DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		LETED
		345509	B. WING				C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD		
Nincome					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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221 SS=E	483.10(e)(1), 483.12( FROM PHYSICAL RE	a)(2) RIGHT TO BE FREE ESTRAINTS	F	221			10/18/17
	§483.10(e) Respect a	and Dignity.					
	and dignity, including §483.10(e)(1) The rig physical or chemical in purposes of discipline required to treat the ric consistent with §483.12(a)(2). 42 CFR §483.12, 483	ht to be free from any restraints imposed for e or convenience, and not esident's medical symptoms,					
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to					
	(a) The facility must-						
	or chemical restraints discipline or convenier required to treat the me symptoms. When the indicated, the facility me alternative for the lease document ongoing re- restraints. This REQUIREMENT by:	esident's medical e use of restraints is must use the least restrictive st amount of time and -evaluation of the need for				- of	
	interview, the facility usides of bed (Resider	ew, observation and staff utilized the side rails on both its #96, #40, #22 & #76) and			Preparation and submission of the plan correction by Kings Wood Nursing Cent does not constitute an admission or	ter,	
		cushion (Resident #61)			agreement by the provider of the truth of	DI	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

**Electronically Signed** 

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

10/06/2017

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	B		MPLETED
						С
		345509	B. WING		0	9/21/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD		
				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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE
F 221	Continued From page	e 1	F 22	21		
1 22 1			F 22	the facts alleged or the correct	stross of the	
	without considering the restraint and not have	ing medical symptoms for its		conclusions set forth on the s		
		ed residents reviewed for		deficiencies. The plan of con		
		# 40, #96, #22, #76, & #61).		prepared and submitted sole		
	Findings included:	-,, , -, -, -,		the requirements under state	• •	
				laws.		
	1. Resident #96 was	admitted to the facility on				
	8/25/17 with multiple			F 221		
		fracture of the upper end of		1. Resident #96 bedrail / as		
		lls. The admission Minimum		evaluation was reviewed and		
	Data Set (MDS) asse			10/5/17 by the Director of Nu	rsing (DON)	
		ent #96 had memory and		– side rails were removed.		
		blems and she was not using al restraint. The assessment		Resident # 40 was discha	arged on	
	also indicated that Re			Resident #22 side rail / a	ssist har	
		with bed mobility and she		evaluation was reviewed on r		
		e staff for transfer and		10/5/17 by the DON. Turning		
	locomotion.			Repositioning (T& R) bars are		
		plan dated 8/25/17 was		the head of the bed to assist		
	reviewed. One of the	e care plan problems was		turning and positioning. T& R	are padded.	
	"the resident is high r	risk for falls related to		Resident #76 bedrail / as	sist bar	
		oning and unaware of safety		revaluation was reviewed and		
		as "resident will not sustain		10/5/17 by the DON. Evaluat		
		n the next review date". The		need for T&R bars at head of		
		nclude the use of bilateral		resident in turning and position	•	
	side rails.			Resident #61 was evalu		
	Resident #06's Red F	Rail/Assist Bar Evaluation		/17 by Occupational Therapy on 10/4/17. Trial reduction wi		
		as reviewed. The form		length wedge cushion was at		
		ent #96 had history of falls		Husband was present and die		
		sibility that she would climb		comfortable for resident to be		
		sist bar. The form also		cushion due to how she move	es her legs.	
	indicated that there w	vas evidence that Resident		Resident was assessed and		
		eason to get out of bed. The		cushions were placed and ev		
		if side rails were indicated or		restraint due to frontal lobe de		
		did not include the medical		2. An audit was completed	•	
		e use of side rails. The form		and the Assistant Director of	-	
		if the Responsible Party or		(ADON) by 10/05/17 of the cu		
	the Physician were no	otified for the use of the side		residents' devices to include	ine side rails	

Facility ID: 970412

If continuation sheet Page 2 of 83

	S FOR MEDICARE &	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039	
	F CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED	
		345509	B. WING		C 09/21/2017		
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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 221	Continued From page	e 2	F 22	1			
		62	1 22		na aida		
	rails.			and T&R bars, the position of th rails/ the T&R bars on the bed,			
	Attempts were made	to interview the author of		cushions, special mattresses ar	•		
		Bar Evaluation form dated		adaptive devise to ensure the le			
	8/25/17 but the author	or was not available for		restrictive alternative is used. E			
	interview.			forms regarding devise acting a	is a		
				restraint will be completed by th			
		e Aide (NA) Information		ADON and Unit Manager (UM)			
		NA) was observed posted		10/17/17. Ongoing documentati			
		sident's closet. The sheet		re-evaluation of the need for res			
	had a check mark un			be completed quarterly and as with change in resident status.	neeaea		
	On 9/19/17 at 3:20 P	M and on 9/20/17 at 8:45		with change in resident status.			
		as observed out of bed.		3. The Nursing staff (to includ	le		
		(SR) were observed installed		week-end and as needed staff)			
	in the middle of her b	ed.		re-education was began promp 10/05/17. Training will be comp			
	On 9/20/17 at 8:46 Δ	M, Medication Aide (MA) #2		10/17/17. In-service includes: v	-		
		e stated that Resident #96		use of a restraint is indicated th			
		f bed if she wanted to. She		restrictive alternative for the lea			
	-	shift staff had to get her out		of time is used.			
	of bed because she t						
		urther stated that Resident		4. Licensed nursing staff, to in			
		ne on one during the day		week-end and prn staff, will be			
		get out of the chair. She		by SDC or DON no later than 1			
		ident was using bilateral ½		regarding completion of restrain			
		bed for bed mobility. She esident was unable to		assessment, and documentatio to restraint use.	n related		
	remove or lower the						
	On 0/20/17 at 9:49 A	M. Nursing Assistant (NA) #5		5. An audit will be completed	by the		
		M, Nursing Assistant (NA) #5 e stated that she was the		Assistant Director of Nursing (A			
		6. She indicated that night		weekly for 4 weeks and monthly			
		the resident up because she		months to ensure that when the			
		and chair unassisted. NA		restraints is indicated, the least			
	-	hat Resident #96 was using		alternative will be used . Ongoir			
	bilateral ½ SR when			evaluation and documentation v	-		
				completed quarterly and prn wit			
	On 9/20/17 at 9:20 A	M. Nurse #2 was		status change. The DON will p			

Facility ID: 970412

If continuation sheet Page 3 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				21/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 221	form was not fully cor the summary of findin completed to include indicated, the reason Physician were notifie Resident #96 constant and chair and she wat added that the reside for repositioning. Nur resident was able to g not able to walk due to On 9/20/17 at 10:39 A had observed the side both sides rails were bed. She indicated th were not supposed to her bed but they were she already informed the side rails to the up indicated that having bed, Resident #96 hat be able to get out. On 9/21/17 at 1:23 Pl (DON) was interviewed she expected the staft the Bed Rail/Assist B observing the resider medical and physical side rails.	2 reviewed the Bed ation form and e evaluation/assessment npleted. She indicated that ags should have been the type of SR to use if for its use and if RP and ed. Nurse #2 revealed that ntly tried to get out of bed us high risk for falls. She nt was using bilateral ½ SR rse #2 stated that the get out of bed but she was to the fracture on her leg. AM, Nurse #2 stated that she e rails of Resident #96 and installed in the middle of the nat Resident #96's side rails to be installed in the middle of e. Nurse #2 indicated that the maintenance to move oper part of her bed. She the SR in the middle of her id to scoot down the bed to M, the Director of Nursing ed. The DON stated that if to fully complete and follow	F 2	221	report to the Quality Assurance (QA) Committee monthly for 4 months Th QA Committee consist Medical Director Administrator, DON, ADON, Treatmen Nurse, SDC, MDS Coordinator, Maintenance Director, Activity Director Housekeeping & Laundry Director, Die Director, Medical Record, Business Of Manager (BOM), Human Resource Director (HR). Date of Compliance: 10/18/17	r, t , tary	

If continuation sheet Page 4 of 83

-		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF PROVIDER OR SUI		-		9	STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
Resident #4 Dementia au admission M dated 5/17/ <sup>7</sup> severe cogr using side ra assessment needed exte and transfer with locomo limb prosthe Resident #4 reviewed. O "risk for falls experience 90 days". T use of bilate Resident #4 form dated £ indicated tha and there w over the bed indicated tha #40 has a d evaluation o to justify the indicate if th were notified form was no the author. Resident #4	11/17 and 0 had mu dinimum I 17 indicate itive impa- ails as a p further in ensive ass and he n tion using esis. 0's care p One of the ". The go serious in he appro- tral side ra 0's Bed F 5/11/17 w at Reside as a poss d rails/ass at there w esire or ra lid not inc use of si e Respond for the using of s Nurse guide for of the res	d expired on 6/1/17. Iltiple diagnoses including olic encephalopathy. The Data Set (MDS) assessment ed that Resident #40 had airment and he was not ohysical restraint. The indicated that Resident #40 sistance with bed mobility needed limited assistance g a walker, wheelchair and olan dated 5/11/17 was e care plan problems was oal was "resident will not jury from falls over the next aches did not include the	F	221			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345509	B. WING				C / <b>21/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 221	Continued From page	9 5	F	22 <sup>-</sup>	1		
	She stated that Resid rails (SR) in the middl able to remove or low wanted to get out of b Resident #40 was abl to chair and chair to b On 9/19/17 at 2:50 Pf Nursing (ADON) was reviewed the Bed rail dated 5/11/17 and state evaluation, Resident a rails in bed. He was a On 9/20/17 at 10:43 A interviewed. She state bilateral ½ SR in his b	M, the Assistant Director of interviewed. The ADON /Assist Bar Evaluation form ated that based on the #40 should not have side able to lift self out of bed.					
	(DON) was interviewed she expected the staft the Bed Rail/Assist Ba observing the resident medical and physical side rails. 3. Resident #76 was a	at and to document the indication for the use of the admitted to the facility on					
	disease, respiratory fand history of falling.	es that included Alzheimer ' s ailure, difficulty in walking,					
		Resident #76 included the s of Daily Living (ADLs)					

Facility ID: 970412

If continuation sheet Page 6 of 83

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &						FORM	D: 10/25/2017 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345509	B. WING					C 21/2017
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	TE, ZIP CODE		
KINGSWOOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
reviewed on 6/13/17. require the assistance plan of care for Reside problem area of the r 3/13/17 and most reco There was no mention Resident #76 's plan A plan of care note da Resident #76 was at was unsteady while a unaware of his safety was noted to frequen and get out of bed wi chair alarm were imp The quarterly Minimu assessment dated 9/ 's cognition was seve assessed as depend mobility, toileting, dree Resident #76 require of one staff for transfe unit and the limited a locomotion on the un was only able to stab Resident #76 was as incontinent of bladde assessment indicated physical restraints (do method or physical o material or equipmen resident 's body that remove easily which movement or normal The bed rail/assist ba	2/7/16 and most recently He was indicated to e of staff with all ADLs. The dent #76 also included the isk for falls initiated on cently reviewed on 6/13/17. n of the use of side rails on of care. ated 6/30/17 indicated moderate risk for falls, he ambulating, and was / limitations. Resident #76 tly attempt to stand, transfer, thout assistance. A bed and lemented to prevent falls. m Data Set (MDS) 9/17 indicated Resident #76 erely impaired. He was ent on one staff for bed essing, and personal hygiene. d the extensive assistance ers and locomotion off the ssistance of one staff for it. He was not steady and ilize with staff assistance. sessed as always r and bowel. The d Resident #76 had no efined as any manual r mechanical device, it attached or adjacent to the the individual cannot	F	221				

Facility ID: 970412

If continuation sheet Page 7 of 83

		D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		SURVEY PLETED	
		345509	B. WING				21/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE	
F 221	desire to have bed ra his own safety and/or visual deficits. Reside not able to get in/out a indicated not to use th positioning, support, of position to a sitting/str required a summary of results of the assess findings for Resident a was not signed by sta An interview was con 9/18/17 at 11:52 AM. was not capable of get Nurse #4 revealed sh #76 had side rails. Si record and was unable order for side rails for asked Nursing Assista Resident #76 's side An interview was con 9/18/17 at 11:54 AM. had bilateral quarter I the middle section of An observation was of 12:26 PM of Resident was located in the fact Resident #76 had bilat the middle section of Each side rail was ap length and there was 34 inches from the to top end of the mattres	ils/assist bar while in bed for comfort. He was noted with ent #76 was assessed as of bed safely. He was ne bed rails/assist bar for or to help rise from a laying anding position. The form of findings to explain the nent. This summary of #76 was blank and the form iff. ducted with Nurse #4 on She indicated Resident #76 etting out of bed on his own. e had not known if Resident he reviewed the medical e to locate a physician ' s Resident #76. Nurse #4 ant (NA) #5 to observe rails. ducted with NA #5 on She indicated Resident #76 ength side rails positioned in the bed. onducted on 9/18/17 at t #76 ' s bed in his room that cillity ' s secured unit. ateral side rails positioned in	F	221				

Facility ID: 970412

If continuation sheet Page 8 of 83

				FORM	): 10/25/2017 APPROVED ). 0938-0391
	1 · /			(X3) DATE COMP	SURVEY LETED
345509	B. WING		_		21/2017
		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
JST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
on 9/19/17. Resident the half-length side rails on the half-length side rails on the half-length side rails on the half-length side rails on the detail/assist bar ewed with Nurse #2. In form was to be the resident to determine and their ability to ssistance. She indicated get out of bed of then side rails were not a resident had weakness, hem get out of bed and aution the rails were d if the bed rail/assist bar e resident needed side on the form what length hey notified the physician otified the family. #2 continued. Resident the Nurse #2. She was incomplete. She hadings were to be ent #76's side rails that iddle section of each side d with Nurse #2. She were not supposed to be section of the bed for any she explained that the e rotated so they were the bed rather than in in bed. She revealed the 6 were in the wrong	F 221				
		DICAID SERVICES DROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345509 B. WING 345509 B. WING A. BUILDING A. BUILDING B. WING A. BUILDING B. WING A. BUILDING B. WING A. BUILDING B. WING A. BUILDING F. B. WING F. B. B. WING F. B. WING F. B. WING F. B. B. WING F. B.	DICAID SERVICES         ) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         345509       B. WING         IDENTIFICATION NUMBER:       ISTREET ADDRESS, CITY, ST 915 PEE DEE ROAD ABERDEEN, NC 28315         ABENDEED BY FULL DENTIFYING INFORMATION)       PREFIX FAG         CROSS-REFEREI CONSS-REFEREI CROSS-REFEREI CROSS-REFEREI CROSS-REFEREI CROSS-REFEREI IDENTIFYING INFORMATION)         F 221         formation Sheet on 9/19/17. Resident re half-length side rails on         ted with Nurse #2 on bed rail/assist bar swed with Nurse #2. n form was to be the resident to determine and their ability to ssistance. She indicated get out of bed the resident needed side on the form what length ey notified the physician otified the family.         #2 continued. Resident e valuation dated th Nurse #2. She was incomplete. She rdings were to be mit #76's side rails that iddle section of each side l with Nurse #2. She were not supposed to be section of the bed for any She explained that the e rotated so they were the bed rater than in in bed. She revealed the 6 were in the wrong	HUMAN SERVICES         DICAID SERVICES         PROVIDERSUPPLERVCLIA IDENTIFICATION NUMBER:         345509         B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE         915 PFED DEE ROAD ABERDEEN, NC 28315         AENT OF DEFICIENCIES STIBE PRECEDED BY FULL DENTIFING INFORMATION)         PREFIX TAG         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BI (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)         formation Sheet on 9/19/17. Resident e half-length side rails on         ted with Nurse #2 on bed rail/assist bar ewerd with Nurse #2. In form was to be the resident to determine and their ability to ssistance. She indicated get out of bed the rails were of if the bed rail/assist bar e resident needed side ion the form what length hey notified the physician otified the family.         #2 continued. Resident e resident needed side ion the form what length was incomplete. She wages not supposed to be section of each side i with Nurse #2. She was encomplete. She wage not supposed to be section of the bed for any the explained that the rotated so they were 'the bed rather than in in bed. She revealed the 6 were in the wrong	HUMAN SERVICES       FORM         DICAID SERVICES       OMB NC         DICAID SERVICES       OMB NC         IDENTIFICATION NUMBER:       A BUILDING       COMP         34509       B. WING       COMP         34509       B. WING       STREETADDRESS, CITY, STATE, ZIP CODE       919 PEE DEE ROAD         ABERDEEN, NC 28315       ABERDEEN, NC 28315       ABERDEEN, NC 28315         ABERDEEN, NC 28315       TRG       PROVIDERS PLAN OF CORRECTION NOUNDEE         DENTIFINING INFORMATION)       FZ21       CROSS-REFERENCED TO HE APPROPRIATE         DO 9/19/17. Resident       F 221       CROSS-REFERENCED THE APPROPRIATE         Deficiency       FZ21       FZ21       FCROSS-REFERENCED THE APPROPRIATE         Tormation Sheet       F 221       FF 221       FF 221         formation Sheet       F 221       FF 221       FF 221         formation Sheet       FF 221       FF 221       FF 221         for the aff 2 on She 2 on S

