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<tr>
<th>ID</th>
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<th>TIC</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tbody>
<tr>
<td>F 241</td>
<td>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</td>
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<td>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on record review and staff interviews, the facility failed to treat 1 of 1 resident (Resident #1) capable of urinary continence, with dignity, when requesting assistance with toileting.</td>
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<td>The findings included:</td>
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<td>Resident #1 was admitted to the facility on 10/17/13 after a weeklong stay in the hospital for pneumonia, lung cancer and cardiomyopathy. Resident #1 was not interviewed since she was discharged to the hospital on 10/27/13, and then later placed on Hospice.</td>
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<td>The admission Minimum Data Set (MDS) assessment was not available due to the length of her stay in the facility, however, on the FL-2, a form used by professionals to determine a patient's level of care needs for a skilled nursing environment, dated 10/16/13, it determined that Resident #1 had constant mental orientation to person, place and time. She was continent of bowel and bladder but required extensive assistance for ambulation, transfers and toileting.</td>
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<td>A written statement from Nurse #2, dated 10/27/13 (7am to 7 pm shift) revealed that Resident #1 reported to a nurse aide (unknown) at the beginning of the shift that she had not been</td>
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**LABORATORY DIRECTORS OR PROVIDER/SupPLIER REPRESENTATIVE SIGNATURE**

Dyanita Bailey

**DURATION**

11/27/13

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions) Except for nursing homes, the findings stated above are discloseable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
F 241

Continued from page 1

changed all night. The nurse went into the room
to talk with Resident #1 and she stated, "look at
my gown and bed." She wrote that the gown and
bed was soaking wet with a brown ring under the
resident. The resident also stated to her that she
was told by a female staff to go ahead and wet
the bed and we will try to get back to you. Nurse
#2 found the resident's entire gown and bed
was very cold.

A phone interview was conducted with Nurse #2,
on 11/11/13 at 11:15 am. She stated that last
Sunday, she was called to the room of resident
#1 and found her soaked in urine and was told that
she had been wet, all night long. The resident
told her that she hadn't been touched all night
long and her gown and sheets were wet. She
stated that the resident was cognitively intact.

She continued by stating that the night shift staff
had already left, but she brought her concerns to
the attention of administrative nurse #3. She also
mentioned that when she entered the room, she
noticed that resident #1's call bell cord was:
hanging down next to her bed, but she was
uncertain if she had used her call bell during the
night.

The nurse said that Nurse Aide #1 was one of the
aides working that morning who came to the
room to clean resident #1 up.

Nurse #2 then went to speak to nurse #3, who
worked on the floor the night of 10/26/13. The
nurse told her that she was unaware that
resident #1 was soaked all night long. She
assured nurse #2 that she had toileted resident
#1, using the bedpan, the night before, while her
family was present.
A copy of the Visitor's Log from 10/22/13 was reviewed. It revealed that Patient #1 had a family visit from 6:30 pm to 8:15 pm.

On 11/17/13 at 7:43 pm, a phone call was placed for Resident #1. The caller stated that there was no response. The call was returned on 11/17/13 at 10:23 pm. The caller stated that they had left the room and seen the resident on the floor. The caller stated that the resident was not responding.

The report was discussed with the Administrator and the Survey Coordinator.

The survey coordinator will follow up with the facility to ensure that all necessary actions are taken.

The resident's family was contacted and informed about the situation. The resident was transferred to the hospital for further evaluation.

The facility will improve its communication with the resident's family to ensure that they are informed of the resident's status.

The facility will review its procedures for handling emergency situations.

The facility will implement a new protocol for handling emergency situations, including having a designated person to handle calls and ensuring that the resident's family is informed of the situation.

The facility will review its procedures for handling emergency situations, including having a designated person to handle calls and ensuring that the resident's family is informed of the situation.

The facility will implement a new protocol for handling emergency situations, including having a designated person to handle calls and ensuring that the resident's family is informed of the situation.

The facility will review its procedures for handling emergency situations, including having a designated person to handle calls and ensuring that the resident's family is informed of the situation.
Continued from page 3

expressed no concerns for herself.

