STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 221 SS=E	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility utilized the side rails on both sides of bed (Residents #96, #40, #22 & #76) and the full length wedge cushion (Resident #61)	F 221	Preparation and submission of the plan of correction by Kings Wood Nursing Center, does not constitute an admission or agreement by the provider of the truth of	10/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/06/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 221	Continued From page 1 without considering them to be a physical restraint and not having medical symptoms for its use for 5 of 6 sampled residents reviewed for restraints (Residents # 40, #96, #22, #76, & #61). Findings included: 1. Resident #96 was admitted to the facility on 8/25/17 with multiple diagnoses including Alzheimer's disease, fracture of the upper end of tibia and repeated falls. The admission Minimum Data Set (MDS) assessment dated 9/1/17 indicated that Resident #96 had memory and decision making problems and she was not using side rails as a physical restraint. The assessment also indicated that Resident #96 needed extensive assistance with bed mobility and she was dependent on the staff for transfer and locomotion. Resident #96's care plan dated 8/25/17 was reviewed. One of the care plan problems was "the resident is high risk for falls related to confusion, deconditioning and unaware of safety needs". The goal was "resident will not sustain serious injury through the next review date". The approaches did not include the use of bilateral side rails. Resident #96's Bed Rail/Assist Bar Evaluation form dated 8/25/17 was reviewed. The form indicated that Resident #96 had history of falls and there was a possibility that she would climb over the bed rails/assist bar. The form also indicated that there was evidence that Resident #96 has a desire or reason to get out of bed. The form did not indicate if side rails were indicated or not. The evaluation did not include the medical symptom to justify the use of side rails. The form also did not indicate if the Responsible Party or the Physician were notified for the use of the side	F 221	the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. F 221 1. Resident #96 bedrail / assist bar evaluation was reviewed and revised on 10/5/17 by the Director of Nursing (DON) – side rails were removed. Resident # 40 was discharged on 6/1/17. Resident #22 side rail / assist bar evaluation was reviewed on revised on 10/5/17 by the DON. Turning and Repositioning (T& R) bars are in place at the head of the bed to assist resident in turning and positioning. T& R are padded. Resident #76 bedrail / assist bar revaluation was reviewed and revised on 10/5/17 by the DON. Evaluation indicated need for T&R bars at head of bed to aid resident in turning and positioning. Resident #61 was evaluated on 10/5 /17 by Occupational Therapy (OT) screen on 10/4/17. Trial reduction without the full length wedge cushion was attempted. Husband was present and did not feel comfortable for resident to be without cushion due to how she moves her legs. Resident was assessed and wedge cushions were placed and evaluated as a restraint due to frontal lobe dementia. 2. An audit was completed by the DON and the Assistant Director of Nursing (ADON) by 10/05/17 of the current residents' devices to include the side rails	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 221	Continued From page 2 rails. Attempts were made to interview the author of The Bed Rails/Assist Bar Evaluation form dated 8/25/17 but the author was not available for interview. Resident #96's Nurse Aide (NA) Information Sheet (care guide for NA) was observed posted at the back of the resident's closet. The sheet had a check mark under ½ side rail. On 9/19/17 at 3:20 PM and on 9/20/17 at 8:45 AM, Resident #96 was observed out of bed. Bilateral ½ side rails (SR) were observed installed in the middle of her bed. On 9/20/17 at 8:46 AM, Medication Aide (MA) #2 was interviewed. She stated that Resident #96 was able to get out of bed if she wanted to. She added that the night shift staff had to get her out of bed because she tried to get out of bed unassisted. MA #2 further stated that Resident #96 was placed on one on one during the day because she tried to get out of the chair. She revealed that the resident was using bilateral ½ SR when she was in bed for bed mobility. She also stated that the resident was unable to remove or lower the side rails down. On 9/20/17 at 8:48 AM, Nursing Assistant (NA) #5 was interviewed. She stated that she was the sitter for Resident #96. She indicated that night shift staff had to get the resident up because she tried to get out of bed and chair unassisted. NA #5 further indicated that Resident #96 was using bilateral ½ SR when she was in bed. On 9/20/17 at 9:20 AM, Nurse #2 was	F 221	and T&R bars, the position of the side rails/ the T&R bars on the bed, wedges, cushions, special mattresses and adaptive devise to ensure the least restrictive alternative is used. Evaluation forms regarding devise acting as a restraint will be completed by the DON , ADON and Unit Manager (UM) by 10/17/17. Ongoing documentation and re-evaluation of the need for restraints will be completed quarterly and as needed with change in resident status. 3. The Nursing staff (to include week-end and as needed staff) re-education was began promptly on 10/05/17. Training will be completed by 10/17/17. In-service includes: when the use of a restraint is indicated the least restrictive alternative for the least amount of time is used. 4. Licensed nursing staff, to include week-end and prn staff, will be in-serviced by SDC or DON no later than 10/16/17 regarding completion of restraint assessment, and documentation related to restraint use. 5. An audit will be completed by the Assistant Director of Nursing (ADON) weekly for 4 weeks and monthly for 3 months to ensure that when the use of restraints is indicated, the least restrictive alternative will be used . Ongoing re evaluation and documentation will be completed quarterly and prn with resident status change. The DON will present a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 221	Continued From page 3 interviewed. Nurse #2 reviewed the Bed Rail/Assist Bar Evaluation form and acknowledged that the evaluation/assessment form was not fully completed. She indicated that the summary of findings should have been completed to include the type of SR to use if indicated, the reason for its use and if RP and Physician were notified. Nurse #2 revealed that Resident #96 constantly tried to get out of bed and chair and she was high risk for falls. She added that the resident was using bilateral ½ SR for repositioning. Nurse #2 stated that the resident was able to get out of bed but she was not able to walk due to the fracture on her leg. On 9/20/17 at 10:39 AM, Nurse #2 stated that she had observed the side rails of Resident #96 and both sides rails were installed in the middle of the bed. She indicated that Resident #96's side rails were not supposed to be installed in the middle of her bed but they were. Nurse #2 indicated that she already informed the maintenance to move the side rails to the upper part of her bed. She indicated that having the SR in the middle of her bed, Resident #96 had to scoot down the bed to be able to get out. On 9/21/17 at 1:23 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to fully complete and follow the Bed Rail/Assist Bar Evaluation form by observing the resident and to document the medical and physical indication for the use of the side rails. 2. Resident #40 was originally admitted to the	F 221	report to the Quality Assurance (QA) Committee monthly for 4 months. . The QA Committee consist Medical Director, Administrator, DON, ADON, Treatment Nurse, SDC, MDS Coordinator, Maintenance Director, Activity Director, Housekeeping & Laundry Director, Dietary Director, Medical Record, Business Office Manager (BOM), Human Resource Director (HR). Date of Compliance: 10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 4	F 221		

facility on 5/11/17 and expired on 6/1/17. Resident #40 had multiple diagnoses including Dementia and Metabolic encephalopathy. The admission Minimum Data Set (MDS) assessment dated 5/17/17 indicated that Resident #40 had severe cognitive impairment and he was not using side rails as a physical restraint. The assessment further indicated that Resident #40 needed extensive assistance with bed mobility and transfer and he needed limited assistance with locomotion using a walker, wheelchair and limb prosthesis.

Resident #40's care plan dated 5/11/17 was reviewed. One of the care plan problems was "risk for falls". The goal was "resident will not experience serious injury from falls over the next 90 days". The approaches did not include the use of bilateral side rails.

Resident #40's Bed Rail/Assist Bar Evaluation form dated 5/11/17 was reviewed. The form indicated that Resident #40 had history of falls and there was a possibility that he would climb over the bed rails/assist bar. The form also indicated that there was evidence that Resident #40 has a desire or reason to get out of bed. The evaluation did not include the medical symptom to justify the use of side rails. The form did not indicate if the Responsible Party or the Physician were notified for the use of the side rails. The form was not signed therefore unable to interview the author.

Resident #40's Nurse Aide (NA) Information Sheet (care guide for NA) was observed posted at the back of the resident's closet. The sheet had a check mark under ½ side rail.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 5	F 221		

On 9/19/17 at 2:15 PM, NA #2 was interviewed. She stated that Resident #40 was using ½ side rails (SR) in the middle of his bed and he was not able to remove or lower the SR down when he wanted to get out of bed. NA #2 indicated that Resident #40 was able to transfer self from bed to chair and chair to bed.

On 9/19/17 at 2:50 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON reviewed the Bed rail/Assist Bar Evaluation form dated 5/11/17 and stated that based on the evaluation, Resident #40 should not have side rails in bed. He was able to lift self out of bed.

On 9/20/17 at 10:43 AM, Nurse #5 was interviewed. She stated that Resident #40 had bilateral ½ SR in his bed during the fall on 6/1/17 and it appeared that he climbed over the rails and fell onto the floor.

On 9/21/17 at 1:23 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to fully complete and follow the Bed Rail/Assist Bar Evaluation form by observing the resident and to document the medical and physical indication for the use of the side rails.

3. Resident #76 was admitted to the facility on 12/1/15 with diagnoses that included Alzheimer ' s disease, respiratory failure, difficulty in walking, and history of falling.

The plan of care for Resident #76 included the focus area of Activities of Daily Living (ADLs)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 221	Continued From page 6	F 221		

function initiated on 12/7/16 and most recently reviewed on 6/13/17. He was indicated to require the assistance of staff with all ADLs. The plan of care for Resident #76 also included the problem area of the risk for falls initiated on 3/13/17 and most recently reviewed on 6/13/17. There was no mention of the use of side rails on Resident #76 ' s plan of care.

A plan of care note dated 6/30/17 indicated Resident #76 was at moderate risk for falls, he was unsteady while ambulating, and was unaware of his safety limitations. Resident #76 was noted to frequently attempt to stand, transfer, and get out of bed without assistance. A bed and chair alarm were implemented to prevent falls.

The quarterly Minimum Data Set (MDS) assessment dated 9/9/17 indicated Resident #76 ' s cognition was severely impaired. He was assessed as dependent on one staff for bed mobility, toileting, dressing, and personal hygiene. Resident #76 required the extensive assistance of one staff for transfers and locomotion off the unit and the limited assistance of one staff for locomotion on the unit. He was not steady and was only able to stabilize with staff assistance. Resident #76 was assessed as always incontinent of bladder and bowel. The assessment indicated Resident #76 had no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body).

The bed rail/assist bar evaluation dated 9/12/17 indicated Resident #76 had not expressed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 221	Continued From page 7	F 221		

desire to have bed rails/assist bar while in bed for his own safety and/or comfort. He was noted with visual deficits. Resident #76 was assessed as not able to get in/out of bed safely. He was indicated not to use the bed rails/assist bar for positioning, support, or to help rise from a laying position to a sitting/standing position. The form required a summary of findings to explain the results of the assessment. This summary of findings for Resident #76 was blank and the form was not signed by staff.

An interview was conducted with Nurse #4 on 9/18/17 at 11:52 AM. She indicated Resident #76 was not capable of getting out of bed on his own. Nurse #4 revealed she had not known if Resident #76 had side rails. She reviewed the medical record and was unable to locate a physician ' s order for side rails for Resident #76. Nurse #4 asked Nursing Assistant (NA) #5 to observe Resident #76 ' s side rails.

An interview was conducted with NA #5 on 9/18/17 at 11:54 AM. She indicated Resident #76 had bilateral quarter length side rails positioned in the middle section of the bed.

An observation was conducted on 9/18/17 at 12:26 PM of Resident #76 ' s bed in his room that was located in the facility ' s secured unit. Resident #76 had bilateral side rails positioned in the middle section of each side of the bed. Each side rail was approximately 26 inches in length and there was an opening of approximately 34 inches from the top end of the side rail to the top end of the mattress and 21 inches from the bottom end of the side rail to the bottom end of the mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 8	F 221		

The Nursing Assistant Information Sheet (undated) was reviewed on 9/19/17. Resident #76 was indicated to have half-length side rails on his bed.

An interview was conducted with Nurse #2 on 9/20/17 at 9:40 AM. The bed rail/assist bar evaluation form was reviewed with Nurse #2. She stated this evaluation form was to be completed by observing the resident to determine their bed mobility status and their ability to transfer with or without assistance. She indicated if a resident was able to get out of bed independently and safely then side rails were not needed. She reported if a resident had weakness, needed the rails to help them get out of bed and transfer, or as a fall precaution the rails were needed. Nurse #2 stated if the bed rail/assist bar evaluation determined the resident needed side rails, the Nurse indicated on the form what length side rails they needed, they notified the physician to obtain an order, and notified the family.

The interview with Nurse #2 continued. Resident #76 ' s bed rail/assist bar evaluation dated 9/12/17 was reviewed with Nurse #2. She revealed this evaluation was incomplete. She stated the summary of findings were to be completed in full. Resident #76 ' s side rails that were positioned in the middle section of each side of his bed was discussed with Nurse #2. She stated that the side rails were not supposed to be positioned in the middle section of the bed for any resident in the facility. She explained that the side rails were able to be rotated so they were positioned at the head of the bed rather than in in the middle section of the bed. She revealed the side rails for Resident #76 were in the wrong position. She additionally revealed with the side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 9	F 221		

rails positioned in the middle section of the bed, Resident #76 would have had to slide down below the end of the side rail to be able to get out of bed. Nurse #2 reported she was unable to say if Resident #76 was capable of getting out of bed with the side rails positioned in the middle section of the bed.

An interview was conducted with Nurse #3 on 9/20/17 at 11:20 AM. She stated she began working at the facility on 6/25/17. The bed rail/assist bar evaluation form was reviewed with Nurse #3. She reported she had been instructed on how to complete the bed rail/assist bar evaluation when she began working at the facility. She stated the resident was to be observed, staff were to be interviewed, and the form was to be completed in full.

