D PLAN OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
		IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345509	B. WING		09	C 9/23/2016
AME OF PR	OVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
INGSWOO	OD NURSING CENTER			5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE
F 000	INITIAL COMMENTS	3	F 000			
	A complaint investiga from 9/20/16 through Jeopardy was identifi					
(J CI (J	(J)	309 at a scope and severity 323 at a scope and severity				
		F490 and F520 at a scope				
	The tags F309 and F Quality of Care.	323 constituted Substandard				
		began on 9/10/16 and was An extended survey was				
	On 10/26/16, the 256 was added at F282 E	7 was amended. A new tag				
	The scope and sever changed from D to E	ity of F314 and F353 was				
	amended.	53, F490 and F520 were	5 00 4			
	483.13(c) PROHIBIT MISTREATMENT/NE	GLECT/MISAPPROPRIATN	F 224			11/14/16
	policies and procedu	t, and abuse of residents				

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

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					С
		345509	B. WING		09/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD	
	OB NOROING GENTER			ABERDEEN, NC 28315	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET
F 224	Continued From page	91	F 224	1	
	by: Based on record revi physician, resident ar neglected to provide v by the physician for 4 and #13) of 6 sampler wound treatment. Findings included: 1. Resident #10 was a 4/12/16. The Minimum 7/11/16 revealed he h and an indwelling catt were in part, chronic u urinary tract disease a Review of the care pla updated on 7/19/16 re nursing staff to provid every shift and as nee Review of the physici revealed to clean the soapy water and appl and as needed. Review of the physici revealed to clean the site with normal salin (an antibiotic) ointmen debridement agent) g Review of Resident # administration record catheter was not clea (Saturday), 8/14/16 (8/20/16 (Saturday) or Additionally, supraput	ad staff interview, the facility wound treatment as ordered 4 (Residents #9, # 10, #11 d residents reviewed for admitted to the facility on n Data Set (MDS) dated had a mild memory problem, heter. His current diagnoses urinary tract infection, and dementia. an initiated 7/21/16 and evealed in part, for the le suprapubic catheter care eded. an order dated 7/27/16, surgical incision with warm y dry dressing every day an order dated 8/17/16, right suprapubic catheter he and apply Mipirocin 2% ht and Santyl (a auze every day . #10's August 2016 treatment (TAR) revealed, suprapubic on revealed the suprapubic ned and changed on 8/6/16 Sunday), 8/13/16 Sunday), 8/15/16 (Monday),		 F 224 1. Resident #9 sacrum treatment w performed per physician order by the wound nurse on 9/21/16. Resident #' suprapubic catheter treatment was performed per physician order by the wound nurse on 9/22/16. Resident # lesion on back treatment was perform per physician order by the wound nur on 9/22/16. Resident #13 bilateral to and left heel treatment was performe physician orders by wound nurse on 9/21/16. Physician was notified on 9/28/16. Education of staff assigned these shifts began on 9/22/16. 2. Licensed Nursing staff were re-educated on performing treatment physician or 9/23/16 and prior to n shift worked. Any new licensed empl will receive this education upon orientation. Every licensed nurse will observed during treatment round(performing treatment round(performing treatment and skills checklist will be observed during treatment round(performing treatment and skills checklist will be completed certified Wound Care nurse and or supervisor. 	10 11 hed rse es d per to to s per ext oyee l be s ed by 11 w g ts)

Facility ID: 970412

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345509 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 224 Continued From page 2 F 224 and changed on 8/20/16 (Saturday) and 8/21/16 3. An audit of treatment administration (Sunday), with Santyl and Mipirocin 2% ointment. records was performed by the ward clerk Review of Resident #10's September 2016 TAR on 10/4/16. All incidences of omission revealed the suprapubic catheter dressing was discussed with the Medical Director change was not administered on 9/10/16 on 9/28/16 and was taken to QA meeting (Saturdav) or 9/11/16 (Sundav). on 10/22/16. Any licensed nurse not During an interview via telephone on 9/22/16 at completing treatments as ordered will 10:00am, Nurse #4 indicated she had not receive disciplinary action per policy up to performed any dressing changes for Resident and including termination of employment. #10 until 8/20/16. Nurse #4 stated she was assigned to do Resident #10's suprapubic 4. Residents with treatments ordered by dressing change on 8/15/16, but did not perform the physician have the potential to be this dressing change as ordered, because she affected. didn't know she was supposed to. During an interview via telephone on 9/22/16 at 5. An audit of treatment administration 2:22pm, Nurse #9 (weekend supervisor), records will be conducted every day for revealed she was responsible to complete the completeness by the wound nurse and or weekend treatments. When she worked on the the floor nurse for two months. Then the hall with a resident assignment the treatments audit will be conducted three times per were delegated to the nurses who had the week for one month, then monthly for assigned residents. She stated she had elected eleven months. which treatments to do and chose not to do the suprapubic dressing change when she worked on The results of audits will be discussed by the weekends. The schedule revealed she was Director of Nursing during the monthly QA assigned to do Resident #10 suprapubic meeting monthly for twelve consecutive treatment on 8/6/16 (Saturday). She stated there months and then periodically to ensure wasn't enough time to do everything and she had compliance is met. informed the Director of Nursing (DON). During an interview via telephone on 9/22/16 at 4:48pm, Nurse # 12 revealed she was not hired to do treatments. She was hired to pass medications. She had not done any treatments. Nurse #12 specified she did not perform Resident #10's suprapubic dressing changes as ordered when she worked. She was assigned to do the suprapubic dressing changes for Resident #10 on 8/7 (Sunday), 8/14 (Sunday), 8/20 (Saturday) and 8/21 (Sunday). During an observation on 9/22/16 at 8:43pm,

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/21/2016 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING		_	(09/2	_ 23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Nurse #1 changed the Observation revealed exudate and pink tiss site. There was no for cleaned with normal s was dried and covere paper tape. During interview on 9. Director of Nursing in expected to do the tree they were assigned a shift. 2. Resident # 11 was 3/26/14. The most reco (MDS) assessment da she had severe cogni wound. The most reco Alzheimer disease an (auto inflammatory dis Review of the most re 1/8/16, revealed in pa done as ordered to th Review of the physicia revealed to apply Cloi corticosteroid) ointme daily and cover with a powder (sic)(to enhan calcium alginate (abs Review of the physicia revealed apply FlagyI 500 mg tablet crushed bed medial back then above. A clarification 8/26/16, to apply the I Review of Resident # administration record treatment was not dow	e suprapubic dressing. a scant amount of dried ue from around the incision al odor. The site was saline on gauze the area d with a split gauze and /22/16 at 5:30pm, the dicated that nurses were satments of the residents ind to document after each admitted to the facility on cent Minimum Data Set ated 8/12/16 revealed that tive impairment and a ent diagnoses were in part, d pyoderma gangrenosum sorder) cent wound care plan dated int, wound care was to be e lesion on the medial back. an order dated 7/25/16, betasol propionate 0.05% (a int to the ulcer on the back dhesive and collagen to tissue growth) and orbed exudate). an order dated 8/19/16 (for a bacterial infection) d and apply to the wound follow current treatment order was added on Flagyl for a total of 1 month. 11's July 2016 treatment (TAR) revealed wound cumented as being on 7/2/16 (Saturday),	F 22	4			

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2016 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENC AND PLAN OF CORRECTIO	IES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING				C /23/2016	
NAME OF PROVIDER OR	SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				9	915 PEE DEE ROAD			
KINGSWOOD NURSI	NG CENTER			A	ABERDEEN, NC 28315			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ACTION SHOULD BE CO TO THE APPROPRIATE		
Review o revealed documen 8/7/16 (S (Sunday) (Sunday) being adr (Saturday Review o revealed as as bein documen (Saturday During th wound dr Nurse #1 resident# with dark wound wa Clobetase applied a During ar 4:48pm, f Resident when she the dress revealed was hired any treatr not do the (Sunday) (Sunday) During in Director o expected they were shift. 3. Residen	the wound t ted as perfo unday), 8/13 , 8/15/16 (M . The Flagyl ninistered to y) and 8/21/- f Resident # wound treat ng performe ted as being y). e observation essing chan , the wound 11's back ha rolled edge as cleaned wo ol, Calcium / nd was cove interview v Nurse # 12 s # 11's dress worked. N ing changes she was not to pass me nents. Nurse e treatment , 8/7 (Sunda serview on 9 of Nursing in to do the tre e assigned a ent # 9 was	e 4 e 4 e 4 e 4 e 11's August 2016 TAR reatment was not rmed on 8/5/16 (Friday), 8/16 (Saturday), 8/14/16 onday) or on 8/21/16 was not documented as the wound on 8/20/16 16 (Sunday). e 11's September 2016 TAR ment was not documented d and the Flagyl was not g administered on 9/10/16 on of the resident's back age on 9/22/16 at 8:10am, care nurse, revealed ad a large clean pink wound s and had no odor. The with Normal Saline, and Alginate and Flagyl were ered with dressing. ia telephone on 9/22/16 at said she did not perform ing changes as ordered urse #12 was assigned to do a for the Resident. She t hired to do treatments. She edication. She had not done se #12 specified that she did for the resident on 7/24 ay), 8/14 (Sunday), and 8/21 /22/16 at 5:30pm, the dicated that nurses were eatments of the residents and to document after each admitted to the facility on m Data Set (MDS) dated	F	224				

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/21/2016 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			-		C 23/2016
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
				9	915 PEE DEE ROAD			
KINGSWO	OOD NURSING CENTER				ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 224	a stage 3 pressure uld dementia and enceph discharged on 8/11/10 Review of the care pla Resident #9 had a sta her sacrum. The appr ulcer were in part, to 9 monitor the effectiven report to the physician deterioration within 2 Review of her physician (used to absorb exud- dressing every day ar The resident's July 20 treatment administration reviewed. The boxes nurse's initial to indica provided on 7/2/16 (S 7/24/16 (Saturday), 8, (Sunday). During an interview vi 4:48pm, Nurse # 12 m to do treatments. She medication. She had She was assigned to Resident #9 on 7/24/7 (Sunday) and Nurse # perform these treatment During an interview of Director of Nursing in the treatments were m weekends. She indica that the nurses had m	had a memory problem and cer. Diagnoses were in part, alopathy. She was 5. an dated 6/25/16, revealed age 3 pressure ulcer sore on toaches to heal the pressure give medication as ordered, ess of the treatment and in f no change or weeks. an order dated 7/6/16, was m with normal saline, apply briding ointment), Mipirocin ment) and calcium alginate ate) cover with foam ind as needed. 016 and August 2016 ion records (TAR) were on the TAR did not have ate that the treatment was aturday), 7/3/16 (Sunday), /6/16 (Saturday) and 8/7/16 a telephone on 9/22/16 at evealed she was not hired was hired to pass not done any treatments. do the dressing changes for 16 (Sunday) and 8/7/16 \$12 confirmed she did not ents. n 9/22/16 at 3:06 pm, The dicated she was not told that not being completed on the ated she had heard murmurs o time to get wounds done.	F	224				

TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	PLETED
						С
		345509	B. WING		09/	23/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	e 6	F 2	24		
	swamped with staffing	g issues.				
		admitted to the facility on				
	8/29/16. The Minimu	m Data Set (MDS)				
		10/16 indicated that the				
		ely intact and with gangrene				
		ht toes. Her diagnoses				
		e, diabetes mellitus and				
	peripheral vascular di					
		dated 8/30/16 indicated to				
	•	id left heel with betadine gangrene dry as possible.				
		#13's September 2016				
		ion record (TAR) revealed				
		the resident's bilateral toes				
		documented as performed				
) and 9/11/16 (Sunday).				
	During the interview of	on 9/20/16 at 2:47 PM,				
	Nurse #1 (wound care	e nurse) revealed it was				
	•	resident's heel painted with				
	-	ne spread of gangrene.				
	•	/20/16 at 2:47 PM, Resident				
		e betadine was applied to her				
	feet most days.					
		ervation on 9/21/16 at 7:00				
		left and right feet revealed mild edema on both feet.				
		red to paint the foot and heel				
	with betadine and let	-				
		n 9/22/16 at 8:10 AM, Nurse				
		urse, indicated that the				
		done when she was off				
	during the week and	on the weekends because				
		kends and had found the				
	-	he had put on the resident				
	-	s on Monday morning.				
	During an interview o	n 9/22/16 at 2:22 PM, Nurse				
	#9 (weekend supervis	sor) revealed she was e the treatments on the				

Facility ID: 970412

If continuation sheet Page 7 of 57

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345509	B. WING			23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	resident assignment, delegated to the nursi- residents. She indica dressing for the stage and the treatments or remaining treatments stated she was sched treatment on 9/10/16 #13 and the treatment resident. She stated t do everything and she Nurse #14 was assign 9/10/16 and 9/11/16. available for interview During an interview of DON indicated she was treatments were not b weekends. She indicat that the nurses had nurse shad nurse shad nurse swamped with staffing 483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by of accordance with each care. This REQUIREMENT by: Based on record revia and staff interview, th care plan for wound of	the treatments were es assigned to the ted that she changed the a 3 and 4 pressure ulcers dered for twice a day. The were omitted. Nurse #9 huled to provide the betadine and 9/11/16 for Resident t was not provided to the here wasn't enough time to a had informed the DON. ned to Resident #13 on Nurse #14 was not t. n 9/22/16 at 3:06 pm, the as not told that the being completed on the ated she had heard murmurs the nurses were refusing to cause we had been g issues. ICES BY QUALIFIED the PLAN d or arranged by the facility qualified persons in a resident's written plan of f is not met as evidenced ew, observation and family he facility failed to follow the are for 3 of 5 (Resident # oled residents who received	F 224		-	11/14/16

