PRINTED: 06/30/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP COD 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES FY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	investigation was cor through 5/24/2022. T compliance with the i	certification and complaint inducted on 5/15/2022 The facility was found in requirement CFR 483.73, dness. Event ID #VBH811.	F 0	00		
		complaint survey was /2022 through 5/24/2022.				
	Immediate Jeopardy	was identified at:				
	J)	689 at a scope and severity (
	CFR 483.60 at tag F8	802 at a scope and severity (
	The tag F689 consitu	uted Substandard Quality of				
	was removed for F72	began on 05/11/2022 and 26, F802, and F835 on yed for F689 on 5/20/2022. was conducted.				
	NC00182409, NC001 NC00187835, NC001	s were investigated: 0184736, NC00182268, 182302, NC001877755, 187578, NC00188186, 178997, NC00188370.				
	24 of 43 complaint al	legations were substantiated				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE

06/17/2022

Electronically Signed

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C 05/24/2022
	ROVIDER OR SUPPLIER RE HEALTHCARE OF KII	NSTON	,	STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	1 00/2 H2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	Continued From page resulting in deficienci Self-Determination	es.	F 000		6/21/22
SS=D	promote and facilitate through support of renot limited to the right (1) through (11) of thi §483.10(f)(1) The resactivities, schedules (waking times), health care services consist assessments, and plaapplicable provisions §483.10(f)(2) The reschoices about aspect facility that are significable with members of the community activities if facility. §483.10(f)(8) The resparticipate in other acreligious, and community activities if facility. This REQUIREMENT by: Based on record revinterviews, the facility	mination. right to and the facility must resident self-determination sident choice, including but its specified in paragraphs (f) is section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make so of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the sident has a right to interact community and participate in both inside and outside the sident has a right to etivities, including social, nity activities that do not its of other residents in the resident and staff failed to honor a residents wers for 1 of 1 resident		F561 1. Resident #5 has been asked her preference regarding showers. Her	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			1	C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2-1/2022
					07 CUNNINGHAM ROAD		
SIGNATUI	RE HEALTHCARE OF KII	NSTON			KINSTON, NC 28501		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X 	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 561	Continued From page	F t	561				
	Findings included:				preference is being honored and care planned accordingly.		
	Resident #5 was adm	nitted to the facility on			2. All residents have the potential to be	•	
		es that included Parkinson's			affected. In-house review of the curren		
	Disease and diabetes.				resident population to identify residents	s	
					bathing preference to include showers		
		um Data Set dated 2/21/22			Care plans and resident care cards		
		had moderate cognitive			updated accordingly. Education provid		
		eded limited assistance with			by the Staff Development Coordinator		
		pendent on staff for bathing.			Licensed Nurses and Certified Nursing		
	between and bed bat	for Resident #5 to choose			Assistants on resident bathing preferen		
	between and bed bath and shower.				to include shower schedule by June 20 2022. Newly admitted residents bathin		
	Resident #5's care nl	an included resident's ability			preference will be obtained on admissi		
	I	of daily living: for example,			and care planned. This education will		
		n, walk in corridor, dress,			included in new hire orientation for		
	eat, toilet, maintain pe				Licensed Nurses and CNAs.		
	deteriorated related to	o debility and Parkinson's					
	Disease.				3. Ongoing audits to include resident		
					interviews and observations will be		
		M Resident #5 stated she			completed by Director of Nursing, SDC		
		5 weeks. She stated she			and/or Unit Manager to validate reside		
		et a shower, but she was not			bathing preference is being honored to	1	
		this interview resident was			include adherence to the shower	اء ما	
	observed to have gre	asy nair and no odor.			schedule. These audits will be complete		
	A review of the showe	or schodulo indicated			on (5) residents 5 x weekly x 1 week, (residents weekly x 2 weeks, and (5)	5)	
		posed to be showered on			residents monthly x 3 months. All data	will	
	Tuesday and Friday.	posed to be showered on			be summarized and presented to the	VVIII	
	racoday and mady.				facility Quality Assurance and		
	An interview with Nur	sing Assistant (NA) #11, who			Performance Improvement meeting		
		dent #5, was conducted on			monthly by the DON or Assistant Direct	tor	
	_	nd she stated she did not			Of Nursing. Any issues or trends		
	offer showers to her r	esidents today. She stated			identified will be addressed by the QAF	기	
		t given out until 8:00 AM			committee as they arise, and the plan	will	
		e to do them. She also			be revised to ensure continued		
		w there was a shower			compliance. The QAPI committee		
schedule.				consists of the Administrator, DON,			

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		345365	B. WING				С
		345365	B. WING_			05/	/24/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF KII	NSTON			07 CUNNINGHAM ROAD		
				K	INSTON, NC 28501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGGERION ON EGG IDENTIL TING IN ONWATION)		IAG		DEFICIENCY)	VIL.	
F 561	Continued From page	e 3	F 5	561			
					ADON, SDC, MDS Coordinator,		
	An interview was con	ducted with NA #10 at 2:55			Admissions Coordinator, Rehabilitation	i	
		he stated she didn't know			Manager, Medical Director, and Direct		
		chedule. She stated baths			of Social Services. Other members ma	У	
	were given to her residents.				be assigned as the need should arise.		
	NA #4 was interviewe			4. The Administrator and Director of			
	and she stated she did not offer showers to any				Nursing is responsible for implementing		
	her residents today b	ut they were given baths.			and maintaining the acceptable plan of		
	On 5/10/22 at 1:20 th	e Administrator stated he			correction. Corrective action to be completed by June 21, 2022.		
		get their showers if they			completed by June 21, 2022.		
	want one.	get their showers in they					
F 582		overage/Liability Notice	F.	582			6/21/22
SS=B	CFR(s): 483.10(g)(17		, ,				0/2 1/22
	() = = = (0)(, -, -, -, -, -, -, -, -, -, -, -, -, -,					
	§483.10(g)(17) The fa	acility must					
	(i) Inform each Medic	aid-eligible resident, in					
		admission to the nursing					
	-	resident becomes eligible for					
	Medicaid of-						
		rvices that are included in					
		es under the State plan and					
		t may not be charged;					
	` '	s and services that the					
		which the resident may be ount of charges for those					
	services; and	ount of charges for those					
		caid-eligible resident when					
		the items and services					
		g)(17)(i)(A) and (B) of this					
	section.	,,,					
	 §483.10(g)(18) The fa	acility must inform each					
		the time of admission, and					
		e resident's stay, of services					
		y and of charges for those					
	services, including an	ny charges for services not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C 05/24/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	05/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 582	covered under Medica facility's per diem rate (i) Where changes in and services covered Medicaid State plan, in notice to residents of reasonably possible. (ii) Where changes aritems and services the facility must inform the 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or est deposit or charges all per diem rate, for the resided or reserved of facility, regardless of adischarge notice requivity. The facility must resident representative the resident within 30 date of discharge from (v) The terms of an act behalf of an individual facility must not conflict these regulations. This REQUIREMENT by: Based on record revifacility failed to provide Medicare and Medicar Nursing Facility Advantagement of the provide Medicare and Medicar (SNF ABN) (form 100)	coverage are made to items by Medicare and/or by the he facility must provide the change as soon as is e made to charges for other at the facility offers, the e resident in writing at least mentation of the change. Or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually retained a bed in the any minimum stay or irements. Refund to the resident or e any and all refunds due days from the resident's in the facility. It is each admission contract by or on a seeking admission to the ct with the requirements of is not met as evidenced ew and staff interviews, the e the required Centers for id Services (CMS) Skilled inced Beneficiary Notice 55) for 2 of 3 residents ary protection notification and Resident #2).	F 582	F582 1.Resident #5 has been discharged from the facility. Resident #2's Resident Representative was notified on 6/7/202 by the Business Office Manager about Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN).	22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	'	00/2 1//2022	
SIGNATUE	RE HEALTHCARE OF KI	NSTON		907 CUNNINGHAM ROAD			
SIGNATOR	NETILALITIOANE OF N	NOTON		KINSTON, NC 28501			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 582	Continued From page	e 5	F 58				
		admitted to the facility on e Part A skilled services.		2.Residents who should receive CMS-10055 Advanced Beneficia (SNF-ABN) as required by federarequirements have been identified.	ary Notice al		
	assessment dated 2/ moderate cognitive in Resident #5's Medica	are Part A skilled services		having the potential to be affected house, audit completed starting to identify residents remaining in facility and validate they have be provided notification of the SNF-	ed. In May 2022 the een		
	Record review revea Resident #5 or the re were provided the CN Facility Advanced Be The Notice of Medica CMS 10123-NOMNO	sident's responsible party AS-10555 Skilled Nursing neficiary Notice (SNF-ABN). Ire Non-Coverage (Form		3.The Business Office Manager was educated on 5/25/2022 by the Regional Business Office Coordi (RBOC) on who should receive the CMS-10055 Advanced Beneficial (SNF-ABN) as required by federal requirements. This education will included in the new hire orientating Business Office Managers.	he inator he ary Notice al I be		
	Resident #5 received receive the SNF-ABN	ssing the notifications and the NOMNC but did not I. She reported she was ling the forms. She indicated efit days remaining.		4. Ongoing audits to validate res requiring the CMS-10055 Advan Beneficiary Notice (SNF-ABN) has provided as required by The Adn or MDS Coordinator will audit five residents monthly for 3 months were residents.	ced ave been ninistrator e		
	indicated Resident #8 CMS-10555 as requi He further stated he was not provided by Manager.	9/22 at 10:45 AM who 5 should have received the red by Federal guidelines. was unsure why the form the Business Office		longer require skilled services to the CMS-10055 Advanced Bene Notice (SNF-ABN) was provided of the audits will be presented by Administrator in the monthly Qua Assurance and Performance Improvement (QAPI) Meeting months and presented to the facility Quantum a	ficiary . Results / the ality onthly for mmarized		
	6/22/21. She was admitted to	admitted to the facility on Medicare Part A skilled Resident #2's Medicare		and presented to the facility Qua Assurance and Performance Improvement meeting monthly b DON or ADON. Any issues or tre identified will be addressed by the	y the ends		

,		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C 05/24/2022		
NAME OF PR	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	05/24	4/2022	
SIGNATUE	RE HEALTHCARE OF KII	NETON		907 CUNNINGHAM ROAD			
SIGNATOR	TE HEALTHCARE OF KII	4310N		KINSTON, NC 28501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
F 582	F 582 Continued From page 6		F 58	32			
	remained in the facilit Resident #2's annual	Minimum Data Set 11/22 revealed she had		committee as they arise, and the pl be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilita	,		
	were provided the CI Facility Advanced Ber The Notice of Medica CMS 10123-NOMNC	sident's responsible party MS-10555 Skilled Nursing neficiary Notice (SNF-ABN). re Non-Coverage (Form) was provided.		Manager, Medical Director, and Dir of Social Services. Other members be assigned as the need should ari 5. The Administrator is responsible implementing and maintaining the acceptable plan of correction. Correction to be completed by June 21,	may ise. for ective		
	Manager on 5/19/22 a was an error in proce Resident #2 received receive the SNF-ABN	with the Business Office at 8:41 AM she stated there assing the notifications and the NOMNC but did not l. She reported she was ling the forms. She indicated efit days remaining.					