The interview with Nurse #3 continued. Nurse #3 verified she completed the bed rail/assist bar evaluation dated 9/12/17 for Resident #76. She revealed she had not completed the form in full and she had not signed the form. She stated she should have indicated on the form Resident #76 required half-length side rails positioned at the head of the bed. She revealed she had spoken with Nurse #2 on 9/20/17 prior to this interview and had observed the side rails on Resident #76 ' s bed. She confirmed the bilateral side rails were positioned in the middle section of each side of the bed. She revealed the side rails for Resident #76 were in the wrong position. She stated the side rails should have been rotated so they were positioned at the head of Resident #76 ' s bed. Nurse #3 additionally revealed the side rails positioned in the middle section of the bed were not beneficial to Resident #76 as they would have made it more difficult for him to get in and out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 10	F 221		

bed because he would have had to slide down below the end of the side rail for it not to restrict his movement.

An observation was conducted on 9/20/17 at 11:50 AM of Resident #76 ' s bed in his room. Resident 76 ' s bilateral side rails had been rotated so they were positioned at the head of the bed.

An interview was conducted with NA #2 on 9/20/17 at 12:07 PM. NA #2 stated she was familiar with Resident #76. She reported Resident #76 required assistance to get out of bed safely. She indicated Resident #76 had attempted to get out of bed independently in the past, but he was unsteady on his feet. NA #2 reported Resident #76 was at risk for falls. She indicated she thought Resident #76 ' s bilateral side rails that had been positioned in the middle section of the bed were for fall prevention. She explained that Resident #76 rolled around in bed at times and the rail would have stopped Resident #76 from falling if he rolled into it. She reported if the side rail was not on the bed and Resident #76 rolled over too far he would have fallen to the ground. She stated she worked with Resident #76 frequently and the bilateral rails had been positioned in the middle section of the bed for as long as she could remember.

An interview was conducted with the Director of Nursing (DON) on 9/21/17 at 11:09 AM. She indicated her expectation was for the bed rail/assist bar evaluation to be completed on admission and quarterly. She stated the form should be completed in full by observing the resident to determine if the resident was utilizing the side rails. She reported if a side rail was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 11	F 221		

going to be used the medical and physical indication was to be noted on the bed rail/assist bar evaluation. The DON stated the facility had not utilized side rails as restraints.

An interview was conducted with the Administrative Consultant/Regional Director on 9/21/17 at 11:56 AM. She reported the facility had not been monitoring the use of side rails. She indicated bilateral side rails positioned in the middle section of the bed could restrict the movement of a resident who was not independent with bed mobility and transfers.

4. Resident #22 was admitted to the facility on 1/14/17 and readmitted on 5/8/17 with diagnoses that included dementia, diabetes mellitus, cerebrovascular disease, major depressive disorder, anxiety, difficulty in walking, and history of falling.

The plan of care for Resident #22, initiated on 1/27/17 and most recently reviewed on 5/16/17, included the focus area of Activities of Daily Living (ADLs) function. Resident #22 ' s care plan indicated she required assistance from staff with all ADLs.

A plan of care note dated 6/30/17 indicated Resident #22 attempted to exit bed without assistance and was not steady enough to ambulate without a walker. A bed alarm was implemented to prevent falls/injury.

The bed rail/assist bar evaluation dated 8/8/17 indicated Resident #22 had not expressed a desire to have bed rails/assist bar while in bed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 12	F 221		

her own safety and/or comfort. She was noted with a cognitive deficit related to dementia, visual deficits, and a history of falls. Resident #22 was assessed as not able to get in/out of bed safely. She was indicated not to use the bed rails/assist bar for positioning, support, or to help rise from a laying position to a sitting/standing position. This assessment asked if there was a risk to the resident if bed rails/assist bar were used and the question was not answered. This assessment asked if the bed rails/assist bar alternatives created more risks than bed rails/assist bar use and the question was not answered. The form required a summary of findings to explain the results of the assessment. This summary of findings for Resident #22 was blank. The form was signed by Nurse #2.

The plan of care for Resident #22 included the need/problem area of the potential for falls initiated on 2/9/17 and most recently reviewed on 8/15/17. The interventions included, in part, quarter length side rails for turning and positioning.

The quarterly Minimum Data Set (MDS) assessment dated 8/15/17 indicated Resident #22 ' s cognition was severely impaired. She was assessed as requiring the extensive assistance of two or more staff with bed mobility, toileting, dressing, and personal hygiene. Resident #22 required the extensive assistance of one staff for transfers and locomotion on/off the unit. The assessment indicated Resident #22 had no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 13	F 221		

movement or normal access to one ' s body).

An interview was conducted with Nurse #4 on 9/18/17 at 12:00 PM. She indicated Resident #22 was not capable of getting out of bed on her own. Nurse #4 revealed she had not known if Resident #22 had side rails. She reviewed the medical record and was unable to locate a physician ' s order for side rails for Resident #22. Nurse #4 asked Nursing Assistant (NA) #5 to observe Resident #22 ' s side rails.

An interview was conducted with NA #5 on 9/18/17 at 12:03 PM. She indicated Resident #22 had bilateral quarter length side rails positioned in the middle section of the bed.

An observation conducted on 9/18/17 at 12:26 PM of Resident #22 revealed she was sleeping in bed in her room that was located in the facility ' s secured unit. Resident #22 had bilateral quarter length side rails on her bed. The quarter length side rails were positioned in the middle section of each side of the bed.

The Nursing Assistant Information Sheet (undated) was reviewed on 9/19/17. Resident #22 was indicated to have quarter length side rails on her bed at all times.

An interview was conducted with Nurse #2 on 9/20/17 at 9:40 AM. The bed rail/assist bar evaluation form was reviewed with Nurse #2. She stated this evaluation form was to be completed by observing the resident to determine their bed mobility status and their ability to transfer with or without assistance. She indicated if a resident was able to get out of bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 14	F 221		

independently and safely then side rails were not needed. She reported if a resident had weakness, needed the rails to help them get out of bed and transfer, or as a fall precaution the rails were needed. Nurse #2 stated if the bed rail/assist bar evaluation determined the resident needed side rails, the Nurse indicated on the form what length side rails they needed, they notified the physician to obtain an order, and notified the family.

The interview with Nurse #2 continued. Resident #22 ' s bed rail/assist bar evaluation dated 8/8/17 was reviewed with Nurse #2. She revealed this evaluation was incomplete. She stated all questions as well as the summary of findings were to be completed in full. Resident #22 ' s quarter length side rails that were positioned in the middle section of each side of her bed was discussed with Nurse #2. She stated that the side rails were not supposed to be positioned in the middle section of the bed for any resident in the facility. She explained that the side rails were able to be rotated so they were positioned at the head of the bed rather than in in the middle section of the bed. She revealed the side rails for Resident #22 were in the wrong position. She additionally revealed with the side rails positioned in the middle section of the bed, Resident #22 would have had to slide down below the end of the side rail to be able to get out of bed. Nurse #2 reported she was unable to say if Resident #22 was capable of getting out of bed with the side rails positioned in the middle section of the bed.

An interview was conducted with Nurse #3 on 9/20/17 at 11:20 AM. She stated she began working at the facility on 6/25/17. The bed rail/assist bar evaluation form was reviewed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 15	F 221		

Nurse #3. She reported she had been instructed on how to complete the bed rail/assist bar evaluation when she began working at the facility. She stated the resident was to be observed, staff were to be interviewed, and the form was to be completed in full.

The interview with Nurse #3 continued. Nurse #3 verified she completed the bed rail/assist bar evaluation dated 8/8/17 for Resident #22. She revealed she had not completed the form in full. She stated she should have indicated on the form that Resident #22 required quarter length side rails positioned at the head of the bed. She revealed she had spoken with Nurse #2 on 9/20/17 prior to this interview and she had observed the side rails on Resident #22 ' s bed. She confirmed the bilateral quarter length side rails were positioned in the middle section of each side of the bed. She revealed the side rails for Resident #22 were in the wrong position. She stated the side rails should have been rotated so they were positioned at the head of Resident #22 ' s bed. Nurse #3 additionally revealed the side rails positioned in the middle section of the bed were not beneficial to Resident #22 as they would have made it more difficult for her to get in and out of bed because she would have had to slide down below the end of the side rail for it not to restrict her movement.

An observation was conducted on 9/20/17 at 11:55 AM of Resident #22 in bed in her room. Resident 22 ' s bilateral quarter length side rails had been rotated so they were positioned at the head of the bed.

An interview was conducted with NA #3 on 9/20/17 at 12:00 PM. NA #3 stated she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 16	F 221		

familiar with Resident #22. She reported Resident #22 was not able to get out of bed without assistance. She stated Resident #22 was able to move around in bed independently, although she had not moved around in bed frequently. NA #3 reported Resident #22 was at risk for falls. She indicated she was unsure why Resident #22 ' s bilateral quarter length side rails had been positioned in the middle section of the bed. She reported she kept the side rails in the position they were in and had not moved them to a different position.

An interview was conducted with NA #4 on 9/20/17 at 12:04 PM. NA #4 stated she was familiar with Resident #22. She reported Resident #22 was not able to get out of bed without assistance. She stated Resident #22 was able to hold onto the side rail for assistance with positioning. NA #4 reported Resident #22 was at risk for falls. She indicated she was unsure why Resident #22 ' s bilateral quarter length side rails had been positioned in the middle section of the bed. She reported she kept the side rails in the position they were in and had not moved them to a different position.

An interview was conducted with the Director of Nursing (DON) on 9/21/17 at 11:09 AM. She indicated her expectation was for the bed rail/assist bar evaluation to be completed on admission and quarterly. She stated the form should be completed in full by observing the resident to determine if the resident was utilizing the side rails. She reported if a side rail was going to be used the medical and physical indication was to be noted on the bed rail/assist bar evaluation. The DON stated the facility had not utilized side rails as restraints.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 17	F 221		

An interview was conducted with the Administrative Consultant/Regional Director on 9/21/17 at 11:56 AM. She reported the facility had not been monitoring the use of side rails. She indicated bilateral side rails positioned in the middle section of the bed could restrict the movement of a resident who was not independent with bed mobility and transfers.

5. Resident #61 was admitted to the facility on 11/26/14 and diagnoses included: Dementia and weight loss.

A review of the quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/16/17 for Resident #61 revealed she was not coded as having physical restraints. The assessment indicated walking in the room or in the corridor did not occur. The assessment also indicated locomotion on and off unit/hallway did not occur during the look back period. The resident required total assistance with all activities of daily living (ADLs), was severely impaired memory and was always incontinent of bowel and bladder. The resident was coded as having impairment on both sides of the arms and legs for functional range of motion.

A review of the care plan for Resident #61 most recently updated on 8/15/17 revealed a problem of a history of falls. The listed interventions for the resident to be free from injury for falls included: Floor mats beside bed and wedges under the sheets. There was no plan of care in place that identified the use of a winged mattress and how Resident #61 would be evaluated to ensure she had the least restrictive restraint.

An observation on 9/18/17 at 3:11 PM of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 18	F 221		

#61 revealed her to be lying in her bed and her family member feeding her. The bed was observed to be in a low position. The right side of the bed was against the wall. The mattress was observed to be a raised perimeter mattress with the height of the mattress at its sides greater than the height of the mattress at its center. On the left side of the bed there were two wedge cushions. The wedge cushions were under the fitted sheet of the bed and were held in place by the raised perimeter of the mattress. The wedges were in an end to end position and were on the resident's left side from approximately her head to the area between her knee and her foot of her left leg. There were no side rails on the bed. The resident's family pointed out a mat which was underneath the resident's bed. The resident's family added the fall mat was pulled out at night and placed next to the resident's bed. The resident's family stated the resident did not have a recent history of falls.

A review of the medical record for Resident #61 revealed that there was not a specific diagnosis identified for the use of the winged mattress or the use of wedges. A restraint evaluation was not present and there was not a plan in place to evaluate the ongoing use of a restraint.

An observation on 9/20/17 at 9:11 AM of Resident #61 revealed she was lying in bed. She was lying on a raised perimeter mattress, the right side of the bed was against the wall, the two wedge cushions remained under the sheet, along the raised perimeter of the mattress on the resident's left side, and her bed was in a low position. The resident was observed to have had mild movements with her arms and her legs, but was not observed putting her arms or legs over the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 19	F 221		

wedge cushion or coming into contact with the wall.

An interview and observation on 9/20/17 at 9:15 AM with Nursing Assistant (NA) #7 revealed Resident #61 had a raised perimeter mattress and wedges on her bed and she could not get out of bed. She stated the wedge cushions were in place to keep her from putting her legs over the side of the bed. NA#7 referred to the resident's Nurse Aide Information Sheet on the resident's closet door. Under the supportive section of the information sheet, "Pillows" was checked and a hand written next to pillows was "Bilateral Wedges." Under comments, "fall mat" was included. There was no mention of positioning the bed against the wall or the use of a raised perimeter mattress.

An interview and observation on 9/20/17 at 2:55 PM with the Nurse #2 revealed Resident #61 to be lying in her bed. The bed was in low position. The right side of the bed was against the wall. The raised perimeter mattress was in place. The two wedge cushions were on the resident's left side along the raised perimeter mattress, and were end to end, lengthwise down the resident's left side. Nurse #2 stated the wedge pillows were to be placed next to the resident's body for protection because she moved her legs frequently and to protect her from the wall. Nurse #2 stated the wedge cushions were being used for positioning.