Event ID: 3B3711

Facility ID: 970412

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345509 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 8 F 282 1. Resident # 9 was admitted to the facility on wound nurse on 9/22/16. Resident #11 4/23/15. The Minimum Data Set (MDS) dated lesion on back treatment was performed 6/22/16 revealed she had a memory problem and per physician order by the wound nurse a stage 3 pressure ulcer. Diagnoses were in part, on 9/22/16. Resident #13 bilateral toes dementia and encephalopathy. She was and left heel treatment was performed per discharged on 8/11/16. physician orders by wound nurse on Review of the care plan dated 6/25/16, revealed 9/21/16. MD notified on 9/28/16. Resident #9 had a stage 3 pressure ulcer on her Education of staff assigned to these shifts sacrum. The approaches to heal the pressure began on 9/22/16. ulcer were in part, to give medications as New treatment orders are reviewed daily ordered, monitor the effectiveness of the Monday through Friday in clinical meeting treatment and report to the physician if no change and care planned by MDS Coordinator or or deterioration within 2 weeks. Supervisor. Wounds will be reviewed in Review of her physician order dated 7/6/16, was weekly Patient at Risk meetings. in part, to clean sacrum with normal saline, apply Santyl (a chemical debriding ointment), Mipirocin 2. Licensed Nursing staff were educated 2% (an antibiotic ointment) and calcium alginate on performing treatments per physician s (used to absorb exudate) cover with foam orders by the Director of Nursing and or dressing every day and as needed. Staff Development Coordinator on 9/23/16 The July and August 2016 treatment and prior to next shift worked. Any new administration record (TAR) were reviewed. The licensed employee will receive this boxes on the TAR did not have nurse's initial to education upon orientation. All current licensed Nursing staff will be observed indicate that the treatment was provided on 7/2 (Saturday), 7/3 (Sunday), 7/24/16 (Saturday), 8/6 during a treatment round(perform (Saturday) and 8/7(Sunday). treatments) and a skills checklist will be During interview on 9/20/16 at 2:33pm, Nurse #1, completed by Certified Wound Nurse and the wound care nurse, indicated the weekend or Supervisor by 11-14-16 or prior to next nurse supervisor changed the dressings on the shift. Every new Licensed Nursing staff weekend. When the nursing supervisor was will be observed during a treatment working on a hall passing medications, all nurses round(perform treatments) and a skills were responsible to do the treatments of their checklist will be completed by the Certified assigned residents. Wound Nurse and or Supervisor. During an interview via telephone on 9/22/16. Nurse # 8 who was assigned to Resident #9 on 3. An audit of treatment administration 7/2 and 7/3/16, indicated the wound treatments records was performed by the ward clerk were completed by the weekend nurse supervisor on 10/4/16. All incidences of omission (Nurse #9.) was discussed with the Medical Director During an interview via telephone on 9/22/16 at on 9/28/16 and was taken to the QA 2:22pm, Nurse #9 (weekend supervisor), meeting on 10/22/16. Any nurse not

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Facility ID: 970412

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ С 345509 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 9 F 282 revealed she was responsible to complete the completing treatments as ordered will weekend treatments, and the pressure ulcer receive disciplinary action per policy up to treatments. When she worked on the hall with a and including termination of employment. resident assignment the treatments were delegated to the nurses who had the assigned Residents with treatments ordered by 4. residents. She indicated when she was busy as the physician have the potential to be the supervisor she had elected which treatments affected. she would do and omitted the other treatments. The schedule revealed she was assigned to do 5. An audit of treatment administration the treatment on 8/6/16 for Resident #9. records will be conducted every day for completeness by the wound nurse and or Review of the schedule revealed Nurse #12 was assigned to Resident #9 on 7/24/16 and 8/7/16 the floor nurse for two months. Then the and the dressing change was documented as not audit will be conducted three times per done on both days. week for one month, then monthly for During an interview via telephone on 9/22/16 at eleven months. 4:48pm. Nurse # 12 revealed she was not hired to do treatments. She was hired to pass The results of the audits will be discussed medication. She had not done any treatments. by the Director of Nursing and or 2. Resident #10 was admitted to the facility on Administrator during monthly QA meeting 4/12/16. The annual Minimum Data Set (MDS) monthly for twelve consecutive months dated 7/11/16 revealed he had moderate and then periodically to ensure cognitive impairment and an indwelling catheter. compliance is met. His current diagnoses were in part, chronic urinary tract infection, urinary tract disease and dementia. Review of the care plan initiated 7/19/16 and updated on 7/21/16 revealed in part, for the nursing staff to provide suprapubic catheter care every shift and as needed. Review of the physician order dated 7/27/16, revealed to clean the surgical incision with warm soapy water and apply dry dressing every day and as needed. Review of the physician order dated 8/17/16, revealed to clean the right suprapubic catheter site with normal saline and apply Mipirocin 2% (an antibiotic) ointment and Santyl (a debridement agent) gauze every day . Review of the August 2016 treatment

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SU COMPLE C 345509 B. WING 09/23	ETED
345509 B. WING 09/23	
	.5/2010
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
915 PEE DEE ROAD	
KINGSWOOD NURSING CENTER ABERDEEN, NC 28315	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 Continued From page 10 administration record (TAR) revealed suprapubic catheter documentation revealed the suprapubic catheter was not cleaned and changed on 8/6 (Saturday), 8/15 (Monday), 8/13 (Saturday), 6/14 (Sunday), Additionally, suprapubic catheter documentation revealed the suprapubic catheter was not cleaned and changed on 8/20 (Saturday) and 8/21 (Sunday), with Santyl and Miprocin 2% ointment. Review of the September 2016 TAR revealed the suprapubic catheter dressing change was documented as not done on 9/10 (Saturday) or 9/11 (Sunday). During interview on 9/20/16 at 2:33pm, Nurse #1, the wound care nurse, indicated the weekend nurse supervisor changed the dressings on the weekend. When the nursing supervisor worked on a hall passing medications, all nurses were responsible to do the treatments of their assigned residents. During an interview on 9/21/16 at 5:15pm, a family member of Resident #10 indicated his suprapubic catheter dressing change, were not done every weekend. During an interview on 9/21/16 at 8:10am, Nurse #1 indicated treatment were not done when she was off during the week or on the weekends. On 9/21/6 at 8:43pm, Nurse #1 was observed during the suprapubic catheter dressing change. The suprapubic site was observed to have a scant amount of dred exudate and pink tisus from around the incision site. There was no foul dodo. The site was cleaned with normal saline and covered with a perforated gauze dressing and paper tape. During an interview via telephone on 9/22/16 at 10:00am, Nurse #4 indicated she had not done any dressing changes until affine f2/2016. The	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	LETED
		345509	B. WING				C 23/2016
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD		
Rindowe				1	ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(X5) COMPLETION DATE	
F 282	Continued From page schedule revealed sh treatment on 8/15/16 During an interview vi 2:22pm, Nurse #9 (we revealed she was res weekend treatments. hall with a resident as were delegated to the assigned residents. S elected to do the treat day and not to do the changes. The schedut assigned to do Reside treatment on 8/6/16 (3 During an interview vi 4:48pm, Nurse # 12 m to do treatments. She medication. She had She was assigned to changes on 8/7 (Sund (Saturday) and 8/21 (Nurse #15 was not a was assigned to do the (Saturday). During interview on 9 Director of Nursing in expected to do the treat they were assigned a shift. 3. Resident # 11 was 3/26/14. The most rect (MDS) assessment days wound. The most rect	e 11 e was assigned to do the (Monday). ia telephone on 9/22/16 at eekend supervisor), ponsible to complete the When she worked on the assignment the treatments e nurses who had the the indicated she had tments scheduled for twice a suprapubic dressing ule revealed she was ent #10 suprapubic Saturday). ia telephone on 9/22 at evealed she was not hired e was hired to pass not done any treatments. do the suprapubic dressing day), 8/14 (Sunday), 8/20 Sunday). vailable for interview. She he dressing change on 8/13		282	DEFICIENCY)		
	(auto inflammatory dia Review of the most re						

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 11/21/201 FORM APPROVE IB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		DNSTRUCTION	(X3) DATE SURV COMPLETED	
		345509	B. WING				C 09/23/2016
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CO	DE	
KINGSWC	OD NURSING CENTER			915	PEE DEE ROAD		
RINGSWC	OD NORSING CENTER			ABE	ERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 282	done as ordered to the Review of the physici revealed to apply Clo corticosteroid) ointme daily and cover with a powder (sic)(to enhan calcium alginate (abs Review of the physici revealed apply Flagy 500 mg tablet crushe bed medial back then above. Clarification o to apply the Flagyl for Review of the July 20 record (TAR) reveale wound of Resident # done on 7/2 (Saturda (Sunday). Review of the August wound treatment was on 8/5 (Friday), 8/7 (S 8/14 (Sunday). The Flagyl wound on 8/20 (Saturday)	the lesion on the medial back. an order dated 7/25/16, betasol propionate 0.05% (a ent to the ulcer on the back adhesive and collagen nece tissue growth) and orbed exudate). an order dated 8/19/16 (for a bacterial infection) d and apply to the wound of follow current treatment rder was added on 8/26/16, r a total of 1 month. 16 treatment administration d that treatment to the 10 was documented as not y), 7/3 (Sunday) and on 7/24 c 2016 TAR revealed the a documented as not done Sunday), 8/13 (Saturday),	F	282			
	and the Flagyl was de administered on 9/10 During an interview o #1, the wound care n nurse supervisor cha weekend. When the n on a hall passing men responsible to do the residents. During interview on 9 indicated the wound	(Saturday). n 9/20/16 at 2:33pm, Nurse urse, indicated the weekend nged the dressings on the nursing supervisor worked dications, all nurses were treatments of their assigned /21/16 at 8:35am, Nurse #1 was changed daily due to the A crushed 500 mg Flagyl					

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 11/21/2016 RM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTIO		(X3) DA	ATE SURVEY DMPLETED
		345509	B. WING				C 09/23/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRES	SS, CITY, STATE, ZIP CODE	-	
				915 PEE DEE R	OAD		
KINGSWO	OD NURSING CENTER			ABERDEEN, N	NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORF CH CORRECTIVE ACTION S SS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	9/22/16 at 8:10am, re wound with dark rolle wound was cleaned w dressed with Clebeta Flagyl and dressed. During interview on 9 Nurse #1, she indicat always being change vacation and on the w medication card of Fl were still in the card w weekend.		F 2	82			
	changes were require clean and the dressin Flagyl to promote the During an interview v 11:15 am, Nurse #6 in any weekends. She in Resident # 11 and ch left shoulder that had back. She was unable Nurse # 6 was assign Resident #11's back o During an interview v 1:43pm, Nurse # 8 im nurse or the weekend dressings and the tre	Resident #11 dressing ed for the wounds to be ing to be changed daily with healing of the wound. ia telephone on 9/22/16 at indicated she had not worked indicated she worked with anged the dressing on her a cause an ulcer to her e to recall the treatment. ined to do wound care to on 8/5/16 (Friday). ia telephone on 9/22/16 at dicated the wound care d supervisor completed the atments. The supervisor when to do treatments and					
	dressings. The TAR w She wasn't aware of a missed. Review of the #8 was scheduled to 7/2(Saturday) and 7/2	vas kept on the wound cart. any treatment she had e schedule revealed Nurse do the treatment on					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING _				C / 23/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 282 F 309 SS=J	to do treatments. She medication. She had She was assigned to Resident #11 on 7/24 8/14 (Sunday) and 8/ Nurse # 14 the assign 9/10/16 (Saturday) w interview. During interview on 9 Director of Nursing in expected to do the treat they were assigned a shift. 483.25 PROVIDE CA HIGHEST WELL BEI Each resident must re provide the necessar or maintain the highe mental, and psychoso	evealed she was not hired e was hired to pass not done any treatments. do the dressing changes on (Sunday), 8/7 (Sunday), 21(Sunday). ned nurse for the hall on as not available for /22/16 at 5:30pm, the dicated that nurses were eatments of the residents ind to document after each RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical,		309			11/14/16
	by: Based on record rev interview, the facility assessed/examined to possible injuries befo the fall for 1 (Residen with a van accident. head injury and cervin facility also failed to the	is not met as evidenced iew and physician and staff failed to have the resident by a qualified person for re moving a resident after at #5) of 1 sampled resident Resident #5 sustained a cal strain from the fall. The reat wounds as ordered for 3 and #13) of 3 sampled r wounds.			 F 309 1. Resident #5 was moved prior to ar assessment by a medical professional after an accident in which entailed the resident falling out of the facility van. Th resident was transferred to the emerge room for evaluation and treatment. 2. Residents who require van transportation have the potential to be 	he	