F 585 SS=D	CMS-10555 as requir He further stated he was not provided by t Manager.	n/22 at 10:45 AM who should have received the red by Federal guidelines. was unsure why the form the Business Office	F 58	35	6	5/21/22	
	grievances to the faci that hears grievances reprisal and without fe	s. ident has the right to voice lity or other agency or entity s without discrimination or ear of discrimination or nces include those with					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345365	B. WING _			C 05/24/2022		
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP O 907 CUNNINGHAM ROAD KINSTON, NC 28501	CODE	0012412022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BI THE APPROPRIA	DATE		
F 585	respect to care and tr furnished as well as t furnished, the behavi residents, and other of facility stay. §483.10(j)(2) The residential facility must make professive grievances the accordance with this factorial facility must make professive grievances the accordance with this factorial facility factorial facility factorial facility factorial facility factorial facility of the resident. §483.10(j)(4) The factorial facto	reatment which has been hat which has not been or of staff and of other concerns regarding their LTC ident has the right to and the ompt efforts by the facility to be resident may have, in paragraph. Illity must make information ance or complaint available illity must establish a ansure the prompt resolution ording the residents' rights agraph. Upon request, the copy of the grievance policy rievance policy must individually or through a locations throughout the file grievances orally in writing; the right to file custy; the contact information all with whom a grievance is or her name, business email) and business phone are expected time frame for or of the grievance; the right cision regarding his or her	F	585				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
				С	
345365	B. WING			05/	24/2022
		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STON		9	07 CUNNINGHAM ROAD		
STON		K	(INSTON, NC 28501		
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			,		(X5) COMPLETION DATE
and advocacy system; ince Official who is eing the grievance process, grievances through to their ny necessary investigations ning the confidentiality of all I with grievances, for of the resident for those anonymously, issuing sions to the resident; and and federal agencies as pecific allegations; ing immediate action to all violations of any resident violation is being 83.12(c)(1), immediately colations involving neglect, as of unknown source, and of resident property, by vices on behalf of the strator of the provider; and aw; if the resident's grievance, a set if indings or conclusions is concerns(s), a statement vance was confirmed or not ive action taken or to be a result of the grievance, in decision was issued; corrective action in law if the alleged violation is confirmed by the facility naving jurisdiction, such as	F	585			
The same roll of a substitution of the same roll of the s	345365 STON TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 8 and advocacy system; nce Official who is eing the grievance process, grievances through to their ny necessary investigations aing the confidentiality of all with grievances, for if the resident for those anonymously, issuing sions to the resident; and and federal agencies as pecific allegations; ng immediate action to al violations of any resident violation is being 83.12(c)(1), immediately blations involving neglect, es of unknown source, n of resident property, by rices on behalf of the strator of the provider; and w; itten grievance decisions ievance was received, a the resident's grievance, stigate the grievance, a ent findings or conclusions s concerns(s), a statement vance was confirmed or not ive action taken or to be a result of the grievance, n decision was issued; corrective action in law if the alleged violation is confirmed by the facility	STON TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL EXC IDENTIFYING INFORMATION) 8 and advocacy system; nee Official who is eing the grievance process, grievances through to their my necessary investigations aing the confidentiality of all with grievances, for and the resident for those anonymously, issuing sions to the resident; and and federal agencies as pecific allegations; and immediate action to all violations of any resident violation is being 83.12(c)(1), immediately olations involving neglect, as of unknown source, or of resident property, by rices on behalf of the strator of the provider; and w; itten grievance decisions involving neglect, as of unknown source, or fresident property, by rices on behalf of the strator of the provider; and w; itten grievance decisions is evance was received, a the resident's grievance, a cent findings or conclusions as concerns(s), a statement rance was confirmed or not involve action taken or to be a result of the grievance, in decision was issued; corrective action in law if the alleged violation is confirmed by the facility laving jurisdiction, such as	345365 B. WING TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 8 and advocacy system; nce Official who is eing the grievance process, grievances through to their ny necessary investigations ing the confidentiality of all with grievances, for f the resident for those anonymously, issuing sions to the resident; and and federal agencies as pecific allegations; ng immediate action to al violations of any resident violation is being 83.12(c)(1), immediately colations involving neglect, as of unknown source, n of resident property, by frices on behalf of the strator of the provider; and w; itten grievance decisions ievance was received, a the resident's grievance, stigate the grievance, a ent findings or conclusions s concerns(s), a statement vance was confirmed or not ive action taken or to be a result of the grievance, n decision was issued; corrective action in law if the alleged violation is confirmed by the facility laving jurisdiction, such as	STON STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501 PREMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 8 8 8 F 585 and advocacy system; nce Official who is eing the grievance process, grievances through to their ny necessary investigations ing the confidentiality of all with grievances, for f the resident; and and federal agencies as secific allegations; ng immediate action to all violations of any resident violation is being 83.12(c)(1), immediately blations involving neglect, as of unknown source, or of resident property, by rices on behalf of the strator of the provider; and w; titten grievance decisions ievance was received, a the resident's grievance, and findings or conclusions s concerns(s), a statement rance was confirmed or not ive action taken or to be a result of the grievance, or decision was issued; corrective action in law if the alleged violation is confirmed by the facility aving jurisdiction, such as	STON STEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIENTIFYING INFORMATION) 8 F 585 ST SEET ADDRESS, CITY, STATE, ZIP CODE 97 CUNNINGHAM ROAD KINSTON, NC 28501 ID PROVIDERS PLAN OF CORRECTION MUST BE PRECEDED BY FULL SCIENTIFYING INFORMATION) F 585 SAND Advocacy system; nee Official who is eing the grievance process, grievances through to their ny necessary investigations ing the confidentiality of all with grievances, for if the resident for those anonymously, issuing sions to the resident; and and federal agencies as pecific allegations; ng immediate action to al violations of any resident violation is being 33.12(c)(1), immediately bolations involving neglect, so of unknown source, no f resident property, by rices on behalf of the strator of the provider; and w; witten grievance decisions ievance was received, a the resident's grievance, stigate the grievance, a afte findings or conclusions s concerns(s), a statement rance was confirmed or not tive action taken or to be a result of the grievance, n decision was issued; corrective action in law if the alleged violation is confirmed by the facility aving jurisdiction, such as

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		345365	B. WING _		05/2	4/2022
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	03/2	4/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 585	confirms a violation of rights within its area (vii) Maintaining evid result of all grievance 3 years from the issudecision. This REQUIREMEN' by: Based on record reviacility failed to docu investigated and resuctions taken, if the eart and the complainant failed to address the and failed to maintai grievance that was froccurred for 3 of 3 receivences. Findings included: Review of the facility complaint/Grievance documented in part than the corrective account on the grievance/corrective account on the grievances/complaininclude the nature of all grievances/complaineviewed by the Admidays of the receipt of	al law enforcement agency for any of these residents' of responsibility; and ence demonstrating the es for a period of no less than nance of the grievance T is not met as evidenced View and staff interviews the ment if a grievance was olved, the results of the complainant was satisfied remarks. The facility also complaint of the resident in documented evidence of a led by a resident. This esidents (Resident #17, Resident #321) reviewed for 's "Investigate Policy" dated 3-24-22 that grievances/complaints etion would be documented	F 5	F585 1. Resident #17, #370 and #321 grievances were resolved on June 2022. 2. All residents have the potential to affected. The Social Services Direct and/or the Nursing Home Administr (NHA) reviewed grievance log for the 30 days to validate grievances were followed through to resolution by June 2022. Incomplete grievances will be resolved and reviewed by the Administrator within 3 working days receipt of the grievance/complaint. SSD will be educated by June 20, 2000 the NHA on the Grievance Process Grievance Resolution. This education is included in new hire orientation social Services Directors. 3. Ongoing audits will be completed validate grievance resolution via resinterviews and auditing of the grievance. These audits will be completed weekly for 1 week, weekly x 1 weel	to be stor rator ne last e une 20, e sof the The 2022 by and on will for to sident ance ed 5 x x x and	
		n Data Set (MDS) dated ident #17 was cognitively		monthly x 3 months by auditing thre grievances to validate resolution. A will be summarized and presented	II data	

				COM	(X3) DATE SURVEY COMPLETED	
			B. WING		C 05/24/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	0/24/2022	
SIGNATURE HEALTHCARE OF KINSTON			KINSTON, NC 28501			
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE PI TAG REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 585 Continued From page 10 intact. Resident #17 was interviewed of 8:40am. The resident stated she grievance in April 2022 related to baths and incontinence care. Resident had not received any inform her concern. Review of grievances for April 2 grievance from Resident #17 dagrievance documented Resident a specified care giver because to being provided. The form had the Worker (SW) as the person comand the name of the Staff Devel Coordinator (SDC) and the name Manager as the staff responsible the grievance. The areas of inversolve, results of actions taken grievance resolved, complainant complainant remarks did not had documentation. During an interview with the SD 9:15am, the SDC stated she was had been assigned a grievance She explained the SW would refrom the resident and then assign to which ever department the grievance of Resident #17's grievar. The Unit Manager was interview 10:12am. The Unit Manager sta	e had filed a o not receiving esident #17 said nation regarding 022 revealed a sted 4-28-22. The t #17 did not want her care was not he facility's Social heleting the form opment he of the Unit he for investigating estigation, plan to h, was the t satisfaction and he any C on 5-18-22 at he s not aware she to investigate. He ceive the concern he fighter than the grievance he and he grievance he dated 4-28-22. And on 5-18-22 at And on 5-18-22 at	F 58	facility Quality Assurance and Performance Improvement memorthly by the DON or ADOI issues or trends identified will addressed by the QAPI commarise, and the plan will be revensure continued compliance committee consists of the AdDON, ADON, SDC, MDS Condomissions Coordinator, Ref Manager, Medical Director, a of Social Services. Other member assigned as the need shown 4. The Administrator and Social Correction is responsible for impand maintaining the acceptate correction. Corrective action completed by June 21, 2022.	leeting N. Any I be mittee as they rised to a. The QAPI ministrator, ordinator, habilitation and Director mbers may uld arise. sial Service plementing ble plan of to be		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 585	made aware. An interview with the 10:14am. The SW exprise grievances in the de 8:30am and then in the she would hand out up on to the correct of she remembered Reference and said she to the SDC to follow said the SDC must have grievance was plook without being of the Administrator was 5:35pm. The Adminis	again stated she was not a SW occurred on 5-18-22 at explained she presented the partment head meeting at the clinical meeting at 9:30am the grievances to be followed discipline. The SW stated esident #17's grievance dated to had handed the grievance up with Resident #17. She have left it on the table and laced back in the grievance	F 58			
		um Data Set (MDS) dated esident #370 was cognitively				
	May 2022 revealed figrievance dated 12-the grievance was re Administrator and the Resident #370 that a	s from June 2021 through Resident #370 had a 8-21. The document showed eceived by the former e contents was a concern by a former nurse accused him ing changes. Resident #370				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345365	B. WING_		,	C 5/24/2022		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	3/24/2022		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 585	dressing changes, be refusing to change he also stated in the grimessages between I proof she was refusing The grievance indication investigated by the food commentation for the the concern of the renurse. There was no #370 was satisfied worker (\$5-19-22 at 2:28pm. Semployed at the facil #370's grievance but grievance dated 12-8 Resident #370's con and the grievance food completed with the remarks documented. The Administrator was 5:35pm. The Administ	ce he was not refusing his at the former nurse was is dressing. The resident evance he had text nim and the former nurse as ng to change his dressing. It ded the concern was ormer Administrator and the e investigation only included sident texting with the former documentation if Resident with the resolution or any sident. SW) was interviewed on She explained she was not ity at the time of Resident after reviewing the B-21, the SW confirmed cerns were not addressed, rm should have been esident's satisfaction and	F 5	85				

		ATE SURVEY MPLETED				
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		3312-412022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 585	regarding concerns we didn't recall who she so that the state of the s	with the resident's care. She spoke with at the facility. If the Social Worker was stated she was responsible ance form with the concern dispersing them to the expressing them to the expressing them for the strength of the grievance form for the strength of the grievances filed the grievance for Resident #321 in the strength of the grievance she was a strength of the grievance she spoke with at the grievance she spoke she spoke she she she she she she she she she sh	F	85		