An interview and observation on 9/20/17 at 4:45 PM with NA #8 revealed Resident #61 to be lying in her bed. The bed was in low position. The right side of the bed was against the wall. The raised perimeter mattress was in place. The two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 20 wedge cushions were on the resident's left side along the raised perimeter mattress, and were end to end, lengthwise down the resident's left side. NA #8 stated the wedges were to keep the resident from tipping over on the floor. NA #8 added the wedges were always kept on her left side, one by her shoulders and the other by her legs to keep the resident from falling. An interview on 9/21/17 at 10:45 AM with the Assistant Director of Nursing (ADON) revealed the purpose of the wedges was for positioning for Resident #61. The ADON stated the resident had some instances last year when she was throwing her legs towards the walls and the wedges were also an intervention for falls. The ADON added she did not view the wedges as a restraint because the resident had fallen out of the bed after the wedges were put into place. The ADON clarified the resident had not fallen in a long time. The ADON further added the wedges could be used on either side and she did not feel they were a restraint nor restrain the resident's motion. The ADON further clarified the wedges were kept in place because they were effective and the resident was not trying to get out of bed or roll out of bed. The ADON stated there was no restraint assessment completed due to the wedges not being viewed as a restraint. During an interview conducted on 9/21/17 at 11:22 AM with the Director of Nursing (DON) she revealed she was unable to identify if the wedge was a restraint.	F 221		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments	F 272		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 21	F 272		

(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with the resident, as well as communication with licensed and
non-licensed direct care staff members on all shifts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 22 The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the care area assessments which included underlying cause, risk factors, and factors to be considered in developing individualized care plan interventions for three of eight comprehensive assessments reviewed (Resident #33, Resident #63 and Resident #21). The findings included: 1. Resident #33 was admitted to the facility 6/3/16 and last readmitted on 7/3/17. Cumulative diagnoses included dementia and depression. An Annual Minimum Data Set (MDS) dated 6/13/17 indicated Resident #33 was cognitively intact. No mood or behaviors occurred during the observation period. Diagnoses included dementia. Depression was not indicated as a diagnosis for Resident #33. Medications administered during the seven day look pack period included 6 days of antidepressant medication. A Care Area Assessment (CAA) for psychotropic drug use dated 6/14/17 indicated Resident #33 received 6 days of antidepressant medication. It was noted that psychotropic drug use would not be addressed in the care plan. The medication discontinued 6/12/17. There was no information regarding the underlying cause and risk factors to be considered in developing individualized care	F 272	F 272 1. Resident # 33 late entries Care Area Assessment (CAA) with Assessment Reference Date (ARD) note will be completed by 10/17/17 by the ADON. The CAA note will be present in Point Click Cares (PCC) system. The Minimum Data Set (MDS) will not be modified and resubmitted. Resident # 63 late entry CAA with ARD of 5 /12/17 a note will be by 10/17/17 by the ADON. The MDS/CAA note will be in PCC system. The MDS will not be modified and resubmitted. Resident # 21 late entries for CAA with ARD 8/17/17 will be completed by 10/17/17. The note will be in PCC as a MDS/CAA note by the ADON. The MDS will not be modified and resubmitted 1. An audit of the current CAA the last 90 days was completed by the MDS Coordinator on 10/6/17 to ensure CAA was completed. Sixteen MDS required CAAs. All 16 were completed, indicating a 100% compliance in the event MDS coordinator is not available to complete MDS the Unit Manager (UM) or ADON will be responsible for completing all MDSs, including those with CAAs correctly. 2. The UM and the ADON will be educated by the Corporate Clinical Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 23 plan interventions. A review of the June Medication Administration Record (MAR) revealed Resident #33 received Remeron (antidepressant medication) until 6/12/17. It was discontinued on 6/12/17. A review of the July MAR revealed Remeron was restarted on Resident #33 ' s return from the hospital on 7/3/17. The MDS Coordinator who had completed the MDS dated 6/13/17 was no longer employed at the facility. On 9/20/17 at 10:00 AM, an interview was conducted with the MDS nurse. She reviewed the CAA for psychotropic drug use and stated Resident #33 had a care plan for behaviors and the use of psychotropic medications. Therefore, the CAA was incomplete and should have been completed with all the information. On 9/21/17 at 11:29 AM, an interview was conducted with the Director of Nursing who stated she expected the CAA ' s to be completed as per regulation. 2. Resident # 63 was readmitted to the facility 5/5/17. Cumulative diagnoses included a sacral pressure ulcer. An Admission MDS dated 5/12/17 indicated Resident #63 was moderately impaired in cognition. Skin condition indicated Resident #63 had two stage 3 pressure areas and one unstageable pressure area during the assessment period.	F 272	regarding accurate and timely completing of all MDS assessments, including CAAs by 10/17/17. 3. The MDS Coordinator will be reeducated by the Regional Nurse Consultant by 10/17/17 related to ensuring CAAs are completed accurately and timely. 4. Audits will be completed by the DON or the Corporate Nurse Consultant weekly for 4 weeks and monthly for 3 months to ensure CCAs continue to be completed. The DON will present a report to the QA Committee monthly for 4 months. Date of Compliance: 10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 24	F 272		

A CAA for pressure ulcers dated 5/26/17 stated Resident #63 had two stage 3 pressure ulcers and a shear wound. The CAA was completed 21 days after the Assessment Reference Date (ARD) which was not within 14 days of admission.

The MDS Coordinator who had completed the MDS dated 6/13/17 was no longer employed at the facility.

On 9/20/17 at 10:00 AM, an interview was conducted with the MDS nurse. She reviewed the CAA for pressure ulcers for Resident #63 and stated the CAA should have been completed by 5/18/17 as per regulation.

On 9/21/17 at 11:29 AM, an interview was conducted with the Director of Nursing who stated she expected the CAA ' s to be completed as per regulation.

3. Resident #21 was admitted to the facility on 3/31/15 with diagnoses that included dementia, muscle weakness, hyperlipidemia, and hypertension.

The annual Minimum Data Set (MDS) assessment dated 4/8/17 indicated Resident #21 ' s cognition was severely impaired. She had no behaviors and no rejection of care. She required supervision with set up help only for Activities of Daily Living (ADLs). Resident #21 had received antipsychotic medication, antidepressant medication and antianxiety medication on 7 of 7 days during the MDS look back period. She received an antibiotic of 1 of 7 days during the MDS look back period.

The Care Area Assessments (CAAs) triggered from Resident #21 ' s 4/8/17 comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 25	F 272		

assessment dated 4/8/17 were ADL Functional/Rehabilitation Potential, Cognitive Loss/Dementia, Psychotropic Drug Use, Dehydration/Fluid Maintenance, Nutritional Status, Falls, and Pressure Ulcer.

The CAA summaries (required to address the underlying causes, contributing factors, and factors that must be considered in developing individualized care plan interventions) were not completed for the following areas:
- ADL Functional/Rehabilitation Potential
- Cognitive Loss/Dementia
- Psychotropic Drug Use
- Dehydration/Fluid Maintenance
- Falls
- Pressure Ulcer

An interview was conducted on 9/20/17 at 3:41 PM with the MDS Coordinator. She stated she officially started working at the facility on 9/1/17. She indicated that prior to her coming to the facility, she was informed there had been an issue in the past with MDS assessments being completed late or not fully being completed. The 4/8/17 MDS assessment for Resident #21 that had 6 triggered CAAs that were incomplete was reviewed with the MDS Coordinator. The MDS Coordinator stated CAA summaries were to be completed for each of triggered areas. She reported if a triggered area was not going to be included in the plan of care there was to be a documented explanation as to why that decision was made.

An interview was conducted on 9/21/17 at 11:09 AM with the Director of Nursing (DON). She indicated it was her expectation that MDS assessments were fully completed as per the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 26 regulations.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) This REQUIREMENT is not met as evidenced 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). Findings included: 1. Resident #58 was admitted to the facility on 5/3/17. The resident's admission diagnoses included: Abnormal heart beat, high blood pressure, impaired breathing, generalized weakness, and debility. Review of Resident #58's comprehensive admission MDS assessment revealed an	F 273	F 273 1. The MDS Coordinator who completed the assessment for Resident #58 and #53 is no longer employed at this facility. 2. An audit of the current resident in the last 90 days was completed by the MDS Coordinator on 10/06/17. The audit was 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% compliance.	10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 27 Assessment Reference Date of 5/10/17. The MDS completion date (Z0500B) was observed to be 5/24/17, the 21st day after admission. Review of the Care Area Assessment (CAA) completion date (V0200B2) revealed a completion date of 5/24/17, the 21st day after admission. An interview was conducted on 9/20/17 at 3:42 PM with the MDS Coordinator. The MDS Coordinator stated she officially started the position of MDS Coordinator at the facility on 9/1/17. In addition she stated prior to her coming to work at the facility she was informed by a nurse, who was no longer employed at the facility, there had been an issue with late assessments. She reviewed the admission assessment MDS and CAAs with an ADR of 5/3/17 and stated they were not completed within the allotted amount of time. An admission assessment and CAAs should be fully completed by the 13th day after admission. An interview was conducted on 9/21/17 at 11:18 AM with the Director of Nursing. The DON stated it was her expectation the regulation be followed for the completion of the admission assessment along with care area assessments. 2. Resident #53 was admitted to the facility on 4/13/17. The resident's admission diagnoses included: High blood pressure, difficulty swallowing, generalized weakness, diabetes, debility, kidney disease, cognitive loss, and osteoporosis. Review of Resident #52's comprehensive admission MDS assessment revealed an Assessment Reference Date of 4/17/17. The MDS completion date (Z0500B) was observed to	F 273	3. The MDS Coordinator will be reeducated by the Corporate Nurse Consultant by 10/17/17 related to ensuring all Comprehensive Assessments are completed with 14 days of admission. 4. An audit will be completed by the DON weekly x 4 weeks and monthly for 3 months to ensure Comprehensive Assessments continue are completed timely. The DON will submit a report to the QA Committee monthly for 4 months. The QA Committee consist Medical Director, Administrator, DON, ADON, Treatment Nurse, SDC, MDS Coordinator, Maintenance Director, Activity Director, Housekeeping & Laundry Director, Dietary Director, Medical Record, Business Office Manager (BOM), Human Resource Director (HR). Date of Compliance: 10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 28 be 5/1/17, the 18th day after admission. Review of the Care Area Assessment (CAA) completion date (V0200B2) revealed a completion date of 5/1/17, the 18th day after admission. An interview was conducted on 9/20/17 at 3:42 PM with the MDS Coordinator. The MDS Coordinator stated she officially started the position of MDS Coordinator at the facility on 9/1/17. In addition she stated prior to her coming to work at the facility she was informed by a nurse, who was no longer employed at the facility, there had been an issue with late assessments. She reviewed the admission assessment MDS and CAAs with an ADR of 4/17/17 and stated they were not completed within the allotted amount of time. An admission assessment and CAAs should be fully completed by the 13th day after admission. An interview was conducted on 9/21/17 at 11:18 AM with the Director of Nursing. The DON stated it was her expectation the regulation be followed for the completion of the admission assessment along with care area assessments.	F 273		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the quarterly Minimum Data Set (MDS) assessment within 92 days of the	F 276	F 276 1. The MDS Coordinator was reeducated by the Corporate Nurse	10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 276	Continued From page 29 Assessment Reference Date (ARD) of the previous MDS assessment for 1 of 14 sampled residents (Resident #76). The findings included: Resident #76 was admitted to the facility on 12/1/15 with multiple diagnoses that included Alzheimer ' s disease. A review of Resident #76 ' s medical record revealed a quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 6/9/17. A review of the electronic medical records system on 9/20/17 at 2:28 PM indicated Resident #76 ' s quarterly MDS assessment with an ARD of 9/9/17 was in progress. This was 104 days after the most recent MDS assessment ' s ARD (6/9/17). An interview was conducted on 9/20/17 at 3:41 PM with the MDS Coordinator. She stated she officially started working at the facility on 9/1/17. She indicated that prior to her coming to the facility, she was informed there had been an issue in the past with MDS assessments being completed late. A review of the electronic medical records system on 9/21/17 at 9:45 AM indicated Resident #76 ' s quarterly MDS assessment with an ARD of 9/9/17 was completed on 9/21/17. This was 105 days after the most recent MDS assessment ' s ARD (6/9/17). An interview was conducted on 9/21/17 at 9:50 AM with the MDS Coordinator. The MDS assessment for Resident #76 with an ARD of 9/9/17 and completion date of 9/21/17 was reviewed with the MDS Coordinator. The MDS	F 276	Consultant on 10/5/17 related to the requirements that resident # 76's quarterly assessment with ARD of9/9/17 be scheduled within 92 days of the Assessment Reference Date of the previous MDS assessment. #76 quarterly MDS for 9/9/17 was reviewed by the MDS Consultant. She advised that according to Chapter 2 page 31 of the RAI manual we were within compliance of the 92 days between 6/9/17 and 9/9/17 and the 14 days to complete and transmit to CMS on 9/21/17. The MDS for 9/9/17 was submitted and validation was received without indication of lateness. 2. An audit was completed by the MDS Coordinator on 10/06/17 of the current residents' quarterly assessment s for the last 90 days to ensure quarterly assessments are completed within 92 days of the ARD of the previous MDS assessment. 50 assessments were audited for completion within the appropriate time frame. All 50 were timely. We are currently at 100% compliance. 3. The MDS Coordinator will be reeducated by the Corporate Nurse Consultant by 10/17/17 related to ensuring quarterly assessments are scheduled within 92 days of ARD of the prior assessment. 4. An audit will be completed by the DON weekly x 4 weeks of all quarterly assessment and monthly for 3 months to ensure quarterly assessments are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 276	Continued From page 30 Coordinator indicated she had not noticed this 9/9/17 quarterly assessment for Resident #76 was completed late. An interview was conducted on 9/21/17 at 11:09 AM with the Director of Nursing (DON). She indicated it was her expectation that MDS assessments were completed timely as per the regulations.	F 276	scheduled within 92 days of the assessment reference date of the previous MDS assessment as required. The DON will submit a report to the QA Committee monthly for 4 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Compliance: 10/18/17	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F 278		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 31 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: 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. Findings included: 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. The Minimum Data Set (MDS) quarterly assessment dated 7/20/17 indicated Resident #25 was coded as having had no pressure ulcers. Resident #25's coded diagnoses included: dementia, anxiety, depression, psychotic disorder, and generalized muscle weakness. Resident #25 was coded as being totally dependent for bed mobility, transfer (i.e. from the bed to a chair), and for toilet use with the assistance of one person.	F 278	F278 1. Resident #6 MDS assessment with ARD date of 9/1/17 was corrected by the MDS coordinator by 9/4/17 and transmitted on 9/4/17 Resident #25 MDS assessment with ARD date of 7/20/17 was corrected by the MDS Coordinator by 9/8/ 17 and transmitted. It was accepted on 9/19/17. Resident #61 MDS assessment with ARD date 8/16/17 was corrected by the MDS Coordinator on 10/12/17 and transmitted 10/12/17 Resident #22 MDS assessment with ARD date of 8/15/17 was reviewed. MDS was not corrected due to lack of documentation regarding side rails. New side rail assessment and a new restraint assessment was completed on 9/26/17. The side rails have been assessment as not being a restraint, and have been moved to the head of the bed and padded to be used as a positioning device. Side rails were moved to the top of the bed on 9/26/17 by maintenance staff Therefore a correction or additional MDS is not needed. Resident #96 MDS assessment with ARD	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 32 A review of the medical record of Resident #25 revealed a wound care specialist evaluation note dated 7/19/17. The chief complaint was listed as the resident had a wound on their sacrum. The History of Present Illness (HPI) Statement stated the resident had a stage III pressure wound to her sacrum and the wound had light drainage. The evaluation provided further detail the MDS stage of the wound was a stage III. The listed measurements of the wound were 0.9 centimeters (cm) long by 1.3 cm wide by 0.1 cm deep, with a surface area of 1.17 square centimeters. An interview conducted on 9/21/17 at 9:49 AM with Nurse #2 revealed she had completed the skin section, section M, for the MDS assessment dated 7/20/17. She stated she had not received the Wound Care Specialist Evaluation form until after the assessment was completed. The nurse further added she had not corrected the MDS assessment when she received the form. An interview conducted on 9/21/17 at 11:14 AM with the Director of Nursing (DON) revealed her expectation was for the MDS assessments to be accurate. 2. Resident #61 was admitted on 11/26/14 and diagnoses included: Dementia and weight loss. A review of the quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/16/17 for Resident #61 revealed she was not coded as having physical restraints. The assessment indicated walking in the room or in the corridor did not occur. The assessment also indicated locomotion on and off unit/hallway did not occur during the look back period. The resident required total assistance with all activities	F 278	date of 9/1/17 was reviewed. MDS was not corrected due to lack of documentation regarding the side rails. New side rail assessment and new restraint assessment will be completed. She was assessed for side rails on 10/5. Side rails were removed from the bed by maintenance staff on 10/5/17. Therefore neither a correction nor additional MDS is needed. Resident #40 MDS assessment with ARD date of 5/11/17 was reviewed MDS was not corrected due to lack of documentation to support side rails. The resident was discharged on 6/1/17. Therefore the correction was not done. Resident was discharged prior to survey Resident #76 MDS assessment with ARD date of 9/9/17 was not corrected due to lack of documentation regarding the side rails. New side rail assessment and a new restraint assessment was completed on 10/5/17. The side rails were moved to the top of the bed on 10/5/17 by the maintenance staff. On evaluation side rails did not constitute a restraint. Therefore neither a correction nor an additional MDS is needed. Resident #21 MDS assessment with ARD date 8/17/17 will be corrected by the MDS Coordinator. Modification was done 9/21/17and was transmitted 9/21/17. Resident #29 MDS assessment with ARD date of 8/23/17, diagnoses list was updated to show that pressure ulcers were resolved; the first resolved on 8/21/15, the second one was resolved on 5/21/15. Diagnosis list was updated 10/12/17. The MDS modification was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 33 of daily living (ADLs), was severely impaired memory and was always incontinent of bowel and bladder. The resident was coded as having impairment on both sides of the arms and legs for functional range of motion. A review of the care plan for Resident #61 most recently updated on 8/15/17 revealed a problem of a history of falls. The listed interventions for the resident to be free from injury for falls included: Floor mats beside bed and wedges under the sheets. There was no plan of care in place that identified the use of a winged mattress and how Resident #61 would be evaluated to ensure she had the least restrictive restraint. An observation on 9/18/17 at 3:11 PM of Resident #61 revealed her to be lying in her bed and her family member feeding her. The bed was observed to be in a low position. The right side of the bed was against the wall. The mattress was observed to be a raised perimeter mattress with the height of the mattress at its sides greater than the height of the mattress at its center. On the left side of the bed there were two wedge cushions. The wedge cushions were under the fitted sheet of the bed and were held in place by the raised perimeter of the mattress. The wedges were in an end to end position and were on the resident's left side from approximately her head to the area between her knee and her foot of her left leg. There were no side rails on the bed. The resident's family pointed out a mat which was underneath the resident's bed. The resident's family added the fall mat was pulled out at night and placed next to the resident's bed. The resident's family stated the resident did not have a recent history of falls. A review of the medical record for Resident #61	F 278	made on 10/17/17 and submitted Resident #39 MDS assessment with ARD date of 8/10/17 was modified by the MDS Coordinator by 9/21/17 and was transmitted & accepted on 9/21/17 2. An audit of the current residents' MDS assessment was completed by the MDS Coordinator on 10/06/17 to ensure the assessments accurately reflect the residents' current status and any identified corrections were completed and submitted as required. 66 MDSs were audited. Of the 66, 56 were correct. There were 10 that had corrections made and were resubmitted to CMS. The corrections and resubmission were made between 9/8/17-10/6/17. 3. The MDS Coordinator will be reeducated by the Regional Nurse Consultant by 10/2/17 related to ensuring MDS assessments accurately reflect the resident's current status. 4. An audit will be completed by the DON weekly x 4 weeks for all MDS or a maximum of 10 MDSs per week, which ever is higher and monthly for 3months to ensure MDS assessment continue to accurately reflect the resident's current status. The DON will submit a report to the Quality Assurance Committee monthly for 4 months. Date of Compliance: 10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 34	F 278		

