MDS in the data recorded on the data recorded on 2. Resident #36 was a 10/12/12. Diagnoses Infection.  Nurse's notes dated 1 Resident #36 was comedications, and was combative towards not 10/19/12 was coded to no behavioral symptom 10/19/12 was coded to no behavioral symptom 10/13/12 - 10/19/12.  During an Interview or Administrative Staff #2 reviewed nurse's note and acknowledged tha #36's behaviors incom 3. Resident #30 was a 5/9/07. Diagnoses incident The quarterly Minimum 11/4/12, was coded to the stage of	cated she made an error ressure ulcer should have eable on the Skin/Wound QI  11/17/12 at 9:27 AM, 2 stated she expected the a recorded on the resident's er Progress Report. She turse and physician rely on the log.  admitted to the facility on included urinary tract  0/13/12 at 6AM indicated in fused, refused care and physically and verbally resing assistants.  Im Data Set (MDS) dated or indicate Resident #36 had ms or rejection of care from 11/16/12 at 2:63 PM, 5 stated she normally a prior to coding MDS's, at she had coded Resident ectly.	F 278	Coordinator, or any appropriation of Nursing. Minimum Oata Sassessment Quality Assurance audit tool will be completed by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Clinical Care Coordinator.  8. Results of MDS audit will presented in Quality Assurance meeting monthly x 3month quarterly thereafter by the Director of Nursing	or et ice or, I be nce	(A   IU   12

#### PRINTED: 12/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u> QMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C D. WNG 345509 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET AUDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28316 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION! CROSS REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 278 Continued From page 23 F 278 During interview with Administrative Staff #2 on 11/16/12 at 3:30 PM she stated that the half rails on Resident #24's bed were not a restraint as she just used them as an enabler for turning with her good arm and did not try to get out of bod. She added that the seatbelt in Resident #24's chair was not a restraint as the resident could undo it and in addition it was put on her chair at her request several years ago. Ouring interview with Administrative Staff #4 on 11/16/12 at 4 PM she indicated that she coded all side ralls and wheetchair seal belts as restraints because there was no other place to include them on the MDS. She further indicated she was not aware It was incorrect to code these devices as a restraint, if that was not their function, but that she clerified in the Care Area Assessment that these devices were not physical restraints and therefore did not proceed to care plan, 5. Resident #4 was admitted to the facility on 3/28/12. Diagnoses included cardiovascular accident. The quarterly Minimum Data Set (MDS) dated 8/29/12, revealed the resident was cognitively intact. The MDS was coded to indicate the resident used bed raits as a restraint. During an interview on 11/14/12 at 10:36 AM, Nursing Nurse #3 indicated that Resident #4 was not capable of getting out of bed on her own and never tried to get out of bed on her own. She added that the half rails on the bed were enablers for turning and repositioning. During interview with Administrative Staff #2 on

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 8. WNG \_\_\_\_ 346609 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 916 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (8x) Completion (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) YAG CROSS-REFERENCED TO THE APPROPRIATE ľAĠ DATE DEFICIENCY) F 278 Continued From page 24 F 278 11/16/12 at 3:30 PM she stated that the half rails on Resident #4 's bed were not a restraint as she just used them as an enabler for turning with her good arm and dld not try to get out of bed. She added that Resident #4 did not like to get out of bed and would agree to get up with assistance only about once a month. During interview with Administrative Staff #4 on 11/16/12 at 4 PM she indicated that she coded all side rails as restraints because there was no other place to include them on the MDS. She further indicated she was not aware it was Incorrect to code these devices as a restraint, if that was not their function, but that she clarified in the Care Area Assessment that these devices were not physical restraints and therefore did not proceed to care plan, 6. Resident #41 was admitted to the facility on 9/5/11 with osteoporosis and cerebral vascular accident. On the quarterly Minimum Data Set (MDS), 8/27/12, she was coded as having disorganized thinking, needing extensive assistance with transfers and had no activity of walking in her room or on the corridor. The MDS also listed her as having no falls and stated that bed rails were used dally as a physical restraint, as well as a chair, that prevented rising. On 11/13/12 at 10:00 am, Resident #41 was observed sitting in a reclined wheelcheir, eating breakfast. She made no attempts to get up unassisted. On 11/14/12 at 2:00 pm, she was observed sitting in her reclining wheelchair, never allempting to get up. The Administrative Staff #2 was Interviewed on

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY JENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING Ç 8, WNG 345509 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 916 PER DER HOAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28316 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X9) COMPLETION DATE QI (FX) (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX (BACH CORRECTIVE ACTION SHOULD BE PREFIX Cross-referenced to the appropriate REGULATORY OR LSC IDENTIFYING INFORMATION) YAG TÀĠ OCHICIENCY) F 278 | Continued From page 25 F 278 11/16/12 at 3:00 pm, and stated that Resident #41 cannot embulate independently or with assistance. She further stated that she hadn't tried to stand or propel herself in her wheelchair. She added that she was in a reclining wheelchair for comfort and that it should not have been coded as a restraint. Regarding the bod rails used for Resident #41, she stated that they do not prevent her from rising and that she does not attempt to get out of bed, in fact, she laid very still in bod. She shared that the ralls are used an enabling device and should not be coded as a physical restraint. F 279 F 279 £ 279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS SS=D 1. All residents are potentially at risk. A facility must use the results of the assessment to develop, review and revise the resident's 2. Care Plans for residents # 29 comprehensive plan of care. and #30 corrected by Minimum 61/1/161 The facility must develop a comprehensive care Data Set Coordinator. plan for each resident that includes measurable 3. All Dialysis resident's Care objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial Plans audited by Clinical Care needs that are identified in the comprehensive Coordinator on 12/13/12, Fluid assessment. restrictions and checking of The care plan must describe the services that are shunt for thrill and bruit added to be furnished to attain or maintain the resident's highest practicable physical, mental, and as well as no B/P in arm with psychosocial well-being as required under shunt (specific arm identified \$483.25; and any services that would otherwise be required under §483,26 but are not provided on each one) and added to the due to the resident's exercise of rights under Kardex for CNA staff by Clinical §483.10, Including the right to refuse treatment Care Coordinator, under §483.10(b)(4).

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MA I-CAME OF	,	346809	B. WNG	-		11/17	/2012
	OVIDER OR SUPPLIER OD NURSING CENTER			91	ET ADDRESS, CITY, STATE, ZIP CODE 6 PEE DEE ROAD BERDEEN, NO. 28316 PROVIDER'S PLAN OF CORRECT	ION	(25)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDEO BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(each corrective action shou cross-reperenced to the appro deficiency)	)PRIATE	DAYN
F 279	by: Based on record revolutions of the resident's care drainage tubing to the suprapubic catheter."  Resident #30 was a 5/9/07. Diagnoses thy perfrophy with used the "Lippincott of the resident's care included a problem included. There wa plan intervention for 11/15/12 at 8:11 the suprapubic catheter.	ris not met as evidenced  riew, staff interview and a re facility falled to develop plans for 2 (Residents #29 ents. The findings included;  w on 11/16/12 at 9:13 AM,  #2 indicated the facility did at addressed securing or getheters. She said for care facility had no policy, staff Manual" as a standard of  res: "Nursing Practice", 9th a following under care of res: "Nursing Action: Secure atteral abdomen with tape. Included to the facility on included benign prostatic rinary retention, and	IT.	279	4. All Care Plans of all reside with catheters audited by Clinical Care Coordinator of 12/13/12 and Intervention secure catheter added to e Care Plan and Kardex by Clicare Coordinator.  5. All Care Plans will be browned to dally Department head meeting along with new of from the previous day and Plans will updated by Minion Data Set Coordinator, Director Nursing, Assistant Director Nursing, Assistant Director Nursing, Assistant Director Nursing, Clinical Care Coordinator, and Staff Development Coordinator accuracy using the Care Plans will audited monthly by Director Nursing, Clinical Care Coordinator, and Staff Development Coordinator accuracy using the Care Plans will audity Assurance Audit to Results of these audits will reviewed in Quality Assurance Audit to meeting monthly x 3 months.	to ach inical ought rders Care imum ector ctor of Il be or of for ian ool. iil be rance	13/14/12
上	unsecuted.					Continuation si	Get Page 27 of