Facility ID: 970412

TATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING				C 23/2016
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	00/	20/2010
				915	5 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER				BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From pag	e 15	F 3	09			
					affected.		
	Immediate Jeopardy	began on 9/10/16 when					
		ved prior to have a qualified			3. An audit of residents receiving		
		amined her for possible			transportation via facility van was		
	-	and was removed on 9/23/16			conducted on 9/22/16 by Staff		
	at 4:14 PM when the				Development Coordinator to determine	•	
		allegation of compliance.			accident or incident occurrence. Only		
		n out of compliance at a			Resident #5 was affected.		
		evel E (no actual harm with an minimal harm that is not			4. All staff were educated on the		
	•	for Residents #10, #11 &			accident and incident policy and		
		#5 to ensure all staff were			procedure and not moving a resident p	rior	
		's accident and incident			to a medical assessment following an		
	policy and procedure				incident on 9/20/16 or prior to their nex	t	
					shift worked by the Director of Nursing		
	The findings included				and or Administrator. New employees	will	
		nd procedure for accident			be educated upon orientation.		
		3/11/04 was reviewed. The					
		Regardless of how minor an			5. In-house facility transportation was		
		may be, it must be reported			terminated on 9/22/16. An independent	t	
	· ·	pervisor. Employees			transportation company is providing transportation services.		
	-	nt or incident involving a the occurrence to his or her			transportation services.		
	· ·	r as soon as possible. Do			1. Resident #10 suprapubic catheter		
		t victim unattended unless it			treatment was performed per physiciar	1	
		ary to summon assistance.			order by the wound nurse on 9/22/16.		
	The charge nurse mu	-			Resident #11 lesion on back treatment		
	accidents or incident	s so that medical attention			was performed per physician order by		
		ould you witness an accident			wound nurse on 9/22/16. Resident #13		
		o aid an accident victim, you			bilateral toes and left heel treatment wa		
		liate assistance. Do not			performed per physician orders by wou		
		he/she has been examined			nurse on 9/21/16. Physician was notifi		
	for possible injuries.				on 9/21/16. Education of staff assigned these shifts began 9/22/16.	1 (0	
	 1 Resident #5 was a	admitted to the facility on			these shins beyan 9/22/10.		
		diagnoses including End			2. Licensed Nursing staff were education	ated	
		e on hemodialysis. The			on performing treatments per physiciar		
	-	ata Set (MDS) assessment			orders by the Director of Nursing and c		
		d that Resident #5's			Staff Development Coordinator on 9/23		

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II T		CONSTRUCTION	OMB NC	
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							С
		345509	B. WING				23/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				9	15 PEE DEE ROAD		
KINGSWC	OOD NURSING CENTER			Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 309	Continued From page	<u>> 16</u>	F	309			
	cognition was modera			503	or prior to payt shift worked. Any new		
		cated that the resident was			or prior to next shift worked. Any new licensed employee will receive this		
		isfers and needed limited			education upon orientation. Every		
	assistance with ambu				licensed nurse will be observed during	а	
		M and on 9/21/16 at 9:25			treatment round(providing treatments)		
		interviewed. She stated			a skills checklist will be completed by t		
		e on the part of the driver for			Certified wound care nurse and or		
		on what she was doing."			supervisor by 11-14-16 or prior to next		
	Resident #5 stated th	e Van Driver was pushing			shift. Any new licensed nurse will be		
	her backward in whee	elchair and the driver was			observed during a treatment		
	facing the back door.	The resident stated that the			round(providing treatments) and a skill		
		ticed that the lift was not up			checklist will be completed by the certi-	fied	
		and she ended up falling. e had bruises on her thigh,			wound care nurse or supervisor.		
	back and elbow from	the fall. She revealed that			3. An audit of treatment administration	on	
		omething and was hurting			records was performed by the ward cle		
		licated that she asked the			on 10/4/16. All incidences of omission		
		ne hospital because she was			was discussed with the Medical Director		
		e broken bones. The			on 9/28/16 and taken to QA meeting of	n	
		he driver should have called			10/22/16. Any licensed nurse not		
		ervices (EMS) and not			completing treatments as ordered will	- 1-	
		iced her back in wheelchair			receive disciplinary action per policy up		
	she did.	ave some broken bones but			and including termination of employme	nit.	
		ated 9/10/16 at 10:00 AM			4. Residents with treatments ordered	1 by	
		moving Resident #5 from			4. Residents with treatments ordered the physician have the potential to be	лоу	
		s center, the resident who			affected.		
		chair fell from the van. The					
	-	the emergency room			5. An audit of treatment administration	on	
	immediately for evalu				records will be conducted every day fo		
	-	t from Van Driver #1 dated			completeness by the wound nurse and		
		d. The written statement			the floor nurse for two months. Then the		
	read " I was at the di	alysis office at 10:10 AM			audit will be conducted three times per		
		I unloaded the first patient.			week for one month, then monthly for		
	-	t back up to prepare for the			eleven months.		
	next resident to come						
	already put the lift bac				The results of the audits will be discus	sed	
	-	. Unhooked her straps from			by Director of Nursing and or		
	the front and back an	d unfastened her seatbelt. I			Administrator during monthly QA meet	ina	1

Facility ID: 970412

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	S FOR MEDICARE &					<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · /	TE SURVEY MPLETED
			A. BUILDING			
		245500	B. WING			С
		345509	B. WING			9/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E	
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD		
	1			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From page	e 17	F 30	9		
		e resident back to the lift.	1 30		o months	
		hit have the lift part up I tried		and then periodically to ensur		
to pull her back but			compliance is met.			
		asked the resident if she				
	the dialysis to get help. No					
	•	part. So I knocked on the				
side door, no o resident. Sat h good. I ran bac putting her in th again. So I we		me. So I went back to the				
		looked over her body real				
		the dialysis to get help with				
	-	ir, no one came to the door				
		k to the resident asked her if				
		pain anywhere. She said				
		bow. Once I found out what				
	was wrong I went bac	ck in to dialysis, knocked on				
	door again, no one ca	ame. So I went back outside				
	to the resident, picked	d her up and put her back in				
	the wheelchair. She	complained of her head				
	hurting bad and said	that she wanted to go to the				
		n to the dialysis so I could				
		emergency medical service				
		ν, but no one came out				
		told the resident I could not				
	u	I the phone. She said once				
		go to the hospital ". So I				
		the van, strapped her down				
		/ straps, buckled her seatbelt				
		e her to the emergency				
		when I got to the emergency resident and took her inside				
		e hospital that we fell off the				
		e nospital that we led on the				
		used the security guard's				
		ity. I called the facility and				
		by there with the resident. I				
	spoke with the superv					
		(ER) discharge instruction				
		ed diagnoses of superficial				
	I nead iniury and cervi	cal strain and was given a				

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	MENT OF HEALTH AN					FORM): 11/21/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345509	B. WING		_	09/2	23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	medication) 50 milligr mouth every 4-6 hour On 9/20/16 at 10:20 A interviewed. She stat transportation coordin through Friday and at indicated that she war resident after the fall. call the facility first an accident. Then she w the nurse to either cal come assess the resi On 9/20/16 at 11:35 A (DON) was interviewe she was informed on accident involving the expected the driver no the fall but the driver no the drivers were reed On 9/20/16 at 2:52 PI DON were interviewe that she started worki administrator 2 weeks the department heads incident reports on a no other residents with happened in the past. they had not been mo before or after the 9/1 On 9/20/16 at 3:10 PI interviewed. She stat months ago, on the p system in the facility of	ams (mgs) 1-2 tablets by s as needed for pain. M, Van Driver #2 was ed that she was the lator, worked Monday times on weekends. She s trained not to move the She stated that she would d inform the nurse about the vould follow the advice from II EMS or wait for the staff to dent. M, the Director of Nursing ed. The DON stated that 9/10/16 that there was an van. She stated that she of to move the resident after had tried to get some help anybody. So the driver had and took her to the ER. The I that Van Driver #1 was not an anymore and the rest of ucated on 9/10/16. M, the Administrator and the d. The Administrator stated ing at the facility as an s ago. The DON stated that s had been reviewing the daily basis and there were h the same incident The DON revealed that onitoring the van drivers 0/16 incident. M, Van Driver #1 was ed that she was trained 2-3 roper use of the securement van and on the proper use of d unload residents safely.	F 305				

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	B	COMPLETED
					с
		345509	B. WING		09/23/201
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO	
			915 PEE DEE ROAD		
KINGSWC	OOD NURSING CENTER			ABERDEEN, NC 28315	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPL TE APPROPRIATE DA
F 309	Continued From page	e 19	F 30	9	
		ost 2 months now. At the	1.00		
	dialysis parking lot, s				
		to the dialysis clinic. She			
	proceeded to unload				
	Resident #5. After sl	ne unstrapped and			
	unbuckled her, she p	ushed her wheelchair			
		ner from the van. She did			
	-	e was not up so she and the			
		an. She revealed that she			
		on the ground to get help			
		c but she could not get any			
		ttempts of getting help, she p and placed her in the			
	•	f. After Resident #5 was			
	-	nair, she unloaded the third			
		her to the dialysis clinic.			
		sident #5 into the van and			
		gency room. Van Driver #1			
		#5 was complaining that her			
	head was hurting and	she wanted to go to the			
		the facility's transport van			
	-	d her personal phone was			
	-	harging. She stated that			
		III EMS or the facility and she			
	could not get any hel	•			
	•	n Driver #1 stated was to, "			
		and take her to the ER. " for Van Driver #1 were			
	0	vice sheet dated 7/14/16			
		iver #1 was trained on the			
		curement system in the			
		to safely transport residents			
		ly use the lift gate on the			
		to load and unload residents			
		safety procedures. There			
	-	an Driver #1 was trained on			
	the facility's accident	incident policy and			
	procedure on reportir	ng and assessing the			
	resident prior to drivir				

Facility ID: 970412

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
			A. BUILDING		С	
		345509	B. WING		09/23/20	016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		010
				915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	MPLETIO DATE
F 309	Continued From page	e 20	F 30	9		
		M, Resident #5's attending				
		ewed. She indicated that her				
		he Van Driver to call the				
	-	o transport the resident to				
the ER after the fall. S that the driver had trid unable to get any hel by herself, placed her to the ER. On 9/20/16 at 5:00 P	She added that she was told					
		p so she moved the resident				
		r in wheelchair and took her				
		M the Administrator and the				
		of the immediate jeopardy.				
		an acceptable credible				
		nce on 9/23/16 at 4:14 PM.				
	The credible allegatio					
		016, Resident #5 was being				
	-	llysis center. Upon arrival,				
	the transportation aid	e had unloaded another				
	resident. When she r	returned, she came back in				
		ide door. She proceeded to				
		sident in question and				
	•	the resident. At which time				
		l level and was not level with				
		he transportation aide				
		e audible alarm sounded to				
	•	as wrong. She tried to stop ing. The momentum pulled				
		, landing on the ground.				
		0am. The transportation				
	aide went inside the c	•				
		nocked on the treatment				
	-	et assistance. When she did				
		ne to the door and did not				
	-	ailable (she left the cell				
		o charge), she looked the				
		apparent injuries and asked				
		is in pain. Resident stated				
	hor hood and alhow h	ourt and wanted to go to the	1			
		nurt and wanted to go to the ne transportation aide lifted				

Facility ID: 970412

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	D: 11/21/2016 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING		_		C 23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	position. She loaded is van to go to the Emer at 10:35 am. The res- injury in the Emergen of headache and elbo On September 10, 20 was removed from pr services now and in the transportation aide sta her human error. The facility reviewed by practice. It is determine would require transpo- would be at risk. The Director of Nursing with facility 's accident/inde to include reporting an In-servicing began on one not in-serviced with start of their next shift Staff will seek approp prior to moving resided or have an injury, after accident. "Regardless or incident may be, it department supervisor accident or incident in report the occurrence supervisor as soon as Staff will be in-serviced regarding incidents and the process for assess to moving resident affi possible injury by Sta or assigned administr	the resident in the facility gency Room for evaluation ident was evaluated for cy room due to complaints whurting. 16, the transportation aide oviding transportation he future. The ated the incident was due to residents that were v the alleged deficient ned that any resident who ortation on the facility van Administrator and or II in-service all staff on ident policy and procedure nd assessing residents. September 20, 2016. Any ill be educated prior to the the incident and or so of how minor an accident must be reported to the or. Employee witnessing an ivolving a resident must to his or her immediate s possible. " ed upon new hire orientation nd accident policy as well as sment by medical staff prior ter an accident or incident or ff Development Coordinator	F 30	9			