revealed that there was not a specific diagnosis identified for the use of the winged mattress or the use of wedges. A restraint evaluation was not present and there was not a plan in place to evaluate the ongoing use of a restraint.

An observation on 9/20/17 at 9:11 AM of Resident #61 revealed she was lying in bed. She was lying on a raised perimeter mattress, the right side of the bed was against the wall, the two wedge cushions remained under the sheet, along the raised perimeter of the mattress on the resident's left side, and her bed was in a low position. The resident was observed to have had mild movements with her arms and her legs, but was not observed putting her arms or legs over the wedge cushion or coming into contact with the wall.
An interview and observation on 9/20/17 at 9:15 AM with Nursing Assistant (NA) #7 revealed Resident #61 had a raised perimeter mattress and wedges on her bed and she could not get out of bed. She stated the wedge cushions were in place to keep her from putting her legs over the side of the bed. NA#7 referred to the resident's Nurse Aide Information Sheet on the resident's closet door. Under the supportive section of the information sheet, "Pillows" was checked and a hand written next to pillows was "Bilateral Wedges." Under comments, "fall mat" was included. There was no mention of positioning the bed against the wall or the use of a raised perimeter mattress.

An interview and observation on 9/20/17 at 2:55 PM with the Nurse #2 revealed Resident #61 to be lying in her bed. The bed was in low position. The right side of the bed was against the wall. The raised perimeter mattress was in place. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 35	F 278		

two wedge cushions were on the resident's left side along the raised perimeter mattress, and were end to end, lengthwise down the resident's left side. Nurse #2 stated the wedge pillows were to be placed next to the resident's body for protection because she moved her legs frequently and to protect her from the wall. Nurse #2 stated the wedge cushions were being used for positioning.

An interview and observation on 9/20/17 at 4:45 PM with NA #8 revealed Resident #61 to be lying in her bed. The bed was in low position. The right side of the bed was against the wall. The raised perimeter mattress was in place. The two wedge cushions were on the resident's left side along the raised perimeter mattress, and were end to end, lengthwise down the resident's left side. NA #8 stated the wedges were to keep the resident from tipping over on the floor. NA #8 added the wedges were always kept on her left side, one by her shoulders and the other by her legs to keep the resident from falling.

An interview conducted on 9/21/17 at 9:30 AM with Nurse #2 revealed she reviewed the medical record to see if there was a physician's order for a restraint in order to determine if a restraint needed to be coded in the MDS. She explained if there was a restraint, there was to be a physician's order for it in the resident's medical record. Nurse #2 indicated if there was a physician's order for a restraint she then went and observed the resident to determine the kind of restraint and assess the continued need for the restraint. She revealed she had not routinely observed residents to assess for physical restraints unless there was a physician's order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 36	F 278		

An interview conducted on 9/21/17 at 9:50 AM with the MDS Coordinator revealed she had officially began working at the facility 9/1/17. She indicated when coding the MDS for restraints she reviewed any assessments in the medical record and also looked at the physician's orders for information regarding restraints. She stated if a resident had a restraint there would be a physician's order as well as restraint assessments utilized for restraint reduction in the medical record. She reported if the medical record review indicated a resident had a restraint the resident would then be observed and staff would be spoken to determine the type of restraint as well as the continued need for the restraint. She revealed if the medical record review indicated the resident had no restraint, she had not routinely observed the resident as part of her restraint assessment for the MDS.

An interview conducted on 9/21/17 at 9:57 AM with Nurse #2 revealed she had completed the Restraints section, section P, for the MDS assessment dated 9/1/17. She stated it had not been brought to her attention the Resident #61 may have been restrained.

An interview on 9/21/17 at 10:45 AM with the Assistant Director of Nursing (ADON) revealed the purpose of the wedges was for positioning for Resident #61. The ADON stated the resident had some instances last year when she was throwing her legs towards the walls and the wedges were also an intervention for falls. The ADON added she did not view the wedges as a restraint because the resident had fallen out of the bed after the wedges were put into place. The ADON clarified the resident had not fallen in a long time. The ADON further added the wedges could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 37	F 278		

used on either side and she did not feel they were a restraint nor restrain the resident's motion. The ADON further clarified the wedges were kept in place because they were effective and the resident was not trying to get out of bed or roll out of bed. The ADON stated there was no restraint assessment completed due to the wedges not being viewed as a restraint.

An interview conducted on 9/21/17 at 11:14 AM with the Director of Nursing (DON) revealed her expectation was for the MDS assessments to be accurate.

3. Resident #6 was admitted on 12/20/00 with multiple diagnoses that included: Anxiety, facial paralysis, impaired breathing, malignancy, diabetes, anemia, and depression.

The Minimum Data Set (MDS) quarterly assessment dated 9/1/17 indicated Resident #6 was coded as receiving hospice services. A review of the Health Conditions section it was observed the resident was not coded as having had a prognosis of having had a condition or chronic disease that may have resulted in a life expectancy of less than 6 months. Resident #6's coded diagnoses included: Diabetes, dementia, anxiety, depression, impaired breathing, and impaired swallowing.

A review of the medical record of Resident #6 revealed the resident has been receiving hospice services since 5/25/16 from a local hospice provider and the admitting diagnosis was listed as vaginal cancer.
A review of Resident #6's care plan which has been most recently updated on 9/12/17 revealed the resident was care planned for hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 38	F 278		

services and having a terminal disease diagnosis.

An interview conducted on 9/21/17 at 9:46 AM with Nurse #2 revealed she had completed the Health Conditions section, section J, for the MDS assessment dated 9/1/17. She stated life expectancy of less than 6 months should have been coded in the MDS quarterly assessment.

An interview conducted on 9/21/17 at 11:14 AM with the Director of Nursing (DON) revealed her expectation was for the MDS assessments to be accurate.

4. Resident #76 was admitted to the facility on 12/1/15 with diagnoses that included Alzheimer ' s disease, respiratory failure, difficulty in walking, and history of falling.

The quarterly Minimum Data Set (MDS) assessment dated 9/9/17 indicated Resident #76 ' s cognition was severely impaired. He was assessed as dependent on one staff for bed mobility, toileting, dressing, and personal hygiene. Resident #76 required the extensive assistance of one staff for transfers and locomotion off the unit and the limited assistance of one staff for locomotion on the unit. He was not steady and was only able to stabilize with staff assistance. Resident #76 was assessed as always incontinent of bladder and bowel. The assessment indicated Resident #76 had no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 39	F 278		

An interview was conducted with Nurse #4 on 9/18/17 at 11:52 AM. She indicated Resident #76 was not capable of getting out of bed on his own. Nurse #4 revealed she had not known if Resident #76 had side rails. She reviewed the medical record and was unable to locate a physician ' s order for side rails for Resident #76. Nurse #4 asked Nursing Assistant (NA) #5 to observe Resident #76 ' s side rails.

An interview was conducted with NA #5 on 9/18/17 at 11:54 AM. She indicated Resident #76 had bilateral quarter length side rails positioned in the middle section of the bed.

An observation was conducted on 9/18/17 at 12:26 PM of Resident #76 ' s bed in his room that was located in the facility ' s secured unit. Resident #76 had bilateral side rails positioned in the middle section of each side of the bed. Each side rail was approximately 26 inches in length and there was an opening of approximately 34 inches from the top end of the side rail to the top end of the mattress and 21 inches from the bottom end of the side rail to the bottom end of the mattress.