Facility ID: 970412

If continuation sheet Page 9 of 83

	MENT OF HEALTH AN					FORM	: 10/25/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			( 09/2	; 21/2017
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 221	rails positioned in the Resident #76 would h below the end of the s of bed. Nurse #2 rep if Resident #76 was c with the side rails pos of the bed. An interview was com 9/20/17 at 11:20 AM. working at the facility rail/assist bar evaluat Nurse #3. She report on how to complete th evaluation when she She stated the reside were to be interviewe completed in full. The interview with Nur verified she complete evaluation dated 9/12 revealed she had not and she had not signe should have indicated required half-length si head of the bed. She with Nurse #2 on 9/20 and had observed the s bed. She reveale #76 were in the wrong side rails should have positioned at the head Nurse #3 additionally positioned in the mido not beneficial to Resid	middle section of the bed, ave had to slide down side rail to be able to get out orted she was unable to say apable of getting out of bed itioned in the middle section ducted with Nurse #3 on She stated she began on 6/25/17. The bed ion form was reviewed with ed she had been instructed	F 221				

Facility ID: 970412

If continuation sheet Page 10 of 83

	S FOR MEDICARE &					D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED
						С
		345509	B. WING		09	/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221	bed because he woul below the end of the his movement. An observation was of 11:50 AM of Residem Resident 76 's bilater rotated so they were bed. An interview was con 9/20/17 at 12:07 PM. familiar with Resident Resident #76 require bed safely. She indic attempted to get out of past, but he was unst reported Resident #7 indicated she thought side rails that had be section of the bed we explained that Reside at times and the rail w Resident #76 from fa reported if the side ra Resident #76 frequer been positioned in the for as long as she con	Id have had to slide down side rail for it not to restrict conducted on 9/20/17 at t #76 ' s bed in his room. ral side rails had been positioned at the head of the ducted with NA #2 on NA #2 stated she was t #76. She reported d assistance to get out of cated Resident #76 had of bed independently in the teady on his feet. NA #2 6 was at risk for falls. She t Resident #76 ' s bilateral en positioned in the middle ere for fall prevention. She ent #76 rolled around in bed would have stopped lling if he rolled into it. She nil was not on the bed and over too far he would have She stated she worked with htly and the bilateral rails had e middle section of the bed uid remember.	F 22			
	Nursing (DON) on 9/2 indicated her expecta rail/assist bar evaluat admission and quarte should be completed	21/17 at 11:09 AM. She ation was for the bed tion to be completed on erly. She stated the form in full by observing the e if the resident was utilizing				

Facility ID: 970412

If continuation sheet Page 11 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD \BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 221	bar evaluation. The I not utilized side rails a An interview was con Administrative Consu 9/21/17 at 11:56 AM. had not been monitor She indicated bilatera middle section of the movement of a reside with bed mobility and 4. Resident #22 was 1/14/17 and readmitte that included dementic cerebrovascular disea disorder, anxiety, diffi of falling. The plan of care for F 1/27/17 and most rec included the focus are (ADLs) function. Res indicated she required all ADLs. A plan of care note da Resident #22 attempt assistance and was r ambulate without a w implemented to prevent	medical and physical noted on the bed rail/assist DON stated the facility had as restraints. ducted with the litant/Regional Director on She reported the facility ing the use of side rails. al side rails positioned in the bed could restrict the ent who was not independent transfers. admitted to the facility on ed on 5/8/17 with diagnoses ia, diabetes mellitus, ase, major depressive iculty in walking, and history Resident #22, initiated on ently reviewed on 5/16/17, ea of Activities of Daily Living sident #22 ' s care plan d assistance from staff with	F	221			
		22 had not expressed a ils/assist bar while in bed for					

Facility ID: 970412

If continuation sheet Page 12 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		345509	B. WING				C 21/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE				
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 221	with a cognitive defici deficits, and a history assessed as not able She was indicated no bar for positioning, su laying position to a sit assessment asked if resident if bed rails/as question was not ans asked if the bed rails/ created more risks the and the question was required a summary of results of the assess findings for Resident was signed by Nurse The plan of care for F need/problem area of initiated on 2/9/17 and 8/15/17. The interver quarter length side ra positioning. The quarterly Minimu assessment dated 8/7 #22 's cognition was assessed as requiring two or more staff with dressing, and persona required the extensive transfers and locomot assessment indicated physical restraints (de method or physical or	r comfort. She was noted t related to dementia, visual of falls. Resident #22 was to get in/out of bed safely. t to use the bed rails/assist upport, or to help rise from a tting/standing position. This there was a risk to the sist bar were used and the wered. This assessment assist bar alternatives an bed rails/assist bar use not answered. The form of findings to explain the ment. This summary of #22 was blank. The form #2. Resident #22 included the t the potential for falls d most recently reviewed on ntions included, in part, ils for turning and m Data Set (MDS) 15/17 indicated Resident severely impaired. She was g the extensive assistance of bed mobility, toileting, al hygiene. Resident #22 e assistance of one staff for tion on/off the unit. The d Resident #22 had no efined as any manual mechanical device, t attached or adjacent to the the individual cannot	F	221					

Facility ID: 970412

If continuation sheet Page 13 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		345509	B. WING				C 21/2017		
NAME OF P	ROVIDER OR SUPPLIER		I		TREET ADDRESS, CITY, STATE, ZIP CODE	·			
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD ABERDEEN, NC 28315	315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 221		e 13 access to one ' s body).	F	221					
	9/18/17 at 12:00 PM. was not capable of ge Nurse #4 revealed sh #22 had side rails. S record and was unab order for side rails for	ducted with Nurse #4 on She indicated Resident #22 etting out of bed on her own. he had not known if Resident he reviewed the medical le to locate a physician ' s Resident #22. Nurse #4 ant (NA) #5 to observe rails.							
	9/18/17 at 12:03 PM.	ducted with NA #5 on She indicated Resident #22 ength side rails positioned in the bed.							
	PM of Resident #22 r bed in her room that secured unit. Resider length side rails on he	ucted on 9/18/17 at 12:26 evealed she was sleeping in was located in the facility ' s nt #22 had bilateral quarter er bed. The quarter length oned in the middle section of							
		ved on 9/19/17. Resident have quarter length side							
	9/20/17 at 9:40 AM. evaluation form was r She stated this evalua completed by observi their bed mobility stat	ing the resident to determine sus and their ability to ut assistance. She indicated							

Facility ID: 970412

If continuation sheet Page 14 of 83

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 10/25/2017 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING					C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 221	independently and sa needed. She reported needed the rails to he transfer, or as a fall p needed. Nurse #2 sta evaluation determined rails, the Nurse indica side rails they needed to obtain an order, an The interview with Nu #22 ' s bed rail/assist was reviewed with Nu evaluation was incom questions as well as t were to be completed quarter length side ra the middle section of discussed with Nurse side rails were not su the middle section of the facility. She expl were able to be rotate the head of the bed. S Resident #22 were in additionally revealed in the middle section of would have had to slid the side rail to be able #2 reported she was a #22 was capable of g side rails positioned in bed. An interview was com 9/20/17 at 11:20 AM. working at the facility	fely then side rails were not if a resident had weakness, elp them get out of bed and recaution the rails were ated if the bed rail/assist bar d the resident needed side ted on the form what length d, they notified the physician d notified the family. rse #2 continued. Resident bar evaluation dated 8/8/17 urse #2. She revealed this plete. She stated all he summary of findings in full. Resident #22 ' s ils that were positioned in each side of her bed was #2. She stated that the pposed to be positioned in the bed for any resident in ained that the side rails ed so they were positioned at ather than in in the middle he revealed the side rails for the wrong position. She with the side rails positioned of the bed, Resident #22 de down below the end of e to get out of bed. Nurse unable to say if Resident etting out of bed with the in the middle section of the	F	221				

If continuation sheet Page 15 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/25/2017 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING		_		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	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 PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 221	on how to complete the valuation when she is She stated the reside were to be interviewer completed in full. The interview with Nurverified she complete evaluation dated 8/8/7 revealed she had not She stated she should that Resident #22 requirals positioned at the revealed she had spo 9/20/17 prior to this in observed the side rail. She confirmed the bills rails were positioned is side of the bed. She Resident #22 were in stated the side rails site of the bed. She Resident #22 were in stated the side rails site of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. She Resident #22 were in stated the side rails of the bed. An observation was contacted the side rails of the bed. An interview was contacted the side rails of the bed.	the side rail/assist bar began working at the facility. In twas to be observed, staff d, and the form was to be rse #3 continued. Nurse #3 d the bed rail/assist bar 17 for Resident #22. She completed the form in full. d have indicated on the form uired quarter length side head of the bed. She ken with Nurse #2 on terview and she had s on Resident #22 ' s bed. ateral quarter length side in the middle section of each revealed the side rails for the wrong position. She hould have been rotated so at the head of Resident #22 itionally revealed the side middle section of the bed Resident #22 as they would fficult for her to get in and ne would have had to slide of the side rail for it not to t.	F 221				
		NA #3 stated she was					

Facility ID: 970412

If continuation sheet Page 16 of 83

CENTER		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		FORM	0: 10/25/2017 MAPPROVED 0: 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
		345509	B. WING		_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	without assistance. S able to move around i although she had not frequently. NA #3 rep risk for falls. She indi Resident #22 ' s bilate had been positioned i bed. She reported sh position they were in a a different position. An interview was con- 9/20/17 at 12:04 PM. familiar with Resident Resident #22 was not without assistance. S able to hold onto the s positioning. NA #4 re risk for falls. She indic Resident #22 ' s bilate had been positioned i bed. She reported sh position they were in a a different position. An interview was con- Nursing (DON) on 9/2 indicated her expecta rail/assist bar evaluate admission and quarte should be completed resident to determine the side rails. She re going to be used the p indication was to be n	#22. She reported able to get out of bed she stated Resident #22 was in bed independently, moved around in bed borted Resident #22 was at cated she was unsure why eral quarter length side rails in the middle section of the e kept the side rails in the and had not moved them to ducted with NA #4 on NA #4 stated she was #22. She reported able to get out of bed she stated Resident #22 was side rail for assistance with ported Resident #22 was at cated she was unsure why eral quarter length side rails in the middle section of the e kept the side rails in the and had not moved them to ducted with the Director of the to get out of bed she stated Resident #22 was at cated she was unsure why eral quarter length side rails in the middle section of the e kept the side rails in the and had not moved them to ducted with the Director of t1/17 at 11:09 AM. She tion was for the bed ion to be completed on rly. She stated the form in full by observing the if the resident was utilizing ported if a side rail was medical and physical oted on the bed rail/assist DON stated the facility had	F 22				

Facility ID: 970412

If continuation sheet Page 17 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345509	B. WING				C / <b>21/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	<ul> <li>9/21/17 at 11:56 AM. had not been monitor She indicated bilatera middle section of the movement of a reside with bed mobility and</li> <li>5. Resident #61 was 11/26/14 and diagnos weight loss.</li> <li>A review of the quarter with an assessment r 8/16/17 for Resident a coded as having phys assessment indicated the corridor did not oc indicated locomotion not occur during the la resident required tota of daily living (ADLs), memory and was alw bladder. The residen impairment on both si functional range of ma A review of the care p recently updated on a of a history of falls. T the resident to be free included: Floor mats I under the sheets. Th place that identified tf and how Resident #6 ensure she had the lage</li> </ul>	ducted with the Itant/Regional Director on She reported the facility ing the use of side rails. I side rails positioned in the bed could restrict the ent who was not independent transfers. admitted to the facility on tes included: Dementia and erly minimum data set (MDS) eference date (ARD) of #61 revealed she was not sical restraints. The I walking in the room or in ccur. The assessment also on and off unit/hallway did pok back period. The I assistance with all activities was severely impaired ays incontinent of bowel and t was coded as having ides of the arms and legs for otion. Dan for Resident #61 most 8/15/17 revealed a problem he listed interventions for	F	221			

Facility ID: 970412

If continuation sheet Page 18 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C / <b>21/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 221	family member feedin observed to be in a lo the bed was against to observed to be a raise the height of the matt left side of the bed the cushions. The wedge fitted sheet of the bed the raised perimeter of wedges were in an er on the resident's left s head to the area betw of her left leg. There bed. The resident's fa which was underneat resident's family adde at night and placed no The resident's family have a recent history A review of the medic revealed that there wa identified for the use of the use of wedges. A present and there wa evaluate the ongoing An observation on 9/2 #61 revealed she was on a raised perimeter the bed was against t cushions remained un raised perimeter of th left side, and her bed resident was observe movements with her a	e lying in her bed and her ig her. The bed was w position. The right side of he wall. The mattress was ed perimeter mattress with ress at its sides greater than ress at its center. On the ere were two wedge e cushions were under the d and were held in place by of the mattress. The nd to end position and were side from approximately her veen her knee and her foot were no side rails on the amily pointed out a mat h the resident's bed. The ed the fall mat was pulled out ext to the resident's bed. stated the resident did not of falls. eal record for Resident #61 as not a specific diagnosis of the winged mattress or restraint evaluation was not s not a plan in place to use of a restraint. 20/17 at 9:11 AM of Resident s lying in bed. She was lying mattress, the right side of the wall, the two wedge nder the sheet, along the e mattress on the resident's was in a low position. The	F	221			

Facility ID: 970412

If continuation sheet Page 19 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE	
		345509	B. WING _				C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD IBERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 221	<ul> <li>wall.</li> <li>An interview and observations of the second seco</li></ul>	ming into contact with the ervation on 9/20/17 at 9:15 stant (NA) #7 revealed aised perimeter mattress ed and she could not get out a wedge cushions were in n putting her legs over the 7 referred to the resident's on Sheet on the resident's resupportive section of the llows" was checked and a willows was "Bilateral ments, "fall mat" was no mention of positioning all or the use of a raised ervation on 9/20/17 at 2:55 revealed Resident #61 to the bed was in low position. bed was against the wall. mattress was in place. The were on the resident's left perimeter mattress, and othwise down the resident's ated the wedge pillows were he resident's body for he moved her legs ect her from the wall. Nurse cushions were being used	F 2	221	DEFICIENCY)		
	in her bed. The bed wright side of the bed w	led Resident #61 to be lying was in low position. The vas against the wall. The ress was in place. The two					

Facility ID: 970412

If continuation sheet Page 20 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	along the raised perin end to end, lengthwis side. NA #8 stated the resident from tipping a added the wedges we side, one by her shoul legs to keep the reside An interview on 9/21/ Assistant Director of I the purpose of the we Resident #61. The A some instances last y her legs towards the we also an intervention for she did not view the we because the resident after the wedges were clarified the resident for The ADON further ad used on either side an a restraint nor restrain ADON further clarified place because they we resident was not tryin of bed. The ADON st assessment complete being viewed as a rest During an interview co 11:22 AM with the Dir	e on the resident's left side neter mattress, and were e down the resident's left e wedges were to keep the over on the floor. NA #8 ere always kept on her left ilders and the other by her ent from falling. 17 at 10:45 AM with the Nursing (ADON) revealed edges was for positioning for DON stated the resident had rear when she was throwing walls and the wedges were or falls. The ADON added vedges as a restraint had fallen out of the bed e put into place. The ADON nad not fallen in a long time. ded the wedges could be no the resident's motion. The d the wedges were kept in vere effective and the g to get out of bed or roll out iated there was no restraint ed due to the wedges not	F2	221			
F 272 SS=D	483.20(b)(1) COMPR ASSESSMENTS	EHENSIVE	F 2	272			10/18/17
	(b) Comprehensive A	ssessments					

Event ID: YIOT11

Facility ID: 970412

If continuation sheet Page 21 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				21/2017
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD		
					ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From page	21	F	272	2		
	must make a compret resident's needs, stre preferences, using the instrument (RAI) spec assessment must incl (i) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behav (vii) Psychological we (viii) Physical fun problems. (ix) Continence. (x) Disease diagnos (xi) Dental and nutriti (xii) Skin Conditions. (xii) Activity purs (xiv) Medications. (xv) Special treatmen (xvi) Discharge pl (xvii) Documentat regarding the addition on the care areas of the Minimum Data (xviii) Documentat assessment. The ass include direct observation the resident, as well a licensed and	ude at least the following: demographic information le. s. s. ior patterns. ell-being. ctioning and structural is and health conditions. ional status. uit. ts and procedures. lanning. ion of summary information nal assessment performed triggered by the completion					