#### PRINTED: 12/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 ENT OF DEFICIENCIES IXI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B, WNO 345509 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 21P CODE 916 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28318 SUMMARY STATEMENT OF DEFICIENCIES iO PROVIDER'S PLAN OF CORRECTION COMPLETION (X4) IO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TEACH CORRECTIVE ACTION SHOULD BE PHEFIX REGULATORY OR LSC IDENTIFYING INFORMATION) OROSS-REFERENCED TO THE APPROPRIATE DAC TAG OUFICIENCY) and quarterly thereafter by the 12/14/12 F 279 Continued From page 27 F 279 Director of Nursing. During an interview on 11/17/12 at 9:33 AM, 7. Minimum Data Set Nursing Assistant I/3 stated she had not been told Coordinator and care plan team to secure the resident's catheter. In-serviced by Director of During an interview on 11/17/12 at 5:25 PM, Nursing on 12/14/12 on how to Administrative Staff #4 stated that she did not Include securing the cetholor on the care plan do individualized resident care because that was part of routine catheter care plans. and staff was expected to know to secure the catheter. 1/2. Resident #29 was admitted to the facility on 9/9/12. Cumulative diagnoses included: end stago ronal diseaso on hemodialysis, Diabotes Mellitus and Hypertension. An Admission Minimum Data Set (MDS) dated 9/13/12 Indicated Resident #29 received dialysis treatment. A Care plan dated 9/28/12 Indicated Resident #29 was at risk for fluid overload related to renal fellure. Goals included: will receive dialysis as ordered through next assessment; will have no signs and/or symptoms of fluid overload through next assessment. Interventions included: assess for signs and/or symptoms of fluid overload; labs per physician orders; assist resident to get ready for dialysis; encourage adequate rest periods; monitor lower extremilies for odema. The Care plan did not address the assessment of the dialysis sile (access sile was a shuni located in

restriction.

the left upper arm) and Resident #20's fluid

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S MENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES  (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. 8U	LDING	CONSTRUCTION	(X3) DATE SUI	RVEY
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KINGSWO	OD NURSING CENTER	-		ŗ	PEE DEE ROAD ERDEEN, NO. 28315	<u> </u>	
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F 279 F 280 SS≠D	fluid restriction 1000 twenty-four (24) hour Physician's orders to an order to check threevery shift.  On 11/16/12 at 2:33 stated she created the that was in the comp different need or charthe care plan, Admin the changes as need stated the care plan included the location the shunt for thrill an pressure in Resident restriction of 1000 cc.  On 11/16/12 at 2:40 stated the care plan including Resident #3 of shunts for thrill an restrictions for shunt also be addressed of 483.20(d)(3), 483.10 PARTICIPATE PLAN.  The resident has the incompetent or other incapacitated under participate in plannin changes in care and A comprehensive cay within 7 days after the	ated 9/30/12 was noted for cubic centimeters (cc) per se.  In November 2012 revealed and bruit at shunt site.  PM., Administrative staff #4 are care plan from information uter. If Resident #29 had a inges needed to be made to istrative staff #4 would make and and the for Resident #29 should have of the shunt, monitoring of the shunt, monitoring of the shunt, monitoring of the shunt, monitoring of the shunt, and the fluid and per twenty-four (24) hours.  PM., Administrative staff #2 for any dialysis resident #29 should include monitoring the bruit and blood pressure site. Fluid restriction should in the dialysis care plan.  (k)(2) RIGHT TO INING CARE-REVISE CP inght, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment.		279	F280 1. All residents are potential risk. 2. Resident #37 Care Plan corrected to reflect Multipod Boot discontinued by the Cilic Care Coordinator on 11/16/1 Kardex updated to inform wildirect care staff.	dis nical	12/11/12
100000	07(02-09) Pravious Varsions Ob			Facili	y 10: 070412 If co	orle nobaunăn	t Page 29 of 52
CWA-X9	ALFAYARA) ELGAIDOM AGINDUZ DO	SMAIN PERIODON	-		-		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION LENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C 345509 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 016 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION (ХЗ) Сфире<del>т</del>юй SUMMARY STATEMENT OF DEFICIENCIES (X4) (D (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **BYND** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY 3. All resident's Care Plans 12/14/12 F 280 F 280 Continued From page 29 audited for accuracy by Minimum interdisciplinary team, that includes the attending Data Set Coordinator, Director of physician, a registered nurse with responsibility Nursing, Assistant Director of for the resident, and other appropriate staff in disciplines as determined by the resident's needs, Nursing, and Clinical Care and, to the extent practiceble, the participation of Coordinator with audit completed the resident, the resident's family or the resident's on 12/14/12. Kardex for each legal representative; and periodically reviewed and revised by a team of qualified persons after resident updated to reflect Care each assessment. Plan for CNA's and all Direct care staff by Clinical Care Coordinator on 12/14/12 with updated Kardex placed in CNA documentation This REQUIREMENT is not met as evidenced books to ensure communication of Based on staff interview and record review, the changes to all direct care staff. facility failed to review and revise care plans for 1 4. 20% of all Care Plans will be (Residents #37) of 27 residents. The findings included: audited monthly by Director of Nursing, Assistant Director of Resident #37 was readmilted to the facility on Nursing, Clinical Care Coordinator, 4/27/12. Diagnoses Included subarachnold hemorrhage, rib fractures, pelvic pain, coronary and Staff Development artery disease and peripheral artery disease. Coordinator for accuracy using the The Admission Minimum Data Set (MDS) dated Care Plan Quality Assurance Audit 5/4/12 indicated Resident #37 had memory tool. Results of these audits will problems, severe impairment of cognilive skills be reviewed in Quality Assurance for daily dacision making, did not reject care, required extensive assistance of 2 for bed meeting monthly x 3 months and mobility, and had 2 unatagoable pressure ulcers quarterly thereafter by the with suspected deep tissue injury. Director of Nursing, Physician orders dated 5/23/12 included "multipodus boots for heel decubitis". Review of monthly Physician Orders revealed the order for the mullipodus bools was still active through

Novembor 2012.

S TABA. S' O PO NAJA DNA	ORFICIENCIES ORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V. BOIL		GONSTRUCTION	COMPLE	ilep
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F 282 SS=D T n a c c v () () 14 n n l l l l l l l l l l l l l l l l l	ncluded pressure ulcomultipodus boot was intervention.  During an interview or administrative Staff #overaight not to include he care plan.  183.20(k)(3)(ii) SERV PERSONS/PER CAR  The services provided by concordance with each excordance with each exare.  This REQUIREMENT by:  Based on observation and staff interviews, life are plan for pressure veckly pressure ulcer 2) of three (3) resident #81 and #5  I. Resident #81 and #5  I. Resident #81 was well be selerosis, sac incontinence.  A Quarterly Minimum Resident #91 had a set the time of the asset the time time the time time time time time time time tim	in, last reviewed on 11/2/12, are as a problem but use of a not included as an in 11/15/12 at 3:34 PM, it indicated that it was an eithe multipodus boot on itces by QUALIFIED E PLAN if or arranged by the facility qualified persons in resident's written plan of its not met as evidenced in, medical record review he facility falled to follow the utcers by not performing ekin assessments for two his with pressure utcers is). Findings included:		282	5. Care Plan Team - Minimu Set Coordinator, Activities Director, Social Services Coordinator, Dietary Managand Willow Springs Unit Coordinator - In-serviced by Director of Nursing on 12/14 on how to do individual resistant plans.  F 282  1. All residents are potential risk. 2. Pressure ulcer weekly documentation sheets compon residents # 91 and #93 waccurate staging and descript of wound by Clinical Care Coordination. 12/7/12 3. Treatment nurse in-service the Director of Nursing on postaging of wounds and how complete the weekly wound report. 4. Complete audit of Treatmerecords along with MD orders written as needed by Treatment nurse.	der, 4/12 dent bleted lith btion ced by roper to i	12/34/12

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		348509	B. WIN	0		11/	17/2012
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F 282	A Pressure Ulcer Risk Indicated a score of el Resident #91 a high ri A Care Plan dated 8/2 #91 was at risk for impressure ulcers due to mobility and incontinor Resident will have all spressure ulcers show assessment. Intervent monitor and measure improvement and/or dineeded; notify MD as A review of the Weekly progress reports reveathe pressure ulcer was August, 2012 and the 2012. Documentation noted on 7/31/12 with 19/19/12.  On 11/16/12 at 9:48 Ai stated she had been done month so did not k documented for August September.  On 11/17/12 at 9:24 A stated the wound care should document on the ulcer progress reports of care meeting which She indicated she experiessure ulcer progress	is form dated 10/23/12 leven (11) which made lisk (or pressure ulcers.  24/12 Indicated Resident paired skin integrity/ of fragite skin, decreased ince. Goal Included; skin breakdown and improvement through next tions included, in part, wound weekly for ectine; change treatment as needed.  If wound/ pressure ulcer inted no documentation of a recorded for the month of first week in September of the pressure ulcer was the next entry being on  M., the Treatment nurse oing the wound care for the wound care for the wound why nothing was	¥.	282	5. Treatment Administration Records will be brought to we Standards of Care meeting (*Director of Nursing, Assistant Director of Nursing, Administ Therapy Manager, Minimum Set Coordinator, Clinical Care Coordinator, Dietary Manager and Willow Springs unit Coordinator) by Treatment of the for review of wounds. Treatments will document weekly treatment notes at this time include wound healing progrand that wound was reviewed Standards of Care meeting. TAR's will be brought to weekly treatment nurses not will be documented there.	veekly with t trator, Data e er, lurse ment to ress ed in All kly	(2) (24) 12