An interview was conducted with Nurse #2 on 9/20/17 at 9:40 AM. Nurse #2 indicated if a resident was determined to need side rails, the Nurse notified the physician to obtain an order and notified the family. Resident #76 ' s side rails that were positioned in the middle section of each side of his bed was discussed with Nurse #2. She stated that the side rails were not supposed to be positioned in the middle section of the bed for any resident in the facility. She explained that the side rails were able to be rotated so they were positioned at the head of the bed rather than in in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 40	F 278		

the middle section of the bed. She revealed the side rails for Resident #76 were in the wrong position. She additionally revealed with the side rails positioned in the middle section of the bed, Resident #76 would have had to slide down below the end of the side rail to be able to get out of bed. Nurse #2 reported she was unable to say if Resident #76 was capable of getting out of bed with the side rails positioned in the middle section of the bed.

An interview was conducted with Nurse #3 on 9/20/17 at 11:20 AM. She revealed she had spoken with Nurse #2 on 9/20/17 prior to this interview and had observed the side rails on Resident #76 ' s bed. She confirmed the bilateral side rails were positioned in the middle section of each side of the bed. She revealed the side rails for Resident #76 were in the wrong position. She stated the side rails should have been rotated so they were positioned at the head of Resident #76 ' s bed. Nurse #3 additionally revealed the side rails positioned in the middle section of the bed were not beneficial to Resident #76 as they would have made it more difficult for him to get in and out of bed because he would have had to slide down below the end of the side rail for it not to restrict his movement.

An interview was conducted with NA #2 on 9/20/17 at 12:07 PM. NA #2 stated she was familiar with Resident #76. She reported Resident #76 required assistance to get out of bed safely. She indicated Resident #76 had attempted to get out of bed independently in the past, but he was unsteady on his feet. NA #2 reported Resident #76 was at risk for falls. She indicated she thought Resident #76 ' s bilateral side rails that had been positioned in the middle

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 41	F 278		

section of the bed were for fall prevention. She explained that Resident #76 rolled around in bed at times and the rail would have stopped Resident #76 from falling if he rolled into it. She reported if the side rail was not on the bed and Resident #76 rolled over too far he would have fallen to the ground. She stated she worked with Resident #76 frequently and the bilateral rails had been positioned in the middle section of the bed for as long as she could remember.

A second interview was conducted with Nurse #2 on 9/21/17 at 9:30 AM. She stated she began working at the facility in late June 2017. She indicated she was initially assisting with the completion of MDS assessments until a position opened up as a floor nurse. She stated the current MDS Coordinator (who began working as a facility employee on 9/1/17) came into the facility as an MDS consultant to assist with training her to complete MDS assessments. Nurse #2 was asked what information she utilized to code the MDS for physical restraints. She stated she reviewed the medical record to see if there was a physician ' s order for a restraint. She explained that if there was a restraint, there was to be a physician ' s order for it in the resident ' s medical record. Nurse #2 indicated if there was a physician ' s order for a restraint she then went and observed the resident to determine the kind of restraint and assess the continued need for the restraint. She revealed she had not routinely observed residents to assess for physical restraints unless there was physician ' s order. She stated the facility had not utilized side rails as restraints and she had not coded any side rails as restraints on the MDS assessments.

An interview was conducted with the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 42	F 278		

Coordinator on 9/21/17 at 9:50 AM. She stated she officially began working at the facility 9/1/17. She indicated prior to that time she was assisting as an MDS consultant on a part time basis. The quarterly MDS assessment dated 9/9/17 that indicated Resident #76 had no physical restraints was reviewed with the MDS Coordinator. She verified she had completed this section of Resident #76 ' s 9/9/17 MDS. The MDS Coordinator was asked what information she utilized to code the MDS for physical restraints. She indicated when coding the MDS for restraints she reviewed any assessments in the medical record and looked at the physician ' s orders. She stated if a resident had a restraint there would be a physician ' s order as well as restraint assessments utilized for restraint reduction in the medical record. She reported if the medical record review indicated a resident had a restraint the resident would then be observed and staff would be spoken to determine the type of restraint as well as the continued need for the restraint. She revealed if the medical record review indicated the resident had no restraint, she had not routinely observed the resident as part of her restraint assessment for the MDS. She further revealed Resident #76 ' s medical record review indicated he had no restraint and he was not observed as part of her restraint assessment for the 9/9/17 MDS. The MDS Coordinator stated the facility had not utilized side rails as restraints and she had not coded any side rails as restraints on the MDS assessments.

An interview was conducted with the Director of Nursing (DON) on 9/21/17 at 11:09 AM. She indicated her expectation was for the MDS to be completely accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 43	F 278		

An interview was conducted with the Administrative Consultant/Regional Director on 9/21/17 at 11:56 AM. She reported the facility had not been monitoring the use of side rails. She indicated bilateral side rails positioned in the middle section of the bed could restrict the movement of a resident who was not independent with bed mobility and transfers.

5. Resident #22 was admitted to the facility on 1/14/17 and readmitted on 5/8/17 with diagnoses that included dementia, diabetes mellitus, cerebrovascular disease, major depressive disorder, anxiety, difficulty in walking, and history of falling.

The Quarterly Minimum Data Set (MDS) assessment dated 8/15/17 indicated Resident #22 ' s cognition was severely impaired. She was assessed as requiring the extensive assistance of two or more staff with bed mobility, toileting, dressing, and personal hygiene. Resident #22 required the extensive assistance of one staff for transfers and locomotion on/off the unit. The assessment indicated Resident #22 had no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body).

An interview was conducted with Nurse #4 on 9/18/17 at 12:00 PM. She indicated Resident #22 was not capable of getting out of bed on her own. Nurse #4 revealed she had not known if Resident #22 had side rails. She reviewed the medical record and was unable to locate a physician ' s order for side rails for Resident #22. Nurse #4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 44	F 278		

asked Nursing Assistant (NA) #5 to observe Resident #22 ' s side rails.

An interview was conducted with NA #5 on 9/18/17 at 12:03 PM. She indicated Resident #22 had bilateral quarter length side rails positioned in the middle section of the bed.

An observation conducted on 9/18/17 at 12:26 PM of Resident #22 revealed she was sleeping in bed in her room that was located in the facility ' s secured unit. Resident #22 had bilateral quarter length side rails on her bed. The quarter length side rails were positioned in the middle section of each side of the bed.

An interview was conducted with Nurse #2 on 9/20/17 at 9:40 AM. Nurse #2 indicated if a resident was determined to need side rails, the Nurse notified the physician to obtain an order and notified the family. Resident #22 ' s side rails that were positioned in the middle section of each side of his bed was discussed with Nurse #2. She stated that the side rails were not supposed to be positioned in the middle section of the bed for any resident in the facility. She explained that the side rails were able to be rotated so they were positioned at the head of the bed rather than in in the middle section of the bed. She revealed the side rails for Resident #22 were in the wrong position. She additionally revealed with the side rails positioned in the middle section of the bed, Resident #22 would have had to slide down below the end of the side rail to be able to get out of bed. Nurse #2 reported she was unable to say if Resident #22 was capable of getting out of bed with the side rails positioned in the middle section of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 45	F 278		

An interview was conducted with Nurse #3 on 9/20/17 at 11:20 AM. She revealed she had spoken with Nurse #2 on 9/20/17 prior to this interview and had observed the side rails on Resident #22 ' s bed. She confirmed the bilateral side rails were positioned in the middle section of each side of the bed. She revealed the side rails for Resident #22 were in the wrong position. She stated the side rails should have been rotated so they were positioned at the head of Resident #22 ' s bed. Nurse #3 additionally revealed the side rails positioned in the middle section of the bed were not beneficial to Resident #22 as they would have made it more difficult for him to get in and out of bed because he would have had to slide down below the end of the side rail for it not to restrict his movement.

An interview was conducted with NA #3 on 9/20/17 at 12:00 PM. NA #3 stated she was familiar with Resident #22. She reported Resident #22 was not able to get out of bed without assistance. She stated Resident #22 was able to move around in bed independently, although she had not moved around in bed frequently. NA #3 reported Resident #22 was at risk for falls. She indicated she was unsure why Resident #22 ' s bilateral quarter length side rails had been positioned in the middle section of the bed. She reported she kept the side rails in the position they were in and had not moved them to a different position.

An interview was conducted with NA #4 on 9/20/17 at 12:04 PM. NA #4 stated she was familiar with Resident #22. She reported Resident #22 was not able to get out of bed without assistance. She stated Resident #22 was able to hold onto the side rail for assistance with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 46	F 278		

positioning. NA #4 reported Resident #22 was at risk for falls. She indicated she was unsure why Resident #22 ' s bilateral quarter length side rails had been positioned in the middle section of the bed. She reported she kept the side rails in the position they were in and had not moved them to a different position.

A second interview was conducted with Nurse #2 on 9/21/17 at 9:30 AM. She stated she began working at the facility in late June 2017. She indicated she was initially assisting with the completion of MDS assessments until a position opened up as a floor nurse. She stated the current MDS Coordinator (who began working as a facility employee on 9/1/17) came into the facility as an MDS consultant to assist with training her to complete MDS assessments. The quarterly MDS assessment dated 8/15/17 that indicated Resident #22 had no physical restraints was reviewed with Nurse #2. She verified she had completed this section of Resident #22 ' s 8/22/17 MDS. Nurse #2 was asked what information she utilized to code the MDS for physical restraints. She stated she reviewed the medical record to see if there was a physician ' s order for a restraint. She explained that if there was a restraint, there was to be a physician's order for it in the resident's medical record. Nurse #2 indicated if there was a physician ' s order for a restraint she then went and observed the resident to determine the kind of restraint and assess the continued need for the restraint. She revealed she had not routinely observed residents to assess for physical restraints unless there was physician ' s order. She stated the facility had not utilized side rails as restraints and she had not coded any side rails as restraints on the MDS assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 47	F 278		

An interview was conducted with the MDS Coordinator on 9/21/17 at 9:50 AM. She stated she officially began working at the facility 9/1/17. She indicated prior to that time she was assisting as an MDS consultant on a part time basis. The MDS Coordinator was asked what information she utilized to code the MDS for physical restraints. She indicated when coding the MDS for restraints she reviewed any assessments in the medical record and looked at the physician ' s orders. She stated if a resident had a restraint there would be a physician ' s order as well as restraint assessments utilized for restraint reduction in the medical record. She reported if the medical record review indicated a resident had a restraint the resident would then be observed and staff would be spoken to determine the type of restraint as well as the continued need for the restraint. She revealed if the medical record review indicated the resident had no restraint, she had not routinely observed the resident as part of her restraint assessment for the MDS. The MDS Coordinator stated the facility had not utilized side rails as restraints and she had not coded any side rails as restraints on the MDS assessments.

An interview was conducted with the Director of Nursing (DON) on 9/21/17 at 11:09 AM. She indicated her expectation was for the MDS to be completely accurately.

An interview was conducted with the Administrative Consultant/Regional Director on 9/21/17 at 11:56 AM. She reported the facility had not been monitoring the use of side rails. She indicated bilateral side rails positioned in the middle section of the bed could restrict the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 48	F 278		

movement of a resident who was not independent with bed mobility and transfers.

6a. Resident #21 was admitted to the facility on 3/31/15 with diagnoses that included dementia, major depressive disorder, and anxiety.

The Quarterly Minimum Data Set (MDS) assessment dated 8/17/17 indicated Resident #21 ' s cognition was severely impaired. Resident #21 had received antianxiety medication and antidepressant medication on 7 of 7 days during the MDS look back period. Section I, the Active Diagnoses section, was not coded for anxiety or depression.

A review of the August Medication Administration Record (MAR) indicated Resident #21 received Zoloft (antidepressant medication) 50 milligrams (mg) once daily for major depressive disorder and Klonopin (antianxiety medication) 0.5 mg twice daily for anxiety during 8/17/17 MDS look back period.

An interview was conducted with Nurse #2 on 9/21/17 at 9:30 AM. She stated she began working at the facility in late June 2017. She indicated she was initially assisting with the completion of MDS assessments until a position opened up as a floor nurse. She stated the current MDS Coordinator (who began working as a facility employee on 9/1/17) came into the facility as an MDS consultant to assist with training her to complete MDS assessments. The quarterly MDS assessment dated 8/17/17 that indicated anxiety and depression were not active diagnoses for Resident #21 was reviewed with Nurse #2. She verified she had completed this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 49	F 278		

section of Resident #21 ' s 8/17/17 MDS. The August 2017 MAR that indicated Resident #21 was administered Zoloft for major depressive disorder and Klonopin for anxiety during the 8/17/17 MDS look back period was reviewed with Nurse #2. Nurse #2 revealed she was still being trained on the completion of MDS assessments during August of 2017. She indicated she made an error on this MDS assessment for Resident #21.

An interview was conducted with the Director of Nursing (DON) on 9/21/17 at 11:09 AM. She indicated her expectation was for the MDS to be completely accurately.

6b. Resident #21 was admitted to the facility on 3/31/15 with diagnoses that included dementia, major depression, and anxiety.

An incident report for Resident #21 indicated she had an unobserved fall in her room on 6/20/17 at 2:45 PM. There were no injuries noted.

An incident report for Resident #21 indicated she had an unobserved fall in her room on 6/21/17 at 6:00 PM. There were no injuries notes.

The Quarterly Minimum Data Set (MDS) assessment dated 8/17/17 indicated Resident #21 ' s cognition was severely impaired. She was indicated to have had no falls since the prior MDS assessment (5/17/17 quarterly assessment).

An interview was conducted with Nurse #2 on 9/21/17 at 9:30 AM. She stated she began working at the facility in late June 2017. She indicated she was initially assisting with the completion of MDS assessments until a position

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 50	F 278		

opened up as a floor nurse. She stated the current MDS Coordinator (who began working as a facility employee on 9/1/17) came into the facility as an MDS consultant to assist with training her to complete MDS assessments. The quarterly MDS assessment dated 8/17/17 that indicated Resident #21 had no falls since her prior MDS assessment (5/17/17) was reviewed with Nurse #2. She verified she had completed this section of Resident #21 ' s 8/17/17 MDS. The incident reports that indicated Resident #21 had two falls without injury (6/20/17 and 6/21/17) were reviewed with Nurse #2. Nurse #2 revealed she was still being trained on the completion of MDS assessments during August of 2017. She indicated she made an error on this MDS assessment for Resident #21.