The Administrative Nurse was interviewed on 11/1/13 at 12:10 pm. She stated that she became aware of the concerns of Nurse Aide #1 and Nurse #2 regarding the lack of care that Resident #1 received on 10/25/13, during the night shift. She expressed that she was concerned the way that the Unit Nurse (Nurse #3) handled the matter.

A resident who is unable to carry out activities of daily living requires the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:

1. Resident #1 cleaned and dried by 7am-7pm NA on 10/27/13.
2. DON spoke with Nursing Supervisor for 7a-7p shift on 10/27/13. Asked if there were any other residents found to be wet or with any care issues noted from the 7p-7a shift 10/26/13. No other residents noted to have any care issues.
3. NA assigned to resident #1 on 7p-7a shift 10/26/13 disciplined by the DON on 11/8/13 for not providing toileting and incontinence care to resident #1.
4. NA re-educated on providing timely care to residents including toileting needs, incontinence care, and any other needs.

F 312

1. Resident #1 cleaned and dried by 7am-7pm NA on 10/27/13.
2. DON spoke with Nursing Supervisor for 7a-7p shift on 10/27/13. Asked if there were any other residents found to be wet or with any care issues noted from the 7p-7a shift 10/26/13. No other residents noted to have any care issues.
3. NA assigned to resident #1 on 7p-7a shift 10/26/13 disciplined by the DON on 11/8/13 for not providing toileting and incontinence care to resident #1.
4. NA re-educated on providing timely care to residents including toileting needs, incontinence care, and any other needs.
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<tr>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 312</td>
<td>Continued From page 4</td>
<td>F 312</td>
<td>disciplined by DON on 11/6/13 for not ensuring that resident's needs were met and rounds made timely.</td>
<td>SDC 11/8/13</td>
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<td>dated 10/16/13, it determined that Resident #1 had constant mental orientation to person, place and time. She was continent of bowel and bladder but required extensive assistance for ambulation, transfers and toileting. Resident #1 was not yet care planned for activities of daily living skills.</td>
<td></td>
<td>5. SDC in-serviced nursing staff on 11/8/13 on ADL care and making rounds timely with a focus on incontinence care and assisting residents with toileting needs as they are voiced by the resident. In-servicing of all nursing staff will be completed by 11/28/13. Any staff member who has not received this in-service will not be allowed to work until they have had this training. Training will also be addressed with all future hires in the initial orientation.</td>
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<td>On a nurse's note, 10/25/13 at 10:00 pm; Nurse #1 recorded that Resident #1 must be assisted to ambulate due to increased weakness. A written statement from Nurse #2, dated 10/27/13 (7am to 7 pm shift) revealed that Resident #1 reported to a nurse aide (unknown) at the beginning of the shift that she had not been changed all night. The nurse went into the room to talk with Resident #1 and she stated, &quot;look at my gown and bed.&quot; She wrote that the gown and bed was soaking wet with a brown ring under the resident. The Resident also stated to her that she was told by a female staff to go ahead and wet the bed and we will try to get back to you. Nurse #2 found the Resident's entire gown and bed was very cold. A phone interview was conducted with Nurse #2 on 11/1/13 at 11:15 am. She stated that last Sunday, she was called to the room of Resident #1 and found her soiled in urine and was told that she had been wet, all night long. She did not convey if Resident #1 remained on the bed pan. The Resident told her that she hadn't been touched all night long and her gown and sheets were wet. She stated that the Resident was cognitively intact. She continued by stating that the night shift staff</td>
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<td>6. DON and SDC facilitated a Nursing Supervisors meeting held on 11/8/13. Areas covered included making rounds, checking to make sure residents ADL care is done timely and properly, and disciplining staff if care is not done.</td>
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<td>7. Nursing Supervisors and Unit Managers will make rounds on their respective shifts to monitor for timely rounds anddisciplinary by DON on 11/6/13 for not ensuring that resident's needs were met and rounds made timely.</td>
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**F 312**

Continued From page 6

had already left, but she brought her concerns to the attention of Administrative Nurse #3. She also
noticed that Resident #1's call bell cord was hanging down next to her bed, but was uncertain if she had used her call bell during the night.