S'. JENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	1	(XX) MULTIPLE CONSTRUCTION		(X3) DAYE SURVEY COMPLEYED	
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(X4) 10 PREFIX TAG	(EACH DEFICIENC)	YEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PAGP TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REPERENCED TO THE APPRO DEPIGIENCY)	lo be	OATE COMPLETION (X5)
F 282	-8/24/12 following a fathe right hip. Other dit Alzheimer's disease at A Pressure Ulcer Risk revealed a total score Resident #93 was at him An Admission Minimu 8/31/12 indicated Respressure ulcers. Ourh Resident #93 had two ulcers (known but not presence of slough enthe wound bed).  A Care Plan dated 8/3 #93 was at risk for impressure ulcere. Goal have all skin breakdov improvement through interventions included measure wound week decline.  A review of the medicates was not an initial presence assessment or any We ulcer progress reports.	admilted to the facility harged to the hospital 8/19- ill resulting in a fracture of agnoses included: and Diabetes Mellitus.  form dated 8/14/12 of nine (9) which indicated aligh risk for pressure ulcers.  In Date Set (MDS) dated ident #93 was at risk for ag the assessment period, (2) unstageable pressure atageable due to the d/or black tissue covering  1/12 indicated Resident will and pressure areas show mext assessment.  In part, monitor and by for improvement and/or and being ulcer wound are ulcer wound are ulcer wound are ulcer wound.  M., Administrative staff #2 of pressure ulcer areas are	F	282	6. Monthly audit of wound documentation, Treatment Administration Records, Physicians Orders, and visualization of the wound but Director of Nursing, Assistan Director of Nursing or Clinic Coordinator will be complet documented on Wound Quantum Assurance Audit Tool. Resul Audit will be addressed in Quantum Assurance by the Director of Nursing monthly x3 and quantum thereafter.	ot al Care ed and ality Its of uality	12/04/12

	of depiciencies F correction ,	IDENTIFICATION NUMBER:	۸. عالیار ۸. مالیار	DINIO	COMPLE	TED
		345500	8. WN	G	<b>5</b>	C 17/2012
	NOVIDER OR SUPPLIER OOD NURSING CENTER	२		STREET AODRESS, CITY, STATE, ZIP 916 PEE DEE ROAD ABERDEEN, NO 28915	C00E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	RTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	completion cate
F 282	documentation form (treatment) nurse ur Administrative alaff see a note regarding of the wound on the documentation form.  On 11/16/12 at 5:35 stated she could not documentation was indicated it should have the could not documentation was indicated it should have.  483.25 PROVIDE C. HIGHEST WELL BE. Each resident must provide the necessa or maintain the highmental, and psychological provides accordance with the and plan of care.  This REQUIREMEN by:  Based on record refacility falled to asse 1 (Resident #36 was at 10/12/12. Diagnoses venous ulcer of the increased an order for the wordered an order for the wordered an order for the wordered and ordered for the wordered for the wo	by the wound care full all areas are healed. #2 indicated she expected to g the progress and/or decline pressure ulcer  PM., the Treatment nurse I say where the pressure ulcer for the sacrum area and ave been in the wound care  ARE/SERVICES FOR EING  receive and the facility must ry care and services to attain est practicable physical, social well-being, in comprehensive assessment  T is not met as evidenced view and staff interview, the es and treat a leg wound for 4 residents reviewed for dings included: dmitted to the facility on a included hip contusion and	F3	F309 1. All residents with wound treatments a at risk. 2. Resident #36 was from the facility prior unable to correct for as she is no longer h. 3. Complete Audit or orders and Treatmen Administration Recorders and Treatmen Administration Recorders and available by Assistant Director with all medications present. 4. Treatment nurse the Director of Nursiaspects of the wound program including Nofany issues such as	ire potentially is discharged or to survey, ir this resident here, of treatment int ord to ensure leations le completed ir of Nursing found to be  In-serviced by ling on all ind care AD notification	13 09 113

PRINTED: 12/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ANISM AN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C D. WNG 345509 11/17/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 015 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) treatment not available, wound [2] W [2 F 309 Continued From page 34 assessment, documentation of F 309 wound assessment, doing wound Review of treatment notes revealed: 10/17/12, care as ordered, and notifying "Resident refused treatment as ordered." On 10/18/12: "Explained to resident and daughter Clinical Care Coordinator If she has that we were wailing for the medihoney to any problems with obtaining perform with dressing change to left lower leg." ordered wound treatment 10/19/12: "Performed treatment to left lower log as ordered without problems." supplies. 5. Director of Nursing spoke with Review of the Treatment Administration Record Pharmacist and arranged to have (TAR) revealed initial treatment to the left leg wound was 10/19/12 by the Treatment Nurse. 2 tubes of medihoney kept in The record had no documentation of an stock in the Director of Nursing assessment of the wound including size. Office. Pharmacy will flag appearance, drainage or odor. company account to send During an interview on 11/16/12 at 10:07 AM, the medihoney when ordered - as this Treatment Nurse indicated that the resident is an OTC medication it was on the refused the treatment on 10/17/12 because she thought the physician was supposed to remove list of do not send medications. the skin graft on her leg. On 10/18/12 the resident 6. Monthly audit of wound was willing to receive the treatment but the medihoney calcium alginate had not come from documentation, Treatment the pharmacy, The Treatment Nurse indicated Administration Records, that she made Administrative Staff #2 awere that Physicians Orders, and the medinoney calcium alginate had not come in.

was available.

but did not notify the physician of the delay in

troalmont or ask if an allomato treatment was

During an interview on 11/17/12 at 4:53 PM,

contact with the pharmacy daily to obtain the medihoney calcium alginate. She added that she

would have expected the Treatment Nurse to

weekly descriptions of any wounds including

notify the physician, and to document initial and

Administrative Staff #2 stated she had been in

advisable until the medihoney calcium alginate

thereafter.

visualization of the wound by

Director of Nursing, Assistant

Director of Nursing or Clinical Care

Coordinator will be completed and

documented on Wound Quality

Assurance Audit Tool, Results of

Audit will be addressed in Quality

Nursing monthly x3 and quarterly

Assurance by the Director of

		ND HUMAN SERVICES				RM APPROVED VO. 0938-0391
STI JENT	OF DEFICIENCIES F CORRECTION	MEDICAIO SERVICES (X1) PROVIDER/SUPPUER/GUIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE:	SURVEY
	•	345509	B. WING	)	11	/17/2012
	ROVIDER OR SUPPLIER	<u></u>		STREET ADDRESS, CITY, STATE, ZIP C 916 PEE DEE ROAD ABERDEEN, NC 20315		
(X4) ID PREFIX TAG	IEACH DEFICIENC	Atement of Deficiencies Y must be preceded by full LSC identifying information	IO PREFIX 7AG	PROVIDER'S PLAN O	THON SHOULD BE THE APPROPRIATE	COMPLETION (XE)
F 309 F 314 SS#D	Continued From page measurements, apper perlwound appearant 483.25(c) TREATME PREVENT/HEAL PR Based on the compreseident, the facility in who enters the facility does not develop presently dual's clinical country were unavoidable pressure sores received services to promote in prevent new sores from the REQUIREMENT by: Based on observation review, the facility fell interventions as order pressure ulcers for 3 #93) of 3 residents. The Regular for 3 residents. The Admission Minim 5/4/12 indicated Residents, severe impror daily decision main required extensive as requir	e 35 strance, drainage and the ce. NT/SVCS TO ESSURE SORES shensive assessment of a must ensure that a resident y without pressure sores asure sores unless the andition demonstrates that le; and a resident having was necessary treatment and resling, prevent infection and om developing.  It is not met as evidenced in, staff interview and record led to assess and implement red for the treatment of (Residente #37, #91 and the findings included:  admitted to the facility on included subarachnoid uros, pelvic pain, coronary pripheral artery disease.  Some Data Set (MDS) dated dent #37 had memory wairment of cognitive skills along, did not reject care, isistance of 2 for bed instaggable pressure ulcers	F 3	OEFICIEN 109	resident altipodis are Plan and nical Care inator spoke regarding ment and n. Resident fare Clinic Care will not go. continue ound Care Coordinator for resident ge order to ly by Clinical 12/14/12 and d Treatment	10/29/10
	The May Treatment /	Administration Record (TAR)				
CMB-250	7(02-99) Previous Vorsions Obs	able Event ID: XSUCT	11	Facility ID: 970412	If continuation she	161 Page 36 of 52

and the Treatment nurse will sign

off on the orders noting that they

have been checked, and will then

pass them to the MDS nurse to

7. Monthly audit of wound care

Administration Records, consults,

program to include Treatment

preventive devices, and wound documentation will be completed

Quality Assurance Audit Tool by

and documented on Wound

Director of Nursing, Assistant

update the Care Plan.