F 623 SS=B	he expected a copy of the grievance book uponce there was a reskept in the grievance Notice Requirements CFR(s): 483.15(c)(3)-\$483.15(c)(3) Notice Before a facility transfersident, the facility more sentative (s) of the reasons for the more of the solution of the grievance of t	dministrator, and he stated f the grievances to remain in ntil there was a resolution. olution, the original was book. Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust-and the resident's ne transfer or discharge and ove in writing and in a rethey understand. The popy of the notice to a Office of the State	F€	223		6/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE COI A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345365	B. WING		C 05/24/2022
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	1 00/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE COMPLÉTION
F 623	accordance with para and (iii) Include in the not paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specifie (c)(8) of this section, discharge required under the paragraph (ii) Notice must be more transfer or dis (A) The safety of individual be endangered under this section; (B) The health of individual control in the paragraph (iii) Notice must be more transfer or dis (A) The safety of individual control in the paragraph (B) The health of individual control in the paragraph (iii) Include in the paragraph (c) (b) The health of individual control in the paragraph (c) (b) The health of individual control in the paragraph (c) (b) of the paragraph (c) (b) of the paragraph (c) (b) of the paragraph (c) (c) of the paragraph (c) (d) of the paragraph (d) of the para	ns for the transfer or dent's medical record in agraph (c)(2) of this section; ice the items described in his section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be at least 30 days before the d or discharged. ade as soon as practicable charge whenviduals in the facility would r paragraph (c)(1)(i)(C) of	F 623	3	
	this section; (C) The resident's he allow a more immediunder paragraph (c)((D) An immediate tra required by the residunder paragraph (c)((E) A resident has no days. §483.15(c)(5) Conternotice specified in pamust include the follo(i) The reason for tra (ii) The effective date (iii) The location to w transferred or discha	ent's urgent medical needs, 1)(i)(A) of this section; or of resided in the facility for 30 ents of the notice. The written uragraph (c)(3) of this section owing: unsfer or discharge; of transfer or discharge; hich the resident is			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	'	3072-17.2322
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	Continued From pag	ue 15	F 6	23		
	including the name, and telephone numbreceives such reque to obtain an appeal of completing the form hearing request; (v) The name, addretelephone number of Long-Term Care Om (vi) For nursing faciliand developmental disabilities, the mailiatelephone number of the protection and addevelopmental disabilities, the mailiatelephone number of the protection and addevelopmental disabilities of the Developmental disabilities of the disabilities of the Developmental disabilities of the	address (mailing and email), wer of the entity which sts; and information on how form and assistance in and submitting the appeal ass (mailing and email) and if the Office of the State abudsman; ty residents with intellectual disabilities or related and and email address and if the agency responsible for dvocacy of individuals with boilities established under Part and Disabilities Assistance to of 2000 (Pub. L. 106-402, 15001 et seq.); and ity residents with a mental isabilities, the mailing and belephone number of the for the protection and als with a mental disorder e Protection and Advocacy duals Act.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI			DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022	
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	- '	0.22022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623		e 16 re Ombudsman, residents of esident representatives, as	F 6	23			
	well as the plan for the relocation of the residence 483.70(I). This REQUIREMENT by: Based on record revinterviews the facility notice of the reason and/or responsible p	the transfer and adequate dents, as required at § T is not met as evidenced view, Ombudsman and staff of failed to provide written for transfer to the resident arty (RP) for 1 of 1 resident		F623 1. Resident #41 is currently d 2. To ensure no other residen	_		
	(Resident #41) reviewed for hospitalization and failed to send notice of transfers to the Ombudsman. Findings included:			affected, an audit of the dischar residents was completed, and notifications were provided for t affected starting the month of M Education on the written notification	those May 2022. ation of		
	9/18/17. On 2/9/22 Resident and was real The quarterly Minimum	dmitted to the facility on #41 was discharged to the admitted on 3/15/22. Jum Data Set dated 4/18/22 41 had severe cognitive		discharge policy and the Ombu Notification Log was provided to Social Services Director and/or Admissions Director. This educ be complete by June 20, 2022. training will also be provided to Services Directors upon hire du orientation.	o the cation will This all Social		
	impairment. An interview was cor Worker on 5/17/22 a she started in Noven a notice with the reasfor the resident or RI not been sending the Ombudsman. The Ombudsman was 11:55 AM and she st	nducted with the Social t 11:47 AM and she stated nber 2021 and was unaware son for transfer was needed P. She also stated she had e notice of transfers to the as interviewed on 5/17/22 at tated she had not received om the facility since January		3. Ongoing audits by the Adm and/or MDS Coordinator for obtand review of proper notification Long-Term Care Ombudsman or resident's discharge will be conweekly for four weeks and monthree months. These audits will include no less than 10% of the discharges from the center. All be summarized and presented facility Quality Assurance and Performance Improvement meemonthly by the Administrator. A	servation n of the of iducted ithly for also e data will to the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345365	B. WING			l	C 24/2022
	ROVIDER OR SUPPLIER	NSTON		90	TREET ADDRESS, CITY, STATE, ZIP CODE OF CUNNINGHAM ROAD INSTON, NC 28501	1 03/	24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625 SS=B	and she stated she we the reason for the trainersident or the reside. On 5/17/22 at 4:45 Pl conducted with Nurse discharged Resident 2/9/22. She stated she them know about the a notice with the reason for the trainersident or their RP anotified. Notice of Bed Hold Poce CFR(s): 483.15(d)(1) Notice of Bed Hold Poce Resident goes on nursing facility transfet the resident or reside specifies— (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed pplan, under § 447.40 (iii) The nursing facility facility.	ewed on 5/17/22 at 12:32 PM as not aware a notice with refer was to be given to the nt's RP. M and interview was at #1, and she stated she #41 to the hospital on the called the family to let discharge but did not send on for transfer to the sinterviewed on 5/19/22 at did he expected a notice with refer to be sent to the notice the oblicy Before/Upon Trnsfr (2) bed-hold policy and returnation to the representative that the state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any;		625	or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Direct Director of Social Services, and Environmental Services. Other member may be assigned as the need should arise. 4. The Administrator or MDS Coordinator is responsible for implementing and maintaining the acceptable plan of correction. Correctivaction to be completed by June 21, 202	r, tor, or, rs	6/21/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TION NUMBER: A. BUILDING COMPLETED		OMPLETED	
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	<u>'</u>	VO. 2 11 20 2 2
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 625	Continued From pag		F 6	25		
	resident to return; an (iv) The information s of this section. §483.15(d)(2) Bed-he time of transfer of hospitalization or the facility must provide resident representation.	old notice upon transfer. At f a resident for rapeutic leave, a nursing to the resident and the ve written notice which				
	described in paragra This REQUIREMEN by: Based on record rev	ecifies the duration of the bed-hold policy scribed in paragraph (d)(1) of this section. s REQUIREMENT is not met as evidenced used on record review and staff interviews the		F625		
	facility failed to provide the bed hold policy to the resident and the Responsible Party (RP) when the resident was discharged to the hospital for 1 of 1 resident (Resident #41) reviewed for hospitalization. This practice had the potential to effect other residents.			1.Resident returned to the facility resident's bed was held. 2. All residents had the potential affected. Residents transferred thospital in the last 30 days were	to be o a reviewed	
	9/18/17.	Imitted to the facility on Im Data Set dated 4/18/22		and residents were able to return desired. Education on Facility Be policy was provided to the Licen Nurses by the Staff Developmer Coordinator by June 20, 2022. T training will also be provided to I	ed Hold sed nt This	
	revealed Resident #4 impairment.	11 had severe cognitive #41 was discharged to the		Nurses upon hire during orientat 3.Ongoing audits by the Director Nursing and/or Unit Manager wil completed to include observation record reviews to validate prope	ion. r of ll be n and	
	and she stated she o	ewed on 5/17/22 at 12:10 PM loes not send the bed hold ent to the hospital or give it to		notification has been provided in the resident and/or resident representative explaining how a bed is held while the resident is from the facility due to the hospi	resident's absent	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345365	B. WING _			1	C 24/2022
	ROVIDER OR SUPPLIER	NSTON		90	TREET ADDRESS, CITY, STATE, ZIP CODE 07 CUNNINGHAM ROAD INSTON, NC 28501	1 00	Z-11 Z V Z Z
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660 SS=D	On 5/17/22 at 12:32 Finterviewed, and she the bed hold policy whospital or giving it to The interim Director on 5/17/22 at 3:00 PN unaware if the bed howhen a resident is distorated with Nurse discharged Resident 2/9/22. She stated she policy with Resident stated she didn't knowneeded to be notified a resident was sent to The Administrator state he expected the bed resident when they are Discharge Planning FCFR(s): 483.21(c)(1) Discharge Plann	PM Nurse #6 was stated she was not sending ith the resident to the the RP. If Nursing was interviewed and she stated she was old policy was being sent out scharged or being provided If and interview was at a the time that the time that the hospital on the did not send the bed hold at the tothe hospital. She will the the time that the hospital that the hospital. It the hospital that the discharged to the hospital that the discharged to the hospital that the process (i)-(ix) If you will not send the bed hold policy when the hospital that the discharged to the hospital that the discharged to the hospital that the process (i)-(ix) If you will not the time that t		660	Additional auditing to include validation the bed hold policy included in discharg paperwork. These audits will be conducted 5 x weekly for 1weeks, wee for 2 weeks, and monthly for three months. All data will be summarized ar presented to the facility Quality Assuration and Performance Improvement meeting monthly by the Administrator. Any issured or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrato DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Direct Director of Social Services, and Environmental Services. Other member may be assigned as the need should arise. 4. The Administrator and Director of Nursing are responsible for implementiand maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	ge kly nd nce g es y l r, tor, tor,	6/21/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345365	B. WING				24/2022
	ROVIDER OR SUPPLIER	NSTON		9	TREET ADDRESS, CITY, STATE, ZIP CODE 07 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	rights set forth at 483 (i) Ensure that the dis resident are identified development of a dis resident. (ii) Include regular reidentify changes that discharge plan. The cupdated, as needed, (iii) Involve the interd by §483.21(b)(2)(ii), ideveloping the discharge plan and the resident's or person(s) capacity ar required care, as par discharge needs. (v) Involve the reside representative in the discharge plan and ir resident representative (vi) Address the reside treatment preference (vii) Document that a about their interest in regarding returning to (A) If the resident ind to the community, the referrals to local contappropriate entities in (B) Facilities must up comprehensive care appropriate, in responsion referrals to local appropriate entities. (C) If discharge to the	sistent with the discharge 1.15(b) as applicable and- scharge needs of each d and result in the charge plan for each -evaluation of residents to require modification of the discharge plan must be to reflect these changes. isciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support ind capability to perform it of the identification of int and resident development of the inform the resident and ive of the final plan. Itent's goals of care and s. resident has been asked receiving information of the community. icates an interest in returning er facility must document any act agencies or other made for this purpose.	F	660			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _		0.	C 5/ 24/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	•	J12412022	
0.01.47				907 CUNNINGHAM ROAD			
SIGNATUI	RE HEALTHCARE OI	KINSTON		KINSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 660	SNF or who are de LTCH, assist resider representatives in provider by using limited to SNF, HI patient assessme measures, and dathe data is available the post-acute call assessment data, data on resource the resident's goal preferences. (ix) Document, coon the resident's record, the evaluation must be resident's represent information must be discharge plan to to avoid unnecess discharge or transent This REQUIREMI by: Based on record facility failed to implanning process home health serving the serving resident to the serving planning process home health serving provider to serving planning process home health serving provider to serving planning process home health serving provider to serving planning process planting process	nation and why. It who are transferred to another ischarged to a HHA, IRF, or idents and their resident selecting a post-acute care data that includes, but is not HA, IRF, or LTCH standardized int data, data on quality into an resource use to the extent oble. The facility must ensure that the standardized patient data on quality measures, and use is relevant and applicable to ils of care and treatment Implete on a timely basis based meeds, and include in the clinical action of the resident's discharge rige plan. The results of the ediscussed with the resident or intative. All relevant resident or intative. All relevant resident's designation and sary delays in the resident's	F	F660 1. Resident #269 already disthe facility. Unable to issue dof care.	charged from		
	prior to discharge a planned dischar community (Resid The findings inclu	for 1 of 1 resident reviewed for ge from the facility to the lent #269).		All residents had the poter affected. Audit completed of discharged in May 2022 to verteetiveness of the dischargand ensure durable medical along with home health servi	residents alidate e process equipment		

	A. BUILDING		PLETED			
		345365	B. WING		0.5	C 5/ 24/2022
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				907 CUNNINGHAM ROAD		
SIGNATUR	RE HEALTHCARE OF KI	NSTON	KINSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 660	Continued From page	e 22	F 66	50		