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345509	B. WING				C 23/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					915 PEE DEE ROAD		
KINGSWC	OD NURSING CENTER				ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	the facility's accident/ procedure. The in-se and the in-service on procedure was started the van drivers reveal transport was termina transportation compar- residents for appointed was locked at the adr 2. Resident #10 was a 4/12/16. The annual M dated 7/11/16 revealed cognitive impairment His current diagnoses urinary tract infection, dementia. Review of the care pla updated on 7/21/16 re nursing staff to provid every shift and as nee Review of the physicia revealed to clean the soapy water and appli and as needed. Review of the physicia revealed to clean the site with normal salin (an antibiotic) ointment debridement agent) g Review of the August administration record catheter was not clean Saturday), 8/7 (Sund	have received in-service on incident policy and rvice records were reviewed accident/incident policy and d on 9/20/16. Interview with led that the in house the and a third party my would transport all nents. The transport van out of service and the key ministrator's office. admitted to the facility on Minimum Data Set (MDS) ed he had moderate and an indwelling catheter. were in part, chronic urinary tract disease and an initiated 7/19/16 and evealed in part, for the e suprapubic catheter care eded. an order dated 7/27/16, surgical incision with warm y dry dressing every day an order dated 8/17/16, right suprapubic catheter e and apply Mipirocin 2% nt and Santyl (a auze every day .	F	30	9		

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/21/2016 1 APPROVED
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	LETED
		345509	B. WING		_	(09/:	C 23/2016
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
			9	15 PEE DEE ROAD			
KINGSWO	OD NURSING CENTER		4	BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page (Sunday). Additionally documentation reveal was not cleaned and and 8/21 (Sunday), w ointment. Review of the Septern suprapubic catheter of documented as not de 9/11 (Sunday). During interview on 9/ the wound care nurse nurse supervisor char weekend. When the r on a hall passing med responsible to do the residents. During an interview of family member of Res suprapubic catheter of done every weekend. During an interview of #1 indicated treatment was off during the we On 9/22/16 at 8:43pm during the suprapubic suprapubic site was of amount of dried exuda around the incision si The site was cleaned covered with a split ga	e 23 y, suprapubic catheter led the suprapubic catheter changed on 8/20 (Saturday) ith Santyl and Mipirocin 2% aber 2016 TAR revealed the dressing change was one on 9/10 (Saturday) or /20/16 at 2:33pm, Nurse #1, e, indicated the weekend nged the dressings on the bursing supervisor worked dications, all nurses were treatments of their assigned n 9/21/16 at 5:15pm, a sident #10 indicated his dressing changes were not n 9/22/16 at 8:10am, Nurse at were not done when she ek or on the weekends. n, Nurse #1 was observed c dressing change. The observed to have a scant ate and pink tissue from te. There was no foul odor. with normal saline and	F 309				
	any dressing changes schedule revealed sh treatment on 8/15/16 During an interview vi 2:22pm, Nurse #9 (we revealed she was res	ia telephone on 9/22/16 at					

Facility ID: 970412

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	-					FORM	M APPROVED
				TID			
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	. ,				
			A. BUILD	ING	·	Ι.	<u> </u>
		345509	B. WING				-
NAME OF PI	ROVIDER OR SUPPLIER	NN IDENTIFICATION NUMBER: A. BUILDING COMPLETED 345509 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 09/23/2016 SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES CCH DEPRCIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE d From page 24 F 309 F 309 F 309 a resident assignment the treatments segated to the nurses who had the I residents. She indicated she had to do the treatments scheduled for twice a not to do the suprapubic dressing F 309 The schedule revealed she was to do Resident #10 suprapubic t on 8/6/16 (Saturday). ninterview via telephone on 9/22 at Nurse # 12 revealed she was not hired atments. She was hired to pass on. She had not done any treatments. assigned to do the suprapubic dressing on 8/7 (Sunday), 8/14 (Sunday), 8/20 y) and 8/21 (Sunday). Fi 309 f Swas not available for interview. She gned to do the dressing change on 8/13 F 309					
					915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER						
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE						
TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION)	IAG	i		(IE	DATE
	1				, 		
- 000							
F 309			F	30	9		
	-						
	•						
	-						
	-						
	-	-					
		-					
		-					
		· · ·					
		•					
	(Saturday).						
		/22/16 at 5:30pm, the					
	•	•					
	-						
	they were assigned a	nd to document after each					
	shift.						
	3 Resident # 11 was	admitted to the facility on					
		-					
	-	-					
	(auto inflammatory dis						
		ecent wound care plan dated					
		art, wound care was to be					
		e lesion on the medial back.					
	Review of the physici	an order dated 7/25/16,					
		betasol propionate 0.05% (a					
		ent to the ulcer on the back					
	daily and cover with a	dhesive and collagen					
	powder (sic)(to enhar	nce tissue growth) and					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 11/21/201 RM APPROVE NO. 0938-039
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		345509	B. WING		0	9/23/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	DE	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 309	revealed apply Flagy 500 mg tablet crushe bed medial back ther above. Clarification o to apply the Flagyl fo Review of the July 20 record (TAR) reveale wound of Resident # done on 7/2 (Saturda (Sunday). Review of the August wound treatment was on 8/5 (Friday), 8/7 (S 8/14 (Sunday), 8/15 ((Sunday). The Flagyl wound on 8/20 (Satu Review of the Septer wound treatment was and the Flagyl was d administered on 9/10 During an interview of #1, the wound care in nurse supervisor cha weekend. When the in on a hall passing me responsible to do the residents. During interview on 9 indicated the wound tissue necrotization. A tablet was used in the management of the v changes. During the dressing o 9/22/16 at 8:10am, re wound with dark rolle	orbed exudate). an order dated 8/19/16 I (for a bacterial infection) d and apply to the wound infollow current treatment rder was added on 8/26/16, in a total of 1 month. D16 treatment administration d that treatment to the 10 was not documented as y), 7/3 (Sunday) and on 7/24 E 2016 TAR revealed the is documented as not done Sunday), 8/13 (Saturday), Monday) or on 8/21 was not administered to the rday) and 8/21 (Sunday). mber 2016 TAR revealed is documented as not done bocumented as not done bocumen	F 30	9		

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	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MI II TU	PLE CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	• • •	G	· · ·	IPLETED	
			AL DOILDING	S		С	
		345509	B. WING		0	9/23/2016	
NAME OF P	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CO		,20,2010	
				915 PEE DEE ROAD			
KINGSWC	OD NURSING CENTER			ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE COMPLETI		
IAG		,		DEFICIENCY			
F 309	Continued From page		F 30	09			
		sol, calcium alginate and					
	Flagyl and dressed.						
	/22/16 at 8:10am, with						
		ed this wound was not					
		d while she was out on					
		veekends. She produced the					
		agyl and indicated the pills					
		when she returned from the					
	weekend.						
	-	n 9/22/16 at 9:20am, the					
	•	Resident #11 dressing					
	÷ .	ed for the wounds to be					
		ig to be changed daily with					
	÷• ·	healing of the wound.					
	-	ia telephone on 9/22/16 at					
		ndicated she had not worked					
	any weekends. She i	ndicated she worked with					
	Resident # 11 and ch	anged the dressing on her					
	left shoulder that had	a cause an ulcer to her					
	back. She was unable	e to recall the treatment.					
	Nurse # 6 was assigr	ned to do wound care to					
	Resident #11's back	on 8/5/16 (Friday).					
	During an interview v	ia telephone on 9/22/16 at					
	1:43pm, Nurse # 8 in	dicated the wound care					
	nurse or the weekend	supervisor completed the					
	dressings and the tre	atments. The supervisor					
	delegated the nurses	when to do treatments and					
	-	vas kept on the wound cart.					
		any treatment she had					
		e schedule revealed Nurse					
	#8 was scheduled to	do the treatment on					
	7/2(Saturday) and 7/3	3 (Sunday).					
		ia telephone on 9/22 at					
	-	evealed she was not hired					
	to do treatments. She						
		not done any treatments.					
		do the dressing changes on					
	÷	(Sunday), 8/7 (Sunday),					

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM): 11/21/2010 1 APPROVEI 0. 0938-039	
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 09/23/2016				
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE				
KINGSWC	OOD NURSING CENTER				PEE DEE ROAD ERDEEN, NC 28315				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 309	 9/10/16 (Saturday) winterview. During interview on 9 Director of Nursing in expected to do the truthey were assigned a shift. 4. Resident # 13 was Minimum Data Set (N 9/10/16 indicated tha intact and with gangr toes. Her diagnoses diabetes mellitus, and disease. The physician's order paint bilateral toes are every day to keep ga Review of the Septer administration record treatment was docum 9/10/16 (Saturday) at During an interview of # 1, the wound care reimportant to keep the to prevent the spread During interview on 9 #13 indicated the bet most days. During a wound obset 7:00am, of the left and and total amputation was noted to both fee and heel with betadir reapplied the heel provision of the left and and total amputation was noted to both fee and heel with betadir reapplied the heel provision of the left and heel with betadir reapplied the heel provision was noted to both fee and heel with betadir reapplied the heel provision of the left and heel with betadir reapplied the heel provision of the heel prov	ned nurse for the hall on as not available for //22/16 at 5:30pm, the dicated that nurses were eatments of the residents and to document after each s admitted on 8/29/16. The MDS) assessment dated t the resident was cognitively ene to her left foot and right were in part, gangrene, d peripheral vascular r dated 8/30/16 indicated to nd left heel with betadine ngrene dry as possible. nber 2016 treatment (TAR) revealed the nented as not done on nd 9/11/16 (Sunday). on 9/20/16 at 2:27pm, Nurse nurse, revealed it was heel painted with betadine I of gangrene. //20/16 at 2:47pm, Resident adine was applied to her feet ervation on 9/21/16 at id right feet, revealed a mputation of the small toes partially amputated 1st toe of the 2nd toe. Mild edema et. Nurse #1 painted the foot ne bilaterally and let it dry and	F	309					

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 11/21/20 [,] 1 APPROVE). 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345509		B. WING		C 09/23/2016		
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CO			
KINGSWO	OD NURSING CENTER		915 ABE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
	were not done when or on the weekends. During an interview v 2:22pm, Nurse #9 (w revealed she was res weekend treatments. hall with a resident as were delegated to the assigned residents. S the stage 3 and 4 pre dressings that were s the remaining treatme was scheduled to pro 9/11/16. Nurse # 14 the assign 9/10 and 9/11 was no During interview on 9 Director of Nursing in expected to do the treat they were assigned a shift. 483.25(c) TREATME PREVENT/HEAL PR Based on the compre- resident, the facility n who enters the facility n	urse, indicated treatment she was off during the week ia telephone on 9/22/16 at eekend supervisor), sponsible to complete the When she worked on the assignment the treatments e nurses who had the She indicated she changed essure ulcers dressings and scheduled for twice a day, ents were omitted. Nurse #9 wide treatments on 9/10 and hed nurse for the hall on ot available for interview. //22/16 at 5:30pm, the dicated that nurses were eatments of the residents and to document after each NT/SVCS TO ESSURE SORES chensive assessment of a hust ensure that a resident y without pressure sores ssure sores unless the	F 309			11/14/16	
	they were unavoidable pressure sores receive services to promote he prevent new sores from	ondition demonstrates that le; and a resident having ves necessary treatment and healing, prevent infection and om developing.					

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE). 0938-03 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	A. BUILDING			
	345509				С		
			B. WING		09/	23/2016	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
KINGSWOOD NURSING CENTER				915 PEE DEE ROAD			
All COVIC	OD NORSING CENTER			ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE	
F 314	Continued From page	29	F 31	14			
	1.0	iew, observation, resident		F 314			
		le facility failed to treat the		1. Resident #9 sacrum	treatment was		
		dered on weekends for 2 of		performed per physician of			
	3 sampled residents			wound nurse on 9/22/16.	•		
	(Resident#9 and #13	•		bilateral toes and heel tre	atment was		
	Findings included:			performed per physician of			
				wound nurse on 9/21/16.			
		admitted to the facility on		notified on 9/28/16. Educa			
		m Data Set (MDS) dated		assigned to these shifts b	egan on		
		had a memory problem and		9/22/16.			
	dementia and encept	cer. Diagnoses were in part,		2. Licensed Nursing sta	ff wore educated		
	discharged on 8/11/1			on performing treatments			
		an dated 6/25/16, revealed		orders by the Director of N			
		age 3 pressure ulcer on her		Staff Development Coord			
		thes to heal the pressure		or prior to next shift. All n			
	ulcer were in part, to	give medication as ordered,		will receive this education	upon		
	monitor the effectiver	ness of the treatment and		orientation.			
	report to the physicia	0					
	deterioration within 2			3. All licensed nurses w	-		
		nt's physician order dated		descriptions reviewed with			
		clean sacrum with normal		Nursing and or Staff Deve			
	saline, apply Santyl (a	2% (an antibiotic ointment)		Coordinator and signed b prior to next shift. Job de	•		
		(used to absorb exudate)		licensed nurses will be re	-		
	-	sing every day and as		Director of Nursing and or			
	needed.			Development coordinator			
	The July and August	2016 treatment		year and annually thereaf			
	administration record	(TAR) were reviewed. The		licensed nurses will review			
		I not have nurse's initial to		upon orientation and follo	w quarterly cycle		
		ment was provided on 7/2		and annually thereafter.			
		lay), 7/24/16 (Saturday), 8/6			administratio-		
	(Saturday) and 8/7(S	unday). Ile revealed Nurse #12 was		4. An audit of treatment records was performed by			
		#9 on 7/24/16 and 8/7/16		on 10/4/16. All incidences			
	-	nge was documented as not		was discussed the Medica			
	done on both days.			9/28/16 and was taken to			
	-	ia telephone on 9/22/16 at		on 10/22/16.			
		evealed she was not hired					