#### PRINTED: 12/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 JENY OF DEFICIENCIES (X1) PROVIDER/GUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 348509 11/17/2012 NAME OF PROVIDER OR SUPPLIER Syreet Address, City, State, Zip Code 916 PRE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28318 SUMMARY STATEMENT OF DEPICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) (D (X&) COMPLETION (CACH DEFICIENCY MUST BE PRECEDED BY FULL LEAGH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE CATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY 5. Complete audit of Treatment 12/04/12 F 314 | Continued From page 36 F 314 records along with MD orders to Included Skin Prep to bilateral heels daily. be completed. MD notified of any clarification orders received and Physician orders dated 5/23/12 included "multipodus bools (a protective orthosis that written as needed by the minimizes the risk of preseure on the heef) for Treatment purse. heel decubilis". 6. Clinical Care Coordinator will The June TAR revealed the order was changed review all new treatment/wound from Skin Prop to a hydrogel product to both care orders daily with the heels dolly until ulcers were resolved. The June TAR also indicated Reeldent #37 used Treatment nurse to include new the multipodus boots on the 3-11 shift except for treatments, consultation orders, 1 refusal on 6/26/12. and preventive equipment orders. The July TAR revealed the treatment to the right Both the Clinical Care Coordinator

the boots were actually used.

TAR's from August through November Indicated the enzymo treatment for the right heat was continued daily, and the multipodus boot remained listed as an FYI without documentation.

heel was changed to an enzyme ointment on

7/18/12. The left heel wound was resolved on

7/27/12. The July TAR listed the multipodus boots for heel decubits as a treatment but handwritten

In was "FYI". The TAR lacked documentation that

Right heel pressure vicer measurements included: 5/9/12; unstageable 2 by 3 cm (centimeter), area dark red; 8/31/12; 3 by 4.2 by 0.2 cm; 10/5/12; 4 by 3 cm, unstageable due to wound bed covered with yellow slough; 10/25/12 and 10/31/12; 3 by 3 cm, unstageable with wound bed red and moist; 11/8/12 and 11/14/12; 3 by 3 cm, unstageable with wound bed yellow slough.

On 11/16/12 at 8:35 AM, Resident #37 was

of actual use.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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AN WAY	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION HUMBER:	(X2) M A. 8UI		TIPLE CONSTRUCTION (X3) DATE SUR COMPLETE		
		345509				1	C 17/2012
	COVIDER OR SUPPLIER			9	eët address, city, state, zip code 15 pee dee road Berdeen, NC 28315	1	1116011
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F 314	observed in her whee dressing and paper by resident's foot was in foot rest. There was in to her heef. At 2:35 Pobserved in bed lying under her knees and it were restling on the bowas lying on her dress. During an interview or Nursing Assistant (NA know what the multipodus was at the time of the asset the time.	Ichair. Her right foot had a coolie to cover the foot. The esting on the wheelchair to visible source of pressure M. Resident #37 was on her back. A pillow was lower lags but her heels ed. The multipodus boot ser.  In 11/15/12 at 2:35 PM, If the stated she did not odus boot was and she had lident.  In 11/15/12 at 5:30 PM NA tily look care of Resident but was never told to put the out.  In 11/16/12 at 1:48 PM, It sald she expected the worn when the resident worn when the resident but was included: ral decubitus and urinary.  Data Set (MDS) indicated age four (4) pressure ulcer essment. The pressure at on the prior assessment.	L.	314	Director of Nursing, Clinical Ca Coordinator. Results of audit to be addressed by Director of Nursing in Quality Assurance meeting monthly x3 and quarte thereafter.	will	13139114

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

	of deficiencies Correction	(X1) PROVIDER/GUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLEY	
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(X4) ID PREFIX TAG	(EACH OFFICIENC	ATEMENT OF DEFICIENCIES Y MUST RE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	OTION SHOULD BE OTHE APPROPRIATE	(x3) COMPLETION DATE
F 314	stage IV (4) decubitus wound care. Resider the wound cfinic.  A review of the medic consultation from the through November 20 On 11/17/12 at 9:34 a Resident #91 had a hyrequired the physiciar a wound clinic appoint physician had written her to make the appoint of the authorist again to obtain Resident #91.  On 11/17/12 at 10:00 stated the physician in the wound care clinic spoken to nursing state appointment. She did had been made.  On 11/17/12 at 10:50 was the one who calle appointment in July basked her to find out authorization for the vishe and ward clerk #1 the authorization but in as to who would obtain #1 stated nothing was conversation to obtain	at had a slow decline but the shad been stabilized with at #91 had agreed to go to sail record revealed no wound clinic from July 2012 2012.  It was deck #1 stated yee of insurance that in to obtain authorization for atment. She stated the an order in July and asked intent. She said she ordinator that the physician eation and she had not been an appointment for the analysis of the said she ordinator that the physician eation and she had not been an appointment for the said she ordinator that the physician eation and she had not been an appointment for the suit have verbally if about making the the formula of the suit obtaining yound clinic. Nurse #1 stated she ead regarding the wound care escause the physician had about obtaining yound clinic. Nurse #1 said I talked about who would do never came to a conclusion in the authorization. Nurse	F :			

		2-00 HOE'S				FORM	12/04/2012 APPROVED . 0938-0391
ne-Q'fil	ENT OF HEALTH AN	ND HUMAN SERVICES				WALDATE SUR	VEY
CE. ERS  STATEMENT OF AND PLAN OF C	FOR MEDICANIE SO	MEDICAID SERVICES  (XI) PROVIDER/SUPPLIENCUA (DENTIFICATION NUMBER:	A. BUILD		····	COMPLETE	
YND bryn or o	ORNEOTION						
		346309		STREET ADDRESS	, CHY, STATE, ZIP CODE	•	{
	dyioer on supplier			816 PEE DEE R	OAD NC 28316		(K6)
KINGSWO	dd nursing center		10		PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION	SHOOFO BE	COMPLETION
(X4) ID PREMX YAG	SUMMARY S (EACH OEFICIEN REGULATORY OF	TAYEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	PREFI) YAG	CHO	SS-REFERENCED TO THE ACTION OF	APPROPRIATE	
F 314	ţ	ge 39	F	314			
	8/14/12. He was a -8/24/12 following in the right hip. Of he Alzhelmer's disease.  A physician's order Resident #93 was hip internal rotation pressure and a less pressure.  An observation of Resident #93 in the right foot.  On 11/16/12 at 3 #93 had pressure boot on one foot on the other foot what equipment stated she would the nurse on the care plan book at the nursing swearing any boot was noted.  A review of the there were no	on 11/16/12 at 3:42 PM, revealed leeping in bed. He was not bote at that time. A pressure relief in the chair.  3 Kardex for Resident #93 revealed bools listed to be applied for					
	Resident #93.	. <u> </u>		Fedily ID	; 970412	Il conflavol	lon sheet Page 40 of
× ->,		Evoni IC	);X\$U011		÷	•	

PRINTED: 12/04/2012

09:33AM

02/07/13

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES 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: MAN OF CORRECTION A. BUILDING C B. WNG. 11/17/2012 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) SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (GACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ۲۸Ġ YAG DEFICIENCY F 314 Continued From page 40 F 314 ON 11/17/12 at 10:00 AM., Administrative staff #2 stated she expected staff to follow physician's orders and Resident #93 should wear bilateral pressure relief boots as ordered by the physician. F315 13/14/13 F 315 483,25(d) NO CATHETER, PREVENT UTI, 1. All residents are potentially F 315 RESTORE BLADDER SS≃D at risk. 2. Resident # 30's catheter was Based on the resident's comprehensive assessment, the facility must ensure that a secured to his abdomen with resident who enters the facility without an tape and this was added to the indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that TAR, Kardex, and Care plan by catheterization was necessary; and a resident Clinical Care Coordinator on who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract 12/11/12 infections and to restore as much normal bladder 3. Care plans and Kardex's for function as possible. all residents with Supra Public catheters audited by Clinical This REQUIREMENT is not met as evidenced by: Care Coordinator using Based on observation, staff interview, record Catheter Audit tool and review and nursing reference, the facility falled to secure a urinary catheter for 1 (Resident #30) of corrected to include securing of 2 residents. The findings included: catheters to the abdomen. During an interview on 11/16/12 at 9:13 AM, 4. All residents with Supra Administrative Staff #2 Indicated the facility did Public catheters will have secure not have a policy that addressed securing or anchoring indwelling catheters. She said for care catheter tubing to the issues for which the facility had no policy staff abdomen added to the used the Lippincott Manual as a standard of Treatment Administration nursing practice. Record by the Treatment Nurse The "Lippincott Manual of Nursing Practice", 9th

9440914

Edition, included the following under care of suprapuble catheters; "Nursing Action; Secure

drainage tubing to lateral abdomen with tape.

to be checked and documented

by the nurse each shift.