	2/17/22 with diagnose infarction (stroke).	es that included a cerebral		place as ordered by the physician 20, 2022. Education on the disciplanning policy was provided to	harge	
		ission Minimum Data Set 24/22 coded him as having a		Services Director by the Staff Development Coordinator by Ju	ine 20	
	moderate cognitive in	npairment, requiring limited		2022. This training will also be	provided	
		activities of daily living, and on to be discharged to the		to all Social Services Directors during orientation.	upon nire	
	•	t#269 received physical				
	(PT), speech (ST), a services while a resid	nd occupation therapy (OT) dent of the facility.		Ongoing audits by the Directon Nursing and/or Unit Managers for observation and review to ensure the second s	or	
		prehensive care plan goal dated 2/28/22 of		discharge planning process is of for discharged residents. These	ompleted	
	access to necessary			be conducted weekly for four w		
		ring environment post d nursing facilities. All		monthly for three months. Thes will also include no less than 10		
	-	arked as to be determined at		discharges from the center. All		
	discharge planning m			be summarized and presented facility Quality Assurance and		
	_	e summary completed by		Performance Improvement mee		
		ed 4/18/22 revealed a read "Resident to discharge		monthly by the Administrator. A or trends identified will be addre	-	
	to home with home h	ealth services for PT, OT,		the QAPI committee as they ari	se, and	
	ST. [Durable Medical			the plan will be revised to ensur		
		mp, and hospital be from an Discharge order obtained".		continued compliance. The QAI committee consists of the Admit DON, Staff Development Coord	nistrator,	
	Review of Resident # was discharged home	#269's record revealed he e on 4/18/22.		MDS coordinator, Admission Co Rehabilitation Manager, Medica Director of Social Services, and	oordinator, Il Director,	
	There was no evidence of a discharge planning			Environmental Services. Other		
	meeting as indicated further mention of dis	in the care plan and no scharge planning for		may be assigned as the need s arise.	hould	
	Resident #269 from t (2/17/22) through the (4/18/22).	ne time of admission date of his discharge home		The Administrator and Direct Nursing is responsible for imple and maintaining the acceptable	menting	
	An interview was con	ducted with Resident #269's		correction. Corrective action to	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345365	B. WING _				24/2022	
	ROVIDER OR SUPPLIER	KINSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 660	reported Resident # contact from home medical equipment. the family was able until the hospital be reported Resident # for the resident and from family member indicated Resident; with his wife due to support. She reveal contacted the reside follow up on Reside An interview was co #1 on 5/17/22 at 10 facility's protocol for process was to beg date was received. was advised of Res from his insurance of week prior to his dis stated she contacted durable medical equipment take Resident #269 she sent over inform #269 to a third ager provider that worker #1 revealed verification of receip the third agency and confirmation they we for services. She fur contact with Reside was discharged. An interview was co	in/16/22 at 1:26 PM. She it269 had not received any inealth services or any durable. The family member stated to borrow a used hospital bed discrived on 4/26/22. She it269's wife was providing care was receiving assistance is. The family member it269 was safe at home living family and community ed the facility had not ent or any of the family to int #269's discharge. Inducted with Social Worker in DAM who stated the inthe discharge planning in planning once a discharge Social Worker #1 stated she ident #269's discharge date company approximately one ischarge. The social worker dit two home health and dipment agencies who did not is insurance. She explained ination and orders for Resident incy as they were the only did with his insurance. Social she never received of of the information sent to did she also received no ere accepting Resident #269 of ther revealed she had no int #269 or his family after he	F	completed by June 21, 202	?2.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			/ Boiles			С	
		345365	B. WING			05/	24/2022
	ROVIDER OR SUPPLIER RE HEALTHCARE OF KII	NSTON		90	TREET ADDRESS, CITY, STATE, ZIP CODE D7 CUNNINGHAM ROAD INSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 661 SS=D	discharge planning fo due to insurance issu Worker #1 started in I trained by another so corporation. The Adm Social Worker was re DME and services are the time of discharge.	and he was aware that In Resident #269 was difficult In Reside		660			6/21/22
	must have a discharge but is not limited to, the (i) A recapitulation of includes, but is not lim of illness/treatment or radiology, and consul (ii) A final summary or include items in parage the time of the dischargelease to authorized the consent of the respresentative. (iii) Reconciliation of a medications with the medications (both preover-the-counter). (iv) A post-discharge developed with the parage developed with the parage discharge plant of the post-discharge plan	cipates discharge, a resident e summary that includes, ne following: the resident's stay that nited to, diagnoses, course therapy, and pertinent lab, tation results. f the resident's status to graph (b)(1) of §483.20, at rge that is available for persons and agencies, with sident or resident's all pre-discharge resident's post-discharge escribed and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION _DING		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•	312412022	
CICNIATU		KINGTON		907 CUNNINGHAM ROAD			
SIGNATU	RE HEALTHCARE OF	KINSTON		KINSTON, NC 28501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 661	Continued From pa	age 25	F 6	61			
	that have been ma care and any post- non-medical servic This REQUIREME by:	de for the resident's follow up discharge medical and ses. NT is not met as evidenced					
	facility failed to cor for 1 of 1 resident	review and staff interviews the implete a recapitulation of stay reviewed for a planned a facility to the community		1. Resident #269 already di the facility. Unable to initiate summary in the closed reco	e discharge		
	2/17/22 with diagn infarction (stroke). Resident #269's at assessment dated moderate cognitive	ded: s admitted to the facility on oses that included a cerebral dmission Minimum Data Set 2/24/22 coded him as having a e impairment and having the discharged to the community.		2. All residents had the pote affected. Discharge summa completed on residents disc 2022 and going forward. State Development Coordinator peducation on the discharge policy to the Licensed Nurse 20,2022. This training will provided to all Licensed Nurse during orientation.	ries to be charged in May aff rovided summary es by June also be		
	was discharged he review revealed no completed a recap stay in the facility. The facility Social interview on 5/18/2 aware who was rerecapitulation of Refacility. During a second in on 5/18/22 at 4:18 responsible for cor Resident #269's st	at #269's record revealed he ome on 4/18/22. Further of evidence the facility situlation of Resident #269's Worker #1 stated during an exact at 3:10 PM she was not sponsible for completing the esident #269's stay in the esident #269's stay in the exact worker #1 PM she reported she was empleting the recapitulation of eay in the facility. Social Worker did the Administrator advised her		3. Ongoing audits by the Dil Nursing and/or Unit Manage observation and review to edischarge summary process for discharged residents. The conducted weekly for formonthly for three months. Will also include no less that discharges from the center. be summarized and presentacility Quality Assurance and Performance Improvement monthly by the Administration trends identified will be a the QAPI committee as they the plan will be revised to elections.	ers for ensure the s is completed hese audits will ur weeks and These audits n 10% of the All data will ted to the hd meeting or. Any issues ddressed by y arise, and nsure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345365	B. WING _			05/	24/2022
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			90	TREET ADDRESS, CITY, STATE, ZIP CODE OT CUNNINGHAM ROAD INSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 661 F 677 SS=E	She reported she was in the facility and beg 2021. She reported s 3-4 additional commubegan the position of An interview was con Administrator who stastill learning her role a responsible for comp Resident #269's stay	art of her responsibilities. Is new to the social work role an her position in November the had been responsible for unity discharges since she social worker in the facility. I ducted with the ated Social Worker #1 was and was not aware she was leting the recapitulation of		661	committee consists of the Administrator DON, Staff Development Coordinator, MDS coordinator, Admission Coordinat Rehabilitation Manager, Medical Direct Director of Social Services, and Environmental Services. Other member may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	tor, or, rs	6/21/22
	out activities of daily services to maintain of personal and oral hygometric than the personal hygom	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced iew, observations, staff and e facility failed to provide ing (ADL) care to dependent red for 5 of 8 residents 446, #52 and #270) reviewed admitted to the facility on e diagnoses that included im Data Set (MDS) dated sident #53 was severely			F677 1. Activities of Daily Living (ADL) care is been provided for Resident #53, #17, # and #52. Resident #270 has been discharged. 2. All residents had the potential to be affected. An audit of the current resider population to ensure the delivery of AD care to dependent residents. ADL care has been provided for all identified residents by June 16, 2021. The Staff Development Coordinator provided education to the licensed nurses and the	446, nt L	

OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
	345365	B. WING			C 05/24/2022		
POVIDED OR SLIDDLIED	0.0000		STDEET AT	DDPESS CITY STATE ZIP CODE	05/	24/2022	
NOVIDER OR SUFFLIER							
RE HEALTHCARE OF KI	NSTON						
			KINSTON	N, NC 28501			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
677 Continued From page 27		F 6	77				
Continued From page 27 cognitively impaired with no refusal of care and required extensive assistance with 2 people for bed mobility, total assistance with one person for dressing and toileting, total assistance with 2 people for personal hygiene and bathing did not occur. Resident #53's care plan dated 5-13-22 revealed a goal that he would be appropriately groomed and dressed. The interventions for the goal were in part provide ADL care to ensure daily needs were met. Review of Resident #53's ADL care documentation revealed no documentation that he had received any bathing for the following dates: - October 2021: 10/1, 10/2, 10/5, 10/7 - 10/10, 10/15 - 10/17, 10/19, 10/22 - 10/24, 10/27, 10/28, 10/20, 10/31 - November 2021: 11/2, 11/4, 11/6, 11/7, 11/11 - 11/13, 11/18, 11/20, 11/21, 11/24 - 11/29		F6	certification control compression compress	on ensuring ADL care such as ang and incontinent cares are being for facility residents. This training lab be provided to all licensed nursertified nursing assistants upon hig orientation. Ingoing audits will be completed by stor of Nursing, SDC, and/or the Usager for observation and validation ADL care has been provided for andent residents. These audits with sucted for (5) residents 5 x weekly veeks, (5) residents weekly for two seeks, (5) residents monthly for the control of th	g g rses ire the Init n II be for o nree		
- May 2022: 5/2, 5/10 ADL care for Resider 5-17-22 at 9:15am wi #4. Resident #53's sk however his brief was through onto the bed was noted to have drareas. During an interview w 9:40am, the NA state incontinence care up	at #53 was observed on with Nursing Assistant (NA) with was noted to be intact, is observed to be saturated is under pad. The under pad ited areas as well as wet with NA #4 on 5-17-22 at it dishe had not provided on starting her shift or before		days admit cares incon times times will b All da to the Perfo monti or tre the Q	a week to ensure that all newly tted residents are receiving ADL including bathing cares and attinent cares x 4 weeks, then threes a week for 2 weeks, then weekly a 2 weeks. Any concerns identified the corrected as observed. The attained and present at a will be summarized and present at a will be summarized and present facility Quality Assurance and the attained armance Improvement meeting the control of the Administrator. Any issues and identified will be addressed to API committee as they arise, and	nted es		
	ROVIDER OR SUPPLIER RE HEALTHCARE OF KII SUMMARY ST (EACH DEFICIENC REGULATORY OR II Continued From page cognitively impaired or required extensive as bed mobility, total ass dressing and toileting people for personal h occur. Resident #53's care p a goal that he would and dressed. The inte in part provide ADL co were met. Review of Resident # documentation revea he had received any dates: - October 2021: 10/1, 10/15 - 10/17, 10/19, 10/20, 10/31 - November 2021: 11 11/13, 11/18, 11/20, 1 - April 2022: 4/1, 4/2, 4/22 - 4/30 - May 2022: 5/2, 5/10 ADL care for Resider 5-17-22 at 9:15am wi #4. Resident #53's sh however his brief was through onto the bed was noted to have dr areas. During an interview w 9:40am, the NA state incontinence care up breakfast and was no	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 cognitively impaired with no refusal of care and required extensive assistance with 2 people for bed mobility, total assistance with 2 people for dressing and toileting, total assistance with 2 people for people for personal hygiene and bathing did not occur. Resident #53's care plan dated 5-13-22 revealed a goal that he would be appropriately groomed and dressed. The interventions for the goal were in part provide ADL care to ensure daily needs were met. 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The under pad was noted to have dried areas as well as wet	ROVIDER OR SUPPLIER RE HEALTHCARE OF KINSTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 cognitively impaired with no refusal of care and required extensive assistance with 2 people for bed mobility, total assistance with 2 people for bed mobility, total assistance with 2 people for personal hygiene and bathing did not occur. Resident #53's care plan dated 5-13-22 revealed a goal that he would be appropriately groomed and dressed. The interventions for the goal were in part provide ADL care to ensure daily needs were met. 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During an interview with NA #4 on 5-17-22 at 9:40am, the NA stated she had not provided incontinence care upon starting her shift or before breakfast and was not sure when Resident #53	REHEALTHCARE OF KINSTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 cognitively impaired with no refusal of care and required extensive assistance with 2 people for bed mobility, total assistance with 2 people for personal hygiene and bathing did not occur. Resident #53's care plan dated 5-13-22 revealed a goal that he would be appropriately groomed and dressed. The interventions for the goal were in part provide ADL care to ensure daily needs were met. 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Review of Resident #53's ADL care documentation that he had received any bathing for the following dates: - October 2021: 10/1, 10/2, 10/5, 10/7 - 10/10, 10/15 - 10/17, 10/19, 10/22 - 10/24, 10/27, 10/28, 10/20, 10/31 - November 2021: 11/2, 11/4, 11/6, 11/7, 11/11 - 11/1/3, 11/18, 11/20, 11/21, 11/24 - 11/29 - April 2022: 41/4, 42/4, 44/1, 41/3, 4/16, 4/19, 4/22 - 4/30 - ADL care for Resident #53's skin was noted to be intact, however his brief was observed to be saturated through onto the beds under pad. The under pad was noted to have dried areas as well as wet areas. During an interview with NA #4 on 5-17-22 at 9:40am, the NA stated she had not provided incontinence care upon starting her shiff or before breakfast and was not sure when Resident #53's the plan will be revised to ensure the law and performance improvement meeting monthly by the Administrator. Any issue or trends identified will be addressed the plan will be revised to nessure the plan will be revised to resource and performance improvement meeting monthly by the Administrator. Any issue or trends identified will be revised to resource the plan will be revised to resou	TO COMPRECTION 345365 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 3453665 34536665 34536665 34536666666666	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 5/24/2022	