Facility ID: 970412

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	5 FUR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
345509		B. WING			C 09/23/2016		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE			
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	Continued From page	e 30	F 31	4			
	During interview on 9 the wound care nurse	not done any treatments. /20/16 at 2:33pm, Nurse #1, e, indicated the weekend		 Residents with written ordered have the potential Every licensed nurse 	to be affected. will be observed		
	weekend. When the r working on a hall pas	nged the dressings on the nursing supervisor was sing medications, all nurses lo the treatments of their		during treatment round(per treatment) and a skills che completed by certified wou or supervisor by 11-14-16.	cklist will be Ind care nurse		
	Nurse # 8, who was a	ia telephone on 9/22/16, assigned to Resident #9 on ated the wound treatments		licensed nurse will be obse treatment round(perform tr skills checklist will be com certified wound nurse or su	reatment) and a pleted by the		
	were completed by th (Nurse #9.)	ia telephone on 9/22/16 at		Random treatment checks conducted by the certified nurse or supervisor month	will be wound care		
	2:22pm, Nurse #9 (w revealed she was res	-		treatment administration re conducted every day for co the wound nurse and or flo	ecords will be ompleteness by		
	resident assignment to delegated to the nurs	es who had the assigned		two months. Then the audi conducted three times per month, then monthly for ele	week for one		
	the supervisor she has she would do and om The schedule reveale	ted when she was busy as ad elected which treatments nitted the other treatments. ed she was assigned to do 16 for Resident #9. Nurse		7. Results of the treatme administration records will by the Director of Nursing Administrator during month	be discussed and or the		
	Nursing that the treat because of shortage	reported to the Director of ments had not been done of staff on the weekends. vasn't always a nurse to call ad to take a resident		monthly for twelve consect then periodically to ensure met.			
	(DON) was interviewe facility had a full time	M, the Director of Nursing ed. The DON stated that the treatment nurse who was the treatments Monday					

Facility ID: 970412

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/21/2016 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURV COMPLETED	
		345509	B. WING			(09/2	C 23/2016
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE		
			91	5 PEE DEE ROAD			
KINGSWC	OOD NURSING CENTER		A	BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 314	weekends. She addee murmurs that the nurs wounds done. She ind were refusing to do the facility had been swar three months ago whe nurses that quit. 2. Resident # 13 was 8/29/16. The Minimur 9/10/16 indicated that intact and with a deep Her diagnoses were in mellitus, and peripher The physician's order paint bilateral toes an every day to keep gar Review of the Septern administration record treatment was docum 9/10/16 (Saturday) an During an interview of # 1, the wound care in important to keep the to prevent the spread the left heel. During interview on 9/ #13 indicated the beta days. On 9/21/16 at 7:00am observation of the left heel and boggy laterat the foot and heel with reapplied the heel pro Nurse # 14, the assig not available for intern During an interview of	d that she had heard ses had no time to get dicated she felt the nurses he treatments because the mped with staffing issues, en there were aides and admitted to the facility on in Data Set (MDS) dated the resident was cognitively b tissue injury to her heel. in part, gangrene, diabetes ral vascular disease. dated 8/30/16 indicated to d left heel with betadine ingrene dry as possible. inber 2016 treatment (TAR) revealed the lented as not done on ind 9/11/16 (Sunday). in 9/20/16 at 2:27pm, Nurse inurse, revealed it was heel painted with betadine of gangrene and to protect /20/16 at 2:47pm, Resident adine was applied most in, a pressure wound theel revealed a darkened al heel. Nurse #1 painted betadine let dry and otector. ned nurse for the hall, was view. in 9/22/16 at 8:10am, Nurse e ulcer wound dressings	F 314				

Facility ID: 970412

If continuation sheet Page 32 of 57

STATEMENT OF I AND PLAN OF CC NAME OF PROV KINGSWOOL (X4) ID PREFIX TAG	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
NAME OF PROV KINGSWOOD (X4) ID PREFIX TAG	ORRECTION	IDENTIFICATION NUMBER		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
KINGSWOOD (X4) ID PREFIX TAG		AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		G	COMPLETED		
KINGSWOOD (X4) ID PREFIX TAG	345509				C 09/23/2016		
(X4) ID PREFIX TAG	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03	23/2010	
(X4) ID PREFIX TAG				915 PEE DEE ROAD			
PRÉFIX TAG	D NORSING CENTER			ABERDEEN, NC 28315			
F 314 C				PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
N 9. in N w tr V a n in p s N D b w n r e C (I fa s th r e w m w w fa th n D D e :	/10 and 9/11/16 to R interview via telephon lurse #9 (weekend su vas responsible to co reatments, and the pr Vhen she worked on ssignment the treatm urses who had the au ndicated she changed ressure ulcers and d cheduled for twice a lurse #9 indicated sh Director of Nursing that een done because o veekends. She indicated urse to call in for wor esident assignment. Do 9/22/16 at 3:06 PM DON) was interviewed acility had a full time of cheduled to provide of rough Friday. The w esponsible to provide of veekends. She addect nurmurs that the nurse vounds done. She indicated vere refusing to do th acility had been swar or the months ago whe urses that quit. During interview on 9/ Director of Nursing ind xpected to do the tre	led to provide treatments on esident #13. During an e on 9/22/16 at 2:22pm, upervisor), revealed she mplete the weekend ressure ulcer treatments. the hall with a resident nents were delegated to the ssigned residents. She d the stage 3 and 4 ressings that were day, the rest were omitted. e had reported to the at the treatments had not f shortage of staff on the ted there wasn't always a rk and she had to take a <i>A</i> , the Director of Nursing ed. The DON stated that the treatment nurse who was the treatments Monday reekend supervisor was e the treatment on the	F 31	14			
-	hift. 83.25(h) FREE OF A	CCIDENT	F 32	23		10/21/16	

Facility ID: 970412

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345509			B. WING			C 09/23/2016		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
KINGOWG				9	15 PEE DEE ROAD			
KINGSWC	OOD NURSING CENTER			A	ABERDEEN, NC 28315			
(X4) ID PREFIX TAG				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323 SS=J	HAZARDS/SUPERVI The facility must ensu environment remains as is possible; and ea	SION/DEVICES ire that the resident as free of accident hazards	F	323				
	by: Based on record revi interview, the facility f before pushing the re- wheelchair out of the resident to fall backwa sampled resident with #5 sustained a head i from the fall. Immediate Jeopardy I Resident #5 fell off the removed on 9/23/16 a provided an acceptab compliance. The faci compliance at a scope actual harm with pote harm that is not imme staff were in-serviced accident/incident polid The findings included Resident #5 was adm 5/20/15 with multiple of Stage Renal Disease quarterly Minimum Da dated 9/6/16 indicated	e and severity level D (not ntial for more than minimal diate jeopardy) to ensure all on the facility's cy and procedure. : itted to the facility on diagnoses including End on hemodialysis. The ata Set (MDS) assessment			 F 323 1. Resident #5 was moved prior to ar assessment by a medical professional after an accident in which entailed the resident falling out of the facility van an was transferred to emergency room for evaluation and treatment. 2. Residents who require van transportation have the potential to be affected. 3. An audit of residents receiving transportation via facility van was conducted on 9/22/16 by Staff Development Coordinator to determine accident or incident occurrence. Only Resident #5 was affected. 4. All staff were educated on the accident and incident policy and procedure on 9/20/16 or prior to their moshift worked. All staff were educated or not moving a resident without an assessment after an accident by the 	d		

Facility ID: 970412

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		·) CON	IPLETED
	345509				С	
			B. WING		0	9/23/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 34	F 32	3		
		sfers and needed limited		on 9/20/16 or prior to start of	next shift.	
	assistance with ambu			New employees will be educated		
	On 9/20/16 at 9:25 Al	M and on 9/21/16 at 9:25		orientation on these processes		
		interviewed. She stated				
		ce on the part of the driver		5. In-house facility transport		
		on on what she was doing. "		terminated on 9/22/16. An inde	•	
	-	oushing her backward in river was facing the back		company provides transportati	ion services.	
		uld have noticed that the lift				
		iver did not and she ended				
	-	ruises on her thigh, back				
	and elbow from the fa	all. She hit her head on				
	-	urting bad. She asked the				
		ne hospital because she was				
	scared she might hav					
		ated 9/10/16 at 10:00 AM moving Resident #5 from				
		s center, the resident who				
		chair fell from the van. The				
		the emergency room				
	immediately for evalu					
		t from Van Driver #1 (driver				
		accident) dated 9/10/16 was				
		n statement read " I was at				
	the dialysis office at 1	I the first patient. I thought I				
		o prepare for the next				
	-	By me thinking I already put				
		on the van through the side				
		straps from the front and				
		her seatbelt. I proceeded to				
		ck to the lift. When I realized				
		art up. I tried to pull her back I and we both fell. I jumped				
		t if she was okay. I ran into				
		p. No one was in the front				
		n the side door, no one				
		k to the resident. Sat her				
	up, looked over her b					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/21/2016 APPROVED D: 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345509	B. WING			_		
NAME OF PRO	VIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWOO	D NURSING CENTER				15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
tr o b a e b o m v b h u () a galr v a m mtl v s p g s T g ir g n n C ir tt tt ir tt tt ir	chair, no one came to back to the resident as any pain anywhere. See book in to dialysis, known one came. So I went resident, picked her up wheelchair. She composed and said that she nospital. So I went in use the phone to call of EMS) and the facility again. So I went and get nobody so I could again that "I wanna of oaded the resident in with all the necessary and proceeded to take from. At 10:38 AM, w from. I unloaded the he hospital. I told the yan and she hit her he sure she was okay. I befone to call the facility got instructions to stay spoke with the superv The emergency room 0/10/16 revealed diag njury and cervical strat given a prescription for medication) 50 milligra mouth every 4-6 hours On 9/20/16 at 10:20 A nterviewed. She state ransportation coordin hrough Friday and at ndicated that she was	help with putting her in the othe door again. So I went sked her if she was feeling She said only her head and out what was wrong I went ocked on door again, no back outside to the p and put her back in the plained of her head hurting wanted to go to the to the dialysis so I could emergency medical service , but no one came out told the resident I could not the phone. She said once go to the hospital ". So I the van, strapped her down straps, buckled her seatbelt e her to the emergency vhen I got to the emergency resident and took her inside e hospital that we fell off the ead and wanted to make used the security guard's ity. I called the facility and y there with the resident. I visor in charge. " discharge instruction dated inoses of superficial head ain and the resident was or Ultram (an Opioid pain ams (mgs) 1-2 tablets by s as needed for pain. M, Van Driver #2 was	F	323				

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						IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION	· · · ·	E SURVEY
			A. BUILDIN	IG		С
		345509	B. WING		0	9/23/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		5/25/2010
				915 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
E 000						
F 323	Continued From page		F 3	23		
		id inform the nurse about the				
		vould follow the advice from Il EMS or wait for the staff to				
	come assess the resi					
		AM, the transport van was				
		e was observed at the back				
		te can go up or down using				
		e was used to load and				
	•	om the van. The lift was				
	observed to be working	ng properly at this time.				
	On 9/20/16 at 11:35 A	AM, the DON was				
	interviewed. She stat	ted that she was informed				
		was an accident involving				
		d that the Van Driver was in				
		ling Resident #5 from the				
		rking lot. Apparently, the lift				
	•	esident fell backwards and of the resident. She added				
		error on the part of the driver.				
		M, the administrator and the				
		d. The administrator stated				
		ing at the facility as an				
		s ago. The DON stated that				
		s had been reviewing the				
	-	daily basis and there were				
	no other residents wit					
	happened in the past	. She revealed that they				
		ing the van drivers on				
		before or after the 9/10/16				
		indicated that they figured				
		e of the accident was the				
		via the lift gate and entered				
		oor instead of using the lift				
	gate.	M Van Driver #1 was				
	On 9/20/16 at 3:10 Pl	ted that she was trained on				
		securement system in the				
		-				
		e proper use of the lift gate to				

Facility ID: 970412

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TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURVE	ΈY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED)
		345509	B. WING		C	
	ROVIDER OR SUPPLIER	345509	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO	09/23/20)16
NAME OF P	ROVIDER OR SUPPLIER			915 PEE DEE ROAD	UDE	
KINGSWC	OOD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COM HE APPROPRIATE	(X5) IPLETIO DATE
F 323	Continued From page	27		22		
1 020			F 3	23		
		she had been driving the ost 2 months now. She				
		ransporting 3 residents to				
		at Saturday of 9/10/16. She				
		ause 1 resident was not				
		g so she was rushing. At				
		ot, she unloaded the first				
		to the dialysis clinic. She				
	proceeded to unload Resident #5. After sh					
		ushed her backward in				
	· · · ·	her from the van. She did				
		e was not up so she and the				
	resident fell off the va	n. She revealed that she				
		on the ground to get help				
	-	c but she could not get any				
	-	tempts of getting help, she				
		p and placed her in the . After Resident #5 was				
	-	hair, she unloaded the third				
		her to the dialysis clinic.				
		sident #5 into the van and				
		ency room. Van Driver #1				
		#5 was complaining that her				
	-	I she wanted to go to the				
		the facility's transport van d her personal phone was				
	-	harging. She stated that				
		III EMS or the facility and she				
	could not get any hel					
		the resident up and took her				
	to the ER. "					
		for Van Driver #1 were				
		vice sheet dated 7/14/16				
		iver #1 was trained on the				
		urement system in the to safely transport residents				
		a balory transport residents				
	and on how to proper	ly use the lift gate on the				