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

PRINTED: 12/04/2012 FORM APPROVED OMB NO. 0938-0391

AN OF COR	RRECTION		1		CONSTRUCTION	COMPLET	GD
		IDENTIFICATION NUMBER:	A. BUIL				0
		345509	B. WN			11/1	7/2012
	DER OR SUPPLIER			916	ET AOURESS, OITY, STATE, ZIP CODE I PEE DEE ROAD ERDEEN, NC 28315		
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Recal Res 5/9 hy su The ince can need the ince can need to be can	esident #30 was ad 9/07. Diagnoses in pertrophy with urin uprapuble catheter. The resident's care peluded a problem of cluded encourage atheter weekly, irrigueded. There was in 11/15/12 at 8:11 was observed unsecturing an interview administrative Staff sing adhesive secust picked them off. Itempting any alternvolve adhesive to the facility has staned with Velero equired.  On 11/17/12 at 9:33 suprapuble catheter velocity as secured.  On 11/17/12 at 9:33 suprapuble catheter velocity as secured.	Imilited to the facility on cluded benign prostatic hary retention, and plan, last reviewed 10/3/12, of catheter use. Interventions hydration, change suprapubic rate with normal saline as no physician order or care securing the catheter.  AM the suprapubic catheter cured.  AM, and the they had tried using devices but the resident she could not recall mative measures that did not the skin.  AM, Administrative Staff #2 and just received some new legicatheter tubing. The legistraps of and thus adhesive was not salar was observed unsecured.  AM, Resident #30's was observed unsecured.  AM, Resident #30's was observed unsecured.  AM, #3 stated that she had not the catheter. This was her	£.	315	5. Licensed and non-licensed Nursing staff will be in-service the procedure for securing S Public catheter tubing to the abdomen by the Clinical Card Coordinator or Director of N using an employee roster to ensure all staff are in-serviced. Nursing staff wi in-serviced as they return to until all Nursing staff has reconservice.  6. Catheter Audit tool will be completed by the Clinical Co Coordinator or Director of N weekly x4, monthly x3, and quarterly thereafter and discondinator of Nursing.	ced on upra e ursing II be work elved e ursing	12/14/12

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) Mi	JI.TIPI.Ę	CONSTRUCTION	(X3) DATE SU COMPLE	
NCLOLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. DUIL	DING	the Control of the Co		
		345509	B. WN	G		1	C 17/2012
	OVIDER OR SUPPLIER OD NURSING CENTER			915	r address, city, state, zip cods pec dee road Roben, NC 28315		
(X4) ID PREFIX TAG	IPACH OFFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREF TAG	x	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 315	Continued From pag Administrative Staff f include securing the because that was pa and staff was expect catheter. 483.30(e) POSTED I INFORMATION  The facility must pos a daily basis: o Facility name. o The current date. o The total number a by the following cate unlicensed nursing s resident care per shi - Registered nur Licensed practi vocational nurses (a - Certified nurse o Resident census.  The facility must pos specified above on a of each shift. Data a o Clear and readable o In a prominent pla residents and visitor  The facility must, up make nurse staffing for review at a cost standard.	e 42  44 stated that she did not catheter on the care plan of routine catheter care ed to know to secure the NURSE STAFFING  If the following information on and the actual hours worked egories of licensed and staff directly responsible for lift; ses.  Icel nurses or licensed s defined under State law), aides.  Ist the nurse staffing data as daily basis at the beginning must be posted as follows: e format, ce readily accessible to		315	E 356  1. All residents are por at risk. 2. Staffing information posted at nurses static shift by the shift super 3. Shift Supervisor's was serviced by the Direct Nursing on how to cout the Daily Staffing She including deduction of beds fro the total cent counting only direct of and deducting time and deducting time are providing care to HFA from the total number care hours. 4. Staffing sheets with completed at the begach shift by the Shift Supervisor including number of staff work.	n will be on each rvisor. vill be in- or of mplete et of HFA asus, care staff, pent A residents er of direct ill be ginning of ft the	1.2)14/12
	required by State la	w, whichover is greater.			hours worked by eac		

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

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	COMPLET	
		349509	B. WIN		Section Learners and Company of the		C 7/2012
	COVIDER OR SUPPLIER			914	ET ADDRESS, CITY, STATE, ZIP CODE 5 PEE DEE ROAD BERDEEN, NC 28315	·····	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST DE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OLD BE	(VS) COMPLETION CATE
F 356	by: Based on observation interviews, the facility information on the data. The findings include: On 11/13/12 at 12:19 was observed on a whallway, which was a station. On the form, 11/7/12 hung on the recorded for any of the Con 11/14/12 at 9:45 from 11/13/12 hung on the recorded for any of the nurse's station. No act for any of the nursing. The Administrative A 11/15/12 at 11:45 am responsible for handl with the exception of of her work day, she the data for registere practical nurses (LP) medication aides (M/Then she stated that the charge nurse to the carge skilled nurse that she was instructive.	is not met as evidenced  ns, record review and staff failed to record accurate ily staff posting.  pm, the daily staff posting all next to the Greenbrier cross from the nurse's the daily staff posting for wall. No actual hours were ne nursing staff.  am, the daily staff posting on the wall, across from the ctual hours were recorded staff.  ssistant was interviewed on s. She stated she was ing the daily staff posting weekends. At the beginning explained that she filled out d nurses (IRN), licensed d), nurse aldes (NA), A) and resident census. it was the responsibility of update the changes with staff	£	356	discipline, and the total cer for that shift (minus the Assisted Living beds) and so by the person completing form.  5. Staffing sheets will be monitored daily x4 weeks, weekly x3 months, and months thereafter using Staffing S Audit Tool by the Director Nursing with results report Quality Assurance meeting the Director of Nursing.	igned the onthly heet of ted In	12/14/12

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CL LERS	FOR MEDICARE & F DEFICIENCIES COURTECTION	MEDICAID SERVICES  (XI) PROVIDERUSUPPLIERVELIA IDENTIFICATION NUMBER:	Y' BRI		МОІТЭОЙТЕН	(X3) DATE SUR COMPLETE	YEY D
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	OVIDER OR SUPPLIER			915 P	audress, City, Syate, Zip Code Te der Road Ricen, NC 28316		
(X4)1D PREFIX TAG		ATRIMEN) OF DEFICIENCIES LY MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	10 PREF TAG	ıx	Provider's PLAN of Corr (Each Corrective Action 8) Cross-Referenced to the Af Drf[Ciency]	ADDITO &C	DYA6 COWNTHAION (NR)
r 356	count, although she was not on a medical The Administrative / they were not captu worked for the RN. It is they were not captu worked for the RN. It is the was unable to delity staffing hadn't elx days, even thou during this time per staff posting was not yealerday's shift, as The Director of Nur 11/15/12 at 3:20 pm believed that she will duty, at least once since the facility acresidents. Therefor Administrative Assusually under the I that on the weeker the floor and was at therefore she fell it hours then.  She shared that the on teave earlier in helped to complete her return, she sta sometimes got conwas to update the probably the reason 11/1/12 to 11/1/13/14	registered Nurses (RN) was aware that the ADON no cart or giving patient care. Assistant acknowledged that dring the total actual hours LPN, NA and MA, per shift.  Offer an explanation why the been changed and posted for gh she worked weekdays ind. She was unsure why the of posted at the beginning of swell.  Sing was interviewed on n. She commented that she has required to post a RN on a day on the daity staffing hively had more then 80 e. she instructed the stant to post her ADON hours for the RN. She did add hot title ADON was called to beclually working with residents, was accurate to record her  e Administrative Assistant was the year and another employee the delity staff posting. Since the delity staff posting. Since the delity staff posting, which was on why it was overlooked from	**************************************	356			Page 46 of 5
يسر	THE DOM STORES				No. 10. 070/12	If continuation s	heat Page 46 of 5