An interview was conducted with the Director of Nursing (DON) on 9/21/17 at 11:09 AM. She indicated her expectation was for the MDS to be completely accurately.

7. a. Resident #29 was admitted to the facility on 12/10/13. Cumulative diagnoses included major depressive disorder, anxiety, insomnia and psychosis.

A Quarterly Minimum Data Set (MDS) dated 8/23/17 indicated Resident #29 was cognitively intact. Diagnoses included L89.90 pressure ulcer of unspecified site, unspecified stage. L97.413 nonpressure chronic ulcer of right heel and mid-foot with necrosis muscle.

A review of the medical record revealed Resident #29 did not have any pressure ulcers during the seven day look back period.

On 9/19/17 at 1:58 PM, an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 51	F 278		

conducted with the MDS Coordinator. She stated she began teaching Nurse #2 how to complete the MDS when she came to the facility in July 2017. The MDS Coordinator said she became responsible for the MDS the first of September 2017. She said she had been completing the MDS for about 3 years and the skin issues should not have been included in the diagnoses.

On 9/21/17 at 9:42 AM, an interview was conducted with Nurse #2. She stated she had completed the MDS assessment for Resident #29 dated 8/23/17. She said she was completing the MDS at that time and was learning the process. Nurse #2 said inactive diagnoses should not be included on the MDS and the diagnoses for the pressure ulcer were inaccurate.

On 9/21/17 at 11:14 AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to contain accurate information.

7. b. Resident #29 was admitted to the facility on 12/10/13. Cumulative diagnoses included major depressive disorder, anxiety, insomnia and psychosis.

A Quarterly Minimum Data Set (MDS) dated 8/23/17 indicated Resident #29 was cognitively intact. A review of section I for diagnosis did not indicate anxiety, insomnia and psychosis as active diagnoses for Resident #29.

A review of physician orders for August 2017 revealed the following medications: Amitriptyline (antidepressant medication) 150 milligrams by mouth every bedtime, Ambien (hypnotic) 5 milligrams by mouth every bedtime, Xanax p.25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 52	F 278		

milligrams every 6 hours as needed for anxiety, Prozac (antidepressant) 60 milligrams daily and Geodon (antipsychotic medication) 40 milligrams twice daily for psychosis.

On 9/19/17 at 1:58 PM, an interview was conducted with the MDS Coordinator. She stated she began teaching Nurse #2 how to complete the MDS when she came to the facility in July 2017. The MDS Coordinator said she became responsible for the MDS the first of September 2017. She said she had been completing the MDS for about 3 years and section I (Diagnosis) would include any new diagnoses noted by the physician and also include any diagnoses related to medications taken by the resident. The diagnoses of anxiety, psychosis and insomnia should have been included on the MDS.

On 9/21/17 at 9:42 AM, an interview was conducted with Nurse #2. She stated she had completed the MDS assessment for Resident #29 dated 8/23/17. She said she was completing the MDS at that time and was learning the process. Nurse #2 said active diagnoses should be included on the MDS.

On 9/21/17 at 11:14 AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to contain accurate information.

8. a. Resident #39 was admitted 8/6/15. Cumulative diagnoses included cardiomyopathy, transient ischemic attack (TIA), insomnia, diabetes and depression.

An Annual Minimum Data Set (MDS) dated 8/10/17 indicated Resident #39 was moderately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 53	F 278		

impaired in cognition. Resident #39 was coded as continent of bladder and bowel.

A review of the Activities of Daily Living (ADL) tracking form completed by the nursing assistants revealed Resident #39 had daily episodes of bladder incontinence from 8/4/17 through 8/10/17 (7 day look back period).

On 9/21/17 at 9:00 AM, an interview was conducted with NA#1. He stated he routinely provided care for Resident #39. NA #1 stated Resident #39 wore incontinent briefs and had daily episodes of bladder incontinence

On 9/21/17 at 9:22 AM, an interview was conducted with Nurse #2. She stated she was being trained in August on completing the MDS. She stated she obtained information for completing the bladder continence from reviewing the ADL tracking form and talking to the nursing assistants. After reviewing the MDS and the information on the ADL tracking form, she said the MDS was coded incorrectly.

On 9/21/17 at 11:14 AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to contain accurate information.

8. b. Resident #39 was admitted 8/6/15. Cumulative diagnoses included cardiomyopathy, transient ischemic attack (TIA), insomnia, diabetes and depression.

An Annual Minimum Data Set (MDS) dated 8/10/17 indicated Resident #39 was moderately impaired in cognition. Mood assessment noted Resident #39 felt tired or little energy never or 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 54	F 278		

day. No behaviors occurred during the assessment period. A review of the medications administered during the seven day look back period 8/ 4/17-8/10/17) indicated Resident #39 had not received any insulin or anticoagulant medication during the seven day look back period.

A review of physician orders revealed an order for Novolog insulin 10 units subcutaneous before breakfast, Toujeo insulin 70 units subcutaneous every morning and Xarelto 9anticoagulant medication) 15 milligrams by mouth daily.

A review of August Medication Administration Record (MAR) for 8/4/17 through 8/10/17 revealed Resident #39 resident received Novolog insulin and Toujeo insulin 7 days during the look back period. He also received Xarelto 7 days during the look back period.

On 9/21/17 at 9:22 AM, an interview was conducted with Nurse #2. She stated she was being trained in August on completing the MDS. She said she reviewed the medical record, hospital record, physician ' s orders and Medication Administration Record when she completed the information for medications administered during the seven day look back period. She reviewed the MAR for 8/4/17-8/10/17 and stated she should have coded 7 days of insulin injection and 7 days of anticoagulant medication.

On 9/21/17 at 11:14 AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to contain accurate information.
9. Resident # 96 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 55	F 278		

8/25/17 with multiple diagnoses including Alzheimer's disease and fracture upper end of tibia. The admission Minimum Data Set (MDS) assessment dated 9/1/17 indicated that Resident #96 had memory and decision making problems. The assessment further indicated that Resident #96 was not using side rails as a physical restraint.

Resident #96's Nurse Aide (NA) Information sheet (a care guide for NA) was reviewed. The sheet indicated that Resident #96 was using ½ side rails due to cognitive status and she tried to walk every now and then.

On 9/19/17 at 3:20 PM and 9/20/17 at 8:45 AM, Resident #96 was observed out of bed. Her bed was observed to have bilateral ½ side rails in the middle of her bed.

On 9/20/17 at 8:46 AM, Medication Aide (MA) #2 was interviewed. She stated that Resident #96 was using ½ side rails when she was in bed for bed mobility. She further stated that Resident #96 was not able to remove or lower the SR down when she wanted to get out of bed.

On 9/21/17 at 9:30 AM, Nurse #2 was interviewed. She stated that she started working at the facility in late June 2017 assisting with the completion of MDS assessments until a position opened up for a floor nurse. She added that the current MDS Nurse started September 2017. Nurse #2 stated that the facility had not utilized side rails as restraints and she had not coded any side rails as restraints on the MDS assessments. Nurse #2 also indicated that she had not routinely observed residents to assess for physical restraints unless there was a physician's order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 56	F 278		

On 9/21/17 at 9:50 AM, the MDS Coordinator was interviewed. She stated that she started working at the facility on 9/1/17. The MDS Coordinator indicated that if the medical record review indicated that a resident had no restraint, she had not routinely observed the resident as part of her restraint assessment for the MDS. She further stated that the facility had not utilized side rails as restraints and she had not coded any side rails as restraints on the MDS assessments.

On 9/21/17 at 1:23 PM, the Director of Nursing (DON was interviewed. The DON stated that she expected the MDS assessments to be accurate.

10. Resident #40 was originally admitted to the facility on 5/11/17 and expired on 6/1/17. The admission Minimum Data Set (MDS) assessment dated 5/17/17 indicated that Resident #40 had severe cognitive impairment and he was not using side rails as a physical restraint.

Resident #40's Nurse Aide (NA) Information sheet (a care guide for NA) was reviewed. The sheet indicated that Resident #40 was using ½ side rails.

On 9/19/17 at 2:15 PM, NA #2 was interviewed. She stated that Resident #40 was using ¼ side rails (SR) in the middle of his bed and he was not able to remove or lower the SR down when he wanted to get out of bed.

On 9/20/17 at 10:43 AM, Nurse #5 was interviewed. She stated that Resident #40 had ½ SR in his bed during the fall on 6/1/17 and it appeared that he climbed over the rails and fell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 57 onto the floor. On 9/21/17 at 9:30 AM, Nurse #2 was interviewed. She stated that she started working at the facility in late June 2017 assisting with the completion of MDS assessments until a position opened up for a floor nurse. She added that the current MDS Nurse started September 2017. Nurse #2 stated that the facility had not utilized side rails as restraints and she had not coded any side rails as restraints on the MDS assessments. Nurse #2 also indicated that she had not routinely observed residents to assess for physical restraints unless there was a physician's order On 9/21/17 at 9:50 AM, the MDS Coordinator was interviewed. She stated that she started working at the facility on 9/1/17. The MDS Coordinator indicated that if the medical record review indicated that a resident had no restraint, she had not routinely observed the resident as part of her restraint assessment for the MDS. She further stated that the facility had not utilized side rails as restraints and she had not coded any side rails as restraints on the MDS assessments. On 9/21/17 at 1:23 PM, the Director of Nursing (DON was interviewed. The DON stated that she expected the MDS assessments to be accurate.	F 278		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 58 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to identify the use of side rails as a potential accident hazard and failed to review the risk and benefits of bed rails with the resident's Responsible Party and to obtain informed consent prior to installation of the bed rails for 1 of 3 sampled residents who were high risk for falls (Resident #40). Findings included: Resident #40 was originally admitted to the facility on 5/11/17 and expired on 6/1/17. Resident #40 had multiple diagnoses including Dementia and Metabolic encephalopathy. The admission Minimum Data Set (MDS) assessment dated 5/17/17 indicated that Resident #40 had severe cognitive impairment and he had no falls.	F 323	F 323 1. Resident # 40 was discharge from the facility on 6/1/17. 2. An audit was completed by the DON and the ADON on 10/05/17 of the current residents' devices to include the side rails and T&R bars, the position of the side rails/ the T&R bars on the bed. 100% of 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 rails, if classified as a restraint and to ensure potential accident hazardous have been addressed and followed up. When side	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 59 Resident #40's Fall Risk Assessment dated 5/11/17 was reviewed. The assessment revealed a total score of 14. The assessment form indicated that a "total score above 10 represents HIGH RISK". Resident #40's care plan dated 5/11/17 was reviewed. One of the care plan problems was "risk for falls". The goal was "resident will not experience serious injury from falls over the next 90 days". The approaches did not include the use of bilateral side rails. Resident #40's Bed Rail/Assist Bar Evaluation form dated 5/11/17 was reviewed. The form indicated that Resident #40 had history of falls and there was a possibility that he would climb over the bed rails/assist bar. The form also indicated that there was evidence that Resident #40 has a desire or reason to get out of bed. The form also did not indicate that the Responsible Party (RP) was notified of risk and benefits of the side rails. The form was not signed therefore the author was not interviewed. Resident #40's Nurse Aide (NA) Information Sheet (care guide for NA) was observed posted at the back of the resident's closet. The sheet had a check mark under ½ side rail. Resident #40's nurse's notes and incident reports were reviewed. The notes and reports revealed that Resident #40 had 5 falls since admission to facility. On 5/16/17 at 5:00 PM, Resident #40 was found sitting on the floor in front of his wheelchair with	F 323	rails are identified as a restraint, resident's representative will be contacted and consent obtained after risk/benefit are explained. 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 device and/ restraint as indicated. 4. Licensed Nurses, including week end and prn, will be reeducated on side rails and restraints by the SDC, Nursing Supervisors, or the DON by 10/17/17. Education will include completing bed rails, T&R bars and restraint assessment, and restraint consents; and frequency of completing assessments. In-service regarding the Restraint Algorithm use will be completed with all licensed nurse, including week-end and prn staff by the SDC, Nursing Supervisors, or the DON by 10/17/17. 5. Certified Nursing Assistances (CNA) and Medication Aides (MA), including week-end and prn, will be re-educated by the SDC or the DON by 10/17/17 regarding caring for residents with restraints and correct positioning and placement of restraint, as well as when to use side rails correctly. 6. ADON, Unit Manager, MDS Coordinator, SDC and nursing supervisors will be responsible for obtaining consents for restraints when need is identified. Staff nurses will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 60 no injury noted. On 5/20/17 at 11:15 AM, Resident #40 was found sitting on the floor in front of his wheelchair. He stated that he was trying to get over in bed. On 5/20/17 at 11:45 PM, Resident #40 was found sitting on the floor. The root cause was poor safety awareness. On 5/31/17 at 6:50 AM, Resident #40 was observed lying face down on floor parallel to bed. The root cause was poor safety awareness. On 6/1/17 at 12:00 midnight, Resident #40 was noted on the floor on his abdomen. He appeared to climb over the side rails trying to get out of bed and landed on the floor beside the bed. The root cause was poor safety awareness. On 9/19/17 at 2:50 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON reviewed the Bed rail/Assist Bar Evaluation form dated 5/11/17 and stated that based on the evaluation, Resident #40 should not have side rails in bed. He was able to lift self out of bed. The ADON stated that facility did not have a consent form for the use of the side rails. The ADON also indicated that she was responsible for investigating the falls and identifying the root cause of falls. She stated that the root cause of falls for Resident #40 was poor safety awareness. She indicated that she didn't look at side rails as an accident hazard for the resident. On 9/20/17 at 10:43 AM, Nurse #5 was interviewed. She stated that Resident #40 had bilateral ½ SR in his bed during the fall on 6/1/17	F 323	complete assessments for side rails and restraints on admission, quarterly and prn with any change in resident status. Consent forms for current residents who have been identified as having a restraint, will have consent forms signed by 10/17/17 . When residents are evaluated for restraint, if a restraint is indicated consent will be signed or verified by nurses within 24 hours of assessments 7. We will charter a Safety Committee consisting of the DON, Maintenance Director, 1 staff nurse, 1 CNA, and other department heads will rotate on to the committee every month. The committee will meet monthly, the first meeting will be schedule for October 18, 2017. The purpose of this committee is to review restraints- to ensure least restrictive devices are being used, falls in order to reduce the risk of injury and to recommend improvement initiatives for fall prevention, and any adverse events. 8. A visual audit will be completed by the DON weekly for 4 weeks of current residents and monthly for 3 months to visualize use and placement of side rails. DON will audit all documentation related 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 x4 and monthly x3. The DON will present results of audits to the QA Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