Event ID: YIOT11

Facility ID: 970412

If continuation sheet Page 22 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 10/25/2017 RM APPROVED IO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		345509	B. WING		C 09/21/2017		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	Continued From page	e 22	F 2	72			
	observation and com as well as communication non-licensed direct car shifts. This REQUIREMENT by: Based on record rever facility failed to comp assessments which in risk factors, and factor developing individual for three of eight com- reviewed (Resident # Resident #21). The f 1. Resident #21). The f 1. Resident #33 was 6/3/16 and last readm diagnoses included d An Annual Minimum I 6/13/17 indicated Res- intact. No mood or b- observation period. If dementia. Depression diagnosis for Resider administered during t- period included 6 day medication. A Care Area Assessm drug use dated 6/14/7 received 6 days of an was noted that psych be addressed in the of discontinued 6/12/17. regarding the underly	ncluded underlying cause, ors to be considered in ized care plan interventions oprehensive assessments 33, Resident #63 and indings included: admitted to the facility hitted on 7/3/17. Cumulative ementia and depression. Data Set (MDS) dated sident #33 was cognitively ehaviors occurred during the Diagnoses included on was not indicated as a ht #33. Medications he seven day look pack		F 272 1. Resident # 33 late entries Assessment (CAA) with Assess Reference Date (ARD) note completed by 10/17/17 by the J CAA note will be present in Pol Cares (PCC) system. The Mini Set (MDS) will not be modified resubmitted. Resident # 63 late entry CAA w 5 /12/17 a note will be by 10/17 ADON. The MDS/CAA note will system. The MDS will not be m resubmitted. Resident # 21 late entries for C ARD 8/17/17 will be completed 10/17/17. The note will be in Pa MDS/CAA note by the ADON. will not be modified and resubm 1. An audit of the current CA 90 days was completed by the Coordinator on 10/6/17 to ensu- was completed. Sixteen MDS r CAAs. All 16 were completed, 100% compliance in the event coordinator is not available to c MDS the Unit Manager (UM) o be responsible for completing a including those with CAAs corr 2. The UM and the ADON w educated by the Corporate Clir	sment will be ADON. The int Click mum Data and vith ARD of 7/17 by the I be in PCC hodified and CAA with I by CC as a The MDS nitted A the last MDS ure CAA required indicating a MDS complete r ADON will all MDSs, ectly. ill be		

Facility ID: 970412

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	& MEDICAID SERVICES					FORN OMB NC	): 10/25/2017 / APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,					SURVEY LETED
	345509	B. WING					21/2017
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWOOD NURSING CENTE	R		5 PEE DEE ROAD BERDEEN, NC 28315				
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
<ul> <li>Record (MAR) reverse Remeron (antideprivation of the Juli restarted on Resid hospital on 7/3/17.</li> <li>The MDS Coordina MDS dated 6/13/17 the facility.</li> <li>On 9/20/17 at 10:0 conducted with the facility.</li> <li>On 9/20/17 at 10:0 conducted with the the CAA for psychot the CAA for psychot the CAA was incor completed with all</li> <li>On 9/21/17 at 11:2 conducted with the she expected the C regulation.</li> <li>Resident # 63 was cognition. Skin co had two stage 3 privation.</li> </ul>	<ul> <li>a Medication Administration ealed Resident #33 received essant medication) until continued on 6/12/17.</li> <li>c MAR revealed Remeron was ent #33 's return from the</li> <li>a tor who had completed the 7 was no longer employed at</li> <li>b AM, an interview was MDS nurse. She reviewed otropic drug use and stated a care plan for behaviors and opic medications. Therefore, nplete and should have been the information.</li> <li>a AM, an interview was Director of Nursing who stated CAA 's to be completed as per</li> <li>c At a stated to the facility e diagnoses included a sacral</li> <li>a dated 5/12/17 indicated moderately impaired in ndition indicated Resident #63 essure areas and one ure area during the</li> </ul>	F 2	272	regarding accurate and timely or of all MDS assessments, includi by 10/17/17. 3. The MDS Coordinator will be reeducated by the Regional Nurs Consultant by 10/17/17 related to ensuring CAAs are completed ac and timely. 4. Audits will be completed by to or the Corporate Nurse Consulta for 4 weeks and monthly for 3 mo ensure CCAs continue to be com The DON will present a report to Committee monthly for 4 months Date of Compliance:	ng CA e se ccurate the DC ont wee onths t npleted the Q	As PN ekly o I. A	

If continuation sheet Page 24 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		345509	B. WING				C /21/2017
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 272	A CAA for pressure ul Resident #63 had two and a shear wound. days after the Assess (ARD) which was not The MDS Coordinato MDS dated 6/13/17 w the facility. On 9/20/17 at 10:00 A conducted with the M the CAA for pressure stated the CAA should 5/18/17 as per regula On 9/21/17 at 11:29 A conducted with the Di she expected the CAA regulation. 3. Resident #21 was 3/31/15 with diagnose muscle weakness, hy hypertension. The annual Minimum assessment dated 4/8 ' s cognition was seve behaviors and no reje supervision with set u Daily Living (ADLs). antipsychotic medicati medication and antiar days during the MDS received an antibiotic MDS look back period	lcers dated 5/26/17 stated o stage 3 pressure ulcers The CAA was completed 21 ment Reference Date within 14 days of admission. r who had completed the vas no longer employed at AM, an interview was DS nurse. She reviewed ulcers for Resident #63 and d have been completed by tion. AM, an interview was irector of Nursing who stated A ' s to be completed as per admitted to the facility on es that included dementia, perlipidemia, and Data Set (MDS) B/17 indicated Resident #21 erely impaired. She had no ection of care. She required up help only for Activities of Resident #21 had received tion, antidepressant nxiety medication on 7 of 7 look back period. She of 1 of 7 days during the	F	272			

If continuation sheet Page 25 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING				C /21/2017
NAME OF P	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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Loss/Dementia, Psyc Dehydration/Fluid Ma Status, Falls, and Pre The CAA summaries underlying causes, co factors that must be o individualized care pla completed for the follo - ADL Functional/F - Cognitive Loss/D - Psychotropic Dru - Dehydration/Fluid - Falls - Pressure Ulcer An interview was com PM with the MDS Coo officially started worki She indicated that pri- facility, she was inform issue in the past with completed late or not 4/8/17 MDS assessm had 6 triggered CAAs reviewed with the MD Coordinator stated C/ completed for each of reported if a triggered included in the plan o documented explanat was made. An interview was com AM with the Director o indicated it was her ex-	Alt7 were ADL tion Potential, Cognitive hotropic Drug Use, intenance, Nutritional assure Ulcer. (required to address the portributing factors, and considered in developing an interventions) were not owing areas: Rehabilitation Potential mementia ag Use d Maintenance ducted on 9/20/17 at 3:41 ordinator. She stated she ng at the facility on 9/1/17. or to her coming to the med there had been an MDS assessments being fully being completed. The ent for Resident #21 that a that were incomplete was US Coordinator. The MDS AA summaries were to be f triggered areas. She area was not going to be f care there was to be a tion as to why that decision ducted on 9/21/17 at 11:09 of Nursing (DON). She	F	272	2		

Facility ID: 970412

If continuation sheet Page 26 of 83

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				OMB NC	MAPPROVE 0. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345509	B. WING				C 21/2017	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 272	Continued From page	e 26	F	272				
F 273 SS=D			F	273			10/18/17	
	(b)(2) When required prescribed in §413.34 must conduct a comp resident in accordance specified in paragrap this section. The time §413.343(b) of this ch							
	excluding readmissio significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) This REQUIREMENT	r days after admission, ns in which there is no the resident's physical or r purposes of this section, a return to the facility absence for hospitalization						
	by: Based on staff interviews and review of the Minimum Data Set (MDS) assessment, the facility failed to complete a comprehensive admission MDS assessment within 14 days of admission to the facility for 2 of 4 sampled residents reviewed (Resident #58 and Resident #53).				F 273 1. The MDS Coordinator who completed the assessment for Resider #58 and #53 is no longer employed at facility.			
		reathing, generalized			2. An audit of the current resident in last 90 days was completed by the MD Coordinator on 10/06/17. The audit wa done to ensure CAA were being completed with 14 days of admission. Sixteen residents met the guidelines for the audit; of those 16, all were completed without error. There is a 100%	oS as or		
	Review of Resident #58's comprehensive admission MDS assessment revealed an				compliance.			

Facility ID: 970412

If continuation sheet Page 27 of 83

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIF	PLE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · ·	MPLETED	
					С		
		345509	B. WING			9/21/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 273	Continued From page	e 27	F 27	73			
		ce Date of 5/10/17. The		3. The MDS Coordinato			
	-	e (Z0500B) was observed to		reeducated by the Corpor			
		day after admission. Review essment (CAA) completion		Consultant by 10/17/17 re ensuring all Comprehensi			
		aled a completion date of		are completed with 14 day	ys of admission.		
	An interview was con PM with the MDS Co	ducted on 9/20/17 at 3:42		<ol> <li>An audit will be comp DON weekly x 4 weeks ar months to ensure Compresentation</li> </ol>	nd monthly for 3		
		ne officially started the		Assessments continue are			
		rdinator at the facility on		timely. The DON will subr			
	9/1/17. In addition sh	ne stated prior to her coming		the QA Committee monthl			
		she was informed by a		The QA Committee consis			
		nger employed at the facility,		Director, Administrator, D			
		sue with late assessments. mission assessment MDS		Treatment Nurse, SDC, M Maintenance Director, Act			
		DR of 5/3/17 and stated they		Housekeeping & Laundry			
		within the allotted amount of		Director, Medical Record,			
		assessment and CAAs		Manager (BOM), Human I	Resource		
		eted by the 13th day after		Director (HR).			
	admission.			Date of Compliance 10/18/17	e:		
	An interview was con	ducted on 9/21/17 at 11:18		10/10/17			
		of Nursing. The DON stated					
		n the regulation be followed					
	for the completion of along with care area	the admission assessment					
	-						
		admitted to the facility on it's admission diagnoses					
	included: High blood	-					
		zed weakness, diabetes,					
		se, cognitive loss, and					
	Review of Resident # admission MDS asse	-					
		ce Date of 4/17/17. The					
		e (Z0500B) was observed to					

If continuation sheet Page 28 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391		
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED		
I		345509	B. WING			/21/2017		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 273	Continued From page be 5/1/17, the 18th da of the Care Area Asse date (V0200B2) revea 5/1/17, the 18th day a An interview was com PM with the MDS Coor Ocordinator stated sh position of MDS Coor 9/1/17. In addition sh to work at the facility sinurse, who was no lot there had been an iss She reviewed the adm and CAAs with an AD were not completed w time. An admission a should be fully complet admission. An interview was completed of it was her expectation for the completion of the along with care area a 483.20(c) QUARTER LEAST EVERY 3 MO	e 28 ay after admission. Review essment (CAA) completion aled a completion date of after admission. ducted on 9/20/17 at 3:42 ordinator. The MDS ue officially started the dinator at the facility on the stated prior to her coming she was informed by a inger employed at the facility, sue with late assessments. mission assessment MDS PR of 4/17/17 and stated they within the allotted amount of issessment and CAAs eted by the 13th day after ducted on 9/21/17 at 11:18 of Nursing. The DON stated in the regulation be followed the admission assessment assessments. LY ASSESSMENT AT NTHS	F 2			10/18/17		
	assess a resident usin instrument specified b by CMS not less freque months. This REQUIREMENT by: Based on record revi facility failed to compl	Assessment. A facility must ng the quarterly review by the State and approved uently than once every 3 <sup>•</sup> is not met as evidenced ew and staff interviews, the ete the quarterly Minimum ssment within 92 days of the		F 276 1. The MDS Coordinator was reeducated by the Corporate Nurse	3			

Event ID: YIOT11

Facility ID: 970412

If continuation sheet Page 29 of 83

CAID SERVICES ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTI			<u> 0938-0391</u>
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
345509	B. WING		09	C / <b>21/2017</b>
		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
		915 PEE DEE ROAD		
		ABERDEEN, NC 28315		
BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
for 1 of 14 sampled The findings included: to the facility on best that included a medical record am Data Set (MDS) ament Reference Date medical records system rated Resident #76 ' s with an ARD of 9/9/17 104 days after the ent ' s ARD (6/9/17). d on 9/20/17 at 3:41 tor. She stated she the facility on 9/1/17. Here had been an assessments being medical records system rated Resident #76 ' s with an ARD of 9/9/17 This was 105 days assessment ' s ARD d on 9/21/17 at 9:50 tor. The MDS 76 with an ARD of of 9/21/17 was	F 2	<ul> <li>Consultant on 10/5/17 related requirements that resident # 7 assessment with ARD of9/9/17 scheduled within 92 days of the Assessment Reference Date of previous MDS assessment.</li> <li>#76 quarterly MDS for 9/9/17 or reviewed by the MDS Consult advised that according to Cha 31 of the RAI manual we were compliance of the 92 days bet and 9/9/17 and the 14 days to and transmit to CMS on 9/21/7 MDS for 9/9/17 was submitted validation was received without of lateness.</li> <li>2. An audit was completed the Coordinator on 10/06/17 of the residents' quarterly assessments are completed without of lateness.</li> <li>2. An audit was completed the Coordinator on 10/06/17 of the residents' quarterly assessments are completed without of the previous assessment. 50 assessments audited for completion within the appropriate time frame. All 50 We are currently at 100% corror 3. The MDS Coordinator will reeducated by the Corporate I Consultant by 10/17/17 related ensuring quarterly assessment.</li> <li>4. An audit will be completed within 92 days of a prior assessment.</li> </ul>	6's quarterly 7 be be of the was ant. She pter 2 page within ween 6/9/17 complete 17. The I and it indication by the MDS e current nt s for the ly vithin 92 us MDS were he were timely. apliance. I be Nurse d to ts are RD of the d by the quarterly months to	
	AT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) te (ARD) of the for 1 of 14 sampled The findings included: to the facility on oses that included as medical record um Data Set (MDS) sment Reference Date nedical records system cated Resident #76 ' s with an ARD of 9/9/17 104 days after the ent ' s ARD (6/9/17). d on 9/20/17 at 3:41 tor. She stated she the facility on 9/1/17. her coming to the nere had been an assessments being nedical records system cated Resident #76 ' s with an ARD of 9/9/17 This was 105 days assessment ' s ARD d on 9/21/17 at 9:50 tor. The MDS 76 with an ARD of of 9/21/17 was prdinator. The MDS	AT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) F 2 te (ARD) of the for 1 of 14 sampled The findings included: to the facility on oses that included s medical record um Data Set (MDS) sment Reference Date hedical records system tated Resident #76 's with an ARD of 9/9/17 104 days after the ent 's ARD (6/9/17). d on 9/20/17 at 3:41 tor. She stated she the facility on 9/1/17. her coming to the here had been an assessments being hedical records system tated Resident #76 's with an ARD of 9/9/17 This was 105 days assessment 's ARD d on 9/21/17 at 9:50 tor. The MDS 76 with an ARD of of 9/21/17 was prdinator. The MDS	STREET ADDRESS, CITY, STATE, ZIP CODE         915 PEE DEE ROAD         ABERDEEN, NC 28315         AT OF DEFICIENCIES         BE PRECEDED BY FULL         NTIFYING INFORMATION)         F 276         Consultant on 10/5/17 related requirements that resident #7 assessment with ARD of9/9/1 scheduled within 92 days of th Assessment Reference Date previous MDS assessment.         aredical record arm Data Set (MDS) sment Reference Date         and Hamman ARD of 9/9/17).         be dical record system tor. She stated she the facility on 9/1/17.         be dical record system tated Resident #76 's with an ARD of 9/9/17).         cordinator on 10/06/17 of the residents with an ARD of 9/9/17).         cordinator on 10/06/17 of the residents' quarterly assessment.         assessment seing assessment seing assessment seing assessment 's ARD         assessment 's ARD for 9/21/17 at 9:50 tor. The MDS         tor n 9/21/17 at 9:50 tor. The MDS         tor. The MDS         tor n 9/21/17 was assessment 's ARD         tor n 9/21/17 was assessment 's ARD         tor n MDS         tor n 9/21/17 was assessment 's ARD	STREET ADDRESS, CITY, STATE, ZIP CODE         915 PEE DEE ROAD         ABERDEEN, NC 23315         AT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)         PREVIDER SPLAN OF CORRECTIVE (EACH CORRECTWE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         F 276         Consultant on 10/5/17 related to the requirements that resident # 76's quarterly assessment with ARD 0f9/9/17 be scheduled within 92 days of the Assessment Reference Date of the previous MDS assessment.         medical record um Data Set (MDS) meet Reference Date         medical record um Data Set (MDS) meet Reference Date         a sedical record um Data Set (MDS) meet Reference Date         a system tated Resident #76 's with an ARD of 9/9/17 104 days after the ent's SARD (6/9/17).         Corr She stated she the facility on 9/1/17, do n 9/20/17 at 3:41 tor. She stated she the facility on 9/1/17, er coming to the passessments being assessments being assessments being assessment's being assessment's ARD do n 9/21/17 at 9:50 tor. The MDS for 01/21/17 at 9:50 tor. The MDS for 01/21/17 at 9:50 tor. The MDS for 01/21/17 was         An audit will be completed by the prior assessments.         An audit will be completed by the prior assessment.         An audit will be completed by the prior assessment.         An audit will be completed by the prior assessment.