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

02/07/13 09:33AH

CENTERS	FOR MEDICARE &	MEDICAID SERVIÇES	1000.10	u sant	E CONSYRUCTION	(X3) DATE SU	IRVEY
STATEMENT O	f deficiencies	(X1) PROVIDERISLIPPLIERICLIA IDENTIFICATION NUMBER:	1		E COMORICO NOS	COMPLE	TED
(N	CORRECTION	10 Man information and an analysis of the	A. BUII	DING	المناقليس معدر التنافلسليم هو التنافلسوية في أو ميدو منتجودة عبدين متحدث الناف يوساسة إيضا		c
		345509	0. WN	IG ,,,,,	and the state of t	11/	17/2012
	OVIDER OR SUPPLIER				EET ADDRESS, CITY, SYATE, ZIP CODE		ĺ
					6 PEE DEE ROAD		į
KINGSWO	OD NURSING CENTER			A	BERDEEN, NC 28316		(X S)
(X4) ID PREFIX TAG	かっ へい わといい(はお)	ratement of deficiencies Ly Must be preceded by full LSC identifying information)	PREF TAC	IX.	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION DATE
F 358	discipline, omit coun in the census, re-ori- instructions to comp	ge 45 The actual hours worked per Using the rest home residents The her staff on the proper The the staffing and assign To complete the task moving	F	356	F371	Salke no	
F 371 \$5≖E	forward.		ŗ	371	All resident are potent risk.     The undated items the needed refrigeration v	it	MINITE
	considered salisfac	m sources approved or tory by Federal, State or local distribute and serve food ditions			Immediately discarded The opened but undat Items in the walk-in co were discarded or dat appropriately immedi 3. A mandatory meeting called so that ALL Diet Staff were in attendar in-serviced on reading	I. ed poler ed ately, was ary ace and	
	by: Based on observa facility failed to (1) salsa after opening and (3) ensure har to handling food. T	NT is not met as evidenced tion and staff interview, the refrigerate soy sauce and g. (2) date items when opened has and gloves were clean prior the findings included:			item they open for sto Instructions for any le amounts and the proj to date and store item opening. Dietary staff store foods according label instructions. Th	orage ft over per way ns after will to	
	at 10:45 AM, a bot opened 11/1/11 and dated as opened 3 the dry storage roo "Refrigerate after				service also included Information on how a when to change glove handling food. Cook received 1-1 in-servic through our discipling	es when #1 ing ary	
	11/17/12 at 10:45	ger said during an interview on AM that she had seen the sey n the dry storage area and			process. This in-serve done by our Dietary I and our Registered D	Vianager	

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

STATEMENT (	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SUI COMPLEY	
		345509				1	C 7/2012
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG	9 · <b>A</b>	EET ADDRESS, CITY, STAYE, ZIP CODE  16 PEE BEE ROAD  BERDEEN, NC 28315  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	ION LO BE	(XS) COMPLETION DATE
F 371	thought they were un immediately discarde when she became av. 2. During the initial to at 10:45 AM, the folio but undated in the was container of honey mof pimento cheese sp dressing and 1 container of honey mof pimento cheese sp dressing and 1 container of honey mof pimento cheese sp dressing and 1 container of honey mof pimento cheese sp dressing and 1 container sho she discarded the hocottage cheese, and 3a. On 11/17/12 at 11 wearing gloves, was bread on the floor. She it on the counter. She aluminum foil and lail bag of bread. She the the bag and wrapped not remove the gloves cook was interviewed removed the gloves aplicking up the bag for During an interview of Dietary Manager ack witnessed the above should have changed the bag that had falled.	opened. She added that she d both items on 11/13/12 ware that they were opened.  The of the kitchen on 11/13/12 awing were observed opened alk-in cooler: 1 jar of jam, 1 sustand dressing, 1 container of cottage cheese.  AM the Dietary Manager wild be dated when opened, aney mustand dressing and dated the other items.  Dietary Manager wild be dated when opened, aney mustand dressing and dated the other items.  Dietary Manager wild be dated when opened, aney mustand dressing and dated the other items.  Dietary Manager wild be dated when opened, aney mustand dressing and dated the other items.  Dietary Manager wild be dated when opened, aney mustand dressing and dated the other items.  Dietary Manager wild be dated when opened, and stated when bag and set anext tore a piece of dit on the counter next to the en removed the bread from it he bread in the foll. She did is during this process. The did and stated she should have and washed her hands after om the floor.  In 11/17/12 at 10:30 AM, the nowledged she had.  She indicated the cook did her gloves after handling	£	371	4. The Dietary Manager and afternoon cook are aiddit the storage areas each disee that items are stored dated and labeled the correct way. Results of the audits are documented don a new auditing tool. Tresults will be presented the Quality Assurance Committee 1 x month x 1 months.  5. All nursing and Departmented Staff in-serviced on 7-12 by the Director of Nursing regarding process for passing trays and infection control in the dining room including sanitizing of tables, wash hands between residents handling food is involved sanitizing hands between handling trays. Director of Nursing and Clinical Care Coordinator will continue in-service until all nursing and Department Head Stahave been in-serviced.	ing ay to helr ally he to 2 ent 12- fure ling and of	12/14/12
	observed taking a br	ead roll out of the plastic bag					<u></u>

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09:33AM

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C
		345509	B. WNG		11/17/2012
	OVIDER OR SUPPLIER OOD NURSING CENTER		0188	FADDRESS, CITY, STATE, ZIP CODE PER DEE ROAD RDEEN; NC 28315	
(X4) ID PREFIX TAG	IGACH DESIGIENC	ratement of Deficiencies by Must he preceded by Full lsc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (GACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETION
F 371	on the resident's din the resident and was her meal when anoth dining room. Without obtained the resident bread roll from the phand and placed the Dn 11/13/2012 a 12 regarding hand was her hands prior to his She stated the facility when passing out the there was no hand a revealed two hands Both hand sanitizer and were functionin. On 11/15/12 at 4:56 stated nursing staff hands before passit tasks. She said the after passing a tray after touching food 483.60(a),(b) PHAF ACCURATE PROC. The facility must pridrugs and biological them under an agressing them under an agressing staff hands before passit tasks. The said the after passing a tray after touching food 483.60(a),(b) PHAF ACCURATE PROC. The facility must pridrugs and biological them under an agressing staff hands permits, but on supervision of a lice	ed hand, she placed the roll ner plate. She sat down with a assisting the resident with her resident entered the at washing her hands, NA #1 at's food tray, removed the lastic bag with her ungloved a roll on the plastic bag.  15 PM., NA #1, when asked hing, stated she should wash anding out the food trays. Ity did not want gloves worn be trays. NA #1 further stated sanitizer available in the dining sispenser. An observation as contained sanilizing agents g properly.  B PM., Administrative staff #2 should wash/senitize their and food trays and between by should wash their hands to a resident and before and litems.  RMACEUTICAL SVC - CEDURES, RPH  ovide routine and emergency als to its residents, or obtain beart. The facility may permit met to administer drugs if State lity under the general	F 425	G. At least one meal service per day will be audited by Department Heads and Nursing Supervisors with results recorded on Dining Service Quality Assurance audit tool and turned into the Director of Nursing. Every meal (Breakfast, Lu and Dinner) will be audite at least twice per week. Audits will be completed daily x4 weeks, then were thereafter. Results of auxill be addressed by the Director of Nursing in monthly Quality Assurant meeting.  F425  1. All residents are potent at risk. 2. Resident #36 discharted from the facility prior to 3. "Please Send" will be documented on each or	nch, ed ekly ekly edit nce ntially ged survey.