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP COD 907 CUNNINGHAM ROAD KINSTON, NC 28501		5/2-4/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 677	hours for incontinence not perform a bed bat assigned to her if the #4 explained she ofter assigned to her and on all of them. NA #5 was interviewed. The NA stated she wand had been assign Resident #53 on 10-2 said if she had not do provided then she did added Resident #53 NA #5 explained the staffed and she was to all the residents should the staffed and she was to all the residents should have a bath explained incontinence rounds 5:00am but she stated sincontinence rounds 5:00am but she stated she had provided incompassion. The Administrator was 5:35pm. The Administrator was 5:35pm. The Administrator was she had provided incontinence care where was aware the restriction of the was aware the restriction of the was aware the restriction. Resident #17 was 10-3-12 with multiple	ts assigned to her every 2 te care. She revealed she did th on all her residents facility was short staffed. NA en had 18-20 residents could not perform ADL care ed on 5-18-22 at 8:12am. as familiar with Resident #53 ted to provide ADL care to 24-21 and 11-25-21. She ocumented a bed bath was d not complete the task. She had not refused ADL care. facility was often short not able to provide ADL care ne was assigned. If y occurred with NA #6 on NA #6 confirmed she had to 7:00am shift ending on she completed her last between 4:00am and ad she could not remember if ontinence care to Resident as interviewed on 5-19-22 at strator stated residents every day and be provided then it was needed. He stated forcior to 4-25-22 but was	F 67	committee consists of the Adr DON, Staff Development Coo MDS coordinator, Admission Rehabilitation Manager, Medi Director of Social Services, an Environmental Services. Othe may be assigned as the need arise. 4. The Administrator and Dire Nursing is responsible for imp and maintaining the acceptab correction. Corrective action t completed by June 21, 2022.	ordinator, Coordinator, ical Director, and er members I should ector of olementing ole plan of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345365	B. WING		05/24/2022	
	ROVIDER OR SUPPLIER	INSTON	,	STREET ADDRESS, CITY, STATE, ZIP CODE 207 CUNNINGHAM ROAD KINSTON, NC 28501	1 33/2-7/2022	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 677	The annual Minimur 3-3-22 revealed Resintact, had not refus extensive assistance mobility, toileting an assistance with 2 per Resident #17's care a goal that she woul Activities of Daily Linfor the goal were in assistance for ADLs Review of Resident revealed no docume other bathing was perfectly between the bathing was perfectly as a complete bed bath observed to have a gown was observed	aral vascular disease. In Data Set (MDS) dated sident #17 was cognitively ed care and required e with 2 people for bed dipersonal hygiene, and total cople for bathing. In plan dated 5-13-22 revealed dipersonal hygiene with ring (ADL). The interventions part provide extensive extensive extensive for the following fo	F 677			
	The NA stated she wand had been assign	red on 5-18-22 at 8:12am. vas familiar with Resident #17 ned to provide ADL care on and 11-25-21. NA #5 said if				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022	
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP COD 907 CUNNINGHAM ROAD KINSTON, NC 28501	Ē	00/14/12011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	D.4.T.E.	
F 677	a bed bath on Resid completed the task. had not refused ADL facility was often sho able to complete AD she was assigned. During an interview of 9:10am, the NA state Resident #17 and hat to provide ADL care, not documented as able to complete a both the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents assigned to the facility was short not always able to coresidents. The Administrator was 3-1-16 with multiple failure and peripheral the facility was short not always able to coresidents. The Administrator was 3-1-16 with multiple failure and peripheral the facility was short not always able to coresidents. The Administrator was 3-1-16 with multiple failure and peripheral the facility was short not always able to coresidents. The Administrator was 3-1-16 with multiple failure and peripheral the facility was short not always able to coresidents.	ent #17, then she had not The NA added Resident #17 Care. She explained the ort staffed and she was not L care on all the residents with NA #9 on 5-18-22 at ed she was familiar with ad been assigned on 5-11-22 She stated if the care was completed then she was not ed bath. She added Resident ADL care. NA #9 explained staffed at times and she was complete ADL care on all the or her. as interviewed on 5-19-22 at estrator stated residents every day. He stated he was were sometimes not prior to 4-25-22 but was an had continued. admitted to the facility on diagnoses that included heart all vascular disease. sum Data Set (MDS) dated esident #46 was cognitively care and required extensive person for bed mobility, ygiene and total assistance	F6	577			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022	
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP COD 907 CUNNINGHAM ROAD KINSTON, NC 28501	E '	0012-472022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 677	staff. The intervention help with Activities of Review of Resident # revealed no documer other bathing was prodates: - October 2021: 10/1, 10/17, 10/19, 10/20, 2- November 2021: 11 11/12, 11/15 - 11/17, 11/30 - April 2022: 4/2, 4/3, 4/23, 4/24, 4/26, 4/28 - May 2022: 5/1, 5/7, Resident #46 was integrated was provided to her such she stated she unstaffed. Resident #46 hospital gown that had top of the gown. NA #4 was interviewed the such was assigned to 11-28-21 to provide A was not documentation assigned to provide a was not provided. She not refused care. NA often short staffed and documents as the staffed and th	while being cared for by as for the goal were in part Daily Living (ADL) care. 46's bathing documentation station a bed bath or any ovided for the following 10/3 - 10/10, 10/14, 10/16, 10/23 - 10/25, 10/28, 10/31 1/3, 11/4, 11/6 - 11/9, 11/11, 11/19 - 11/24, 11/26, 11/28 - 4/6, 4/13, 4/15, 4/16, 4/19, -4/20 5/8, 5/10, 5/12, 5/14, 5/15 erviewed on 5-16-22 at 6 stated she did not receive but when she did the care atisfaction. She explained ave a bed bath every day, aderstands the NAs are short was observed to have on a d a dried substance at the ad on 5-17-22 at 9:30am. The state of the same of the care at the second on the days she was bed bath, then the care added Resident #46 had #4 explained the facility was	F6	77			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C)5/24/2022	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			STREET ADDRESS, CITY, STATE, ZIP COL 907 CUNNINGHAM ROAD KINSTON, NC 28501		1 00/124/2022	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 677	The NA stated she wand had been assign 4-24-22. NA #5 said that she had comple #46, then she had no NA added Resident care. She explained staffed and she was care on all the reside. During an interview va:10pm, The NA staffed and she was care on all the resident #46 and state to her for ADL care of was not documentate days, she worked, that task. She added Resident was not able to residents she was as The Administrator was 135pm. The Administrato	ed on 5-18-22 at 8:12am. Vas familiar with Resident #46 ned to provide ADL care on if she had not documented ted a bed bath on Resident ot completed the task. The #46 had not refused ADL the facility was often short not able to complete ADL ents she was assigned. with NA #7 on 5-18-22 at ted she was familiar with ated she had been assigned on 11-6-21. She said if there ion of a bed bath on the ten she did not complete the sident #46 had not refused blained some days there were eximately 83 residents and complete ADL care on all the essigned. as interviewed on 5-19-22 at strator stated residents every day. He stated he was were sometimes not prior to 4-25-22 but was	F 67	77			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C 05/24/2022	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			TREET ADDRESS, CITY, STATE, ZIP CODE 07 CUNNINGHAM ROAD INSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 677	Resident #52's care a goal that she woul and dressed. The in in part provide total Activities of Daily Liv care to ensure daily Review of Resident revealed no docume other bathing was p dates: - October 2021: 10/10/19, 10/20, 10/23, - November 2021: 11/26, 11/28 - 11/30 - April 2022: 4/1 - 4/4/26, 4/28 - 4/30 - May 2022: 5/1, 5/7 Resident #52 was ir 9:20am. The resider receiving a bath dail hour for incontinence She explained staff provide a bed bath the wait for care because working. Resident # odor and colored liquit the top of her hospit During a follow up in 5-17-22 at 9:45am, and stated she need explained she asked	plan dated 5-13-22 revealed d be appropriately groomed terventions for the goal were assistance with 2 staff for ving (ADL) care, provide ADL needs are met. #52's bathing documentation entation a bed bath or any rovided for the following 1, 10/3 - 10/10, 10/14, 10/16, 10/24, 10/29, 10/31 1/2 - 11/4, 11/6-11/13, 11/15 - 4, 4/6, 4/13, 4/19, 4/23, 4/24, 7, 5/10, 5/12, 5/15 Interviewed on 5-16-22 at an t stated she was not y and had to wait over an e care several times a week. The had told her they could not on her some days and had to see there were not enough staff 52 was observed to have an uid with a dried substance on	F 677			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SUR\ COMPLETE	
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	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CO 907 CUNNINGHAM ROAD KINSTON, NC 28501	DE		· -
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) MPLETION DATE
F 677	with. Observation of ADL of occurred on 5-17-22 Assistant (NA) #8. The Resident #52's brief of through to the under An interview with NA 10:30am. The NA star Resident #52 for incomplete for the unit manager information stated she had not represidents assigned to the last time Resident the last time Resident During a telephone in 5-18-22 at 7:45pm, the 11:00pm to 7:00a She stated she comprounds between 4:00	are for Resident #52 at 10:05am with Nursing the observation revealed was saturated with urine pad on the bed. #8 occurred on 5-17-22 at ted she had checked intinence when she started teakfast. She said she was 2 was assigned to her until rmed her at 10:00am. NA #8 the ceived a report about her ther, so she did not know the #52 had received care. Interview with NA #6 on the NA confirmed she worked m shift ending on 11-17-22. Ileted her incontinence am and 5:00am but she said	Fé	677			
	Incontinence care to NA #4 was interviewed. The NA stated she woon 11-28-21. She stated bath documented the task. She added Rescare. NA #4 explained staffed and she could all the residents she like NA #5 was interviewed. The NA stated she wood not not staffed and she wood not staffed and she wood not she would not she wood not s	ed on 5-17-22 at 9:30am. as assigned to Resident #52 ted if there was not a bed n she did not complete the ident #52 had not refused d the facility was often short I not complete bed baths on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION IG	(X:	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		03/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 677	that she had complete #52, then she had no NA added Resident # care. She explained the staffed and she was rebaths on all the resident #52 on 11-6 not documentation the bed bath then she had She added Resident The NA explained the and she was not able all the residents she will be the she was not able all the residents she will be the she was aware the resident #270 was 10/6/2021 with diagnormal to the she was aware the problem 5. Resident #270 was 10/6/2021 with diagnormal the she was aware the resident #270 was 10/6/2021 with diagnormal the she was aware the problem the she was aware the problem the she was aware the problem to the she was aware the	f she had not documented ed a bed bath on Resident to completed the task. The state of the resident and the resident she was assigned. #7 occurred on 5-18-22 at a she had been assigned to see the resident received a donot complete the task. The state of the resident received a donot complete the task. The state of the resident received a donot complete the task. The state of the resident received a donot complete bed baths on was assigned. It is interviewed on 5-19-22 at trator state of residents were sometimes not be rior to 4-25-22 but was had continued. The state of the resident interviewed to the facility on coses including stroke. It is admitted to the facility on coses including stroke. It is admitted to the facility on coses including stroke. It is admitted to the facility on coses including stroke. It is admitted to the facility on coses including stroke. It is admitted to the facility on coses including stroke. It is a strong the resident intact and required conal hygiene and bathing. It is a strong the resident with the sactivities are to left sided weakness. It is a providing assistance with	F 6	77			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON		KINSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		05/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPREDED T	JLD BE	(X5) COMPLETION DATE
F 677	revealed Resident scheduled for Mondo Documentation of R October 2021 reveany other bathing vidates: October 2021: 10/6 10/16, 10/17, 10/18 10/24, 10/25, 10/26 Resident #270 was 11/8/2021. In a phone interview 5/18/2022 at 4:25 provided Resident NA on 10/7/2022, sthe dates she assist and she documented assist 10/7/2022 or was a not documented as In a phone interview 5/18/2022 at 8:18 premembered providen 10/11/2021, and	ity's shower schedule #270 's showers were day and Thursdays. Resident's #270 ADL care in aled no showers, bed baths or was provided for the following 5, 10/7, 10/8, 10/9, 10/10, 8, 10/19, 10/21, 10/22,10/23, 6, 10/27, 10/29, 10/30, 10/31 I discharged from the facility on W with Nurse Aide #12 on D.m., when asked if she #270 a bath as the assigned the stated she was unsure of sted Resident #270 with baths, and resident's baths in the record. NA#12 had not ling Resident #270 with bath on ble to recall why a bath was	F 67	,		
	aides working on a unable to provide r On 5/19/2022 at 4: interim Director of I baths and showers	due to three to four nurse shift, the nursing staff was esident showers. 32 p.m. in an interview with the Nursing, she stated resident's were based on the resident's rsing staff were to provide				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C 05/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2 1/2022	
SIGNATUI	RE HEALTHCARE OF KII	NSTON	9	007 CUNNINGHAM ROAD		
SIGNATO	RE HEALTHCARE OF KII	4310N	1	KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 677	Continued From page	∍ 37	F 677			
		s requested by the resident.				