Facility ID: 970412

If continuation sheet Page 30 of 83

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVI D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345509	B. WING _				C / <b>21/2017</b>
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OD NURSING CENTER			91	5 PEE DEE ROAD		
				A	BERDEEN, NC 28315		1
(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) COMPLETIC DATE
F 276	Continued From page	e 30	F 2	76			
		I she had not noticed this	12	., 0	scheduled within 92 days of the		
		ssment for Resident #76			assessment reference date of the		
	was completed late.				previous MDS assessment as required		
	A			The DON will submit a report to the Q			
	An interview was conducted on 9/21/17 at 11:09 AM with the Director of Nursing (DON). She				Committee monthly for 4 months. The Director of Nursing will be responsible for		
	indicated it was her e				monitoring and follow up.		
		ompleted timely as per the					
	regulations.				Date of Compliance:		
				_	10/18/17		
F 278 SS=E	483.20(g)-(j) ASSES	SMENT DINATION/CERTIFIED	F 2	278			10/18/17
55=E	ACCORACT/COORL	SINATION/GERTIFIED					
	(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.						
	(h) Coordination						
		ust conduct or coordinate					
	each assessment wit participation of health						
	(i) Certification						
	()	e must sign and certify that mpleted.					
		ho completes a portion of the n and certify the accuracy of sessment.					
	(j) Penalty for Falsific (1) Under Medicare a	ation Ind Medicaid, an individual					
	who willfully and know						
		l and false statement in a is subject to a civil money nan \$1,000 for each					

Facility ID: 970412

If continuation sheet Page 31 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING				C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 278	Continued From page	31	F	278			
	and false statement in subject to a civil mone \$5,000 for each asses (2) Clinical disagreem material and false sta	ient does not constitute a tement.					
	<ul> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments for prognosis (Resident #6), pressure ulcer (Resident #25), restraints (Resident #'s 61, 22, 96, 40 and 76), diagnoses and falls (Resident #21), active diagnoses and diagnoses for pressure ulcer (Resident #29), incontinence and medications (Resident #39) for 10 of 19 sampled residents reviewed for MDS accuracy.</li> <li>Findings included:</li> <li>1. Resident #25 was readmitted on 9/1/17 and was originally admitted on 4/23/13 with multiple diagnoses that included: Dementia, contracture, and muscle weakness.</li> </ul>				F278 1. Resident #6 MDS assessment with ARD date of 9/1/17 was corrected by th MDS coordinator by 9/4/17 and transmitted on 9/4/17 Resident #25 MDS assessment with Al date of 7/20/17 was corrected by the M Coordinator by 9/8/ 17 and transmitted was accepted on 9/19/17. Resident #61 MDS assessment with Al date 8/16/17 was corrected by the MDS Coordinator on 10/12/17 and transmitted 10/12/17 Resident #22 MDS assessment with Al date of 8/15/17 was reviewed. MDS was not corrected due to lack of documentation regarding side rails. Ne	ne RD IDS . It RD S ed RD as	
	#25 was coded as ha Resident #25's coded dementia, anxiety, de disorder, and general Resident #25 was coo	20/17 indicated Resident ving had no pressure ulcers. I diagnoses included: pression, psychotic ized muscle weakness. ded as being totally obility, transfer (i.e. from the protoilet use with the			side rail assessment and a new restrain assessment was completed on 9/26/1 The side rails have been assessment a not being a restraint, and have been moved to the head of the bed and pade to be used as a positioning device. Sid rails were moved to the top of the bed 9/26/17 by maintenance staff Therefor a correction or additional MDS is not needed. Resident #96 MDS assessment with A	nt 7. as ded e on ore	

Event ID: YIOT11

Facility ID: 970412

If continuation sheet Page 32 of 83

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		INSTRUCTION	(X3) DATE COMF	PLETED	
			A. BUILDING	J		с		
		345509	B. WING				21/2017	
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2017	
				915 P	PEE DEE ROAD			
KINGSWO	OOD NURSING CENTER			ABE	RDEEN, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 278	Continued From accord	- 22	E 0	70				
F 270	p3-		F 27	-				
		cal record of Resident #25		-	late of 9/1/17 was reviewed. MDS wa	IS		
		re specialist evaluation note hief complaint was listed as			not corrected due to lack of	-		
		ound on their sacrum. The			locumentation regarding the side rails	5.		
		less (HPI) Statement stated			estraint assessment will be complete	d.		
		age III pressure wound to her			She was assessed for side rails on 10			
		nd had light drainage. The		-	Side rails were removed from the bed	-		
		urther detail the MDS stage			naintenance staff on 10/5/17. Therefo	-		
	of the wound was a s			n	either a correction nor additional MD	S is		
	measurements of the	wound were 0.9		n	needed.			
		g by 1.3 cm wide by 0.1 cm			Resident #40 MDS assessment with A			
	deep, with a surface a	area of 1.17 square		-	late of 5/11/17 was reviewed MDS wa	as		
	centimeters.				not corrected due to lack of			
	A				locumentation to support side rails. T	he		
		ed on 9/21/17 at 9:49 AM			esident was discharged on 6/1/17.	_		
		ed she had completed the MDS assessment			Therefore the correction was not done Resident was discharged prior to surv			
	,	stated she had not received			Resident #76 MDS assessment with A			
		cialist Evaluation form until			late of 9/9/17 was not corrected due			
		was completed. The nurse			ack of documentation regarding the s			
		d not corrected the MDS			ails. New side rail assessment and a			
	assessment when she				estraint assessment was completed			
					0/5/17. The side rails were moved to			
	An interview conducte	ed on 9/21/17 at 11:14 AM		to	op of the bed on 10/5/17 by the			
		ursing (DON) revealed her			naintenance staff. On evaluation side	;		
	•	ne MDS assessments to be			ails did not constitute a restraint.			
	accurate.				Therefore neither a correction nor an			
	2 Decident #01	admitted on 11/00/11 and			additional MDS is needed.			
		admitted on 11/26/14 and Dementia and weight loss.			Resident #21 MDS assessment with A late 8/17/17 will be corrected by the I			
		erly minimum data set (MDS)			Coordinator. Modification was done			
		eference date (ARD) of		-	0/21/17and was transmitted 9/21/17.			
		#61 revealed she was not			Resident #29 MDS assessment with A	ARD		
	coded as having phys				late of 8/23/17, diagnoses list was			
		walking in the room or in			pdated to show that pressure ulcers			
		ccur. The assessment also			vere resolved; the first resolved on			
	indicated locomotion	on and off unit/hallway did		8	8/21/15, the second one was resolved	d on		
	not occur during the le				5/21/15. Diagnosis list was updated			
	resident required tota	I assistance with all activities		1	0/12/17. The MDS modification was		1	

Facility ID: 970412

If continuation sheet Page 33 of 83

AME OF PROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	345509	B. WING		09/21/2017		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
KINGSWOOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETI		
memory and was alw bladder. The resider impairment on both s functional range of m A review of the care p recently updated on a of a history of falls. The the resident to be free included: Floor mats under the sheets. The place that identified the and how Resident #6 ensure she had the le An observation on 9/ #61 revealed her to be family member feedin observed to be in a le the bed was against observed to be a raiss the height of the math left side of the bed the cushions. The wedg fitted sheet of the beet the raised perimeter wedges were in an e on the resident's left head to the area betw of her left leg. There bed. The resident's f which was underneat resident's family adde at night and placed n The resident's family have a recent history	was severely impaired vays incontinent of bowel and at was coded as having sides of the arms and legs for notion. plan for Resident #61 most 8/15/17 revealed a problem The listed interventions for e from injury for falls beside bed and wedges here was no plan of care in the use of a winged mattress 61 would be evaluated to east restrictive restraint. 18/17 at 3:11 PM of Resident be lying in her bed and her ng her. The bed was bow position. The right side of the wall. The mattress with tress at its center. On the ere were two wedge e cushions were under the d and were held in place by of the mattress. The nd to end position and were side from approximately her ween her knee and her foot were no side rails on the family pointed out a mat th the resident's bed. The ed the fall mat was pulled out ext to the resident did not	F 27	<ul> <li>made on 10/17/17 and submitted Resident #39 MDS assessment w date of 8/10/17 was modified by th Coordinator by 9/21/17 and was transmitted &amp; accepted on 9/21/17</li> <li>An audit of the current reside assessment was completed by th Coordinator on 10/06/17 to ensure assessments accurately reflect th residents' current status and any corrections were completed and submitted as required. 66 MDSs w audited. Of the 66, 56 were correct There were 10 that had correction and were resubmitted to CMS. Th corrections and resubmission were between 9/8/17-10/6/17.</li> <li>The MDS Coordinator will be reeducated by the Regional Nurse Consultant by 10/2/17 related to e MDS assessments accurately reflires ident's current status.</li> <li>An audit will be completed by DON weekly x 4 weeks for all MD maximum of 10 MDSs per week, ever is higher and monthly for 3m ensure MDS assessment continu- accurately reflect the resident's cu- status. The DON will submit a rep the Quality Assurance Committee for 4 months. Date of Compliance: 10/18/17</li> </ul>	he MDS 7 ents' MDS e MDS e MDS e MDS e the e identified were ct. ns made ne re made e e ensuring lect the V the VS or a which ponths to e to urrent port to		

Facility ID: 970412

If continuation sheet Page 34 of 83

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
KINGSWC	OOD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE
F 278	revealed that there waidentified for the use of wedges. A present and there waievaluate the ongoing An observation on 9/2 #61 revealed she was on a raised perimeter the bed was against the cushions remained unraised perimeter of the left side, and her bed resident was observed movements with her a not observed putting wedge cushion or corrwall. An interview and observed putting and wedges on her bed of bed. She stated the place to keep her from side of the bed. NA# Nurse Aide Information sheet, "Pi hand written next to p Wedges." Under com included. There was the bed against the w perimeter mattress. An interview and observed putting the bed against the w perimeter mattress.	as not a specific diagnosis of the winged mattress or restraint evaluation was not is not a plan in place to use of a restraint. 20/17 at 9:11 AM of Resident is lying in bed. She was lying mattress, the right side of he wall, the two wedge nder the sheet, along the e mattress on the resident's was in a low position. The d to have had mild arms and her legs, but was her arms or legs over the ming into contact with the ervation on 9/20/17 at 9:15 stant (NA) #7 revealed aised perimeter mattress ed and she could not get out e wedge cushions were in in putting her legs over the 7 referred to the resident's e supportive section of the llows" was checked and a illows was "Bilateral	F	278			

If continuation sheet Page 35 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/25/2017 APPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION			SURVEY PLETED
		345509	B. WING			_		21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
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 PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	two wedge cushions v side along the raised were end to end, leng left side. Nurse #2 sta to be placed next to th protection because sh frequently and to prot #2 stated the wedge of for positioning. An interview and obse PM with NA #8 reveal in her bed. The bed w raised perimeter matt wedge cushions were along the raised perim end to end, lengthwis side. NA #8 stated th resident from tipping of added the wedges we side, one by her shou legs to keep the resid An interview conducted with Nurse #2 revealed record to see if there a restraint in order to needed to be coded in there was a restraint, physician's order for a observed the resident restraint and assess t restraint. She revealed observed residents to	were on the resident's left perimeter mattress, and gthwise down the resident's ated the wedge pillows were he resident's body for he moved her legs tect her from the wall. Nurse cushions were being used ervation on 9/20/17 at 4:45 led Resident #61 to be lying was in low position. The vas against the wall. The ress was in place. The two e on the resident's left side meter mattress, and were the down the resident's left and were to keep the over on the floor. NA #8 ere always kept on her left ulders and the other by her lent from falling. ed on 9/21/17 at 9:30 AM ed she reviewed the medical was a physician's order for determine if a restraint in the MDS. She explained if there was to be a t in the resident's medical icated if there was a a restraint she then went and t to determine the kind of the continued need for the ed she had not routinely	F	278				

Facility ID: 970412

If continuation sheet Page 36 of 83

		ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			· /		E CONSTRUCTION	(X3) DATE		
		345509	B. WING				C 21/2017	
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE			
					915 PEE DEE ROAD			
KINGSWC	OOD NURSING CENTER				ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 278	An interview conducter with the MDS Coordin officially began workin indicated when coding reviewed any assess and also looked at the information regarding resident had a restrait physician's order as w assessments utilized medical record. She record review indicated the resident would the would be spoken to d restraint as well as the restraint. She revealer review indicated the r had not routinely obse her restraint assessme An interview conducter with Nurse #2 revealer Restraints section, se assessment dated 9/7 been brought to her a may have been restrated An interview on 9/21/7 Assistant Director of N the purpose of the we Resident #61. The Al some instances last y her legs towards the v also an intervention for she did not view the v because the resident after the wedges were clarified the resident for	ed on 9/21/17 at 9:50 AM hator revealed she had ong at the facility 9/1/17. She g the MDS for restraints she ments in the medical record e physician's orders for restraints. She stated if a nt there would be a vell as restraint for restraint reduction in the reported if the medical ed a resident had a restraint en be observed and staff etermine the type of e continued need for the ed if the medical record esident had no restraint, she erved the resident as part of ieent for the MDS. ed on 9/21/17 at 9:57 AM ed she had completed the ection P, for the MDS 1/17. She stated it had not ittention the Resident #61 ained. 17 at 10:45 AM with the Nursing (ADON) revealed edges was for positioning for DON stated the resident had rear when she was throwing walls and the wedges were or falls. The ADON added	F	278	3			

If continuation sheet Page 37 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	used on either side and a restraint nor restrain ADON further clarified place because they we resident was not tryin of bed. The ADON st assessment complete being viewed as a rest An interview conducted with the Director of Ne expectation was for the accurate. 3. Resident #6 was a multiple diagnoses the paralysis, impaired br diabetes, anemia, and The Minimum Data S assessment dated 9/- was coded as receiving review of the Health C observed the resident had a prognosis of has chronic disease that re expectancy of less that coded diagnoses inclianxiety, depression, i impaired swallowing. A review of the medic revealed the resident services since 5/25/10 provider and the admi- vaginal cancer. A review of Resident	he has be did not feel they were in the resident's motion. The d the wedges were kept in vere effective and the g to get out of bed or roll out tated there was no restraint ed due to the wedges not straint. ed on 9/21/17 at 11:14 AM ursing (DON) revealed her ne MDS assessments to be admitted on 12/20/00 with at included: Anxiety, facial reathing, malignancy, d depression. et (MDS) quarterly 1/17 indicated Resident #6 ng hospice services. A Conditions section it was t was not coded as having wing had a condition or may have resulted in a life an 6 months. Resident #6's uded: Diabetes, dementia, mpaired breathing, and al record of Resident #6 has been receiving hospice 6 from a local hospice itting diagnosis was listed as #6's care plan which has podated on 9/12/17 revealed	F	278			

Facility ID: 970412

If continuation sheet Page 38 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345509	B. WING _			C 09/21/2017		
NAME OF P	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 278	services and having a An interview conducted with Nurse #2 revealed Health Conditions see assessment dated 9/ expectancy of less the been coded in the ME An interview conducted with the Director of Ne expectation was for the accurate. 4. Resident #76 was a 12/1/15 with diagnosed disease, respiratory fa and history of falling. The quarterly Minimu assessment dated 9/5 's cognition was seve assessed as depended mobility, toileting, dre Resident #76 required of one staff for transfe unit and the limited as locomotion on the unit was only able to stabi Resident #76 was assi incontinent of bladder assessment indicated physical restraints (def method or physical or material or equipment resident 's body that remove easily which the	a terminal disease diagnosis. ed on 9/21/17 at 9:46 AM ed she had completed the ction, section J, for the MDS 1/17. She stated life an 6 months should have DS quarterly assessment. ed on 9/21/17 at 11:14 AM ursing (DON) revealed her ne MDS assessments to be admitted to the facility on es that included Alzheimer ' s ailure, difficulty in walking, m Data Set (MDS) D/17 indicated Resident #76 erely impaired. He was ent on one staff for bed ssing, and personal hygiene. d the extensive assistance ers and locomotion off the esistance of one staff for t. He was not steady and ilize with staff assistance. sessed as always and bowel. The I Resident #76 had no efined as any manual mechanical device, t attached or adjacent to the the individual cannot	F	278				