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						0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BUILDING			С
		345509	B. WING		09	/23/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		20/2010
				915 PEE DEE ROAD		
KINGSWO	OOD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	- 29	F 00	22		
F 323	Continued From page		F 32	23		
	safely and all related					
		M, the administrator was				
	made to terminate the	ted that the decision was				
		third party transportation				
		port all residents to and				
	from appointments.					
		M, the Administrator and the				
		of the immediate jeopardy.				
		an acceptable credible				
		nce on 9/23/16 at 4:14 PM.				
	The credible allegatic	on indicated:				
	On September 10, 20)16, Resident #5, was being				
	-	llysis center. Upon arrival,				
	-	e had unloaded another				
		returned, she came back in				
		ide door. She proceeded to				
		sident in question and				
		the resident. At which time				
		l level and was not level with				
		he transportation aide e audible alarm sounded to				
	indicate something w					
		as pushing the resident and				
	tried to stop the resid					
	· ·	em both off the van, landing				
		occurred at 10:10am. The				
		ed to get assistance from				
	the dialysis center on	three occasions to no avail.				
		rtation policy does not				
	-	cessity.) The transportation				
		ent over for any apparent				
	-	e resident if she was in pain.				
		head and elbow hurt and				
	-	mergency room. The				
		aced the resident back in ansported her via facility van				
			1			1
		om for evaluation at 10:35				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 11/21/2016 RM APPROVED IO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		345509	B. WING			0	C 9/23/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGOWG				9	915 PEE DEE ROAD			
KINGSWC	OD NURSING CENTER			A	ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	and elbow hurting. T performed a Head Co scan and there were anomalies. The resid hospital and was pres medication every four follow up with attendi Resident was transpo 6:00 pm via the trans medication and an ab The transportation aid soon as she had acco September 10, 2016 transportation aide le facility due to needing Weekend supervisor Nursing was contacted incident/occurrence s started to ensure safe Administrator was up aware of incident and Regional Vice Preside 11:56 am. The Physi September 10, 2016 responsible party was 2016 at 1:00 pm. The facility transport on September 10, 20 resident that still require was routed to transpor The facility reviewed potentially affected by practice. It is determ would require transpor would be at risk. On 100% audit was comp with or without transport	e to complaints of headache he Emergency department omputed Tomography (CT) no skull fractures or lent was released from the scribed to take a pain r to six hours as needed and ng physician as needed. orted back to the facility at port company with pain orasion to elbow. de contacted the facility as ess to a telephone on at 10:40am. The ft her cell phone at the g to be charged. The was updated, the Director of ed at 11:42 am and an theet and investigation was e practices were in place. dated at 11:46 am and made I plan of investigation. The ent was made aware at cian was notified on at 4:03 pm and the s notified on September 10, ation aide was suspended 16 at 12:12 pm and any irred transportation services of company. residents that were y the alleged deficient ined that any resident who ortation on the facility van September 20, 2016, a pleted for current residents	F	323				

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/21/2016 MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		345509	B. WING			09	C / 23/2016	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
KINGOW				9'	15 PEE DEE ROAD			
KINGSWC	OOD NURSING CENTER			A	BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 323	for details of fall by D cause analysis was e 10, 2016. On September 10, 20 was removed from pr services now and in t transportation aides t her human error. The Director or Nursi transportation aides o in-serviced with new reentering of the van three active transport on September 10, 20 2016. On September 12, 20 inspected for proper agent. The lift for the order per the servicin The suspension of tra discontinued on Sept in-service of process was implemented. T exiting and entering t as to assure the lift is loading and unloading Added to the pre-trip transport driver form access to cell phone charging system in pl All transportation aide on September 20, 20 2016 by Administrato As of September 22, determined to ensure residents, in-house tr terminated. All reside by a third party transp	irector of Nursing and root established on September 2016, the transportation aide oviding transportation he future. The ated the incident was due to an g called in the current on September 10, 2016 to be process for the exiting and during transports. We have ation aides, training began 16 through September 11, 2016, the lift on the van was working order by servicing e van is in proper working g agent. ansportation services was ember 13, 2016 after and new safety measures The in-service entailed he van in the same manner in the proper position for g of residents. daily inspection report for was the additional check for for emergencies with a ace on September 20, 2016. es were in-serviced on this 16 through September 21, r and or Director of Nursing. 2016 at 5:00pm, it has been	F	323				

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 11/21/2016 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	
		345509	B. WING _					C 23/2016
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STAT	E, ZIP CODE		
KINGSWC	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
	has been parked and parking lot. The trans- heads and administra- the termination of in h- residents on Septemb The keys for the van a Administrator's office. The credible allegatio 5:04 PM by interviewi van drivers that they h the facility's accident/i procedure. The in-se and it was started on van drivers revealed t was terminated and a company would trans- appointments. The tra- parked out of service the administrator's off 483.30(a) SUFFICIEN PER CARE PLANS The facility must have provide nursing and re- maintain the highest p and psychosocial well determined by resider individual plans of car The facility must provin numbers of each of th personnel on a 24-hoi care to all residents in care plans:	locked up in the facility sportation aides, department tive nurses were notified of ouse transports for per 22, 2016 at 5:00 pm. are locked up in the n was verified on 9/23/16 at ng the staff including the have received in-service on incident policy and rvice records were reviewed 9/20/16. Interview with the hat the in house transport third party transportation port all residents for ansport van was observed and the key was locked at ice. IT 24-HR NURSING STAFF e sufficient nursing staff to elated services to attain or oracticable physical, mental, l-being of each resident, as in assessments and re. ide services by sufficient the following types of ur basis to provide nursing a accordance with resident	F 3					11/14/16

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/21 FORM APPR(OMB NO. 0938-	OVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		C 09/23/2016	6
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGOWO				915 PEE DEE ROAD		
KINGSWC	OOD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE	ETION
F 353	Continued From page	e 42	F 3	53		
	section, the facility m	under paragraph (c) of this ust designate a licensed harge nurse on each tour of				
	by: Based on record rev physician, resident ar failed to have adequa to pressure ulcers an ordered for 4 (Reside of 6 sampled resident ulcers and wounds. The findings included This tag is cross refer 1. F314 - Based on re resident and staff inte treat the pressure ulc for 2 of 3 sampled res (Resident#9 & #13). During an interview o #9, the weekend sup reported to the Direct treatments had not be shortage of staff on th there wasn't always a she had to take a res On 9/22/16 at 3:06 Pf (DON) was interview facility had a full time scheduled to provide through Friday. The v responsible to provide weekends. She adde	rred to: ecord review, observation, erview, the facility failed to bers as ordered on weekends sidents with pressure ulcers an 9/22/16 at 2:22 PM, Nurse ervisor, indicated she had for of Nursing that the een done because of the weekends. She indicated a nurse to call in for work and ident assignment. M, the Director of Nursing ed. The DON stated that the treatment nurse who was the treatments Monday weekend supervisor was e the treatment on the		F 353 1. According to the weekend treatments were not performed physician order for Resident #9 and #13 due to misunderstandi assigned duties. Resident #9 treatment was performed per p order by wound nurse on 9/21/ Resident #10 suprapubic cathet treatment was performed per p order by wound nurse on 9/22/ Resident #11 lesion on back tre was performed per physician o wound care nurse on 9/22/16. #13 bilateral toes and left heel was performed per physician o wound nurse on 9/21/16. Physi notified on 9/28/16. Education provided to staff assigned to the treatments began on 9/22/16. 2. Residents with written treat ordered have the potential to b 3. Licensed nursing staff wer on performing treatments per p orders by Director of Nursing a Development coordinator on 9/ prior to start of next shift. Any licensed nurse will receive this on orientation. Every licensed r	per 9, #10, #11 ing of sacrum hysician 16. eter hysician 16. eatment rder by Resident treatment rder by Resident treatment rder by ician was was ese ttments e affected. e educated hysician nd or Staff 23/16 or new education hurse will	

Facility ID: 970412

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUR	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLET	ED
			D. MINIO		С	
		345509	B. WING		09/23/2	2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CO THE APPROPRIATE	(X5) OMPLETIO DATE
F 353	Continued From page	243	F 35	33		
	wounds done. She in were refusing to do the facility had been swat three months ago when nurses that quit. 2. Resident #10 was 4/12/16. His Minimum 7/11/16, revealed he impairment and an in current diagnoses we tract infection, urinary dementia. Review of the care pl updated on 7/21/16 mentia. Review of the care pl updated on 7/21/16 mentia. Review of the physici revealed to clean the water and apply dry of needed. Review of the physici revealed to clean the site with normal salin (an antibiotic) ointme debridement agent) g Review of the August record (TAR) revealed	dicated she felt the nurses ne treatments because the mped with staffing issues, en there were aides and admitted to the facility on n Data Set (MDS) dated had moderate cognitive dwelling catheter. His ere in part, chronic urinary v tract disease and an initiated 7/19/16 and evealed in part, for the rovide suprapubic catheter as needed. an order dated 7/27/16, incision with warm soapy dressing every day and as an order dated 8/17/16, right suprapubic catheter e and apply Mipirocin 2% nt and Santyl (a		 round(perform treatments check sheet will be complecertified wound nurse or some some some some some some some some	eted by the upervisor by 11- . Any new erved during ng eck sheet will be und care nurse tation began on current licensed o descriptions by hift and were ursing and or nator. Any new in job ion. d or Director of ing needs daily clinical meeting needed. inue to recruit and continued provide staffing	
	8/15 (Monday), 8/20 (Sunday). Additional Sunday 8/21 catheter and dressed with Sar ointment. Review of the Septer	ly, on Saturday 8/20 and dressing was not changed		daily(Monday through Frid weekend schedules) by the coordinator and discussed Nursing and or Administrat (Monday through Friday) of An on-call sheet will be put two weeks of the month for nurses to sign up for week	he staffing d with Director of tor in daily clinical meeting. It out the last or full time	

Facility ID: 970412

If continuation sheet Page 44 of 57

		MEDICAID SERVICES				OMB NC	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345509	B. WING _				C 23/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2010
					5 PEE DEE ROAD		
KINGSWO	OOD NURSING CENTER				BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 353	Continued From page	- 44		50			
1 333			F 3	553			
		ervisor, indicated she had			as needed staff to be utilized on on-ca	11	
	treatments had not be	tor of Nursing that the			schedule.	by	
		ne weekends. She indicated			Staffing needs will be presented in QA Administrator and or Director of Nursin		
	-	a nurse to call in for work and				·9·	
	she had to take a res						
		M, the Director of Nursing					
		ed. The DON stated that the					
		treatment nurse who was					
	-	the treatments Monday					
	through Friday. The v	weekend supervisor was					
	responsible to provide	e the treatment on the					
	weekends. She adde	d that she had heard					
	murmurs that the nur	ses had no time to get					
		dicated she felt the nurses					
		ne treatments because the					
		mped with staffing issues,					
		en there were aides and					
	nurses that quit.						
		admitted to the facility on					
		cent Minimum Data Set					
		revealed a severe memory					
	-	und. The most recent					
		art, Alzheimer disease and					
	pyoderma granuloma	an dated 1/8/16, revealed in					
		s to be done as ordered to					
	the lesion on the med						
		ian order dated 7/25/16,					
		betasol propionate 0.05% (a					
		ent to the ulcer on the back					
	, ,	adhesive and collagen					
		tissue growth) and calcium					
	alginate (absorbed ex						
		ian order dated 8/19/16					
		l (for a bacterial infection)					
		d and apply to the wound					
	-	follow current treat above.					
	Clarification order wa	s added on 8/26/16, to apply		1			1