F 689 SS=J		ards/Supervision/Devices (2)	F 689		6/21/22	
	as free of accident has §483.25(d)(2)Each re supervision and assist accidents. This REQUIREMENT by: Based on record revision terviews the facility to prevent accidents with the second revision delivered by system as a liquid) with meals by Nursing Assistent #369 aregular #369 aspirated (breat lungs) and was hospi provided a regular texture who performed activiting independently. This with reviewed for supervisiance accident/hazards (Re #35, #31, #171 and #11 Immediate Jeopardy 15-11-22 when NA #11	sident environment remains sizards as is possible; and estance devices to prevent is not met as evidenced few, staff and Physician failed to provide supervision when residents (Resident 61) who were ordered to th (NPO) and enteral feeding a tube into the digestive ere served regular textured sistant (NA) #1. NA #1 fed allar textured meal. Resident thed food/liquid into the talized for 5 days. NA #1 actured meal tray to Resident the likelihood of serious harm to facility also failed to emperatures for residents sites of daily living (ADLs) was for 8 of 10 residents ion to prevent sidents #369, #61, #47, #12,		1. Resident #369 and Resident #61 remain NPO. Nurse aide #1 and the Assistant Dietary manager no longer wat the facility. Water temperatures have been corrected for Resident #47, #12, #35, #31, #171, and #32. 2. All residents have the potential to be affected. In house audit completed on diets of current resident population to review physician's diet order, diet care plans to match, and dietary tray card worm completed by 5/13/2022 by the Interim DON, Unit Managers, or Dietary Direct Education provided by the Staff Development Coordinator to all staff or the need to provide a diet as ordered at the serious adverse outcomes that couresult from providing an incorrect diet. education also included where to find the diet order of the resident. This education was completed by 5/19/2022. This	e as or. n nd ld The	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	0.0000	 	STREET ADDRESS, CITY, STATE, ZIP CODE] 0:	5/24/2022	
NAME OF T	TOVIDER OR OUT FILE			907 CUNNINGHAM ROAD			
SIGNATUR	RE HEALTHCARE OF KI	NSTON					
				KINSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 38	F 68	39			
F 689	meal. Immediate Jeo on 5-11-22 when NA who was NPO and or textured meal. Immedon 5-20-22 when the implemented an accellimediate Jeopardy remains out of complemented are grounded in the implemented an accellimediate Jeopardy remains out of complements of complete monitoring systems pand to implement a pexamples 3 through frindings included 1. Resident #369 was 9-22-17 with multiple gastrostomy status. The quarterly Minimused the cognitively impaired a with one person for ferm to the fermion of the centimeters of more desident with the fermion of the centimeters of more desident with the centimeters of more desident with the fermion of the centimeters of more desident with the fermion of the centimeters of more desident with the fermion of the centimeters of the	pardy for example #2 began #1 provided Resident #61, n enteral feedings, a regular diate Jeopardy was removed facility provided and eptable credible allegation of removal. The facility iance at a lower scope and actual harm with potential al harm that is not immediate electron, ensure out into place are effective, olan of correction for 10. It admitted to the facility on diagnoses that included Im Data Set (MDS) dated sident #369 was severely and required total assistance electing. The MDS also coded deriving 51% or more of her edding and 501cc (cubic water per day.	F 68	education will be included in ne orientation for all staff. Addition completed on water temperature resident rooms by June 20, 202 range water temperatures were Additional education was provid Maintenance Director and the Maintenance Assistant on the in of maintaining safe water temperatures who perform active daily living independently by the Maintenance Director by June 20 This education will be included orientation for maintenance stards. 3. Ongoing auditing to include a reviews and observations to varesidents are provided accurate per physician orders. Audits will completed by the Director of Nu and/or Unit Manager 5 x weekly weeks, weekly x two weeks, and x 3 months. Additional audits of temperatures will be completed maintenance of safe water tem by the Maintenance Director ar Maintenance Assistant. These be completed 5 x weekly for two weeks, and mor	nal auditing res in all 22. Out of e corrected. ded to the mportance eratures ities of e Regional 20, 2022. in new hire ff. record didate e diets as ll be ursing y for two nd monthly f the water I to validate peratures nd/ or audits will o weeks, nthly x 3		
	an order initiated 7-2 receive a fortified nut	physician's orders included 6-21 for Resident #369 to ritional supplement at 55cc y through enteral feedings.		months. All data will be summa presented to the facility Quality and Performance Improvement monthly by the DON or Assista Of Nursing. Any issues or tren	Assurance t meeting nt Director		
		physician's orders included -21 for Resident #369 to be uth).		identified will be addressed by committee as they arise, and the revised to ensure continued compliance. The QAPI committee	the QAPI ne plan will tee		
	Resident #369's activ	e care plan as of 5-10-22		consists of the Administrator, D			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022	
	RE HEALTHCARE OF K	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	00/2-4/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	revealed a goal that complications related. The interventions for head of the bed elev distention, lung soun Resident #369 had a would remain stable. goal were in part resordered- fortified nut flushes per order. A nursing progress resident #369's room nurse. Nurse #2 documes. Nurse #369's room nurse. Nurse #2 documes fluid. The Physician and fathat Resident #369's remergency room for. The emergency room for. The emergency room for. The emergency room for. The hospital records Resident #369 receivint and the total records resident #369 receivint and the total records resident #369 receivint and the feedings. The back to the facility or During a phone inter at 1:31pm, the NA exiday working at the facility or the properties of the facility or the facility or the properties of the facility or the facility or the properties of the facility or the facility	she would remain free of d to the use of a feeding tube. If the goal were in part keep ated, observe for abdominal ds and check for residual. It second goal that her weight a second goal	F 6	ADON, SDC, MDS Coordinator, Admissions Coordinator, Reha Manager, Medical Director, ar of Social Services. Other membe assigned as the need should the Administrator and Direct Nursing is responsible for impand maintaining the acceptable correction. Corrective action to completed by June 21, 2022.	abilitation and Director abers may ald arise. ctor of lementing le plan of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345365	B. WING				24/2022	
	ROVIDER OR SUPPLIER	INSTON	1	90	TREET ADDRESS, CITY, STATE, ZIP CODE 07 CUNNINGHAM ROAD INSTON, NC 28501	1 0011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	trays on 5-11-22 and another resident (Re a meal tray. NA #1 s and requested 2 me #369 and one for Re She said the dietary textured meal trays apples, sausage pat commented the diet her the residents we went back to the union the tray table and where she began to eggs and orange juibegan to turn red in breathing, so she tu and retrieved help fr meeting. She explainurses on the unit a approximately 1 min she had received no computer access pristated she saw the Resident #369 but disince she did not had check the resident's resident was NPO. The WC nurse was 2:12pm. The WC numorning meeting on the meeting request she walked into Residents. The WC nursitting up in the bed	ge 40 ed handing out breakfast d realizing Resident #369 and esident #61) had not received stated she went to the kitchen al trays (one for Resident esident #61) from dietary staff. estaff provided her 2 regular with eggs, French toast with ty and orange juice and eary staff had not mentioned to ere NPO. NA #1 stated she tt, placed Resident #61's tray d proceeded to Resident #369 feed the resident some of the ce. She stated Resident #369 the face and had trouble rned the resident on her side om a nurse that was in a ned she did not see any nd had left the resident for ute to get help. NA #1 said orientation, training or or starting her shift. She enteral feeding pump for id not know what it was and ve access to the computer to diet, she was unaware the interviewed on 5-17-22 at rse discussed being in a 5-11-22 when NA #1 entered ing help. She stated when ident #369's room, she saw the resident's face and se said the resident was and NA #1 told her she had sident breakfast when the	F	689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		05/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 689	Continued From pa	ge 41	F 68	39	
	12:39pm. The nurs down to Resident # observed the reside coughing with blood mouth. She further informed her NA #1 resident a meal. She Physician, 911 and nurse stated the remergency room for Dietary Aide #1 was 1:20pm. The Dietar on 5-11-22 during the washroom and trays. She explaine	e explained she was called da69's room on 5-11-22 and ent sitting up in the bed, d-tinged fluid coming out of her explained the WC nurse had had been trying to feed the estated she called the the resident's family. The sident was sent to the or further evaluation. In the sident was sent to the or further evaluation. It is interviewed on 5-17-22 at my Aide stated she was working oreakfast but was assigned to did not hand NA #1 any meal and the Assistant Dietary en with and handed the meal			
	Assistant Manager Dietary Assistant M come to the kitcher trays for Resident # discussed checking residents and saw received enteral feet thought staff was treat back onto solid foomeal tray for both F #61 to NA #1. The stated he could onlin the computer. He orders were not entered medical record before he did not know if the computer of the state of the	ew occurred with the Dietary on 5-17-22 at 1:56pm. The lanager stated NA #1 had non 5-11-22 requesting meal #369 and Resident #61. He go the dietary orders for both they were both NPO and ledings but explained he laying to switch the residents do so he provided a regular Resident #369 and Resident Dietary Assistant Manager lay see a resident's dietary order le explained that sometimes the latered into the electronic latered into the electronic latered had been an actual order ents back onto solid foods. He			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		0,	C 5/24/2022	
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	312-412022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Manager or the nursi trays to NA #1. The Medical Director telephone on 5-19-22 Director stated she wincident for Resident was high potential for a resident aspirating. The Director of Nursi on 5-17-22 at 2:25pm accident with Resider avoided if NA #1 had regarding the resident assignment. 2. Resident #61 was 7-6-11 with multiple of gastrostomy status. The May 2022 active an order initiated 7-3 be NPO. The May 2022 active an order initiated 1-7 receive a fortified nut (cubic centimeters) penteral feedings. The quarterly Minimus 5-9-22 revealed Resi cognitively impaired a with one person for ealso coded for tube feedings.	was interviewed by 2 at 3:35pm. The Medical ras aware of the 5-11-22 #369. She indicated there reserious harm resulting from ang (DON) was interviewed in The DON stated the int #369 could have been been oriented and educated in the area prior to receiving her admitted to the facility on liagnoses that included included in the facility on the physician's orders included in the facility on the facility of the facility of the facility on the facility of the fac	F 68				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CO 907 CUNNINGHAM ROAD KINSTON, NC 28501	ODE	03/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	revealed a goal that is signs and symptoms her feeding tube. The were in part administeresident is NPO (noth the head of the bed 3. During a phone intervat 1:31pm, the NA exiday working at the factorial feeding in the properties of the propertie	care plan as of 5-10-22 he would not exhibit overt of complications related to interventions for the goal er feedings as ordered, ing by mouth) and elevate 0-35 degrees while feeding. iew with NA #1 on 5-17-22 plained 5-11-22 was her first politity. She added that it was king in a long-term care defined handing out breakfast realizing Resident #61 and pident # 369) had not NA #1 stated she went to rested 2 meal trays (one for the for Resident #369) from the dietary staff provided meal trays with eggs, les, sausage patty and mented the dietary staff had the residents were NPO. NA tack to the unit, placed in the tray table next to the memented Resident #61 able to reach the tray then to Resident #369's room. not fed Resident #61 but ld have tried to feed the left the meal tray in the had received no recomputer access prior stated since she did not	F	689		
		e was unaware the resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345365 B. WING			C 24/2022		
NAME OF P	ROVIDER OR SUPPLIER	0.0000	1	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	24/2022