Facility ID: 970412

If continuation sheet Page 39 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES			I	FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	TIPLE CONSTRUCTION	(X3)	) DATE SURVEY COMPLETED
		345509	B. WING _			C 09/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
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	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 278	An interview was con 9/18/17 at 11:52 AM. was not capable of ge Nurse #4 revealed sh #76 had side rails. S record and was unab order for side rails for asked Nursing Assist: Resident #76 ' s side An interview was con 9/18/17 at 11:54 AM. had bilateral quarter I the middle section of An observation was of 12:26 PM of Residen was located in the fac Resident #76 had bila the middle section of Each side rail was ap length and there was 34 inches from the to top end of the mattres bottom end of the sid the mattress. An interview was con 9/20/17 at 9:40 AM. resident was determin Nurse notified the phy and notified the family that were positioned in side of his bed was d She stated that the si to be positioned in the for any resident in the the side rails were ab	ducted with Nurse #4 on She indicated Resident #76 etting out of bed on his own. ie had not known if Resident he reviewed the medical le to locate a physician ' s Resident #76. Nurse #4 ant (NA) #5 to observe rails. ducted with NA #5 on She indicated Resident #76 ength side rails positioned in the bed. conducted on 9/18/17 at t #76 ' s bed in his room that cility ' s secured unit. ateral side rails positioned in	F 2	278		

Facility ID: 970412

If continuation sheet Page 40 of 83

		ID HUMAN SERVICES					FORM	D: 10/25/2017 APPROVED D: 0938-0391
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	side rails for Resident position. She addition rails positioned in the Resident #76 would h below the end of the s of bed. Nurse #2 reprif Resident #76 was con- 9/20/17 at 11:20 AM. spoken with hurse #2 interview and had obs Resident #76 ' s bed. side rails were positioned each side of the bed. for Resident #76 ' s bed. side rails were positioned ach side of the bed. for Resident #76 were stated the side rails s they were positioned ' s bed. Nurse #3 add rails positioned in the were not beneficial to have made it more difficult out of bed because he down below the end of restrict his movement An interview was com- 9/20/17 at 12:07 PM. familiar with Resident Resident #76 required bed safely. She indic attempted to get out of past, but he was unst reported Resident #70 indicated she thought	the bed. She revealed the t #76 were in the wrong nally revealed with the side middle section of the bed, have had to slide down side rail to be able to get out orted she was unable to say apable of getting out of bed sitioned in the middle section ducted with Nurse #3 on She revealed she had 2 on 9/20/17 prior to this served the side rails on She confirmed the bilateral oned in the middle section of She revealed the side rails e in the wrong position. She hould have been rotated so at the head of Resident #76 ditionally revealed the side middle section of the bed Resident #76 as they would fficult for him to get in and e would have had to slide of the side rail for it not to the side rail for	F	278				

Facility ID: 970412

If continuation sheet Page 41 of 83

		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/25/2017 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		345509	B. WING			_		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
KINGSWO	OD NURSING CENTER			9	15 PEE DEE ROAD			
RINGSWC	OD NORSING CENTER			A	BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page section of the bed we explained that Reside at times and the rail w Resident #76 from fal reported if the side ra Resident #76 rolled o fallen to the ground. Resident #76 frequent been positioned in the for as long as she cou A second interview wa on 9/21/17 at 9:30 AM working at the facility indicated she was init completion of MDS as opened up as a floor current MDS Coordina a facility employee on facility as an MDS coor training her to complet Nurse #2 was asked w to code the MDS for p stated she reviewed t there was a physician She explained that if t was to be a physician then went and observed the kind of restraint an need for the restraint. routinely observed resi physical restraints un order. She stated the rails as restraints and	e 41 re for fall prevention. She ent #76 rolled around in bed yould have stopped ling if he rolled into it. She il was not on the bed and ver too far he would have She stated she worked with tly and the bilateral rails had e middle section of the bed uld remember. as conducted with Nurse #2 A. She stated she began in late June 2017. She ially assisting with the assessments until a position nurse. She stated the ator (who began working as a 9/1/17) came into the nsultant to assist with the MDS assessments. what information she utilized ohysical restraints. She he medical record to see if a 's order for a restraint. there was a restraint, there 's order for a restraint she ecord. Nurse #2 indicated if a 's order for a restraint she ed the resident to determine and assess the continued She revealed she had not		278				
	An interview was con	ducted with the MDS						

Facility ID: 970412

If continuation sheet Page 42 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/25/2017 APPROVED ). 0938-0391
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		345509	B. WING		_		C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		-
KINGSWO	OOD NURSING CENTER			15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Coordinator on 9/21/1 she officially began w She indicated prior to as an MDS consultan quarterly MDS assess indicated Resident #7 was reviewed with the verified she had comp Resident #76 ' s 9/9/1 Coordinator was aske utilized to code the M She indicated when c she reviewed any ass record and looked at 1 She stated if a residen would be a physician assessments utilized medical record. She record review indicate the resident would the would be spoken to d restraint as well as the restraint. She reveale review indicated the m had not routinely obse her restraint assessm further revealed Resid review indicated he has not observed as part of for the 9/9/17 MDS. T the facility had not util and she had not code on the MDS assessm An interview was comp Nursing (DON) on 9/2	7 at 9:50 AM. She stated orking at the facility 9/1/17. that time she was assisting t on a part time basis. The sment dated 9/9/17 that 6 had no physical restraints e MDS Coordinator. She bleted this section of 7 MDS. The MDS ed what information she DS for physical restraints eessments in the medical the physician 's orders. In thad a restraint there 's order as well as restraint for restraint reduction in the reported if the medical ed a resident had a restraint en be observed and staff etermine the type of e continued need for the ed if the medical record esident had no restraint, she erved the resident as part of ent for the MDS. She dent #76 's medical record ad no restraint and he was of her restraint assessment The MDS Coordinator stated lized side rails as restraints ed any side rails as restraints ents.	F 278				

Facility ID: 970412

If continuation sheet Page 43 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345509	B. WING			09/21/2017		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 278	An interview was con Administrative Consu 9/21/17 at 11:56 AM. had not been monitor She indicated bilatera middle section of the movement of a reside with bed mobility and 5. Resident #22 was 1/14/17 and readmitte that included dementi cerebrovascular disea disorder, anxiety, diffi of falling. The Quarterly Minimu assessment dated 8/7 #22 's cognition was assessed as requiring two or more staff with dressing, and persona required the extensive transfers and locomo assessment indicated physical restraints (de method or physical or material or equipmen resident 's body that remove easily which in movement or normal An interview was con 9/18/17 at 12:00 PM. was not capable of ge Nurse #4 revealed sh #22 had side rails. Si record and was unab	ducted with the Itant/Regional Director on She reported the facility ing the use of side rails. al side rails positioned in the bed could restrict the ent who was not independent transfers. admitted to the facility on ed on 5/8/17 with diagnoses a, diabetes mellitus, ase, major depressive culty in walking, and history Im Data Set (MDS) 15/17 indicated Resident severely impaired. She was g the extensive assistance of bed mobility, toileting, al hygiene. Resident #22 e assistance of one staff for tion on/off the unit. The I Resident #22 had no efined as any manual mechanical device, t attached or adjacent to the the individual cannot	F	278				

Facility ID: 970412

If continuation sheet Page 44 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 10/25/2017 APPROVED ). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION			SURVEY LETED
		345509	B. WING			_		_ 21/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	asked Nursing Assista Resident #22 's side An interview was com 9/18/17 at 12:03 PM. had bilateral quarter le the middle section of An observation condu PM of Resident #22 re bed in her room that was secured unit. Resider length side rails on he side rails were positione each side of the bed. An interview was com 9/20/17 at 9:40 AM. If resident was determin Nurse notified the phy and notified the family that were positioned if side of his bed was di She stated that the side to be positioned in the for any resident in the the side rails were ab positioned at the head the middle section of side rails for Resident position. She addition rails positioned in the Resident #22 would he below the end of the so of bed. Nurse #2 rep- if Resident #22 was com	ant (NA) #5 to observe rails. ducted with NA #5 on She indicated Resident #22 ength side rails positioned in	F 2	78				

Facility ID: 970412

If continuation sheet Page 45 of 83

		ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C 21/2017
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	Y STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					(X5) COMPLETION DATE
F 278	An interview was con 9/20/17 at 11:20 AM. spoken with Nurse #2 interview and had obs Resident #22 ' s bed. side rails were positioned for Resident #22 were stated the side rails s they were positioned ' s bed. Nurse #3 add rails positioned in the were not beneficial to have made it more dir out of bed because he down below the end of restrict his movement An interview was con 9/20/17 at 12:00 PM. familiar with Resident Resident #22 was not without assistance. S able to move around although she had not frequently. NA #3 rep risk for falls. She indi Resident #22 ' s bilate had been positioned in bed. She reported sh position they were in a different position. An interview was con 9/20/17 at 12:04 PM. familiar with Resident Resident #22 was not without assistance. S	ducted with Nurse #3 on She revealed she had on 9/20/17 prior to this served the side rails on She confirmed the bilateral oned in the middle section of She revealed the side rails in the wrong position. She hould have been rotated so at the head of Resident #22 ditionally revealed the side middle section of the bed Resident #22 as they would fficult for him to get in and e would have had to slide of the side rail for it not to the side rail for it not to the stated Resident #22 was in bed independently, moved around in bed borted Resident #22 was at cated she was unsure why eral quarter length side rails in the middle section of the he kept the side rails in the and had not moved them to ducted with NA #4 on NA #4 stated she was	F	278			

Facility ID: 970412

If continuation sheet Page 46 of 83

		D HUMAN SERVICES //EDICAID SERVICES				FORM	: 10/25/2017 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		(X3) DATE COMPI	SURVEY LETED
		345509	B. WING		_	09/2	, 21/2017
NAME OF PROV	IDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
KINGSWOOD	NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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
A or we in cc op cc a fa fa fa fa fa fa fa fa fa fa fa fa f	sk for falls. She indic esident #22 ' s bilate ad been positioned in ed. She reported shi bation they were in a different position. second interview wa n 9/21/17 at 9:30 AM orking at the facility in dicated she was initi- bonded up as a floor r urrent MDS Coordina facility employee on cility as an MDS cor- aining her to comple- uarterly MDS assess dicated Resident #2 as reviewed with Nu ad completed this se 22/17 MDS. Nurse formation she utilize hysical restraints. SI edical record to see der for a restraint. as a restraint, there durse #2 indicated if t der for a restraint sh e resident to determ ssess the continued vealed she had not assess for physical hysician ' s order. SI ilized side rails as re-	borted Resident #22 was at ated she was unsure why aral quarter length side rails in the middle section of the e kept the side rails in the and had not moved them to as conducted with Nurse #2 I. She stated she began in late June 2017. She ally assisting with the sessments until a position nurse. She stated the ator (who began working as 9/1/17) came into the asultant to assist with te MDS assessments. The ment dated 8/15/17 that 2 had no physical restraints rse #2. She verified she ction of Resident #22 ' s	F 2				

Facility ID: 970412

If continuation sheet Page 47 of 83

	-	ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	9 47	F	278	3		
	she officially began w She indicated prior to as an MDS consultan MDS Coordinator was she utilized to code the restraints. She indicat for restraints she revise the medical record are orders. She stated if there would be a physe restraint assessments reduction in the medical the medical record re had a restraint the rest observed and staff wo the type of restraint a for the restraint. She record review indicate restraint, she had not resident as part of he the MDS. The MDS of facility had not utilized she had not coded are the MDS assessments An interview was con Nursing (DON) on 9/2 indicated her expectation completely accurately An interview was con Administrative Consu 9/21/17 at 11:56 AM. had not been monitor	17 at 9:50 AM. She stated orking at the facility 9/1/17. that time she was assisting t on a part time basis. The s asked what information he MDS for physical hed when coding the MDS ewed any assessments in hd looked at the physician ' s a resident had a restraint sician ' s order as well as s utilized for restraint cal record. She reported if view indicated a resident sident would then be build be spoken to determine s well as the continued need revealed if the medical ed the resident had no routinely observed the r restraint assessment for Coordinator stated the d side rails as restraints and my side rails as restraints on s. ducted with the Director of 21/17 at 11:09 AM. She tion was for the MDS to be v.					

Facility ID: 970412

If continuation sheet Page 48 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 10/25/2017 1 APPROVED 0: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION			LETED
		345509	B. WING		_		C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315	i		
(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 278	Continued From page movement of a reside with bed mobility and	ent who was not independent	F 27	78			
		admitted to the facility on es that included dementia, brder, and anxiety.					
	#21 ' s cognition was Resident #21 had rec and antidepressant m during the MDS look	17/17 indicated Resident severely impaired. eived antianxiety medication redication on 7 of 7 days back period. Section I, the tion, was not coded for					
	Record (MAR) indicat Zoloft (antidepressan (mg) once daily for m Klonopin (antianxiety	t Medication Administration red Resident #21 received t medication) 50 milligrams ajor depressive disorder and medication) 0.5 mg twice g 8/17/17 MDS look back					
	9/21/17 at 9:30 AM. S working at the facility indicated she was init completion of MDS as opened up as a floor current MDS Coordina a facility employee on facility as an MDS con training her to complet quarterly MDS assess indicated anxiety and diagnoses for Resider	in late June 2017. She ially assisting with the ssessments until a position nurse. She stated the ator (who began working as 9/1/17) came into the					

Facility ID: 970412

If continuation sheet Page 49 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		·	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	section of Resident #/ August 2017 MAR tha was administered Zol disorder and Klonopir 8/17/17 MDS look bac Nurse #2. Nurse #2 r trained on the comple during August of 2017 an error on this MDS #21. An interview was com Nursing (DON) on 9/2 indicated her expecta completely accurately 6b. Resident #21 was 3/31/15 with diagnose major depression, and An incident report for had an unobserved fa 2:45 PM. There were An incident report for had an unobserved fa 6:00 PM. There were The Quarterly Minimu assessment dated 8/ #21 's cognition was indicated to have had assessment (5/17/17 An interview was com 9/21/17 at 9:30 AM. S working at the facility indicated she was init	21's 8/17/17 MDS. The at indicated Resident #21 off for major depressive of for anxiety during the ck period was reviewed with revealed she was still being ation of MDS assessments 7. She indicated she made assessment for Resident ducted with the Director of 21/17 at 11:09 AM. She tion was for the MDS to be 7. admitted to the facility on as that included dementia, d anxiety. Resident #21 indicated she all in her room on 6/20/17 at a no injuries noted. Resident #21 indicated she all in her room on 6/21/17 at a no injuries notes. Im Data Set (MDS) 17/17 indicated Resident severely impaired. She was no falls since the prior MDS quarterly assessment). ducted with Nurse #2 on	F	278			

Facility ID: 970412

If continuation sheet Page 50 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER				115 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	opened up as a floor current MDS Coordin a facility employee or facility as an MDS con training her to complet quarterly MDS assess indicated Resident #2 prior MDS assessment with Nurse #2. She v this section of Reside The incident reports t had two falls without i were reviewed with N she was still being tra MDS assessments du indicated she made a assessment for Reside An interview was con Nursing (DON) on 9/2 indicated her expecta completely accurately 7. a. Resident #29 w 12/10/13. Cumulative depressive disorder, a psychosis. A Quarterly Minimum 8/23/17 indicated Res intact. Diagnoses inc of unspecified site, ur nonpressure chronic mid-foot with necrosis A review of the medic	nurse. She stated the ator (who began working as a 9/1/17) came into the nsultant to assist with the MDS assessments. The sment dated 8/17/17 that 21 had no falls since her int (5/17/17) was reviewed erified she had completed int #21 ' s 8/17/17 MDS. hat indicated Resident #21 njury (6/20/17 and 6/21/17) urse #2. Nurse #2 revealed ined on the completion of uring August of 2017. She in error on this MDS lent #21. ducted with the Director of 21/17 at 11:09 AM. She tion was for the MDS to be v. vas admitted to the facility on e diagnoses included major anxiety, insomnia and Data Set (MDS) dated sident #29 was cognitively duded L89.90 pressure ulcer ispecified stage. L97.413 ulcer of right heel and a muscle. al record revealed Resident pressure ulcers during the period.	F	278			