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KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 323	Continued From page 61 and it appeared that he climbed over the rails and fell onto the floor. On 9/21/17 at 1:23 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to fully complete and follow the Bed Rail/Assist Bar Evaluation form to include documenting the alternative interventions utilized and notification of RP and Physician of side rails used..	F 323	monthly for 4 months. Date of Compliance: 10/18/17	
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 334		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

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F 334	Continued From page 62	F 334		

was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical

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	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

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F 334	Continued From page 63 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to offer and to administer the pneumococcal vaccine to 5 of 5 sampled residents reviewed for immunization (Residents # 93, #5, #95, #89 & # 98). Findings included: The facility's policy on Pneumococcal vaccine dated December 2012 was reviewed. The policy read in part "Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax (Pneumococcal vaccine) and when indicated, will be offered the vaccine within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status will be conducted within 5 working days of the resident's admission if not conducted prior to admission. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given or refused) per our facility's physician approved pneumococcal vaccination protocol. Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. For residents who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record." 1. Resident # 93 was admitted to the facility on 5/22/17 with multiple diagnoses including Hypertension, Diabetes Mellitus and Chronic Obstructive Pulmonary Disease (COPD). Review	F 334	F 334 1. Resident # 93 Pneumonia / Flu consent was completed on 10/5/ 17 by the SDC. Vaccine for Flu was given 10/9/17. Pneumonia vaccine was refused. Resident #5 the Pneumonia / Flu consent was completed on 10/5/17 by the SDC. Flu vaccine was given on 10/3/17. The Pneumonia vaccine will be given by 10/16/17. Resident #95 the Pneumonia / Flu consent was completed on 10/5/17 by SDC. Pneumonia vaccine was given on 10/9/17. Flu vaccine was given on 10/13/17. Resident #89 the Pneumonia /Flu consent was completed on 10/6/17 by the SDC with resident refusal. Resident #98 was discharged to the hospital on 10/4/17. Resident return from hospital on 10/9/17. Pneumonia/Flu consent was obtained on 10/12/17. Resident refused all attempts to give flu vaccine as of 10/12/17. 2. An audit of the current residents was completed by the Infection Control Nurse and the ADON on 10/5/17 to assess need for Pneumococcal / Flu vaccines to be given. Audit showed out of 72 residents 52 need Pneumonia/flu vaccine. Pneumococcal/ Flu consents or declination will be obtained for the 52 residents needing one or more vaccine. Pneumococcal/Flu vaccines will be given	

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	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 334	Continued From page 64 of the resident's medical records revealed that the resident's responsible party (RP) had consented to administer Pneumococcal vaccine to Resident #93 on 5/22/17. Resident #93's medical records including the electronic records were reviewed and there was no documentation that Pneumococcal vaccine was administered to the resident. On 9/21/17 at 9:29 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she was the Infection Control Nurse. She revealed that the facility had identified immunization as a concern last August 2017. The ADON stated that the Admission Coordinator was responsible for obtaining the consent for the pneumococcal vaccine on admission but she quit working at the facility in August 2017. The ADON further stated that when a resident or RP consented to receive the vaccine, it was not communicated to nursing and therefore the vaccine was not administered. The ADON indicated that she had not started auditing the chart yet as to who needed a consent for the pneumococcal vaccine and who had consented to receive the vaccine. On 9/21/17 at 11:20 AM, the DON was interviewed. The DON stated that she was aware that the facility had identified immunization as a concern. She revealed that she started working as DON at the facility on 8/24/17 and she would follow up with the ADON on the immunization status. 2. Resident # 5 was admitted to the facility on 5/23/17 with multiple diagnoses including Dementia. Review of the resident's medical	F 334	to those who consent. Consents will be obtained for immunizations by 10/17/17. 3. The Licensed Nurses, including week-end and prns, will be reeducated by the SDC, DON, ADON, Unit Manager, or week-end supervisor by 10/17/17 or prior to next shift worked, related to ensuring the Pneumococcal / Flu vaccines have been offered and given as required. 4. An audit will be completed by the SDC weekly for 4 weeks and monthly for 3 months to ensure Pneumococcal / Flu vaccines continue to be offered and given as required. The SDC will a report to the Quality Assurance Committee monthly for 4 months. Date of Compliance: 10/18/17	

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F 334	Continued From page 65	F 334		

records revealed that Resident #5 was not offered Pneumococcal vaccine since admission to the facility. There were no documentation in the medical records that the resident or the RP had refused Pneumococcal vaccine or had already received the vaccine in the past.

On 9/21/17 at 9:29 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she was the Infection Control Nurse. She revealed that the facility had identified immunization as a concern last August 2017. The ADON stated that the Admission Coordinator was responsible for obtaining the consent for the pneumococcal vaccine on admission but she quit working at the facility in August 2017. The ADON further stated that when a resident or RP consented to receive the vaccine, it was not communicated to nursing and therefore the vaccine was not administered. The ADON indicated that she had not started auditing the chart yet as to who needed a consent for the pneumococcal vaccine and who had consented to receive the vaccine.

On 9/21/17 at 11:20 AM, the DON was interviewed. The DON stated that she was aware that the facility had identified immunization as a concern. She revealed that she started working as DON at the facility on 8/24/17 and she would follow up with the ADON on the immunization status.

3. Resident # 95 was admitted to the facility on 6/22/17 with multiple diagnoses including Dementia. Review of the resident's medical records revealed that Resident #95 was not offered Pneumococcal vaccine since admission to the facility. There were no documentation in

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	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 334	Continued From page 66	F 334		

the medical records that the resident or the RP had refused Pneumococcal vaccine or had already received the vaccine in the past.

On 9/21/17 at 9:29 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she was the Infection Control Nurse. She revealed that the facility had identified immunization as a concern last August 2017. The ADON stated that the Admission Coordinator was responsible for obtaining the consent for the pneumococcal vaccine on admission but she quit working at the facility in August 2017. The ADON further stated that when a resident or RP consented to receive the vaccine, it was not communicated to nursing and therefore the vaccine was not administered. The ADON indicated that she had not started auditing the chart yet as to who needed a consent for the pneumococcal vaccine and who had consented to receive the vaccine.

On 9/21/17 at 11:20 AM, the DON was interviewed. The DON stated that she was aware that the facility had identified immunization as a concern. She revealed that she started working as DON at the facility on 8/24/17 and she would follow up with the ADON on the immunization status.

4. Resident # 89 was admitted to the facility on 5/5/17 with multiple diagnoses including Dementia. Review of the resident's medical records revealed that Resident #89 was not offered Pneumococcal vaccine since admission to the facility. There were no documentation in the medical records that the resident or the RP had refused Pneumococcal vaccine or had already received the vaccine in the past.

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	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 334	Continued From page 67 On 9/21/17 at 9:29 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she was the Infection Control Nurse. She revealed that the facility had identified immunization as a concern last August 2017. The ADON stated that the Admission Coordinator was responsible for obtaining the consent for the pneumococcal vaccine on admission but she quit working at the facility in August 2017. The ADON further stated that when a resident or RP consented to receive the vaccine, it was not communicated to nursing and therefore the vaccine was not administered. The ADON indicated that she had not started auditing the chart yet as to who needed a consent for the pneumococcal vaccine and who had consented to receive the vaccine. On 9/21/17 at 11:20 AM, the DON was interviewed. The DON stated that she was aware that the facility had identified immunization as a concern. She revealed that she started working as DON at the facility on 8/24/17 and she would follow up with the ADON on the immunization status. 5. Resident # 98 was admitted to the facility on 6/9/17 with multiple diagnoses including Dementia. Review of the resident's medical records revealed that Resident #98 was not offered Pneumococcal vaccine since admission to the facility. There were no documentation in the medical records that the resident or the RP had refused Pneumococcal vaccine or had already received the vaccine in the past. On 9/21/17 at 9:29 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON	F 334		

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F 334	Continued From page 68 stated that she was the Infection Control Nurse. She revealed that the facility had identified immunization as a concern last August 2017. The ADON stated that the Admission Coordinator was responsible for obtaining the consent for the pneumococcal vaccine on admission but she quit working at the facility in August 2017. The ADON further stated that when a resident or RP consented to receive the vaccine, it was not communicated to nursing and therefore the vaccine was not administered. The ADON indicated that she had not started auditing the chart yet as to who needed a consent for the pneumococcal vaccine and who had consented to receive the vaccine. On 9/21/17 at 11:20 AM, the DON was interviewed. The DON stated that she was aware that the facility had identified immunization as a concern. She revealed that she started working as DON at the facility on 8/24/17 and she would follow up with the ADON on the immunization status.	F 334		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 371	Continued From page 69 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to clean food service equipment for one of three appliances. The facility failed to maintain an intact control panel pad for one of three appliances. The facility failed to maintain a sealed drain on one of three drains for the three compartment sink. The facility failed to protect food from possible contamination as evidenced by the failure of dietary staff to properly restrain facial hair while preparing food for three of three male dietary staff members with observed facial hair. Findings Included: 1. Observations were conducted of the kitchen on 9/18/17 at 10:11 AM, on 9/20/17 at 10:59 AM, and on 9/20/17 at 2:07 PM that revealed the following: a. The drain for the middle sink for the three compartment sink was observed leaking copious amounts of water onto the floor. b. The control panel pad for the convection oven was observed where the plastic covering had broken exposing internal buttons which could	F 371	F 371 1. The drain for the middle sink for the three compartment sink that was leaking water was repaired by the Maintenance Director on 9/21/17. The grease trough was not easily removable. This was fixed on 9/21/17 Stove top and grill had grease and build up. This was cleaned on 9/20/17 The part for the Control panel pad for the convection oven that had the broken exposed internal buttons was ordered on 9/20/17 and will be repaired by the Maintenance Director. 2. An inspection of the kitchen was completed by Dietary Manager on 9/21/17 to ensure food service equipment is clean and functioning as required. Identified area were cleared and no new areas were noted. 3. The Dietary staff, including week end	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 371	Continued From page 70 not be cleaned. c. The stove top had six of six burners with visible burnt food and grease build up. d. The flat top grill had visible grease build up under the top of the grill. e. The grease trough was not removable from the flat top grill and had visible food, grease, and debris in the drawer. An interview conducted with the Dietary Manager on 9/20/17 at 2:17 PM revealed she was unable to remove the grease trough drawer from under the flat top grill. The Dietary Manager stated her expectation was for the grease trough to be easily removable for cleaning, stove top burners to be clean, and for the area under the flat top grill to be clean. In addition the Dietary Manager stated her expectation was for kitchen equipment such as the leaking drain on the three compartment sink or the control panel on the convection oven to be in proper working order. The dietary manager added it was also her expectation if there was a piece of kitchen equipment or an appliance which was in need of being repaired a work order needed to be completed by the dietary employee finding the needed repair. The work order would then be forwarded to the maintenance department for repair of the equipment or appliance. In addition the Dietary Manager stated the panel oven buttons on the convection oven needed to be intact so the surface would be smooth and cleanable. 2. An observation of the kitchen on 9/18/17 at 10:50 AM revealed the following: a. Dietary Aide #1 was preparing food with unrestrained facial hair. b. Dietary Aide #2 was washing dishes with unrestrained facial hair.	F 371	and prn staff, have been in-serviced on the process and policy for cleaning, reporting maintenance issues and facial hair covering started on 9/20/17 by the District Manager and will be completed by Dietary Manager no later than 10/17/17. Dietary staff will be in-serviced monthly by the Dietary Manager on the topics of: work orders written timely, wearing facial covering and cleaning properly over the next 3 months. 4. The Dietary Manager and/ Head Cook will identify and track kitchen maintenance concerns, proper facial covering, proper cleaning schedule and complete the audit monitoring tool. Using the audit form monitoring tool daily x 4 weeks, then weekly for 4 weeks, then monthly x1 month. Corrections will be made when identified by the Dietary Manager during the audits. The District Dietary Manager will review the audits weekly x 4 weeks, then 1 times a month for 1 months, then on visits. Results of the audits will be reported monthly x 4 month to the QA Committee by the Dietary Manager or the District Dietary Manager. The QA Committee consist Medical Director, Administrator, DON, ADON, Treatment Nurse, SDC, MDS Coordinator, Maintenance Director, Activity Director, Housekeeping & Laundry Director, Dietary Director, Medical Record, Business Office Manager (BOM),and Human Resource Director (HR). Date of Compliance:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 371	Continued From page 71 An interview conducted with the Dietary Manager on 9/20/17 at 2:17 PM revealed her expectation was if a dietary employee had facial hair it should be restrained with a beard guard. 3. An observation of the kitchen on 9/20/17 at 10:59 AM revealed the following: a. Dietary Aide #3 was preparing food with unrestrained facial hair. b. Dietary Aide #2 was washing dishes with unrestrained facial hair. An interview conducted with the Dietary Manager on 9/20/17 at 2:17 PM revealed her expectation was if a dietary employee had facial hair it should be restrained with a beard guard. An interview conducted with the Maintenance Director on 9/20/17 at 3:16 PM revealed he had not received a work order or made of aware the three compartment sink drain leak, the grease trough not being easily removable, nor was he made aware of the control panel cover for the buttons of the convection oven being cracked and impaired. He stated it was his expectation to receive a work order from the dietary staff for appliances or equipment when it was not in proper working order.	F 371	10/18/17	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/21/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 72	F 431		