SIGNATU	RE HEALTHCARE OF KI	NSTON			07 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Assistant Manager or Dietary Assistant Marcome to the kitchen of trays for Resident #6 discussed checking the residents and saw the received enteral feed thought staff was trying back onto solid food, meal tray for both Re #369 to NA #1. The Estated he could only sing the computer. He corders were not entermedical record before he did not know if the to switch the resident revealed he should he Manager or the nursi trays to NA #1. The Medical Director telephone on 5-19-22 Director stated she we 5-11-22. She indicate for serious harm from and fed solid foods to The Director of Nursi on 5-17-22 at 2:25pm potential accident with been avoided if NA # educated regarding the receiving her assignments.	occurred with the Dietary 15-17-22 at 1:56pm. The 15-17-22 at 1:56pm. The 15-17-22 requesting meal 1 and Resident #369. He 15 the dietary orders for both 16 the were both NPO and 16 ings but explained he 17 ing to switch the residents 18 so he provided a regular 18 sident #61 and Resident 19 the dietary Assistant Manager 19 the dietary order 19 the	F	689			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _		- ,	C 05/24/2022	
	ROVIDER OR SUPPLIER	KINSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	-	F 6	39			
		ents who have suffered, or a serious adverse outcome as ompliance:					
	Resident #369's die Resident #61's diet						
	the facility on 5/11/2 On 5/11/2022 during Nurse Aide #1 recog and #61 had not rec to the kitchen and re- residents and was p textured meals from Manager. At approx #1 delivered a breal room and the break bedside table of Re- reach). Resident #3 scrambled eggs, sa	gency staff, began working at 22 at approximately 7:00 AM. In the proximately 7:00 period that Residents #369 serived meal trays. She went requested meal trays for both provided trays with regular at the Dietary Assistant eximately 8:40 am, Nurse Aide fast tray to Resident #369's fast tray was placed on the resident #61 (out of residents' 1869's tray consisted of 1969's tray consisted of 1969's tray to Residents had the 1969's 1969'					
	Shortly thereafter, resome difficulty and I orange juice. Resid Nurse Aide #1 turne called out for nursin reported resident be (vomit). Staff called was sent to the hos am, while alert and and treatment. At n breathing or lose co	own to feed Resident #369. esident appeared to have Nurse Aide #1 gave her lent's color appeared red. ed resident on her side and g assistance. Arriving nurse egan to vomit bloody emesis I MD and 911 and the resident pital at approximately 9:40 oriented, for further evaluation to time did Resident #369 stop ensciousness during event. Known) immediately removed Resident #61's room when					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C 05/24/2022	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON		IINSTON	g	STREET ADDRESS, CITY, STATE, ZIP CODE 107 CUNNINGHAM ROAD KINSTON, NC 28501	03/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 689		ge 46 of the concern with Resident I was not fed the regular	F 689			
	Quality Assurance & (QAPI) meeting for the Interdisciplinary Regional Nurse Corconsists of the Adm (DON), Staff Develor Minimum Data Set (Medical Director, Respecial Projects DC - Plan developed. Five the following: Nuat the facility was 5/orientation or training She had no long-ter failure to orient prior contributed to the defacility failed to validate respirate of the physicists where the diet or failed to validate respirate to requesting a Dietary Assistant Mapolicy to validate the with the dietary mark to determine if there residents' diet order two residents (Resider Nurse Aide #1 no Her last day was 5/not return to the floor	otified, and in-depth ad hoc Reformance Improvement this event held 5/11/2022, with Team, Medical Director and insultant. The QAPI committee inistrator, Director of Nursing opment Coordinator (SDC), MDS) Coordinator, the egional Nurse Consultant, No, and the Unit Manager. Root cause was determined to irse Aide #1's first day working 11/2022 and she received no ing prior to working on the floor. If the experience and the record working on the floor efficiency. In addition, the late Nurse Aide #1's access to eat record. She had no cian's orders or care plans to ders were. Nurse Aide #1 sidents' diet with charge nurse in meal tray from dietary. The anager failed to follow the entry card system and consult mager and/or a licensed nurse is was a change in the prior to fixing a meal tray for dents #369 and #61). Ionger works at the facility. 11/2022. Nurse Aide #1 did or after the incident. Manager was suspended on				

C 05/24/2022	
DE 03/24/2022	
(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/A AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 5/24/2022	
	ROVIDER OR SUPPLIER	KINSTON		STREET ADDRESS, CITY, STATE, ZIP C 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	51 Z41 ZUZZ	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	staff will be reeduce on (i) locating and information if in queresident meal trays residents at mealting resident room, whe consistency of dieter mechanical soft, put thickened liquid), a cards when setting ensure matching. by the IDT by 05/18 agency staff will wountil education has provided by the DC "Assistant with Meare served the correction of resident guides, what NPO resident the wrong episodes, aspiration death of the reside - The facility staff of immediately educal provide a diet as of outcomes that coul incorrect diet. This 5/17/2022 and comediate to diet and score 100% or written test was conincluded validation of the dietary management of the side of the dietary management	g their food. and unlicensed and dietary ated by the DON and/or SDC verifying resident diet estion, (ii)proper set-up of exproper positioning of me (whether in dining room, elchair, and in bed), (ii) proper s and liquids (e.g., regular, ureed, nectar/pudding/honey nd (iii) checking resident tray up resident meal tray to Reeducation will be completed 8/2022. No staff including ork on the floor after 5/18/22 been received. Education ON and/or SDC on the facility's eals" policy, ensuring residents ect meal as ordered by nts' diets using the CNA care means, and how giving a diet could cause choking n into the lungs, or subsequent	F	589			

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345365 B. WING _				C
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			STREET ADDRESS, CITY, STATE, ZIP CO 907 CUNNINGHAM ROAD KINSTON, NC 28501	<u> </u>	5/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	tracking system. No will work on the floor education has been - The dietary staff w protocol in place to e provided to NPO resphysician. A list of reposted as a second to validate a resident provided by the Reg 5/18/2022. The list of on the bulletin board manager will keep that are made. - Additional education staff by the Director of diet not ordered for a serious adverse outdoes adverse outdoes and/or Region ensure all staff have medical records syst their first assigned w The on- call clinical to manager will be responding to the electronic medical recompleted with the analytic wound nurse, staff diend/or the regional medical regional in the electronic medical recompleted with the analytic wound nurse, staff diend/or the regional in the electronic medical regional in the	ers for accuracy in the meal staff including agency staff after 5/17/2022 until received. ere re-educated on the ensure meal trays are not idents unless ordered by the sident diets is printed and reference for the dietary staff its' diet. This education was ional Dietary Manager on fresident diets was posted in the kitchen. The dietary ie posting updated if changes on was provided to Dietary of Nursing that providing a resident could result in comes. Re-education and a seted on 5/18/2022. Dietary in a 100% by 5/18/2022 or red to work. Topment Coordinator, Wound in Nurse Consultant will access to the electronic item prior to the beginning of ork shift as of 5/16/2022. The earn member or weekend in the EMR access is above for the agency No nursing staff will work on 022 without access to the electrost or the electrost or the electrost or the electrost or the agency No nursing staff will work on 022 without access to the electrost or the electro	F 68	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	<u>'</u>	30,24,2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pag	ne 50	F 6	889		
	the Clinical Team Me are responsible to an validating staff are a medical record for reagency staff are also care delivery guides resident's care need floor. The facility has procopy of the agency of the agency of Agency staff will presigned orientation probe permitted to work material has been con-call phone has be station for agency stover the phone and guides have been pleafor reference. A Clin consisting of either to Wound Care Nurse, Coordinator, will have hours and weekends to conduct training an needed. Should the facility without the or the agency staff will on-call phone/Clinical orientation process to beginning their assignment on off hours and will agency staff orientat the shift or assist with the afternoon hours approximately 2:45 gon Duty will be response.	ember or Weekend Manager udit agency staff and coessing the electronic esident care needs. The instructed on the use of the for information on each is prior to working on the povided the staffing agencies a prientation guide on 5/12/22. Sent to the facility with a cacket. Agency staff will not intuit this agency orientation completed. The number to the een posted at each nurse's aff to receive this education complete agency orientation acced at each nurse's station incal Team Member rotation, the Director of Nursing, or Staff Development the the on-call phone on off is and will be available to staff and other assistance as agency staff arrive to the inentation packet completed, be directed to contact the all team member for the obe completed prior to in the ing of day shift and available be responsible to collect the ion paperwork at the start of the orientation process. In				

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				OIVID INC	<u>7. 0930-039 i</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
						(c
		345365	B. WING			05/	24/2022
	ROVIDER OR SUPPLIER RE HEALTHCARE OF KI	NSTON		90	TREET ADDRESS, CITY, STATE, ZIP CODE OF CUNNINGHAM ROAD INSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	assist the agency staclinical team member process. The Clinical review the schedule of weekend days, to de agency staff person of first time and who will the orientation packet their arrival, or if it must beginning their job do include information of and/or fed by a tube. provided by the Direct Manager for the nurs of residents who are CNA care guide note station. Centralized educated by Clinical Nurse Technologist of access to the electro arrival to the facility. Prior to arrival, the age phone number and a with steps to access be completed that eleaccess is successful their shift. The on-convected weekend manager weekend manage	eviously established, or aff in contacting the on-call of the complete the orientation of the termine who will be an working at the facility for the lineed to have validation of the being completed prior to but the staff working at the facility for the lineed to have validation of the being completed prior to but the staff, going completed prior to but the staff, going over the list of NPO, and adding list to the book located at each nurse's scheduling has been a linformation Technology on providing agency staff on the medical record prior to the staff working all clinical team member or ill be responsible for the cocess. This was staff, to include	F	689			
	The facility's credible	allegation of Immediate					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILD	ING _		l ,	•
		345365	B. WING				C 24/2022
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	-
				9	07 CUNNINGHAM ROAD		
SIGNATUI	RE HEALTHCARE OF K	INSTON		١,	KINSTON, NC 28501		
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREF	ı	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
PREFIX TAG	`	R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
F 689	Continued From pag	ge 52	F	689			
	Jeopardy was valida	ated onsite on 5-24-22					
		vith facility staff including					
	_	etary staff as well as the					
	Regional Consultant	•					
	•	education prior to starting					
		ity. The staff education					
		its and monitoring were					
	reviewed. Nursing s	taff education included					
		tation checklist and obtaining					
	access to the facility						
	system prior to provi						
	use of the resident of	care guides to locate resident					
		uding diets. Nurse aides					
		g resident care guides,					
	located at the nursin	•					
		stated resident diets were					
	-	staff before requesting a diet					
		n. Dietary staff education					
		dent diet list to confirm a					
		o clarify resident diets with the					
		nurse as needed. Dietary staff ry list was printed daily and					
		when nursing staff requested					
		nts, and a list of residents with					
	-	IPO) diets and the resident					
		in the kitchen. All resident					
		or accuracy, and daily meal					
		ssues with residents					
	receiving the correct	t diets. Signage with contact					
		ted at the time clock and both					
	-	inding agency nursing staff					
		ent care until obtaining access					
		onic medical record and					
		ation Checklist. Interviews					
	with the nursing staf	f and a review of staffing					
	audits revealed new	agency staff were receiving					
		's electronic medical record					
	and the orientation of	checklist information prior to					
	or on the first day we	orking in the facility and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345365	B. WING		C 05/24/2022	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 207 CUNNINGHAM ROAD KINSTON, NC 28501	,	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 689	Continued From pag providing resident ca	ire.	F 689			
	of 5-20-22 was valida	edical record revealed				
	4/27/22 noted Reside and needed extensive daily care with the he #47 could feed himse Resident was in a m	n Data Set (MDS) dated ent #47 was cognitively intact re to total assistance for all elp of one person. Resident elf with altered utensils. otorized wheelchair when out pel himself throughout the				
	Activities of Daily Liv interventions of: Res	4/29/22 noted a focus of ing (ADL) function with ident has preferred routine of by 7 AM. Provide assistance ene.				