If continuation sheet Page 51 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/25/2017 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>		E CONSTRUCTION	(X3) DATE	
							C
		345509	B. WING			09/	21/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	conducted with the M she began teaching N the MDS when she ca 2017. The MDS Coor responsible for the MI 2017. She said she h MDS for about 3 year not have been include On 9/21/17 at 9:42 Al conducted with Nurse completed the MDS a dated 8/23/17. She s MDS at that time and Nurse #2 said inactive included on the MDS pressure ulcer were in On 9/21/17 at 11:14 A conducted with the Di she expected the MD information. 7. b. Resident #29 w 12/10/13. Cumulative depressive disorder, a psychosis. A Quarterly Minimum 8/23/17 indicated Res intact. A review of se indicate anxiety, insor active diagnoses for F A review of physician revealed the following (antidepressant media mouth every bedtime,	DS Coordinator. She stated Jurse #2 how to complete ame to the facility in July rdinator said she became DS the first of September had been completing the is and the skin issues should ed in the diagnoses. M, an interview was #2. She stated she had assessment for Resident #29 aid she was completing the was learning the process. e diagnoses should not be and the diagnoses for the haccurate. AM, an interview was irector of Nursing who stated S to contain accurate was admitted to the facility on e diagnoses included major anxiety, insomnia and Data Set (MDS) dated sident #29 was cognitively ction I for diagnosis did not mnia and psychosis as Resident #29. orders for August 2017 g medications: Amitriptyline cation) 150 milligrams by	F	278			

Facility ID: 970412

If continuation sheet Page 52 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:					LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 278	milligrams every 6 ho Prozac (antidepressa Geodon (antipsychoti twice daily for psycho On 9/19/17 at 1:58 PI conducted with the M she began teaching N the MDS when she ca 2017. The MDS Coo responsible for the MI 2017. She said she F MDS for about 3 year would include any ner physician and also ind to medications taken diagnoses of anxiety, should have been inc On 9/21/17 at 9:42 AI conducted with Nurse completed the MDS a dated 8/23/17. She s MDS at that time and Nurse #2 said active included on the MDS. On 9/21/17 at 11:14 conducted with the Di she expected the MD she expected the MD	urs as needed for anxiety, nt) 60 milligrams daily and c medication) 40 milligrams sis. M, an interview was DS Coordinator. She stated lurse #2 how to complete ame to the facility in July rdinator said she became DS the first of September had been completing the s and section I (Diagnosis) w diagnoses noted by the clude any diagnoses related by the resident. The psychosis and insomnia luded on the MDS. M, an interview was e #2. She stated she had issessment for Resident #29 aid she was completing the was learning the process. diagnoses should be AM, an interview was rector of Nursing who stated S to contain accurate as admitted 8/6/15. s included cardiomyopathy, ack (TIA), insomnia, ion.	F	278			

Facility ID: 970412

If continuation sheet Page 53 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		345509	B. WING			09	C / <b>21/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	impaired in cognition. as continent of bladded A review of the Activit tracking form complet revealed Resident #3 bladder incontinence (7 day look back period On 9/21/17 at 9:00 Al conducted with NA#1 provided care for Res Resident #39 wore in daily episodes of black On 9/21/17 at 9:22 Al conducted with Nurse being trained in Augu She stated she obtain completing the bladded the ADL tracking form assistants. After revie information on the AD the MDS was coded i On 9/21/17 at 11:14 A conducted with the Di she expected the MD information. 8. b. Resident #39 w Cumulative diagnoses transient ischemic att	Resident #39 was coded er and bowel. ies of Daily Living (ADL) ted by the nursing assistants 9 had daily episodes of from 8/4/17 through 8/10/17 od). M, an interview was . He stated he routinely sident #39. NA #1 stated continent briefs and had lder incontinence M, an interview was e #2. She stated she was st on completing the MDS. hed information for er continence from reviewing and talking to the nursing ewing the MDS and the DL tracking form, she said ncorrectly. AM, an interview was irector of Nursing who stated S to contain accurate as admitted 8/6/15. s included cardiomyopathy, ack (TIA), insomnia,	F	278			
	8/10/17 indicated Res impaired in cognition.	Data Set (MDS) dated sident #39 was moderately Mood assessment noted d or little energy never or 1					

Facility ID: 970412

If continuation sheet Page 54 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	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 21/2017
NAME OF P	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE		-
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 278	day. No behaviors or assessment period. A administered during the period 8/ 4/17-8/10/17 had not received any medication during the period. A review of physician Novolog insulin 10 un breakfast, Toujeo insu every morning and Xa medication) 15 milligr A review of August Ma Record (MAR) for 8/4 revealed Resident #3 insulin and Toujeo insu back period. He also during the look back p On 9/21/17 at 9:22 Al conducted with Nurse being trained in Augus She said she reviewe hospital record, physi Medication Administra completed the informa administered during the period. She reviewed insulin injection and 7 medication. On 9/21/17 at 11:14 A conducted with the Di she expected the MD information.	ccurred during the A review of the medications he seven day look back 7) indicated Resident #39 insulin or anticoagulant seven day look back orders revealed an order for its subcutaneous before ulin 70 units subcutaneous arelto 9anticoagulant ams by mouth daily. edication Administration /17 through 8/10/17 9 resident received Novolog ulin 7 days during the look received Xarelto 7 days beriod. M, an interview was e #2. She stated she was st on completing the MDS. d the medical record, cian ' s orders and ation Record when she ation for medications he seven day look back I the MAR for 8/4/17-8/10/17 d have coded 7 days of days of anticoagulant	F	278	3		

Facility ID: 970412

If continuation sheet Page 55 of 83

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE		-
KINGSWO	OD NURSING CENTER			9	915 PEE DEE ROAD		
Rindowe	OD NORSING 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	8/25/17 with multiple of Alzheimer's disease a tibia. The admission assessment dated 9/1 #96 had memory and The assessment furth #96 was not using sid restraint. Resident #96's Nurse sheet (a care guide for sheet indicated that R side rails due to cogn walk every now and th On 9/19/17 at 3:20 PN Resident #96 was obs was observed to have middle of her bed. On 9/20/17 at 8:46 AN was interviewed. She was using ½ side rails bed mobility. She furth was not able to remov when she wanted to g On 9/21/17 at 9:30 AN interviewed. She stat at the facility in late Ju completion of MDS as opened up for a floor current MDS Nurse st Nurse #2 stated that t side rails as restraints side rails as restraints Nurse #2 also indicate observed residents to	diagnoses including and fracture upper end of Minimum Data Set (MDS) I/17 indicated that Resident decision making problems. er indicated that Resident le rails as a physical Aide (NA) Information or NA) was reviewed. The tesident #96 was using ½ itive status and she tried to nen. M and 9/20/17 at 8:45 AM, served out of bed. Her bed e bilateral ½ side rails in the M, Medication Aide (MA) #2 stated that Resident #96 is when she was in bed for her stated that Resident #96 is when she was in bed for her stated that Resident #96 is when she was in bed for her stated that Resident #96 is when she was in bed for her stated that Resident #96 is when she was in bed for her stated that Resident #96 is of lower the SR down get out of bed. M, Nurse #2 was ed that she started working une 2017 assisting with the sessments until a position nurse. She added that the carted September 2017. he facility had not utilized is and she had not coded any is on the MDS assessments. ed that she had not routinely	F	278			

Facility ID: 970412

If continuation sheet Page 56 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 278	interviewed. She stat at the facility on 9/1/1 indicated that if the m indicated that a reside not routinely observed restraint assessment stated that the facility restraints and she had restraints on the MDS On 9/21/17 at 1:23 Pf (DON was interviewe expected the MDS as 10. Resident #40 wa facility on 5/11/17 and admission Minimum I dated 5/17/17 indicate severe cognitive impa- using side rails as a p	M, the MDS Coordinator was ted that she started working 7. The MDS Coordinator redical record review ent had no restraint, she had d the resident as part of her for the MDS. She further had not utilized side rails as d not coded any side rails as 3 assessments. M, the Director of Nursing d. The DON stated that she essessments to be accurate. s originally admitted to the d expired on 6/1/17. The Data Set (MDS) assessment ed that Resident #40 had airment and he was not	F	278			
	side rails. On 9/19/17 at 2:15 PI She stated that Resid rails (SR) in the midd	M, NA #2 was interviewed. lent #40 was using ¼ side le of his bed and he was not /er the SR down when he					
	SR in his bed during t	AM, Nurse #5 was ed that Resident #40 had ½ the fall on 6/1/17 and it abed over the rails and fell					

Facility ID: 970412

If continuation sheet Page 57 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C 21/2017
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278 F 323 SS=D	at the facility in late Ju completion of MDS as opened up for a floor current MDS Nurse si Nurse #2 stated that to side rails as restraints side rails as restraints Nurse #2 also indicate observed residents to restraints unless there On 9/21/17 at 9:50 All interviewed. She stat at the facility on 9/1/1 indicated that if the m indicated that a reside not routinely observed restraint assessment stated that the facility restraints and she had restraints on the MDS On 9/21/17 at 1:23 Pf (DON was interviewed expected the MDS as 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI (d) Accidents. The facility must ensu	M, Nurse #2 was ted that she started working une 2017 assisting with the assessments until a position nurse. She added that the tarted September 2017. The facility had not utilized and she had not coded any on the MDS assessments. The MDS coordinator was ted that she had not routinely assess for physical awas a physician's order M, the MDS Coordinator was ted that she started working 7. The MDS Coordinator edical record review ent had no restraint, she had d the resident as part of her for the MDS. She further had not utilized side rails as d not coded any side rails as assessments. M, the Director of Nursing d. The DON stated that she sessments to be accurate. (3) FREE OF ACCIDENT SION/DEVICES are that -		278			10/18/17

Facility ID: 970412

If continuation sheet Page 58 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		345509	B. WING		_	C 09/21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
KINGSWC	OOD NURSING CENTER			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATI EFICIENCY)	(X5) COMPLETION DATE
F 323	<ul> <li>(2) Each resident reco and assistance device</li> <li>(n) - Bed Rails. The f appropriate alternativ bed rail. If a bed or s must ensure correct in maintenance of bed r to the following element</li> <li>(1) Assess the reside from bed rails prior to</li> <li>(2) Review the risks at the resident or reside informed consent prior</li> <li>(3) Ensure that the be appropriate for the resident or the resident to the resident or reside informed consent prior</li> <li>(3) Ensure that the be appropriate for the resident for the resident this REQUIREMENT by: Based on record revisif acility failed to identifipotential accident haz risk and benefits of be Responsible Party an consent prior to instal of 3 sampled resident falls (Resident #40).</li> <li>Resident #40 was origon 5/11/17 and expire had multiple diagnose Metabolic encephalop</li> </ul>	eives adequate supervision es to prevent accidents. Facility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited ents. In for risk of entrapment installation. Ind benefits of bed rails with int representative and obtain or to installation. ed's dimensions are sident's size and weight. I is not met as evidenced ew and staff interview, the by the use of side rails as a card and failed to review the ed rails with the resident's d to obtain informed lation of the bed rails for 1 is who were high risk for Findings included: ginally admitted to the facility ed on 6/1/17. Resident #40 es including Dementia and	F	facility on 6/1/17. 2. An audit was co and the ADON on 1 residents' devices to and T&R bars, the p rails/ the T&R bars of the current residents Based on the visual resident the bed rail restraint assessment	on the bed. 100% of s were visualized. audit of current assessment and	l t s
	5/17/17 indicated that cognitive impairment	Resident #40 had severe and he had no falls.			traint and to ensure azardous have been wed up. When side	

Facility ID: 970412

If continuation sheet Page 59 of 83

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 10/25/2017 MAPPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345509	B. WING		09	C 9/21/2017
NAME OF PI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Resident #40's Fall R 5/11/17 was reviewed a total score of 14. T indicated that a "total HIGH RISK". Resident #40's care p reviewed. One of the "risk for falls". The ge experience serious in 90 days". The appro- use of bilateral side r Resident #40's Bed F form dated 5/11/17 w indicated that Reside and there was a poss over the bed rails/ass indicated that there w #40 has a desire or re form also did not indi Party (RP) was notified side rails. The form v author was not interv Resident #40's Nurse Sheet (care guide for at the back of the res had a check mark un Resident #40's nurse were reviewed. The	Risk Assessment dated d. The assessment revealed the assessment form score above 10 represents olan dated 5/11/17 was e care plan problems was oal was "resident will not ujury from falls over the next aches did not include the ails. Rail/Assist Bar Evaluation as reviewed. The form nt #40 had history of falls sibility that he would climb sist bar. The form also vas evidence that Resident eason to get out of bed. The cate that the Responsible ed of risk and benefits of the was not signed therefore the iewed. Adde (NA) Information NA) was observed posted ident's closet. The sheet	F 323		d and hefit are adopt a tree, to restrictive ive device g week end side rails rsing //17/17. ng bed ssessment, quency of ervice nm use will nurse, aff by the the DON by nces (CNA) cluding ducated by 17 with ng and as when to	
		M, Resident #40 was found front of his wheelchair with		Coordinator, SDC and nursing supervisors will be responsible obtaining consents for restraint need is identified. Staff nurses	for ts when	

Facility ID: 970412

CENTER	S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES	1			FORM OMB NC	): 10/25/2017 APPROVED ). 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C		
		345509	B. WING				21/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OOD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 323	Continued From page no injury noted.	9 60	F 32	23	complete assessments for side rails a restraints on admission, quarterly and			
	sitting on the floor in f stated that he was try On 5/20/17 at 11:45 F sitting on the floor. Th	M, Resident #40 was found ront of his wheelchair. He ing to get over in bed. PM, Resident #40 was found he root cause was poor			with any change in resident status. Consent forms for current residents w have been identified as having a restr will have consent forms signed by 10/17/17 . When residents are evalua for restraint, if a restraint is indicated consent will be signed or verified by	ho aint,		
	The root cause was p On 6/1/17 at 12:00 minoted on the floor on to climb over the side	own on floor parallel to bed. oor safety awareness. idnight, Resident #40 was his abdomen. He appeared rails trying to get out of bed or beside the bed. The root			<ol> <li>We will charter a Safety Committee by nurses within 24 hours of assessment</li> <li>We will charter a Safety Committee consisting of the DON, Maintenance Director, 1 staff nurse, 1 CNA, and oth department heads will rotate on to the committee every month. The committee will meet monthly, the first meeting will meet for October 18, 2017. The purpose of this committee is to review restraints- to ensure least restrictive</li> </ol>	ee her ee ill be		
	Nursing (ADON) was reviewed the Bed rail, dated 5/11/17 and sta evaluation, Resident a rails in bed. He was a The ADON stated tha consent form for the u ADON also indicated investigating the falls cause of falls. She st falls for Resident #40 She indicated that she an accident hazard fo On 9/20/17 at 10:43 A interviewed. She state	#40 should not have side able to lift self out of bed. t facility did not have a use of the side rails. The that she was responsible for and identifying the root ated that the root cause of was poor safety awareness. e didn't look at side rails as r the resident.			devices are being used, falls in order reduce the risk of injury and to recommend improvement initiatives fo fall prevention, and any adverse even 8. A visual audit will be completed b DON weekly for 4 weeks of current residents and monthly for 3 months to visualize use and placement of side ra DON will audit all documentation relat to side rails and/ restraints. Documentation will include initial/ quarterly/prn side rail assessments, initial/quarterly and prn assessment for restraints, and consent for restraints. Charts will be audited by DON weekly and monthly x3. The DON will preser results of audits to the QA Committee	r ts. y the ails. ed r x4		

Facility ID: 970412

If continuation sheet Page 61 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE		
			A. BUILDIN	NG			C	
		345509	B. WING			09/21/2017		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWO	OD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 323		e 61 ne climbed over the rails and	F3	323	monthly for 4 months. Date of Compliance: 10/18	/17		
F 334 SS=E	(DON) was interviewed she expected the staft the Bed Rail/Assist Ba documenting the alter		FS	334			10/18/17	
		umococcal immunizations ility must develop policies sure that-						
	each resident or the r	influenza immunization, esident's representative garding the benefits and of the immunization;						
	-	r 1 through March 31 mmunization is medically resident has already been						
		e resident's representative refuse immunization; and						
	(iv) The resident's me documentation that in following:	dical record includes dicates, at a minimum, the						
	(A) That the resident	or resident's representative						

Facility ID: 970412

If continuation sheet Page 62 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KINGSWO	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 334	<ul> <li>was provided educatia and potential side effectimmunization; and</li> <li>(B) That the resident for immunization or did normalization or did normalization due to refusal.</li> <li>(2) Pneumococcal disting develop policies and potential immunization, each refuse and potential immunization, each refuse sentative received benefits and potential immunization;</li> <li>(ii) Each resident is of immunization, unless medically contraindicate already been immunization;</li> <li>(iii) The resident or the has the opportunity to documentation that infollowing:</li> <li>(A) That the resident is determined and potential side effection immunization;</li> <li>(B) That the resident of the pneumococcal immunization; and</li> </ul>	on regarding the benefits ects of influenza either received the influenza ot receive the influenza medical contraindications or sease. The facility must procedures to ensure that- pneumococcal esident or the resident's es education regarding the side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; e resident's representative or refuse immunization; and edical record includes idicates, at a minimum, the or resident's representative on regarding the benefits ects of pneumococcal	F	334			