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/21/2016 APPROVED D: 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION			LETED
		345509	B. WING			_		C 23/2016
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD			
					ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	(TAR) for July revealed done on 7/2 (Saturday) (Sunday). Review of the TAR for treatment was done of 8/13 (Saturday), 8/14 on 8/21 (Sunday), 8/14 on 8/21 (Sunday). The administered to the w and 8/21 (Sunday). Review of the Septern dressing change or Fi 9/10 (Saturday). During an interview of #9, the weekend super reported to the Direct treatments had not be shortage of staff on the there wasn't always a she had to take a resi On 9/22/16 at 3:06 Pf (DON) was interviewed facility had a full time scheduled to provide through Friday. The w responsible to provide weekends. She addee murmurs that the nurs wounds done. She into were refusing to do the facility had been sware three months ago when nurses that quit. 483.75 EFFECTIVE	of 1 month. ent administration record ed wound treatment was not ed wound treatment was not y), 7/3 (Sunday) and on 7/24 r August revealed no wound on 8/5 (Friday), 8/7 (Sunday), (Sunday) 8/15 (Monday) or e Flagyl was not ound on 8/20 (Saturday) her TAR revealed no lagyl was administered on in 9/22/16 at 2:22 PM, Nurse ervisor, indicated she had or of Nursing that the een done because of he weekends. She indicated nurse to call in for work and dent assignment. M, the Director of Nursing ed. The DON stated that the treatment nurse who was the treatments Monday veekend supervisor was e the treatment on the d that she had heard ses had no time to get dicated she felt the nurses he treatments because the mped with staffing issues, en there were aides and		35				11/14/16
SS=J		ESIDENT WELL-BEING						
	A facility must be adm	ninistered in a manner that						

Facility ID: 970412

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	S		PLETED
						С
		345509	B. WING		09/	23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 490	Continued From page	e 46	F 49	20		
1 430		e 40 esources effectively and	F 49			
	efficiently to attain or	,				
		mental, and psychosocial				
	well-being of each re					
		L is not mot as ovidenced				
	by:	Γ is not met as evidenced				
		iew, observation and		F 490		
		nd staff interview, the		1. Resident #5 fell off the facility	/	
	facility's administration			transport and was moved prior to a		
	manage and to have an effective system in place to maintain compliance with F323 as evidenced			assessment by a qualified person		
		ce with F323 as evidenced		not having means of communication	on on	
		te jeopardy citations at F323		the van and was transferred to the		
		tion survey of 2/4/16 and		emergency room for evaluation an	d	
		nt investigation survey of		treatment.		
		provide a communication		2. An in-service was conducted		
		rtation van for use in case of		Administrator and/or Director of Nu	•	
		sident #5) of 1 sampled ccident. The facility failed to		on 9/10/16 for new safety measure regarding proper way of entering/e		
	have a resident asse			van to ensure lift is in proper positi	-	
		ossible injuries before		receive residents. Automobile em		
		er the fall for 1 (Resident #5)		phone and charger in place in van		
	-	t with a van accident (F309).		3. The Administrator and or Dire		
	The facility failed to p	provide adequate staff to		Nursing educated all staff on facilit	ty'⊡s	
		per physician orders for 4		accident/incident policy and proce		
		#13 and #11) of 6 residents		on 9/20/16. Any one not in-service		
		care (F224, F309, F314,		be educated prior to the start of the		
	F353).	(II) began an 0/10/16 when		shift. All new employees will receiv		
		(IJ) began on 9/10/16 when transportation van and		information during orientation. An in-service was conducted to not m		
	was moved before a	•		resident prior to assessment by a		
		her for possible injuries and		medical professional after an incid		
		on 9/23/16 at 4:14 PM when		9/20/16 by Director of Nursing and		
	the facility provided a	an acceptable credible		Development Coordinator. All new		
		nce. The facility will remain		will be educated upon orientation.		
	-	a scope and severity level E		4. Accidents and or incidents wil		
		potential for more than		reviewed during morning departme		
		not immediate jeopardy) to		head meetings daily Monday throu		

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		MEDICAID SERVICES				OMB NO	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING			C	2
		345509	B. WING				23/2016
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				91	5 PEE DEE ROAD		
NINGSWC	OOD NURSING CENTER			A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 490	Continued From page	e 47	F 49	90			
1 100		in-serviced on facility's	1 43	30	Friday to determine root cause analysis		
		cy and procedure and to			Accidents and incidences will be	-	
	-	tice for residents #9, #10,			discussed in weekly patient at risk		
		as cited at a scope and			meetings to ensure interventions are		
	severity of an E.				appropriate		
	Findings included:				5. Accidents and incidents will be		
	This tag is cross refer				reviewed during QA meetings to monito	r	
		record review and staff			trends and compliance of current		
	-	failed to raise the lift gate up sident who was sitting in a			practices. A corporate representative will be present or on conference call for the		
		transport van causing the			QA meetings to ensure compliance with		
		ard for 1 (Resident #5) of 1			corrective actions.		
		h a van accident. Resident			7. During QA meeting, areas of identit	fied	
	#5 sustained a head	injury and cervical strain			concern will be addressed by the		
	from the fall.				committee. In turn the staff will be		
	The facility was cited	-			educated during staff meetings on two		
		of 2/4/16 at immediate			policies and or procedures identified.		
		securing the resident and			Education will be conducted by		
		transportation van during resident to have a fall.			Administrative staff. The Administrator will oversee the adherence to the		
	The facility was cited				education schedule and policy adheren	ce	
	-	of 3/26/15 at immediate			The Regional Vice President will overse		
		maintaining the water			the Administrator for overall compliance		
	temperatures at or les Fahrenheit.	-			facility policy and procedures.		
		record review and physician			1. Resident #9 sacrum treatment was		
		he facility failed to have the			performed per physician order by the		
		amined by a qualified			wound nurse on 9/21/16. Resident #10		
	1 · · ·	ijuries before moving a for 1 (Resident #5) of 1			suprapubic catheter treatment was performed per physician order by the		
		n a van accident. Resident			wound nurse on 9/22/16. Resident #11		
		injury and cervical strain			lesion on back treatment was performed		
		ility also failed to treat			per physician order by the wound nurse		
		or 3 (Residents # 10, #11			on 9/22/16. Resident #13 bilateral toes		
	and #13) of 3 sample	d residents reviewed for			and left heel treatment was performed p	ber	
	wounds.				physician orders by wound nurse on		
	0-0/00/40 -+ 0-50 D				9/21/16. Physician was notified on	10	
	On 9/20/16 at 2:52 Pl	M, the administrator and the			9/28/16. Residents #9, #10, #11 and #7	13	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345509 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 490 Continued From page 48 F 490 Director of Nursing (DON) were interviewed. The were not adversely affected. Education administrator stated that she started working at was provided to the staff assigned to the facility as an administrator 2 weeks ago. She treatments began on 9/22/16. stated that she could call her Regional Vice President for any guestions. She indicated that a 2. Licensed Nursing staff were educated cell phone will be placed in the van permanently on performing treatments per physician s for the staff to use in case of emergency. The orders by the Director of Nursing and or DON stated that the accident was a human error. Staff Development Coordinator on 9/23/16 On 9/20/16 at 5:00 PM, the Administrator and the and prior to next shift worked. Any new DON were informed of the immediate jeopardy. licensed employee will receive this The facility provided an acceptable credible education upon orientation. Every allegation of compliance on 9/23/16 at 4:14 PM. licensed nurse will be observed during The credible allegation indicated: treatment round(performing treatment)and On September 10, 2016, resident was being skills checklist will be completed by transported to the dialysis center. Upon arrival, Certified wound care nurse and or the transportation aide was unloading the resident supervisor by 11-14-16 or prior to next and the resident fell off the back of the 10:10 am. shift. Every new licensed nurse will be The transportation aide tried to get assistance observed during treatment from the dialysis center to no avail. The round(performing treatments) and skills transportation aide ensured the resident was safe checklist will be completed by certified Wound Care nurse and or supervisor. and transported her to the Emergency room for evaluation 10:35 am. 3. An audit of treatment administration The facility transportation aide was suspended on September 10, 2016 at 12:12 pm permanently records was performed by the ward clerk from driving the van. on 10/4/16. All incidences of omission Facility transportation was suspended on was be discussed with the Medical September 10, 2016 and any resident that still Director on 9/28/16 and was taken to QA required transportation services was routed to a meeting on 9/28/16. Any licensed nurse third party transport company. The full time not completing treatments as ordered will transportation aide called the third party transport receive disciplinary action per policy up to company to set up appointments. and including termination of employment. The vehicle was inspected on September 12, 2016 for proper working order of the by the 4. Residents with treatments ordered by servicing agent. The lift on the van was found to the physician have the potential to be be in proper working order. affected. Transportation services were resumed by facility transportation aides on September 13, 2016. 5. An audit of treatment administration The Administrator and or Director of Nursing will records will be conducted every day for in-service all staff on facility's accident/incident completeness by the wound nurse and or

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		MEDICAID SERVICES				D. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP		(X3) DATE SURVEY COMPLETED		
			A. BUILDING	3		С	
		345509	B. WING			/23/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		23/2010	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE	
F 490	Continued From page	- 40	E 40	20			
F 490			F 49		athe They the		
		to include reporting and		the floor nurse for two mo			
	-	In-servicing began on Any one not in-serviced will		audit will be conducted th week for one month, then			
	-	the start of their next shift.		eleven months.			
	-	priate medical assessment		Results of audits will be d	liscussed by		
		ents who may be at risk for		Director of Nursing and o	•		
	or have an injury, afte			during monthly QA meetin			
	accident. "Regardles	s of how minor an accident		twelve consecutive month	ns then		
	-	must be reported to the		periodically to ensure con	npliance is met.		
		or. Employee witnessing an					
		nvolving a resident must		6. Every month, a repre			
		e to his or her immediate		present or on conference			
	supervisor as soon as			meeting. Every week the			
		(nursing administration and neet daily Monday through		accident log will be sent to Development Coordinato	-		
		eeting and reviews incidents		office for review for six me			
	and accident reports.			monthly thereafter. The o			
	The facility meets mo			regional supervisor and/			
		and or incidents to monitor		will review and provide co			
		e of current practices.		assistance to ensure proc			
	As of September 22,	2016 at 5:00pm, it has been		followed according to poli	icy.		
	determined to ensure	100% safety for all					
		ansportation has been		1. According to the wee			
		ent transport will be provided		treatments were not perfo			
	by a third party transp			physician order for Reside			
		rked and locked up in the		and #13 due to misunder	-		
	facility parking lot. In			assigned duties. Resider			
		Any one not in-serviced will the start of their next shift.		treatment was performed order by wound nurse on			
	The keys for the van			Resident #10 suprapubic			
	Administrator's office	•		treatment was performed			
	During the QA meetir			order by wound nurse on			
	-	essed by the committee. And		Resident #11 lesion on ba			
	in turn the staff will be	e educated during the staff		was performed per physic	cian order by		
	meetings held by the			wound care nurse on 9/22			
		t of on one to two policies		#13 bilateral toes and left			
	identified per meeting			was performed per physic	-		
		re to these policies. If these		wound nurse on 9/21/16.	-		
	policies and procedur	res are not adhered to		notified on 9/28/16. Educ	cation was	1	

Facility ID: 970412

If continuation sheet Page 50 of 57

	S FOR MEDICARE &		a					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILDING	i				
		345509	B. WING		C			
		545509		STREET ADDRESS, CITY, STATE, ZIP CODE	09/23/2016			
NAME OF PI	ROVIDER OR SUPPLIER							
KINGSWOOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO			
F 490	Continued From page	2 50	F 49	0				
	disciplinary action will including termination.	I take place up to and		provided to staff assigned to these treatments began on 9/22/16.				
	•	oversee the adherence to		2. Residents with written treatment	s			
		ile and policy adherence.		ordered have the potential to be affect	-			
	The Regional Vice Pr	esident will oversee the		3. Licensed nursing staff were edu	cated			
		rall compliance of facility		on performing treatments per physici				
	policy and procedures			orders by Director of Nursing and or				
		on was verified on 9/23/16 at		Development coordinator on 9/23/16	or			
	-	ing the staff including the have received in-service on		prior to start of next shift. Any new licensed nurse will receive this education	ation			
	the facility's accident/			on orientation. Every licensed nurse				
	-	ervice records were reviewed		be observed during a treatment				
		9/20/16. Interview with the		round(perform treatments) and a skil	ls			
	van drivers revealed t	that the in house transport		check sheet will be completed by the				
		a third party transportation		certified wound nurse or supervisor b	by 11-			
	company would trans			14-16 or prior to next shift. Any new				
		ansport van was observed		licensed nurse will be observed durin	ng			
	the administrator's of	and the key was locked at		treatment round(performing treatments)and a skills check sheet v	will bo			
		ecord review, observation		completed by certified wound care n				
		nt and staff interview, the		or supervisor.				
		rovide wound treatment as						
		cian for 4 (Residents #9, #		Staff were hired and orientation bega	an on			
	10, #11 and #13) of 6	sampled residents		10/6/16 and on-going. All current lice				
	reviewed for wound tr			personnel have signed job descriptio	-			
	-	n 9/22/16 at 3:06 pm, the		10/24/16 or prior to next shift and we				
	÷ .	OON) indicated she was not		reviewed by Director of Nursing and				
		ts were not being completed e indicated she had heard		Staff Development Coordinator. Any licensed personnel will sign job	new			
		ses had no time to get		descriptions upon orientation.				
		e indicated she felt the		4. The Administrator and or Directo	or of			
	nurses were refusing			Nursing will evaluate staffing needs of				
	-	en swamped with staffing		Monday through Friday in clinical me	-			
	issues.			and make adjustments as needed.				
				Classified want ad to continue to rec	ruit			
		ecord review, observation,		new employees.				
		erview, the facility failed to		5. In-house employees and continu				
	ueat the pressure uic	ers as ordered on weekends		recruitment and hiring will provide sta	annig			