The nurse said that Nurse Aide #1 was one of the aides working that morning who came to the room to clean Resident #1 up.

Nurse #2 then went to speak to Nurse #3, who worked on the hall last night. The nurse told her that she was unaware that Resident #1 was soiled all night long. She assured the nurse that she had put Resident #1 on a bed pan, the night before, while her family was present.

A copy of the Visitor's Log from 10/26/13 was viewed. It revealed that Resident #1 had a family visitor from 6:35 pm to 9:15 pm.

On 11/1/13 at 11:43 am, a phone interview was conducted with Nurse Aide #1. She stated that she worked 10/27/13 from 7 am to 7 pm and was doing rounds that morning, before breakfast, when she entered the room of Resident #1. She remembered asking her if she was okay and was told that she was soaking wet. Resident #1 reported to her that she was told by staff during the night that "I can't get to you, just wet and I'll get to you shortly." Nurse Aide #1 recalled that Resident #1 was wet from head to toe, stating that it was awful and that she apologized to her for the conditions that she found her in. Nurse Aide #1 stated that she went immediately to her Nurse #2, to report her findings.

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**F 312**

Incontinence care, and all other care needs. Unit Managers and Nursing Supervisors will note any issues found on the daily Nursing Supervisors report sheet along with corrective action taken such as staff education and disciplines. Unit Managers will bring Supervisors report sheet to daily stand up meeting x30 days. DON will discuss results of these rounds in QA meeting monthly x3 months then quarterly. Completion date 11/28/13.
F 312  Continued From page 6
Administrative Nurse #3 was interviewed by phone on 11/1/13 at 11:55 am. She confirmed that Nurse #2 discussed her concerns with her after she found Resident #1 very soiled. The nurse on duty, (Nurse #3), on 10/29/13 told her that she had put Resident #1 on a bed pan.

Several phone calls were made to Nurse #3, but unsuccessful.

Resident #1 was not interviewed, since she was admitted to the hospital on 10/27/13 and then later discharged to Hospice.

F 363
SS-D
483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

F 353

1. Nurse #3 disciplined by DON on 11/8/13 regarding not notifying the on-call nurse or the Director of Nursing regarding staffing situation. Discipline included education of expectations of Nursing Supervisor to call Administrative Nurse on call in regards to staffing issues and to notify the DON if issue is not resolved and relief staff found.

2. DON and SDC facilitated a Nursing Supervisors meeting on 11/8/13. Covered expectations of Supervisors including notifying not only the Administrative nurse on-call of staffing situations but also notifying Director of Nursing when...
This **REQUIREMENT** is not met as evidenced by:

Based on record review and staff interviews, the facility failed to provide sufficient nursing staff, on 10/26/13, without compromising the needs of 1 of 3 residents, (Resident #1) needing extensive assistance with activities of daily living.

The findings include:

Resident #1 was admitted to the facility on 10/17/13 after a week-long stay in the hospital for pneumonia, lung cancer, and cardiomyopathy. On the FL-2, a form used by professionals to determine a patient’s level of care, needs for a skilled nursing environment, dated 10/16/13, it determined that Resident #1 had constant mental orientation to person, place and time. She was continent of bowel and bladder but required extensive assistance for ambulation, transfers and toileting. It noted that she should receive continuous oxygen at 4 liters a minute due to her medical diagnosis.

The facility’s Weekday Nursing Assignment sheet was reviewed for 10/26/13, 7pm to 7am. The main unit, which consisted of halls Tangelo, Greenbrier and Somerset, was staffed for 2 nurses to work a split shift on Tangelo and 1 nurse to work on Greenbrier. Two nurse aides were scheduled to work on Tangelo and the two aides scheduled to work on Greenbrier called off at 10:30 am and 12:00 pm. One aide was scheduled to work on Somerset from 3 pm to 11 pm.