Facility ID: 970412

If continuation sheet Page 63 of 83

	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING				C 09/21/2017
NAME OF PF	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				9.	15 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 LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 334	Continued From page	e 63	F	334			
	contraindication or re			001			
		Γ is not met as evidenced					
	by:						
		iew and staff interview, the			F 334		
	facility failed to offer a						
	pneumococcal vaccir	ne to 5 of 5 sampled			1. Resident # 93 Pneumonia / Flu		
		or immunization (Residents #			consent was completed on 10/5/ 17 t	•	
	93, #5, #95, #89 & #	98). Findings included:			SDC. Vaccine for Flu was given 10/9	/17.	
					Pneumonia vaccine was refused.		
		n Pneumococcal vaccine			Resident #5 the Pneumonia / Flu cor		
		2 was reviewed. The policy			was completed on 10/5/17 by the SD		
	-	or upon admission, residents eligibility to receive the			Flu vaccine was given on 10/3/17. The Pneumonia vaccine will be given by	le	
		process vaccine) and when			10/16/17.		
		red the vaccine within 30			Resident #95 the Pneumonia / Flu		
		the facility unless medically			consent was completed on 10/5/17 b	v	
		e resident has already been			SDC. Pneumonia vaccine was given	-	
		ients of pneumococcal			10/9/17. Flu vaccine was given on		
	vaccination status will	ll be conducted within 5			10/13/17.		
		esident's admission if not			Resident #89 the Pneumonia /Flu co		
	-	Imission. Pneumococcal			was completed on 10/6/17 by the SD	С	
		inistered to residents (unless			with resident refusal.		
	-	ated, already given or			Resident #98 was discharged to the		
	pneumococcal vaccir	ity's physician approved			hospital on 10/4/17. Resident return hospital on 10/9/17. Pneumonia/Flu	IOIN	
		atives have the right to refuse			consent was obtained on 10/12/17.		
		ed, appropriate entries will be			Resident refused all attempts to give	flu	
		resident's medical record			vaccine as of 10/12/17.		
	indicating the date of						
	U U	nation. For residents who			2. An audit of the current residents	was	
	receive the vaccine, t	the date of vaccination, lot			completed by the Infection Control N	urse	
	-	ate, person administering,			and the ADON on 10/5/17 to assess		
		ation will be documented in			for Pneumococcal / Flu vaccines to b		
	the resident's medica	al record."			given. Audit showed out of 72 reside	nts	
	1 Decident # 00				52 need Pneumonia/flu vaccine.		
		admitted to the facility on			Pneumococcal/ Flu consents or	,	
	5/22/17 with multiple	diagnoses including			declination will be obtained for the 52 residents needing one or more vacci		

Facility ID: 970412

If continuation sheet Page 64 of 83

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		345509			C 09/21/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/21/2017
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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
F 334	of the resident's media the resident's respons consented to adminis to Resident #93 on 5/ Resident #93's media electronic records we no documentation that was administered to the On 9/21/17 at 9:29 Al Nursing (ADON) was stated that she was the She revealed that the immunization as a co The ADON stated that was responsible for o pneumococcal vaccin working at the facility further stated that wh consented to receive communicated to nur vaccine was not admi indicated that she had chart yet as to who ne pneumococcal vaccin to receive the vaccine On 9/21/17 at 11:20 / interviewed. The DO that the facility had id concern. She revealed as DON at the facility follow up with the ADD status.	ical records revealed that sible party (RP) had ther Pneumococcal vaccine /22/17. cal records including the the resident deter was at Pneumococcal vaccine the resident. M, the Assistant Director of interviewed. The ADON he Infection Control Nurse. e facility had identified incern last August 2017. at the Admission Coordinator obtaining the consent for the ne on admission but she quit in August 2017. The ADON en a resident or RP the vaccine, it was not sing and therefore the inistered. The ADON d not started auditing the eeded a consent for the he and who had consented e. AM, the DON was N stated that she was aware entified immunization as a ed that she started working to n 8/24/17 and she would ON on the immunization	F 334	<ul> <li>to those who consent. Consents w obtained for immunizations by 10/</li> <li>3. The Licensed Nurses, includit week-end and prns, will be reeduc the SDC, DON, ADON, Unit Mana week-end supervisor by 10/17/17 to next shift worked, related to ensist the Pneumococcal / Flu vaccines been offered and given as require</li> <li>4. An audit will be completed by weekly for 4 weeks and monthly for months to ensure Pneumococcal / vaccines continue to be offered ar as required. The SDC will a report Quality Assurance Committee mon 4 months.</li> <li>Date of Compliance: 10/18/17</li> </ul>	17/17. ng cated by ager, or 7 or prior suring have d. the SDC or 3 / Flu nd given t to the

If continuation sheet Page 65 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				21/2017
NAME OF P	ROVIDER OR SUPPLIER			(	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
KINGSWC	OD NURSING CENTER			9	915 PEE DEE ROAD		
1. NOONC	OD NOROINO OENTER				ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 334	to the facility. There we the medical records the had refused Pneumode already received the we On 9/21/17 at 9:29 Al Nursing (ADON) was stated that she was the She revealed that the immunization as a co- The ADON stated that was responsible for o pneumococcal vaccine working at the facility further stated that while consented to receive communicated to nurse vaccine was not admit indicated that she had chart yet as to who ne pneumococcal vaccine to receive the vaccine On 9/21/17 at 11:20 A interviewed. The DO that the facility had id- concern. She revealed as DON at the facility follow up with the ADO status. 3. Resident # 95 was 6/22/17 with multiple Dementia. Review of records revealed that offered Pneumococcal	Resident #5 was not al vaccine since admission were no documentation in hat the resident or the RP coccal vaccine or had vaccine in the past. M, the Assistant Director of interviewed. The ADON he Infection Control Nurse. facility had identified neern last August 2017. t the Admission Coordinator btaining the consent for the e on admission but she quit in August 2017. The ADON en a resident or RP the vaccine, it was not sing and therefore the nistered. The ADON d not started auditing the eeded a consent for the e and who had consented e. MM, the DON was N stated that she was aware entified immunization as a ed that she started working on 8/24/17 and she would ON on the immunization	F	334			

Facility ID: 970412

If continuation sheet Page 66 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345509	B. WING				21/2017
	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 334	had refused Pneumor already received the v On 9/21/17 at 9:29 AI Nursing (ADON) was stated that she was th She revealed that the immunization as a co The ADON stated that was responsible for o pneumococcal vaccin working at the facility further stated that wh consented to receive communicated to nur- vaccine was not admi indicated that she had chart yet as to who ne pneumococcal vaccin to receive the vaccine On 9/21/17 at 11:20 A interviewed. The DO that the facility had id concern. She reveale as DON at the facility follow up with the ADO status. 4. Resident # 89 was 5/5/17 with multiple d Dementia. Review of records revealed that offered Pneumococca to the facility. There was	hat the resident or the RP coccal vaccine or had vaccine in the past. M, the Assistant Director of interviewed. The ADON he Infection Control Nurse. facility had identified incern last August 2017. t the Admission Coordinator btaining the consent for the e on admission but she quit in August 2017. The ADON en a resident or RP the vaccine, it was not sing and therefore the nistered. The ADON d not started auditing the eeded a consent for the e and who had consented a. M, the DON was N stated that she was aware entified immunization as a ed that she started working on 8/24/17 and she would DN on the immunization admitted to the facility on iagnoses including the resident's medical Resident #89 was not al vaccine since admission were no documentation in hat the resident or the RP coccal vaccine or had	F	334			

Facility ID: 970412

If continuation sheet Page 67 of 83

		ID HUMAN SERVICES				FORM	/ APPROVED
	5 FOR MEDICARE & I	MEDICAID SERVICES	(X2) MUIT		E CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
				-		С	
		345509	B. WING			09/	21/2017
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
KINGSWO	OD NURSING CENTER			ę	915 PEE DEE ROAD		
	OB NOROING GENTER				ABERDEEN, NC 28315		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 334	Continued From page	e 67	F	334			
		M, the Assistant Director of					
	U U V	interviewed. The ADON					
	She revealed that the	ne Infection Control Nurse.					
		ncern last August 2017.					
		at the Admission Coordinator					
	was responsible for o	btaining the consent for the					
	-	e on admission but she quit					
		in August 2017. The ADON					
	further stated that wh						
		the vaccine, it was not sing and therefore the					
	vaccine was not admi	-					
		d not started auditing the					
		eeded a consent for the					
	pneumococcal vaccin	e and who had consented					
	to receive the vaccine	Э.					
	On 9/21/17 at 11:20 A	M the DON was					
		N stated that she was aware					
		entified immunization as a					
	-	ed that she started working					
	as DON at the facility	on 8/24/17 and she would					
	follow up with the AD	ON on the immunization					
	status.						
	5. Resident # 98 was	admitted to the facility on					
	6/9/17 with multiple d	-					
		f the resident's medical					
		Resident #98 was not					
		al vaccine since admission					
		were no documentation in					
	the medical records the had refused Pneumo	hat the resident or the RP					
	already received the						
	-	M, the Assistant Director of					
		interviewed. The ADON					

Facility ID: 970412

If continuation sheet Page 68 of 83

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
KINGSWC	OOD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 334 F 371 SS=E	stated that she was the She revealed that the immunization as a could that the immunization as a could be could be a could be a could be a could be could	he Infection Control Nurse. facility had identified incern last August 2017. t the Admission Coordinator btaining the consent for the e on admission but she quit in August 2017. The ADON en a resident or RP the vaccine, it was not sing and therefore the nistered. The ADON d not started auditing the beded a consent for the e and who had consented a. MM, the DON was N stated that she was aware entified immunization as a ed that she started working on 8/24/17 and she would ON on the immunization D PROCURE, ERVE - SANITARY rom sources approved or ry by federal, state or local pod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable		334			10/18/17

Facility ID: 970412

If continuation sheet Page 69 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DATE COMP	SURVEY LETED
		345509	B. WING _				C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		-
KINGOWO				915 PE	EE DEE ROAD		
KINGSWO	OD NURSING CENTER			ABER	RDEEN, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page	: 69	F 3	71			
		es not preclude residents s not procured by the facility.					
		(3) Have a policy regarding use and storage of ods brought to residents by family and other sitors to ensure safe and sanitary storage, andling, and consumption. his REQUIREMENT is not met as evidenced					
	foods brought to resid visitors to ensure safe handling, and consum						
	Based on observation facility failed to clean one of three appliance maintain an intact cor three appliances. The sealed drain on one of compartment sink. The food from possible co			1. thi wa Di	371 The drain for the middle sink for the ree compartment sink that was leaking ater was repaired by the Maintenance frector on 9/21/17. The grease trough was not easily movable. This was fixed on 9/21/17	ng	
	facial hair while prepa	y staff to properly restrain ring food for three of three nbers with observed facial		up Th co ex	tove top and grill had grease and built b. This was cleaned on 9/20/17 the part for the Control panel pad for the provection oven that had the broken toposed internal buttons was ordered of 20/17 and will be repaired by the	he	
	on 9/18/17 at 10:11 A and on 9/20/17 at 2:0 following: a. The drain for the compartment sink wa amounts of water onto b. The control pane oven was observed w	e conducted of the kitchen M, on 9/20/17 at 10:59 AM, 7 PM that revealed the middle sink for the three s observed leaking copious o the floor. I pad for the convection there the plastic covering internal buttons which could		Ma 2. co to an ar	ompleted by Dietary Manager on 9/21 ensure food service equipment is cle ad functioning as required. Identified ea were cleared and no new areas w oted.	ean vere	

Facility ID: 970412

If continuation sheet Page 70 of 83

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		IO. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	
		345509	B. WING		C 09/21/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				915 PEE DEE ROAD		
KINGSWC	OD NURSING CENTER			ABERDEEN, NC 28315		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETIC DATE
IAG		,		DEFICIENCY)		
E 074						
F 371	Continued From page	e 70	F 37			
	not be cleaned.			and prn staff, have been in-ser		
	· ·	ad six of six burners with		the process and policy for clear	-	
	visible burnt food and	•		reporting maintenance issues a		
		had visible grease build up		hair covering started on 9/20/1		
	under the top of the g			District Manager and will be con	•	
		gh was not removable from ad visible food, grease, and		Dietary Manager no later than Dietary staff will be in-serviced		
	debris in the drawer.	iad visible lood, grease, and		the Dietary Manager on the top		
	An interview conduct	ed with the Dietary Manager		orders written timely, wearing fa covering and cleaning properly		
		M revealed she was unable		next 3 months.		
		e trough drawer from under		next 5 months.		
	-	Dietary Manager stated her		4. The Dietary Manager and/	Head Cook	
		he grease trough to be easily		will identify and track kitchen m		
		ng, stove top burners to be		concerns, proper facial covering		
		ea under the flat top grill to		cleaning schedule and complet		
		the Dietary Manager stated		monitoring tool. Using the audit		
		for kitchen equipment such		monitoring tool daily x 4 weeks		
	· ·	on the three compartment		weekly for 4 weeks, then month		
	-	inel on the convection oven		month. Corrections will be mad	-	
	-	ng order. The dietary		identified by the Dietary Manag		
		as also her expectation if		the audits. The District Dietary	-	
	-	kitchen equipment or an		will review the audits weekly x	-	
	· ·	in need of being repaired a		then 1 times a month for 1 mon		
		be completed by the dietary		on visits. Results of the audits		
		needed repair. The work		reported monthly x 4 month to		
	order would then be	•		Committee by the Dietary Mana		
	maintenance departn			District Dietary Manager. The C	-	
	· ·	ice. In addition the Dietary		Committee consist Medical Dire		
		panel oven buttons on the		Administrator, DON, ADON, Tro		
		ded to be intact so the		Nurse, SDC, MDS Coordinator		
	surface would be sm			Maintenance Director, Activity		
				Housekeeping & Laundry Direc		
	2. An observation of	the kitchen on 9/18/17 at		Director, Medical Record, Busin	•	
	10:50 AM revealed th			Manager (BOM), and Human R		
		was preparing food with		Director (HR).		
	unrestrained facial ha					
	b. Dietary Aide #2	was washing dishes with				
	unrestrained facial ha	-		Date of Compliance:		

Facility ID: 970412

If continuation sheet Page 71 of 83

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWC	OOD NURSING CENTER				15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371	An interview conducte on 9/20/17 at 2:17 PM was if a dietary emplo be restrained with a b 3. An observation of 10:59 AM revealed th a. Dietary Aide #3 v unrestrained facial ha b. Dietary Aide #2 v unrestrained facial ha An interview conducte on 9/20/17 at 2:17 PM	ed with the Dietary Manager A revealed her expectation byee had facial hair it should eard guard. the kitchen on 9/20/17 at e following: vas preparing food with ir. vas washing dishes with ir. ed with the Dietary Manager A revealed her expectation byee had facial hair it should	F	371	10/18/17		
F 431 SS=D	Director on 9/20/17 at not received a work of three compartment si trough not being easil made aware of the co- buttons of the convect impaired. He stated if receive a work order the appliances or equipm proper working order. 483.45(b)(2)(3)(g)(h) LABEL/STORE DRUG The facility must provid rugs and biologicals them under an agreen §483.70(g) of this par	DRUG RECORDS, GS & BIOLOGICALS ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general	F	431			10/18/17

Facility ID: 970412

If continuation sheet Page 72 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345509	B. WING				C /21/2017	
NAME OF PI	ROVIDER OR SUPPLIER		ł		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
KINGSWO	OD NURSING CENTER				915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	Continued From page	972	F	431	1			
	<ul> <li>(a) Procedures. A factor pharmaceutical service that assure the accuration dispensing, and admit biologicals) to meet the (b) Service Consultation employ or obtain the service that an accuration of all control detail to enable an accuration of all control detail to enable an accuration of all control detail to enable and period (g) Labeling of Drugs Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the employ and the facility must store locked compartments</li> </ul>	cility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and he needs of each resident. ion. The facility must services of a licensed rem of records of receipt and rolled drugs in sufficient curate reconciliation; and rug records are in order and controlled drugs is dically reconciled. and Biologicals. s used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when and Biologicals. n State and Federal laws, all drugs and biologicals in under proper temperature only authorized personnel to						
	permanently affixed c controlled drugs listed	provide separately locked, ompartments for storage of d in Schedule II of the Abuse Prevention and						