PRINTED: 12/04/2012

	mur oc ubal TH AA	ID HUMAN SERVICES				OMB NO.	APPROVED 0938-0391
Dr RTM Cr ERS	FOR MEDICARE &		LXS) WUL	TIPLE (	CONSTRUCTION	(X3) DATE SUR' COMPLETE	0
ANYOUGHY OF	T DEFICIENCIES	(X1) PROVIDERVOUPPLIERICLIA IDENTIFICATION NUMBER:	A. BUILD		No. 1111-1-1-1 Salar Sal	С	
ND PLAN OF C	CORRECTION		в, WNO		The state of the s	11/17	12012
		348509	1		T ADDRESS, CITY, STATE, ZIP CODE	-	
	OVIDER OR SUPPLIER			\$18EE	PEE DEE ROAD		
			1	ABI	RDEEN, NC 28318	VIAU	(XS)
(X4) 10	OD NURSING CENTER SUMMARY ST	AYEMENT OF DEFICIENCIES	ID PREFE TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION
PREFIX TAG	REGULATORY OR	Fac Identifang Ineormation)			wound care products ser	nt to	12/14/19
		A MINISTER AND A MARKET AND A M		425	the pharmacy by the Tre	atment	
F 425	Continued From pag	je 48		420	the pharmacy by the more	or	
1 740	I I I I I I I I I I I I I I I I I I I	of that assure the according			Nurse or Nurse Supervisi	stock	
	equiring, receiving,	dispensing, and dispension dispen			4. Medihoney added to	ene of	
:	the needs of each f	es dent.			wound supplies by Direc	χ <b>υι ν</b> ι	
		the services of		1	Nursing and kept in the	, ř	
		nploy or obtain the services of list who provides consultation			Director of Nursing offic	e as or	
	on all aspects of the	d biodiston or breath.			12/10/12	od 00	
	services in the facil		1	5. Nurses will be in-servic	unlies to		
				}	ordering of wound care st	adu It	
					Include adding "Please Se	the	
	TEO HOCKE	NT is not met as evidenced			the medication is an Over	o Clinical	
	by:	in the model			Counter medication by th	mulavee	
	Based on record	eview and slaff and phermacist			Care Coordinator using E	care in-	
	Interview, the facil	lon in a timely manner for 1	-		roster to ensure all nurse	:2 UT V 111	
	(Resident #38) of	(138) of 4 residents. The findings			servised  6. To ensure timelines	s of	
]	included:				p. To ensure difference	e orders.	
	Regident #36 Was	admitted to the facility on			initiation of wound car	Morie yan	
	Januaria Disano	802 IUCIBOGO HILV COLLEGE			all orders from the pre	outha	
	venous alcer of the	10 161( Call.			will be checked daily b	y the	
	Orders from the	yound clinic dated 10/16/12	ļ.		Clinical Care Coordina	tor,	
					Director of Nursing, A	ssistant	
	alginate dressing	to tue terr lower was			Director of Nursing, a	nd	
	Review of treatm	ent notes revealed: 10/17/12,			Treatment nurse to e	nsure new	
	"Resident retuse	and to resident and daughter			orders are placed on	the	
	10/18/12: "EXPIN	lling for the medihoney to			Treatment Administra	ation	
	perform with dre	ssing change to left lower leg."			Record, Care Plan, an	d Kardex	
	10/19/12: "Perfo as ordered with	Wed flegimon a co			as needed.		
	as ordered with	on provide			92 Degrees		
	Review of the T	realment Administration Record			273-115- 07M12	if continuation	sheel Page 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES

C : ERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  916 PEP DEE ROAD  ABERDEEN, NC 28316  ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMP  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 426  Continued From page 49  (TAR) revealed initial treatment with medihoney calcium alginate to the left log wound was on  A BULLING  STREET ADDRESS, CITY, STATE, ZIP CODE  916 PEP DEE ROAD  ABERDEEN, NC 28316  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMP  TAG  TAG  F 426  Continued From page 49  (TAR) revealed initial treatment with medihoney  Calcium alginate to the left log wound was on  Administration Records, and	STATEMENT OF OFFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	YEMENT OF		•	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  KINGSWOOD NURSING CENTER  KINGSWOOD NURSING CENTER  (X4) ID PREFIX TAG  F 426  Continued From page 49  (TAR) revealed initial treatment with medihoney calcium alginate to the 1eft 1eg wound was on  TREET ADDRESS, CITY, STATE, ZIP CODE B16 PEE PEE ROAD ABERDEEN, NC 28316  PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (COMPOSED TO THE APPROPRIATE DEFICIENCY)  F 426  Continued From page 49  (TAR) revealed initial treatment with medihoney calcium alginate to the 1eft 1eg wound was on  Administration Records, and	and plan of correction	INTO ALL TOWN OF HOMOSEY.	) PLAN OF CO	[^.'				c
KINGSWOOD NURSING CENTER  KINGSWOOD NURSING CENTER  KINGSWOOD NURSING CENTER  ABERDEEN, NC 28316  ID PROVIDER'S PLAN OF CORRECTION OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL. TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 426 Continued From page 49  (TAR) revealed initial treatment with medihoney calcium alginate to the left leg wound was on  ABERDEEN, NC 28316  PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORREC		346609		8.1	MNO		11/1	7/2012
(X4) 10 PREFIX TAG    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 425   Continued From page 49   (TAR) revealed initial treatment with medihoney calcium alginate to the left leg wound was on   Administration Records, and   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    F 425   Continued From page 49   F 425   Continued From page 49   CTAR) revealed initial treatment with medihoney calcium alginate to the left leg wound was on   Administration Records, and   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	•	•	•		8	15 PEE DEE ROAD		
F 426   Continued From page 49   F 420   Orders, Treatment   Calcium alginate to the left leg wound was on   Administration Records, and   Calcium algorithms   Calcium algorithm	PREFIX (EACH DE	DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PR	BLIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	.DBE	COMPLETION DATE
During an interview on 11/16/12 at 10:07 AM, the Treatment Nurse indicated that the resident refused the freetment on 10/17/12 because she thought the physician was supposed to remove the skin greft on her leg. On 10/18/12 the resident was willing to receive the treatment but the medihoney calcium alginate had not come from the pharmacy. The Treatment Nurse Indicated that the made Administrative Staff #2 aware that the medihoney calcium alginate had not come in.  During a tolephone interview on 11/17/12 at 3:12 PM, the pharmacist stated that the original order for medihoney calcium alginate was faved to the pharmacy on 10/16/12 with a medication order. The pharmacist indicated he believed the technician was unaware that the pharmacy had an agreement with the facility to fill orders for wound care products and therefore did not enter if into the computer. On 10/17/12 the pharmacy received a faxed order to refill the medihoney calcium alginate. The pharmacy received the original order and the medihoney calcium alginate was sent to the facility that night.  During an interview on 11/17/12 at 4:33 PM, Administrative Staff #2 stated she had been in contact with the pharmacy daily to obtain the medihoney calcium alginate. The pharmacy daily to obtain the medihoney calcium alginate was sent to the facility to fill orders for with the pharmacy daily to obtain the medihoney calcium alginate. The pharmacy daily to obtain the medihoney calcium alginate was sent to the facility to fill orders for with the pharmacy daily to obtain the medihoney calcium alginate. The pharmacy daily to obtain the medihoney calcium alginate. The pharmacy daily to obtain the medihoney calcium alginate. The pharmacy daily to obtain the medihoney calcium alginate. The pharmacy daily to obtain the medihoney calcium alginate was sent to the facility of the medihoney calcium alginate. The pharmacy daily to obtain the medihoney calcium alginate was all to the facility of the medihoney calcium alginate was a calcium alginate. The pharmacy daily to obt	(TAR) reveale calcium algina 10/19/12 by the During an interfreatment Nurrefused the treatment Nurrefused the the skin great twas willing to medihoney calcum algina the pharmacy. The pharmacy on the christian was an agreement wound care provided a fax calcium algina no refill could have on file. On the original ore alginate was a During an interpretation of the contact with the medihoney calcum algina to calcium alginale was a deministrative contact with the medihoney calcum algina to calcum alginale was a During an interpretation of the contact with the medihoney calcum algorithms.	led initial treatment with meditioney that to the left leg wound was on the Treatment Nurse.  Serview on 11/16/12 at 10:07 AM, the urse indicated that the resident reatment on 10/17/12 because she obysician was supposed to remove to no her leg. On 10/18/12 the resident or receive the treatment but the calcium alginate had not come from y. The Treatment Nurse indicated the Administrative Staff #2 aware that ey calcium alginate had not come in.  In phorie interview on 11/17/12 at 3:12 reacted stated that the original order ey calcium alginate was faxed to the notificated he believed the as unaware that the pharmacy had not with the facility to fill orders for products and therefore did not enter mouter. On 10/17/12 the pharmacy received order to refill the meditioney mate. The pharmacy responded that the lesued since no original order on 10/18/12 the pharmacy received order and the meditioney calcium sent to the facility that night.  The Staff #2 stated she had been in the pharmacy daily to obtain the salcium alginate.  The DRUG RECORDS.	Control of the world the world the control of the world the control of the contro	he  s ent  nat in.  12 er s f		orders, Treatment Administration Records, a wound documentation will completed and document Wound Quality Assurance Tool by Olrector of Nursing Clinical Care Coordinator, Assistant Director of Nursing Results of Wound Quality Assurance Audit Tool monwill be addressed in Quality Assurance meeting by the Director of Nursing month and quarterly thereafter.	nd II be ed on Audit g, and ing. iitor	; a-141-12