The time sheets for 10/26/13 provided by the Human Resources department indicated that

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- **3. Weekend NA on-call list**
  - Initiated by DON with NA’s signing up to take call on the weekend shifts. This will be done monthly by the DON. Each shift on the weekend will have an NA who is on call to cover any call ins on that shift. NA’s will sign up each month to ensure there is back-up coverage for any staffing issues for each weekend. Call-in’s during the week and on holidays will be covered by prn and weekend staff.
  - Completed 10/31/13

- **4. Nursing Supervisors are to complete the daily staffing/census sheet for their shift. Any noted staffing shortages are to be reported to the Administrative Nurse on call and replacement staff called in from on-call list.**
  - Completion date 11/28/13.

- **5. Administrative Nurse on call will contact the facility at the beginning of each shift on the weekends and speak to the Nursing Supervisor to ensure that all staff scheduled for that shift**
**NAME OF PROVIDER OR SUPPLIER**
KING'S WOOD NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
916 PEE DEE ROAD
ABERDEEN, NC 28316

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**(X2) MULTIPLE CONSTRUCTION**
A. BUILDING
B. WING

**(X3) DATE SURVEY COMPLETED**
C
11/01/2013

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<td>F 353</td>
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<td>Nurse Aides #4 and #5 although scheduled to work, was not in attendance that day. It also reflected that both aides #2 and #3 were allowed lunch breaks at 11:45 pm to 12:15 am, with Nurse #3 taking her break from 12:00 am to 12:30 am.</td>
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<td>A written statement from Nurse #2, dated 10/27/13 (7 am to 7 pm shift) revealed that Resident #1, reported to her that she had not been changed all night and was found soaked in urine and that she was having trouble catching her breath.</td>
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<td>A phone interview was conducted with Nurse #2 on 11/1/13 at 11:15 am. She stated that last Sunday, she was called to the room of Resident #1 and found her soaked in urine and was told that she had been wet, all night long. The Resident told her that she hadn't been touched all night long and her gown and sheets were wet. She stated that the Resident was cognitively intact. She also shared that Resident #1 had attempted to wear oxygen but there was no pressure coming through the canula. When she assisted Resident #1 she found her in respiratory distress with oxygen saturations of 77%.</td>
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<td>On 11/1/13 at 11:43 am, a phone interview was conducted with Nurse Aide #1. Nurse Aide #1 stated that the facility had been short staffed the night of 10/26/13. Normally, there are four aides on duty, for the three halls unit, but that night, they only had 2 aides on the unit. She stated that she worked 10/27/13 from 7 am to 7 pm and was doing rounds that morning, before breakfast, when she entered the room of Resident #1. She remembered asking her if she was okay and was told that she was soaking wet. Resident #1 reported to her that she was told by staff during care.</td>
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<td>F 353</td>
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<td>are in attendance or that a replacement for any absentee staff has been made. Completion date 11/28/13.</td>
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<td>6. Daily staffing/census sheets will be brought to the daily stand up meeting by the Unit Manager for review daily. Administrative Nurse on call will speak with the Nursing Supervisors on weekends and holidays to review staffing for that time and will notify the DON of staffing situations and any issues and how they have been handled. Results will be discussed in QA meeting by the DON monthly x 3 months then quarterly. Completion date 11/28/13.</td>
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**DON**
11/28/13
Continued From page 9

The night that "I can't get to you, just yet and I will get to you shortly."

The Administrative Nurse was interviewed on 11/1/13 at 12:10 pm. She stated that she became aware of the concerns of Nurse Aide #1 and Nurse #2 regarding the lack of care that Resident #1 received on 10/28/13, during the night shift. She expressed that she was concerned the way that the Unit Nurse (Nurse #3) handled the matter. She mentioned that the nurse never informed the administrative staff that they remained short staffed throughout the shift. Then explained that the facility’s scheduler calls at the beginning of each shift to determine if there are any call offs. It was never relayed that Nurse #3 could not gather additional nursing help to the on-call nurse, Administrative Nurse #1 or the Administrator.