Facility ID: 970412

If continuation sheet Page 73 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/25/20 FORM APPROVI OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 09/21/2017	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER			115 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO	
F 431	abuse, except when a package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on record rev interview, the facility is when opened and to in 2 of 4 medication of and Somerset Hall m included: 1. On 9/20/17 at 2:35 Tanglewood Hall was The following were of A used Flovent diskus inhaler (used to treat The manufacturer's in read " discard Floven after opening the foil reads "0", whichever An opened bottle of S (ml) (used for moistur wound debridement a was dated 7/19/17. On 9/20/17 at 2:39 P interviewed. She sta inhaler should have b it was not. Nurse #1 Flovent diskus was g stated that the Sterile days after opening.	nd other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can T is not met as evidenced iew, observation and failed to date medication discard expired medications earts observed (Tanglewood edication carts). Findings PM, the medication cart on observed with Nurse #1. observed: s 50 microgram (mcg) asthma) that was undated. hstruction written on the box t diskus 50 mcg 6 weeks pouch or when the counter comes first". Sterile Water 500 milliliter rizing of wound dressings, and device irrigation) that	F 431	<ul> <li>F431</li> <li>The Flovent Diskus was dat the dispense date from the pharm 9/20/17 by Nurse #1</li> <li>The Sterile Water was discarded #1 on 9/20/17</li> <li>The Fiber Laxative was discarded 9/20/17 by the Medication Aide (I The Humalog insulin pen was dis on 9/20/17 by the Medication Aide (I The Humalog insulin pen was dis on 9/20/17 by the MA #1</li> <li>An audit was completed by t pharmacy on the medication cart: 9/27/17 to ensure medications ar when opened and discarded whe expired. The audit identified 8 exp medications, 16 items not dated wo opened, and 3 medication storag concerns. The identified concerns corrected on 9/27/17 by the licens nurse.</li> <li>The licensed nurse will check medications and dates of opened medications. The nurse supervis check medication room for expire medications and medications not when opened. The DON will che minimum twice a week the medic rooms and medications carts for</li> </ul>	hacy on by Nurse d on MA) #1 ccarded he s on e dated on pired when e s were sed k the d d cor will ed dated ck at cation	

Facility ID: 970412

If continuation sheet Page 74 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING _				C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
KINGSWO	OOD NURSING CENTER			91	5 PEE DEE ROAD		
RINGSWC	ABERDEEN, NC 28315						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 431	On 9/21/17 at 11:20 A (DON) was interviewe she expected the nurs medications when op- to follow the manufac instruction/recommen that she expected the medication carts ever expired medications. 2. On 9/20/17 at 2:40 Somerset Hall was ob (MA) #1. The following were ob A used Humalog insu A bottle of Fiber Laxa tablet with the expirat On 9/20/17 at 2:43 PI She acknowledged the already expired and the undated. She stated anybody checking the the DON. She had of the carts twice since so August 2017. On 9/21/17 at 11:20 A (DON) was interviewe she expected the nurs medications when op- to follow the manufac	AM, the Director of Nursing ed. The DON stated that sees to date the multi dose ened per facility policy and turer's idations. She also stated in urses to check the y night and to discard PM, the medication cart on oserved with Medication Aide oserved: lin pen that was undated tives 625 milligrams (mgs) ion date of 6/17 M, MA #1 was interviewed. tat the Fiber Laxatives was he Humalog insulin pen was that she had not observed e medication carts except oserved the DON checked she started as DON in MM, the Director of Nursing ed. The DON stated that ses to date the multi dose ened per facility policy and turer's idations. She also stated e nurses to check the	F 4	131	medications and dates of opened medications. 4. The Licensed Nurses and MA, to include the week-end and the prn staff will be reeducated by the SDC starting 10/3/17 and by next shift worked or 10/17/17 related to ensuring that open medications are dated and expired medications are discarded as required 5. An audit will be completed by the ADON weekly for 4 weeks and monthl for 3 months to ensure medications are dated when open and discarded when expired. The ADON will submit a repo the QA Committee monthly for 4 month Date of Compliance: 10/18/17	y e	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345509	B. WING				C / <b>21/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	-
KINGSWC	OOD NURSING CENTER				115 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 431	1 Continued From page 75 expired medications.		F4	431			
F 520 SS=E		ERS/MEET	F	520			10/18/17
	(g) Quality assessme	nt and assurance.					
	(1) A facility must mai and assurance comm minimum of:	ntain a quality assessment ittee consisting at a					
	(i) The director of nur	sing services;					
	(ii) The Medical Direc	tor or his/her designee;					
	staff, at least one of w	a board member or other					
	(g)(2) The quality ass committee must :	essment and assurance					
	coordinate and evaluate	n respect to which quality					
		ement appropriate plans of ified quality deficiencies;					
	Secretary may not rec records of such comm such disclosure is rela	mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this					

Facility ID: 970412

If continuation sheet Page 76 of 83

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-0	
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
					С	
		345509	B. WING		09/21/2017	
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 OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLET	
F 520	Continued From page	e 76	F 52	o		
	(i) Sanctions. Good fa	aith attempts by the				
	committee to identify					
	deficiencies will not b	1 3				
	sanctions.					
		is not met as evidenced				
	by:					
		ns, record reviews, resident		F520		
	and staff interviews, t	urance committee (QAA)		F278		
		lemented procedures and		1. Resident #6 MDS assessme	nt with	
		ntions that the committee		ARD date of 9/1/17 was corrected		
		ch of 2017. This was for two		MDS coordinator by 9/4/17 and		
	(2) recited deficiencie	es which were originally cited		transmitted on 9/4/17		
	-	recertification/complaint		Resident #25 MDS assessment w		
		up recertification/ complaint		date of 7/20/17 was corrected by		
		again on the follow-up		Coordinator by 9/8/ 17 and transm	nitted. It	
		aint survey on 6/2/17 and on tion/ complaint investigation		was accepted on 9/19/17. Resident #61 MDS assessment w		
		, F323). The continued		date 8/16/17 was corrected by the		
	failure of the facility d	-		Coordinator on 10/12/17 and tran		
	-	two follow-up surveys of		10/12/17		
		n of the facility ' s inability to		Resident #22 MDS assessment w	vith ARD	
		Quality Assurance Program.		date of 8/15/17 was reviewed. ME not corrected due to lack of		
	Findings included: This tag is cross reference	rred to:		documentation regarding side rail side rail assessment and a new re assessment was completed on 9/	estraint	
				The side rails have been assess		
	1. F278: Assessmen	t accuracy: Based on		not being a restraint, and have be		
	record review and sta	aff interview, the facility failed		moved to the head of the bed and		
	-	e Minimum Data Set (MDS)		to be used as a positioning device		
	assessments for prog			rails were moved to the top of the		
	pressure ulcer (Resid	-		9/26/17 by maintenance staff Th		
		2, 96, 40 and 76), diagnoses		a correction or additional MDS is	not	
		21), active diagnoses and re ulcer (Resident #29) and		needed. Resident #96 MDS assessment w	vith ARD	
		dications (Resident #39) for		date of 9/1/17 was reviewed. MDS		
	10 of 19 sampled res					

Facility ID: 970412

			0/02 100 700			O. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED	
			A. BUILDING	A. BUILDING			
		345509	B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		9/21/2017	
				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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETIC DATE	
F 520	Continued From page	e 77	F 52	n			
	accuracy.	5	1 02	documentation regardir	ng the side rails		
				New side rail assessme	-		
	During the recertificat	tion survey of 3/3/17, the		restraint assessment w			
	facility was cited F278	8 for failure to accurately		She was assessed for s	side rails on 10/5.		
		on the Minimum Data Set		Side rails were remove	•		
		residents reviewed for		maintenance staff on 1			
		lent #4) and for two of two		neither a correction nor needed.	additional MDS is		
		r hospice (Resident #86 and		Resident #40 MDS ass	essment with ARD		
	<i>#</i> 01).			date of 5/11/17 was rev			
	On the current recert	tification/ complaint		not corrected due to lac	ck of		
		of 9/21/17, the facility failed		documentation to supp	ort side rails. The		
		e MDS assessment in the		resident was discharge			
		ressure ulcers, restraints,		Therefore the correction			
	incontinence and me	noses for pressure ulcer,		Resident was discharge Resident #76 MDS ass			
		viewed for MDS accuracy.		date of 9/9/17 was not			
		viewed for MDO decuracy.		lack of documentation r			
	On 9/21/17 at 11:46 A	AM, an interview was		rails. New side rail asse	0 0		
		onal Director and Corporate		restraint assessment w	as completed on		
	Clinical Nurse in the a	absence of the		10/5/17. The side rails	were moved to the		
		stated their focus had been		top of the bed on 10/5/	-		
		all the audits that had been		maintenance staff. On e			
		months. Both said there t person to do the detailed		rails did not constitute Therefore neither a cor			
	-	and clinical record. The		additional MDS is need			
		g audits for the specific		Resident #21 MDS ass			
		3/17 ad not on the entire		date 8/17/17 will be cor			
	MDS.			Coordinator. Modification	on was done		
				9/21/17and was transm			
		Based on record review and		Resident #29 MDS ass			
		cility failed to identify the use ential accident hazard and		date of 8/23/17, diagno updated to show that p			
		sk and benefits of bed rails		were resolved; the first			
		esponsible Party and to		8/21/15, the second on			
		ent prior to installation of the		5/21/15. Diagnosis list			
	bed rails for 1 of 3 sa	mpled residents who were		10/12/17. The MDS mo	-		
	high risk for falls (Res	sident #40).		made on 10/17/17 and			
				Resident #39 MDS ass	essment with ARD		

Event ID: YIOT11

Facility ID: 970412

If continuation sheet Page 78 of 83

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 10/25/201 RM APPROVE O. 0938-039
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		09	C 9/21/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		-
KINCSWO	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 OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	Continued From page	e 78	E 5	20		
F 520	During the recertifica facility was cited F32 root cause of two falls delayed complication two sampled resident (Resident#42). During the follow-up f 5/4/17, the facility was investigate the root c to provide supervision follow the physician c room to a room in clos station resulting in re falls for one of three f accidents (Resident # During the follow-up f 6/2/17, the facility was supervise a cognitive known exit seeking b	tion survey of 3/3/17, the 3 for failure to investigate the s and failed to monitor for is related to a fall for one of ts reviewed for accidents recertification survey on is cited F323 for failure to ause of 1 fall and also failed in to prevent falls by failing to order to relocate resident's oser proximity to the nurses sident sustaining 2 additional residents reviewed for	F 52	<ul> <li>date of 8/10/17 was modified b Coordinator by 9/21/17 and w transmitted &amp; accepted on 9/27</li> <li>2. An audit of the current res assessment was completed by Coordinator on 10/06/17 to ens assessments accurately reflect residents' current status and an corrections were completed an submitted as required. 66 MDS audited. Of the 66, 56 were con There were 10 that had correct and were resubmitted to CMS. corrections and resubmission w between 9/8/17-10/6/17.</li> <li>3. The MDS Coordinator will reeducated by the Regional Nu Consultant by 10/2/17 related the MDS assessments accurately resident's current status</li> </ul>	as 1/17 idents' MDS the MDS sure the the hy identified d So were rrect. tions made The were made be urse to ensuring	
	residents reviewed for On the current recert investigation survey of to identify the use of accident hazard and benefits of bed rails w Responsible Party ar consent prior to insta of 3 sampled residen falls (Resident #40). On 9/21/17 at 11:46 / conducted with Regio Clinical Nurse in the Administrator. They	or accidents (Resident #99). ification/ complaint of 9/21/17, the facility failed side rails as a potential failed to review the risk and with the resident's nd to obtain informed llation of the bed rails for 1 ts who were high risk for AM, an interview was onal Director and Corporate		<ul> <li>4. An audit will be completed DON weekly x 4 weeks for all M maximum of 10 MDSs per wee ever is higher and monthly for ensure MDS assessment conti accurately reflect the resident's status. The DON will submit a the Quality Assurance Commit for 4 months.</li> <li>5. Revision of the QA process April 2017 was revised to incre- by the DON weekly x 4 weeks or a maximum of 10 MDSs per which ever is higher and month 3months to ensure accurate complete the complete the test of the test of the test of the status and the test of the test of the test of the test of the test of the test of the test of the test of the test of the test of test of test of test of test of test of test of test of test of test of test of test of test of test of test</li></ul>	MDS or a ek, which 3months to nue to s current report to tee monthly s dated base audits for all MDS week, hly for	

Facility ID: 970412

If continuation sheet Page 79 of 83

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	): 10/25/2017 1 APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING			( 09/)	C 21/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWOOD NURSING CENTER					15 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 PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 520	Director and Corporat facility was monitoring incident reports were was identified on the i had not monitored the with a new Director of	months. The Regional e Clinical Nurse stated the g actual falls to ensure the filled out and the root cause ncident report. The facility e use of side rails. Both said, Nursing and her knowledge puld be responsible for the	F	520	<ul> <li>MDS assessment in the areas of prognosis, pressure ulcer, restraints, diagnoses, falls, diagnoses for pressure ulcer, incontinence, and medication. Th DON will submit a report to the Quality Assurance Committee monthly for 4 months. The QA Committee consist Medical Director, Administrator, DON, ADON, Treatment Nurse, SDC, MDS Coordinator, Maintenance Director, Activity Director, Housekeeping &amp; Laur Director, Dietary Director, Medical Record Business Office Manager (BOM), Huma Resource Director (HR).</li> <li>6. The Quality Assurance and Performance Improvement (QAPI) Committee will review and revise the F278 Quality Improvement plan by 10/17/17 ensure procedures are implemented ar interventions are being monitored as required.</li> <li>The Quality Assessment and Assurance Committee will review and revise the Quality Improvement Plan for F 323 by 10/17/17 to ensure procedures are in place and implemented and intervention are being monitored as required.</li> <li>F 323</li> <li>Resident # 40 was discharge from facility on 6/1/17.</li> <li>An audit was completed by the DC and the ADON on 10/05/17 of the currer residents' devices to include the side ra and T&amp;R bars, the position of the side</li> </ul>	idry ord, an to nd e ns the NN ent	

Event ID: YIOT11

Facility ID: 970412

If continuation sheet Page 80 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 1 FORM AF OMB NO. 0	PROVED	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C 09/21/2	9/21/2017	
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	001211		
KINGSWC	OOD NURSING CENTER				5 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) OMPLETION DATE	
F 520	Continued From page	₽ 80	F	520	<ul> <li>rails/ the T&amp;R bars on the bed. 100% the current residents were visualized. Based on the visual audit of current resident the bed rail assessment and restraint assessment will be done by 10/17/17 to ensure the need for side raif classified as a restraint and to ensure potential accident hazardous have bee addressed and followed up. When side rails are identified as a restraint, resider representative will be contacted and consent obtained after risk/benefit are explained.</li> <li>3. The facility will develop or adopt a Restraint Algorithm, a decision tree, to facilitate starting with the least restrictive device and moving to an effective devia and/ restraint as indicated.</li> <li>4. Licensed Nurses, including week of and prn, will be reeducated on side rail and restraints by the SDC, Nursing Supervisors, or the DON by 10/17/17. Education will include completing bed rails, T&amp;R bars and restraint Algorithm use the completed with all licensed nurse, including week-end and prn staff by the SDC, Nursing SUpervisors, or the DON by 10/17/17.</li> <li>5. Certified Nursing Assistances (CN and Medication Aides (MA), including week-end and prn, will be re-educated the SDC or the DON by 10/17/17 regarding caring for residents with</li> </ul>	ve ce end s ent, of vill e I by NA)		
	7(02-99) Previous Versions Obs	solete Event ID: YIOT	11		ility ID: 970412 If continu	ation sheet Pa		

Event ID: YIOT11

Facility ID: 970412

If continuation sheet Page 81 of 83

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039		
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 09/21/2017		
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE			
KINGSWC	OD NURSING CENTER			915 PEE DEE ROAD			
				ABERDEEN, NC 28315			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION		
F 520	Continued From page	≥ 81	F 5		as when to S for ts when will e rails and erly and prn atus. dents who a restraint, by ommittee hance and other in to the ommittee ting will be . The review ictive o order to tives for the events. bleted by the frent on related		
	7(02-99) Previous Versions Obs	solete Event ID: YIC	NT11	Documentation will include init quarterly/prn side rail assessm	-		

Event ID: YIOT11

Facility ID: 970412

If continuation sheet Page 82 of 83

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/25/2017 1 APPROVED ): 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345509	B. WING			( 09/:	C 21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KINGSWOOD NURSING CENTER					15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	* 82	F	520	initial/quarterly and prn assessment for restraints, and consent for restraints. Charts will be audited by DON weekly and monthly x3. The DON will present results of audits to the QA Committee monthly for 4 months. The Safety Committee's meeting minutes and recommendations will be reported to the QAPI Committee by an appointed member of the Safety Committee. 7. The Regional Director and Corpora Nurse Consultant reeducated the QA Committee . On 10/11/17 related to ensuring the identified facility Quality improvement plans are implemented at the interventions are being monitored a required. The Administrator and/ the SDC will review weekly the audits and QA proces for each tag cited to ensure facility identified QAPI plan are implemented at being monitored as required. Review to be done weekly x 8 weeks and then monthly x 2 months. The Administrator report to the QAPI Committee compliant of the QA processes for the above cited tags in current Plan of Correction (POC Date of compliance 10/18/17	x4 e ate nd as ss and vill will nce d	

Facility ID: 970412

If continuation sheet Page 83 of 83