Facility ID: 970412

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2016 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345509		345509	B. WING _			C 09/23/2016	
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINCOWO				91	5 PEE DEE ROAD		
KINGSWO	OD NURSING CENTER			A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page (Resident#9 and #13) During an interview of Director of Nursing (D told that the treatment on the weekends. She murmurs that the nurs treatments done. She nurses were refusing because they had bee issues. 4. F353 - Based on re and physician, reside facility failed to have a treatments to pressur provided as ordered ff #11 and #13) of 6 sam pressure ulcers and w During an interview of #9, the weekend supe reported to the Director treatments had not be shortage of staff on th there wasn't always a she had to take a resi On 9/22/16 at 3:06 PM (DON) was interviewe facility had a full time scheduled to provide through Friday. The w responsible to provide weekends. She addee murmurs that the nurs wounds done. She interviewe	e 51 n 9/22/16 at 3:06 pm, the ON) indicated she was not ts were not being completed e indicated she had heard ses had no time to get indicated she felt the to do the treatments en swamped with staffing cord review, observation, nt and staff interview, the adequate staff to ensure e ulcers and wounds were or 4 (Residents #9, # 10, npled residents reviewed for younds. n 9/22/16 at 2:22 PM, Nurse ervisor, indicated she had or of Nursing that the the done because of the weekends. She indicated nurse to call in for work and dent assignment. M, the Director of Nursing ed. The DON stated that the treatment nurse who was the treatments Monday veekend supervisor was e the treatment on the d that she had heard ses had no time to get dicated she felt the nurses	F 4	90		e or of ng. ' up hire II by g.	
	facility had been swar	e treatments because the nped with staffing issues, en there were aides and					

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		ID HUMAN SERVICES MEDICAID SERVICES		FOR	M APPROVED D. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C / 23/2016	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWC	KINGSWOOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 490	Continued From page	e 52	F 49	90			
F 520 SS=J			F 52	20		11/14/16	
	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.						
	by: Based on record revi physician, resident ar facility's Quality Asse (QAA) committee faile procedure and failed			 F 520 1. Prior Survey plan of correction not followed as written. 2. Residents requiring van transport had the potential to be affected. In-transport was terminated on 9/22/16 	ortation house		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345509 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD KINGSWOOD NURSING CENTER ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 520 Continued From page 53 F 520 survey. The facility has repeated deficiencies on independent transportation company accidents (F323), and care and services (F309) provides all resident transportation on the recertification survey of 2/4/16 and on the services. complaint survey of 9/25/16. The facility had 3. Department heads meet Monday systemic failure to treat pressure sores as through Friday and review accidents and ordered by the physician (F314). The continued or incidents and to determine root cause failure of the facility during the two federal analysis. Incidents and accidents are surveys of record and the systemic failure to treat reviewed weekly in patient at risk meeting pressure sores as ordered showed a pattern of to ensure interventions are appropriate. the facility's inability to sustain an effective QAA 4 The QA committee meets monthly to program. review accidents and or incidents to Immediate Jeopardy (IJ) began on 9/10/16 when monitor trends and compliance of current Resident #5 fell off the transportation van and the practices IJ was removed on 9/23/16 at 4:14 PM when the Every month, a member of the 5. facility provided an acceptable credible allegation corporate team will be either on-site or by of compliance. The facility will remain out of conference call for QA meeting. Every compliance at a scope and severity level E (not week the incident and accident log will be actual harm with potential for more than minimal sent by the Staff Development harm that is not immediate jeopardy) for Coordinator to corporate office for review Residents' # 9, #10, #11 and #13) and to ensure for six months and monthly thereafter. all staff were in-serviced on the facility's The corporate office/ regional supervisor accident/incident policy and procedure. and/ or consultants will review, provide collaboration and assistance to ensure Findings included: This tag is cross referred to: processes are being followed according to 1. F323 - Based on record review and staff policy. interview, the facility failed to raise the lift gate up before pushing the resident who was sitting in a Resident #5 was moved prior to an 1. wheelchair out of the transport van causing the assessment by a medical professional resident to fall backward for 1 (Resident #5) of 1 after an accident in which entailed the sampled resident with a van accident. Resident resident falling out of the facility van and #5 sustained head injury and cervical strain from was transferred to emergency room for the fall evaluation and treatment. During the recertification survey of 2/4/16, the facility was cited F323 for not properly securing 2. Residents who require van the resident and the wheelchair in the transport transportation have the potential to be van, failed to notify the administrator about the affected. incident and failed to complete a root cause analysis of the incident. 3. An audit of residents receiving On 9/20/16 at 2:52 PM, the administrator and the transportation via facility van was

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
oonneonon	IDENTIFICATION NOMBER.	A. BUILDIN	A. BUILDING		
	345509	B. WING		C 09/23/2016	
ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP	CODE	
KINGSWOOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
Continued From page	2 54	F 5	20		
DON were interviewe that she started worki administrator 2 weeks the department heads incident reports on a no other residents with happened in the past. they had not been mo before or after the 9/1 Administrator stated t administrator stated t administrator might ha the duration stated or the last survey. 2. F309 - Based on re and staff interview, th resident assessed/ex person for possible in resident after the fall sampled resident with #5 sustained a head i from the fall. The facil wounds as ordered for #13) of 3 sampled resident facility was cited F300 psychological interver residents. On 9/20/16 at 2:52 Pf DON were interviewe that she started worki administrator 2 weeks that they had not bee before or after the 9/1	d. The administrator stated ng at the facility as an s ago. The DON stated that s had been reviewing the daily basis and there were th the same incident . The DON revealed that pointoring the van drivers 0/16 incident. The hat the previous ave done the monitoring for the plan of correction from ecord review and physician e facility failed to have the amined by a qualified juries before moving a for 1 (Resident #5) of 1 n a van accident. Resident njury and cervical strain lity also failed to treat the or 3 (Residents # 10, #11 & sidents reviewed for wounds. ion survey of 2/4/16, the D for not providing ntions for 2 of 2 sampled M, the administrator and the d. The administrator stated ng at the facility as an s ago. The DON revealed n monitoring the van drivers 0/16 incident. The		 conducted on 9/22/16 by 3 Development Coordinator accident or incident occur Resident #5 was affected. 4. All staff were educate accident and incident polic procedure on 9/20/16 or p shift worked. All staff were not moving a resident with assessment after an accid Director of Nursing and or on 9/20/16 or prior to star New employees will be ed orientation on these proce 5. In-house facility trans terminated on 9/22/16. An company provides transport 1. Resident #9 sacrum t performed per physician of wound nurse on 9/22/16. I bilateral toes and heel treat performed per physician of wound nurse on 9/21/16. I #13 did not have any adve Physician was notified on Education was provided to assigned to do treatments 9/22/16. 2. Licensed Nursing stat on performing treatments 	to determine rence. Only ed on the cy and prior to their next e educated on hout an dent by the Administrator t of next shift. fucated upon esses. portation was nindependent ortation services. treatment was order by the Resident #13 atment was order by the Resident #9 and erse affects. 9/28/16. o nurses began on ff were educated per physician □s	
	Continued From page DON WERE INCIES SUMMARY ST, (EACH DEFICIENCY REGULATORY OR I Continued From page DON were interviewe that she started worki administrator 2 weeks the department heads incident reports on a no other residents with happened in the past they had not been mo before or after the 9/1 Administrator stated t administrator stated to the last survey. 2. F309 - Based on re and staff interview, th resident assessed/ex person for possible in resident after the fall sampled resident with #5 sustained a head if from the fall. The facil wounds as ordered for #13) of 3 sampled resident from the fall. The facil wounds as ordered for #13) of 3 sampled resident from the fall. The facil wounds as ordered for #13) of 3 sampled resident from the fall. The facil wounds as ordered for #13) of 3 sampled resident from the fall. The facil wounds as ordered for #13) of 3 sampled resident facility was cited F309 psychological intervent residents. On 9/20/16 at 2:52 PI DON were interviewed that she started worki administrator 2 weeks that they had not bee before or after the 9/1 Administrator stated to	IDENTIFICATION NUMBER: 345509 ROVIDER OR SUPPLIER DOD NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 DON were interviewed. The administrator stated that she started working at the facility as an administrator 2 weeks ago. The DON stated that the department heads had been reviewing the incident reports on a daily basis and there were no other residents with the same incident happened in the past. The DON revealed that they had not been monitoring the van drivers before or after the 9/10/16 incident. The Administrator stated that the previous administrator might have done the monitoring for the duration stated on the plan of correction from the last survey. 2. F309 - Based on record review and physician and staff interview, the facility failed to have the resident assessed/examined by a qualified person for possible injuries before moving a resident after the fall for 1 (Resident #5) of 1 sampled resident with a van accident. Resident #5 sustained a head injury and cervical strain from the fall. The facility also failed to treat the wounds as ordered for 3 (Residents # 10, #11 & #13) of 3 sampled residents reviewed for wounds. During the recertification survey of 2/4/16, the facility was cited F309 for not providing psychological interventions for 2 of 2 sampled	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A BUILDIN 345509 B. WING _ ROVIDER OR SUPPLIER B. WING _ DOD NURSING CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 54 F 5. DON were interviewed. The administrator stated that she started working at the facility as an administrator 2 weeks ago. The DON stated that the department heads had been reviewing the incident reports on a daily basis and there were no other residents with the same incident happened in the past. The DON revealed that they had not been monitoring the van drivers before or after the 9/10/16 incident. The Administrator stated that the previous administrator stated on the plan of correction from the duration stated on the plan of correction from the last survey. 2. F309 - Based on record review and physician and staff interview, the facility failed to have the resident assessed/examined by a qualified person for possible injuries before moving a resident adter the fall for 1 (Resident #5) of 1 sampled resident with a van accident. Resident #5 sustained a head injury and cervical strain from the fall. The facility also failed to treat the wounds as ordered for 3 (Residents # 10, #11 & #13) of 3 sampled residents reviewed for wounds. During the recertification survey of 2/4/16, the facility was cited F309 for not providing psychological interventions for 2 of 2 sampled residents. On 9/20/16 at 2:52 PM, the administrator and the DON were interviewed. The administrator stated that she started working a	CPEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION A BUILDING	

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION			
	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		. ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
		345509	B. WING			09/23/2016	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			09/23/2016	
			915 PEE DEE ROAD	2, 2 0002			
KINGSWOOD NURSING CENTER							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETIC DATE	
IAG	REGULATORT ORT		IAG		FICIENCY)		
F 520	Continued From page	55	F 52				
1 020			F 52		aa will baya iab		
		M, the Administrator and the		3. All licensed nurs	•		
		of the immediate jeopardy.		descriptions reviewed			
		an acceptable credible		Nursing and or Staff	-		
		nce on 9/23/16 at 4:14 PM.		Coordinator and sign			
	The credible allegatio			prior to next shift. Jo			
		eets every month and		licensed nurses will b			
		s and accidents. The		Director of Nursing a			
		in place as per the plan of			nator quarterly for one		
	-	rior incident in February		year and annually the			
	2016. There were no			licensed nurses will r			
		ever, in this incident, the			follow quarterly cycle		
	accident stemmed fro			and annually thereaf	er.		
		(nursing administration and					
		eet daily Monday through		4. An audit of treat			
		eeting and reviews incidents		records was perform			
	and accident reports.			on 10/4/16. All incide	ences of omission		
	The QA committee (A	Administrator, Director of		was discussed with t	he Medical Director		
	Nursing, Staff Develo	pment Coordinator, Social		on 9/28/16 and was t	aken to QA on		
	Worker, Dietary Mana			10/22/16.			
		ledical Director, Activities		5. Residents with w	vritten treatments		
	•	ince Director, Medical		ordered have the pot			
	-	pordinator) meets monthly to					
	review in QA meeting			6. Every licensed n	urse will be observed		
		rends and compliance of		during treatment rour			
	current practices.			treatment) and a skill			
	•	nergency QA meeting on		completed by certifie			
		e four IJ tags listed above to		or supervisor by 11-1			
		to ensure the continued		shift. Any new license			
	•			observed during a tre			
	safety and well- being of all the residents in the facility. Our current policy and procedures in			round(perform treatm			
		for the safety of residents		checklist will be com			
	· · · · · ·	This incident was a result		wound nurse or supe	-		
		e is an audible alarm signal		-	be conducted by the		
		nen improper use of the lift is		certified wound care	-		
		em was operating properly		monthly. An audit of	-		
	when this incident oc			administration record			
		meeting minutes will be sent		every day for comple			
	to corporate office for			nurse and or floor nu	•		
I	TO COLOCATE OTICE TOP						

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	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM	D: 11/21/2016 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
345509		B. WING					23/2016	
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP COD)E	•••	
KINGSWOOD NURSING CENTER					15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 520	ROVIDER OR SUPPLIER DOD NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	520	times per week for one month monthly for eleven months. 7. Results of the audits will by the Director of Nursing and Administrator during monthly monthly for twelve consecutive then periodically to ensure co- met.	be discus d or the QA meeti /e months	ngs	

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