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

PRINTED: 12/04/2012 FORM APPROVED OMB NO. 0938-0391

	of deficiencies F correction	(X1) PROVIDER/SUPPLIFIR/GLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	STAC (CX)	.eteo
	:	345509	8. WN	¢		11	C //17/2012
	ROVIDER OR SUPPLIER  DOD NURSING CENTER  SUMMARY ST	TEMENT OF DEFICIENCIES	10,	91	EET ADDREGG, CITY, STATE, ZIP CODE 16 PLE DEE ROAD BERDEEN, NC 28318 PROVIDER'S PLAN OF CORRECTI	ON	α s)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFD TAG	K	(EACH CORRECTIVE ACTION 6HOUL CRO95-REFERENCED TO THE APPROL DEPICIENCY)		COMPLÉTION
	a licensed pharmacist of records of receipt a controlled drugs in sufaccurate reconcillation records are in order are controlled drugs is male reconcilled.  Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the exapplicable.  In accordance with Stataclifly must store all drucked compartments a controls, and permit on have access to the key.  The facility must provid permanently affixed controlled drugs listed in Comprehensive Orug A Control Act of 1978 and abuse, except when the package drug distribution and permit yet ored is minimal to readily detected.  This REQUIREMENT is by: Based on observations	oy or obtain the services of who establishes a system and disposition of all ficient detail to enable an an account of all intelned and periodically with an account of all intelned and periodically with currently accepted, and include the and cautionary appraisance when the and Federal laws, the ange and biologicals in ander proper temperature by authorized personnel to 3.  The eseparately locked, appartments for storage of a Schedule II of the abuse Prevention and a continuous single unit on systems in which the and a missing dose can as not met as evidenced	F4	131	1. All residents potentially a risk. 2. All expired medications removed from Medication Storage Room on 11/16/12 k Clinical Care Coordinator. 3. All medications in medication storage room, including E-box from pharma refrigerated medications, an stock medications will be checked by the Director of Nursing, Assistant Director of Nursing, Clinical Care Coordinator, Shift Supervisor and Supply Clerk weekly x4 weeks and monthly thereafted to rotate stock and remove a medications about to expire. 4. Medication carts will be audited twice weekly by Thir shift nurses using Medication Cart Audit. Any medications that have expired or close to expiration date will be removed.	oy acy, d f er eny	12/14/12
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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/04/2012 ORM APPROVED 3 NO. 0938-0391									
STATEMENT OF DEFICIENCIES A! WOF CORRECTION  345509  NAME OF PROVIDER OR SUPPLIER  KINGSWOOD NURSING CENTER  (X1) ID  \$UMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH OEPICIENCY MUST BE PRECEDED BY FULL			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS. CITY, STATE, ZIP CODE  916 PEE DEE ROAD  ADERDEEN, NC 28318  JO  PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU			(XI) DATE SURVEY COMPLETED  C 11/17/2012  RECTION SHOULD BE COMPLETION										
								TAG	regulatory of LSC identifying information)		TAG		CROSS-REFERENCED TO THE APPRI DEFICIENCY)		RIATE DATE	
									Continued From page 51 The emergency drug box in 1 of 2 medication rooms (medication room for 100, 200 and 300 halls).  The findings included:  On 11/16/12 at 11 AM the following expired medications were observed in the emergency supply box of the medication room for 100, 200 and 300 hall:  Hydroxyzine Pamoate 25 mg cap expired 10/12 Penicillin expired 10/12 Nitro Patch expired 8/12 Arithromycin tab 250 expired 10/12  Nurse #4 was present at this time and indicated that the medications in the emergency box should not be expired. She stated that pharmacy was responsible for checking the emergency supply box to ensure medications were current. Nurse #4 then placed the above expired medications in the return to pharmacy box and said she would order replacement stock.				cross-referenced to the appropriate		12/14/12	

9440914 p.04 01/28/13 10:57AH HP LASERJET FAX PRINTED: UT/U//2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION JAN 2 8 201 COMPLETED (X1) PROVIDER/SUPPLIENCLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION A BUILDING 01/04/2013 B. WING 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 LEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES 1D PREFIX TAG DATE (X4) ID LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX DIFICIENCY TAG K 000 K 000 | INITIAL COMMENTS Surveyor, 27871 K045 This Life Safety Code(LSC) survey was 1. All residents are potentially at conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced 2. The original lighting has been publications. This building is Type V construction, changed to a new lighting one story, with a complete automatic sprinkler fixture. The new lighting fixture contains the required 2 lighting system. The deficiencies determined during the survey system. 3. The Maintenance Supervisor has are as follows: NFPA 101 LIFE SAFETY CODE STANDARD K 045 formalized a Preventative K 045 Maintenance Program which has SS=E Illumination of means of agress, including exit just been finished this month. discharge, is arranged so that failure of any single The Preventative Maintenance lighting fixture (bulb) will not leave the area in Program includes maintenance darkness. (This does not refer to emergency lighting in accordance with section 7.8.) items that his department checks weekly, monthly, quarterly, semi-annually or yearly. 4. Checking both internal and external exit lighting will be This STANDARD is not met as evidenced by: added to his Preventative Surveyor: 27871 Based on observations and staff interview at Maintenance Program. These approximately 8:30 am onward, the following items will be check on a weekly Items were noncompliant, specific findings include: Lighting must be arranged to provide 5. The Maintenance Supervisor will light from the exit discharge leading to the public way (parking lot). The walking surfaces within the provide to the Administrator a exit discharge shall be illuminated to values of at copy of his audit each week for least 1 ft-candle measured at the floor. Failure of monitoring purposes. any single lighting unit does not result in an 6. The Maintenance Supervisor will illumination level of less than 0.2 ft-candles in any report his Audit Results to the designated area.(100 and 200 hall) NFPA 101 Quality Assurance Meeting each

ABBRATORY DIRECTORS OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE

7.8.1.1, 7.8.1.3, and 7.8.1.4.

In deficiency statement ending with an deterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their sateguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days of their sateguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the shove findings and plans of correction are disclosable 14 ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the shove findings and plans of correction are disclosable 14 ollowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued tays following the date these documents are made available to the facility.

)rogram participation.

month x 12 months.

TITLE

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PRINTED: 01/07/2013

10:57AM

HP LASERJET FAX

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 01 - MAIN BUILDING 01 A BUILDING g, WING 01/04/2013 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) IO PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG YAG DEFICIENCY K 045 K 045 Continued From page 1 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 066 K 066 K066 SS=E 1. All residents are potentially at Smoking regulations are adopted and include no less than the following provisions: 2. The non-compliant containers (1) Smoking is prohibited in any room, ward, or have been replaced with selfcompartment where flammable liquids, closing metal containers in which combustible gases, or oxygen is used or stored ashtrays can be emptied. The and in any other hazardous location, and such containers have been painted red area is posted with signs that read NO SMOKING and the following instructions will or with the international symbol for no smoking. be stenciled on each container. (2) Smoking by patients classified as not "Cigarette Butts Only" responsible is prohibited, except when under 3. Staff will be in-serviced about the direct supervision. purpose of the cigarette butt containers and the need to use (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is the containers and ashtrays permitted. correctly. 4. The Maintenance Supervisor will (4) Metal containers with self-closing cover add 5 x per week monitoring of devices into which ashtrays can be emptied are the smoking areas to his readily available to all areas where smoking is Preventative Maintenance 19.7.4 permitted. Program. 5. The Maintenance Supervisor will provide the Administrator with a copy of his monitoring results so the Administrator can monitor This STANDARD is not met as evidenced by: the program. Surveyor: 27871 Based on observations and staff interview at 6. The Maintenance Supervisor will approximately 8:30 am onward, the following provide the Quality Assurance Items were noncompliant, specific findings

Committee with results of his

x 12 months.

Facility 10: 970412

monitoring system 1 x per month

include: smoking areas do not have self-closing

metal container which eshtrays can be emptied.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIET/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING 01 B. WING \_\_\_ 01/04/2013 345509 STREET ADDRESS, OITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG DEFICIENCY K 086 K 066 Continued From page 2 42 CFR 483,70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 076 K 078 K076 SS≃Œ 1. All residents are potentially at Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. 2. Red signs with black lettering that say "Full Oxygen Tanks Only" or (a) Oxygen storage locations of greater than "Empty Oxygen Tanks Only" will 3,000 cu.ft. are enclosed by a one-hour be attached to the entrance separation. doors of the empty and full (b) Locations for supply systems of greater than oxygen rooms for better visibility. 3,000 cu.ft. are vented to the outside. NFPA 99 An additional red and black 4.3,1.1.2, 19.3.2.4 lettered sign will be placed above the empty or full oxygen tank storage areas. 3. The nursing staff have been inserviced on the proper procedure This STANDARD is not met as evidenced by: for Full or Empty Oxygen Tank Surveyor: 27871 storage. Based on observations and staff interview at 4. The Maintenance Supervisor will approximately 8:30 am onward, the following add monitoring of the oxygen Items were noncompliant, specific findings rooms to his Preventative include; at time of survey, found empty oxygen cylinder tank mix in with full ones(oxygen storage Maintenance Program. room across from nurse station). 5. The Maintenance Supervisor will provide a copy of his 3 x per week 42 CFR 483.70(a) audit of the oxygen rooms to the Administrator 1 x per week so the Administrator can monitor his program, The Maintenance Supervisor will report his audit results to the Quality Assurance Committee 1 x per month for 12 months.