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and

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F 431	Continued From page 73 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to date medication when opened and to discard expired medications in 2 of 4 medication carts observed (Tanglewood and Somerset Hall medication carts). Findings included: 1. On 9/20/17 at 2:35 PM, the medication cart on Tanglewood Hall was observed with Nurse #1. The following were observed: A used Flovent diskus 50 microgram (mcg) inhaler (used to treat asthma) that was undated. The manufacturer's instruction written on the box read " discard Flovent diskus 50 mcg 6 weeks after opening the foil pouch or when the counter reads "0", whichever comes first". An opened bottle of Sterile Water 500 milliliter (ml) (used for moisturizing of wound dressings, wound debridement and device irrigation) that was dated 7/19/17. On 9/20/17 at 2:39 PM, Nurse #1 was interviewed. She stated that the Flovent diskus inhaler should have been dated when opened but it was not. Nurse #1 did not know how long the Flovent diskus was good after opening. She also stated that the Sterile Water was good for 30 days after opening. Nurse #1 was observed discarding the opened bottle of Sterile Water.	F 431	F431 1. The Flovent Diskus was dated with the dispense date from the pharmacy on 9/20/17 by Nurse #1 The Sterile Water was discarded by Nurse #1 on 9/20/17 The Fiber Laxative was discarded on 9/20/17 by the Medication Aide (MA) #1 The Humalog insulin pen was discarded on 9/20/17 by the MA #1 2. An audit was completed by the pharmacy on the medication carts on 9/27/17 to ensure medications are dated when opened and discarded when expired. The audit identified 8 expired medications, 16 items not dated when opened, and 3 medication storage concerns. The identified concerns were corrected on 9/27/17 by the licensed nurse. 3. The licensed nurse will check the medication cart nightly for expired medications and dates of opened medications. The nurse supervisor will check medication room for expired medications and medications not dated when opened. The DON will check at minimum twice a week the medication rooms and medications carts for expired	

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F 431	Continued From page 74 On 9/21/17 at 11:20 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to date the multi dose medications when opened per facility policy and to follow the manufacturer's instruction/recommendations. She also stated that she expected the nurses to check the medication carts every night and to discard expired medications. 2. On 9/20/17 at 2:40 PM, the medication cart on Somerset Hall was observed with Medication Aide (MA) #1. The following were observed: A used Humalog insulin pen that was undated A bottle of Fiber Laxatives 625 milligrams (mgs) tablet with the expiration date of 6/17 On 9/20/17 at 2:43 PM, MA #1 was interviewed. She acknowledged that the Fiber Laxatives was already expired and the Humalog insulin pen was undated. She stated that she had not observed anybody checking the medication carts except the DON. She had observed the DON checked the carts twice since she started as DON in August 2017. On 9/21/17 at 11:20 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to date the multi dose medications when opened per facility policy and to follow the manufacturer's instruction/recommendations. She also stated that she expected the nurses to check the medication carts every night and to discard	F 431	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 monthly for 3 months to ensure medications are dated when open and discarded when expired. The ADON will submit a report to the QA Committee monthly for 4 months. Date of Compliance: 10/18/17	

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F 431	Continued From page 75 expired medications.	F 431		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		10/18/17

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F 520	Continued From page 76 (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility ' s Quality Assessment and Assurance committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place in March of 2017. This was for two (2) recited deficiencies which were originally cited on 3/3/17 during the recertification/complaint survey, on the follow-up recertification/ complaint survey on 5/4/17 and again on the follow-up recertification/ complaint survey on 6/2/17 and on the current recertification/ complaint investigation survey 9/21/17 (F278, F323). The continued failure of the facility during the two federal surveys of record and two follow-up surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F278: Assessment accuracy: 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) and incontinence and medications (Resident #39) for 10 of 19 sampled residents reviewed for MDS	F 520	F520 F278 1. Resident #6 MDS assessment with ARD date of 9/1/17 was corrected by the MDS coordinator by 9/4/17 and transmitted on 9/4/17 Resident #25 MDS assessment with ARD date of 7/20/17 was corrected by the MDS Coordinator by 9/8/ 17 and transmitted. It was accepted on 9/19/17. Resident #61 MDS assessment with ARD date 8/16/17 was corrected by the MDS Coordinator on 10/12/17 and transmitted 10/12/17 Resident #22 MDS assessment with ARD date of 8/15/17 was reviewed. MDS was not corrected due to lack of documentation regarding side rails. New side rail assessment and a new restraint assessment was completed on 9/26/17. The side rails have been assessment as not being a restraint, and have been moved to the head of the bed and padded to be used as a positioning device. Side rails were moved to the top of the bed on 9/26/17 by maintenance staff Therefore a correction or additional MDS is not needed. Resident #96 MDS assessment with ARD date of 9/1/17 was reviewed. MDS was not corrected due to lack of	

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F 520	Continued From page 77 accuracy. During the recertification survey of 3/3/17, the facility was cited F278 for failure to accurately code pressure ulcers on the Minimum Data Set (MDS) for one of four residents reviewed for pressure ulcer (Resident #4) and for two of two residents reviewed for hospice (Resident #86 and #81). On the current recertification/ complaint investigation survey of 9/21/17, the facility failed to accurately code the MDS assessment in the areas of prognosis, pressure ulcers, restraints, diagnoses, falls, diagnoses for pressure ulcer, incontinence and medications for 10 of 19 sampled residents reviewed for MDS accuracy. On 9/21/17 at 11:46 AM, an interview was conducted with Regional Director and Corporate Clinical Nurse in the absence of the Administrator. They stated their focus had been on the citations and all the audits that had been due over the past six months. Both said there had not been the right person to do the detailed accuracy of the MDS and clinical record. The facility had been doing audits for the specific areas identified on 3/3/17 ad not on the entire MDS. 2. F323: Accidents: Based on record review and staff interview, the facility failed to identify the use of side rails as a potential accident hazard and failed to review the risk and benefits of bed rails with the resident's Responsible Party and to obtain informed consent prior to installation of the bed rails for 1 of 3 sampled residents who were high risk for falls (Resident #40).	F 520	documentation regarding the side rails. New side rail assessment and new restraint assessment will be completed. She was assessed for side rails on 10/5. Side rails were removed from the bed by maintenance staff on 10/5/17. Therefore neither a correction nor additional MDS is needed. Resident #40 MDS assessment with ARD date of 5/11/17 was reviewed MDS was not corrected due to lack of documentation to support side rails. The resident was discharged on 6/1/17. Therefore the correction was not done. Resident was discharged prior to survey Resident #76 MDS assessment with ARD date of 9/9/17 was not corrected due to lack of documentation regarding the side rails. New side rail assessment and a new restraint assessment was completed on 10/5/17. The side rails were moved to the top of the bed on 10/5/17 by the maintenance staff. On evaluation side rails did not constitute a restraint. Therefore neither a correction nor an additional MDS is needed. Resident #21 MDS assessment with ARD date 8/17/17 will be corrected by the MDS Coordinator. Modification was done 9/21/17and was transmitted 9/21/17. Resident #29 MDS assessment with ARD date of 8/23/17, diagnoses list was updated to show that pressure ulcers were resolved; the first resolved on 8/21/15, the second one was resolved on 5/21/15. Diagnosis list was updated 10/12/17. The MDS modification was made on 10/17/17 and submitted Resident #39 MDS assessment with ARD	

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F 520	Continued From page 78 During the recertification survey of 3/3/17, the facility was cited F323 for failure to investigate the root cause of two falls and failed to monitor for delayed complications related to a fall for one of two sampled residents reviewed for accidents (Resident#42). During the follow-up recertification survey on 5/4/17, the facility was cited F323 for failure to investigate the root cause of 1 fall and also failed to provide supervision to prevent falls by failing to follow the physician order to relocate resident's room to a room in closer proximity to the nurses station resulting in resident sustaining 2 additional falls for one of three residents reviewed for accidents (Resident #133). During the follow-up recertification survey on 6/2/17, the facility was cited F 323 for failure to supervise a cognitively impaired resident with known exit seeking behaviors to prevent an elopement from the facility for one of three residents reviewed for accidents (Resident #99). On the current recertification/ complaint investigation survey of 9/21/17, the facility failed to identify the use of side rails as a potential accident hazard and failed to review the risk and benefits of bed rails with the resident's Responsible Party and to obtain informed consent prior to installation of the bed rails for 1 of 3 sampled residents who were high risk for falls (Resident #40). On 9/21/17 at 11:46 AM, an interview was conducted with Regional Director and Corporate Clinical Nurse in the absence of the Administrator. They stated their focus had been on the citations and all the audits that had been	F 520	date of 8/10/17 was modified by the MDS Coordinator by 9/21/17 and was transmitted & accepted on 9/21/17 2. An audit of the current residents' MDS assessment was completed by the MDS Coordinator on 10/06/17 to ensure the assessments accurately reflect the residents' current status and any identified corrections were completed and submitted as required. 66 MDSs were audited. Of the 66, 56 were correct. There were 10 that had corrections made and were resubmitted to CMS. The corrections and resubmission were made between 9/8/17-10/6/17. 3. The MDS Coordinator will be reeducated by the Regional Nurse Consultant by 10/2/17 related to ensuring MDS assessments accurately reflect the resident's current status 4. An audit will be completed by the DON weekly x 4 weeks for all MDS or a maximum of 10 MDSs per week, which ever is higher and monthly for 3months to ensure MDS assessment continue to accurately reflect the resident's current status. The DON will submit a report to the Quality Assurance Committee monthly for 4 months. 5. Revision of the QA process dated April 2017 was revised to increase audits by the DON weekly x 4 weeks for all MDS or a maximum of 10 MDSs per week, which ever is higher and monthly for 3months to ensure accurate coding of the	

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F 520	Continued From page 79 due over the past six months. The Regional Director and Corporate Clinical Nurse stated the facility was monitoring actual falls to ensure the incident reports were filled out and the root cause was identified on the incident report. The facility had not monitored the use of side rails. Both said, with a new Director of Nursing and her knowledge and expertise, she would be responsible for the falls investigations and monitoring. .	F 520	MDS assessment in the areas of prognosis, pressure ulcer, restraints, diagnoses, falls, diagnoses for pressure ulcer, incontinence, and medication. The 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 & Laundry Director, Dietary Director, Medical Record, Business Office Manager (BOM), Human Resource Director (HR). 6. The Quality Assurance and Performance Improvement (QAPI) Committee will review and revise the F278 Quality Improvement plan by 10/17/17 to ensure procedures are implemented and interventions are being monitored as required. 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 interventions are being monitored as required. F 323 1. Resident # 40 was discharge from the facility on 6/1/17. 2. An audit was completed by the DON and the ADON on 10/05/17 of the current residents' devices to include the side rails and T&R bars, the position of the side	

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F 520	Continued From page 80	F 520	rails/ the T&R bars on the bed. 100% of 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 rails, if classified as a restraint and to ensure potential accident hazardous have been addressed and followed up. When side rails are identified as a restraint, resident's representative will be contacted and consent obtained after risk/benefit are explained. 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 device and/ restraint as indicated. 4. Licensed Nurses, including week end and prn, will be reeducated on side rails and restraints by the SDC, Nursing Supervisors, or the DON by 10/17/17. Education will include completing bed rails, T&R bars and restraint assessment, and restraint consents; and frequency of completing assessments. In-service regarding the Restraint Algorithm use will be completed with all licensed nurse, including week-end and prn staff by the SDC, Nursing Supervisors, or the DON by 10/17/17. 5. Certified Nursing Assistances (CNA) and Medication Aides (MA), including week-end and prn, will be re-educated by the SDC or the DON by 10/17/17 regarding caring for residents with	

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F 520	Continued From page 81	F 520	restraints and correct positioning and placement of restraint, as well as when to use side rails correctly. 6. ADON, Unit Manager, MDS Coordinator, SDC and nursing supervisors will be responsible for obtaining consents for restraints when need is identified. Staff nurses will complete assessments for side rails and restraints on admission, quarterly and prn with any change in resident status. Consent forms for current residents who have been identified as having a restraint, will have consent forms signed by 10/17/17. 7. We will charter a Safety Committee consisting of the DON, Maintenance Director, 1 staff nurse, 1 CNA, and other department heads will rotate on to the committee every month. The committee will meet monthly, the first meeting will be schedule for October 18, 2017. The purpose of this committee is to review restraints- to ensure least restrictive devices are being used, falls in order to reduce the risk of injury and to recommend improvement initiatives for fall prevention, and any adverse events. 8. A visual audit will be completed by the DON weekly for 4 weeks of current residents and monthly for 3 months to visualize use and placement of side rails. DON will audit all documentation related to side rails and/ restraints. Documentation will include initial/ quarterly/prn side rail assessments,	

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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 x4 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 Corporate Nurse Consultant reeducated the QA Committee . On 10/11/17 related to ensuring the identified facility Quality improvement plans are implemented and the interventions are being monitored as required. The Administrator and/ the SDC will review weekly the audits and QA process for each tag cited to ensure facility identified QAPI plan are implemented and being monitored as required. Review will be done weekly x 8 weeks and then monthly x 2 months. The Administrator will report to the QAPI Committee compliance of the QA processes for the above cited tags in current Plan of Correction (POC). Date of compliance 10/18/17	