	residents who had the	•				
	Assistant Maintenan in the bathroom area registered 118.9. The too high, and the mix adjusted. Resident # asked if he went into his hands and he sta	AM, accompanied by the ce Director, the temperature of Resident #47's room e Assistant stated that was king valve needed to be 47 was in the room and was the bathroom area to wash ted "yes, I can take my chair wash my hands." The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345365	B. WING_			C 05/24/2022
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	I	03/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	Maintenance Director first with the hot watch hands. At 4:55 PM on 5/16/2 water temperature will Director of Maintenance had been adjusted, the temperature throughout the even on 5/17/22 at 2:00 Postated the plumber of mixing valve were flastated the mixing valve was 107.2. 4. A review of the mere Resident #12 was action was 107.2. 4. A review of the mere Resident #12 was action was 107.2. The Annual Minimum 2/15/22 noted Resident meeded supervisor all daily care with MDS indicated Resident model was actionally after the care plan dated Activities of Daily Live.	raged by the Assistant or to turn on the cold water er so he would not burn his 22, Resident #47's sink hot was 121.5. The Assistant noce stated the mixing valve the plumber was in the facility is would be monitored ing. PM, the Maintenance Director same, found rings in the at and broken. The Director live was repaired but water is to reach even ne temperatures were being AM, the temperature of the proom area of Resident #47's redical record revealed dmitted on 8/31/20 with the Mellitus, debility, pain. In Data Set (MDS) dated ent #12 was cognitively intact is ion to extensive assistance of the help of one person. The dent #12 could feed herself tray set up.	F 68	39		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	· · · · · · · · · · · · · · · · · · ·	03/2-4/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pag	e 55	F 6	89		
	were taken in bathro residents who had the bathroom areas to perform the bathroom areas to perform the bathroom area signal temperatures, the test the bathroom area signal temperatures between the bathroom area signal temperatures and interest the bathroom area signal temperatures would evening. Resident #20.1 Assignal temperatures would evening.	e ability to use the sink in the erform self-care. AM, accompanied by the ce Director, who took the mperature of the hot water in nk was 119.9. The Assistant r stated the mixing valve ed. M, hot water temperatures sident #12's bathroom sink				
	5/17/22 at 2:00 PM a found rings in the mix broken. The Director repaired but water meven temperatures, a being monitored. On 5/18/22 at 9:20 A in the bathroom sink	edical record revealed				
		n Data Set (MDS) dated nt #35 to be cognitively intact				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022	
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	30,2-1,2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	for all daily care, with person. The care plan dated Activities of Daily Liv of provide assistance consistent approach, On 5/16/22 at 10:40 Assistant Director of temperatures, the ter from the sink in the b. The Assistant stated	e 56 ervision or was independent the assistance of one 5/17/22 noted a focus of ing (ADL) with interventions of for ADLs as needed, and monitor for pain. AM, accompanied by the Maintenance, who took the mperature of the hot water eathroom area was 118.7. that temperature was too valve needed to be adjusted.	F6	89			
	be 124.8. the Assista stated the mixing val plumber was in the fawould be monitored to the constant of the con	22 the hot water was found to ant Director of Maintenance we had been adjusted, the acility and the temperatures throughout the evening. M, the Maintenance Director ame, found rings in the at and broken. The Director we was repaired but water as to reach even e temperatures were being the shands. Resident # 35 stated he water being too hot. M, the hot water in Resident sink registered at 106.3.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	'	30/2-1/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	#31 was admitted on including stroke, demobstructive uropathy. The annual Minimum 4/6/22 noted Resident impaired and needed assistance with all daperson. The care plan dated assistance with all daperson. The care plan dated assistance with all daperson. The care plan dated assistance with all daperson. Resident #31 was into 10:40 AM and stated his motorized wheeld was observed moving chair, feeding himself Resident #31 stated harea and use the sink. On 5/16/22 at 10:40 AM assistant Director of Itemperature of the hound and the mixing with and the mixing was assistant Director stated the mixing valve be 124.8. The Assistated the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized the mixing valve plumber was in the factorized and included the mixing valve plumber was in the factorized the mixing val	3/17/14 with diagnoses entia, anxiety and Data Set (MDS) dated t #31 was cognitively extensive to total ily care with the help of one 5/16/22 noted a focus of ng (ADL) self- care deficit illow rest periods, total care for pain. erviewed on 5/16/22 at he could propel himself in hair without difficulty and g throughout the facility in his and attending activities. The did go into the bathroom inc. AM, accompanied by the	F 6	889		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	1	03/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	stated the plumber of mixing valve were flat stated the mixing value may require 24 hour temperatures, and the monitored. On 5/18/22 at 9:25 Aff #31's bathroom area at 171 was admitted of including Diabetes. The Admission Mining 5/11/22 noted Reside cognition. Resident at himself. On 5/16/22 at 10:40 Assistant Director of temperature of the himself at 16/10 per at 171 was admitted	PM, the Maintenance Director ame, found rings in the at and broken. The Director we was repaired but water is to reach even be temperatures were being at the sink registered 106.3 and records revealed Resident in 5/6/22 with diagnoses and Data Set (MDS) dated ent #171 was impaired for #171 was observed feeding and AM, accompanied by the Maintenance, the ot water from the sink in the tered 118.7. The Assistant are was too high and the to be adjusted. PM the Maintenance of the hot #171's bathroom sink was Director of Maintenance ve had been adjusted, the acility and the temperatures throughout the evening. PM, the Maintenance Director ame, found rings in the at and broken. The Director ve was repaired but water	F 6	89		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	KINSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	1 00/2-1/2022
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F 689	monitored. Resident #171 was wheelchair on 5/18 if he rolls himself to the sink. Resident # to wash his hands.	observed sitting in his 22 at 8:52 AM and was asked the bathroom area and uses 4171 stated he did use the sink AM, the hot water in Resident	F 68	9	
	Resident #32 was a 4/25/2019, and her and arthritis. A review of the cen #32 had resided in Resident #32's care indicated a risk for daily living. Interver walker or wheelcha and allowing extra to f daily living. The quarterly Minin assessment dated #32 was moderatel independently perfodaily living. The ME	nedical record revealed admitted to the facility on a diagnoses included stroke usus report revealed Resident Room 205A since 4/26/2019. The plan dated 10/29/2019 deterioration in activities of a nations included use of rolling ir, providing set up assistance ime to complete her activities usual part of the plan date of the pl			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345365	B. WING	B. WING		05/24/2022	
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CO 907 CUNNINGHAM ROAD KINSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From pag	ge 60	F 68	89			
	Maintenance Director temperatures in bath available to resident independently use the toperform self-care. Water of the 200-hald degrees Fahrenheit. Director stated the hocked every Mondand the acceptable of Fahrenheit. He state adjusting, and the Adwas informed by the director of the hot was informed by the director of the hot was bathroom inside roo bathroom located in needs. She stated the she washed her handor when staff gathers. On 5/16/2022 at 4:5 observed exiting the voiced no concerns when she washed her barroom she washed her birector accompanied Director to recheck thot water temperatured degrees Fahrenheit, stated the mixing variacility had called a pwould be monitored.	on a.m., the Assistance or checked hot water proom sinks that were is who had the ability to be sink in the bathroom areas. The temperature of the hot is bathroom registered 121.9. The Assistance Maintenance of water temperatures were day, Wednesday and Friday, range was 108-116 degrees and the mixing values needed diministrator and nursing staff assistance maintenance after temperatures. 47 a.m. in an interview with tated due to having no me 205 A she used the 200-hall the hallway for elimination he water did not feel hot when dis in the 200-hall bathroom and with the hot water burning for hands. The Maintenance he 200-hall bathroom sink re, and it registered 121.7. The Maintenance Director live had been adjusted, the polumber, and temperatures throughout the evening.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345365	B. WING				C
NAME OF PE	ROVIDER OR SUPPLIER	0-2000			STREET ADDRESS, CITY, STATE, ZIP CODE	U5/	24/2022
	RE HEALTHCARE OF KII	NSTON		9	07 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690 SS=D	stated the mixing valve may require 24 hours temperatures, and the monitored. On 5/18/2022 at 8:59 Maintenance Director bathroom hot water to temperature registered Fahrenheit. On 5/19/2022 at 4:38 Administrator with the present, the Administrator with the present, the Administrator were to be range. The Maintenan normal range for hot with to 115 degrees Fahren Bowel/Bladder Incont CFR(s): 483.25(e)(1)-\$483.25(e)(1) The factor states of the present who is continuously administrator with the present, the Administrator with the present, the Administrator with the present, the Administrator with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were sent were to be range. The Maintenan normal range for hot with the present were sent who is continuously as a sent with the present with the present who is continuously as a sent with the present with the present who is continuously as a sent with the present with the present who is continuously as a sent with the present with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan normal range for hot with the present were to be range. The Maintenan norm	and broken. The Director we was repaired but water to reach even at temperatures were being a.m., the Assistant checked the 200-hallway emperature. The hot water at 108.6 degrees p.m. in an interview with the emaintenance Director rator stated hot water be within regulatory normal nace Director stated the water temperature was 105 inheit. inence, Catheter, UTI (3) nce. cility must ensure that ment of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. esident with urinary on the resident's esment, the facility must ensure the facility must ers the facility without an not catheterized unless the dition demonstrates that		689			6/21/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	COM	(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C / 24/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	03	12412022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 690	indwelling catheter of is assessed for remoral as possible unless the demonstrates that cannow (iii) A resident who is receives appropriate prevent urinary tract continence to the extended comprehensive assed comprehensive assed ensure that a resider receives appropriate restore as much north possible. This REQUIREMENT by: Based on observation review, the facility fait to a secure device to possible injury to the resident reviewed for Findings included: A review of the medical possible including Diabetes Midisease, and obstruct (kidney damage from kidney.) The annual Minimum 3/2/22 noted Resident reviewed Resident	ters the facility with an r subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. resident with fecal on the resident's assment, the facility must at who is incontinent of bowel treatment and services to mal bowel function as r is not met as evidenced ron, staff interview and record led to attach catheter tubing prevent tension and resident for one of one catheters (Resident #56). real record revealed Resident 5/12/21 with diagnoses ellitus, chronic kidney tive and reflux neuropathy a backflow of urine into the	F 6	F690 1. Resident #56 was discharged 2. All residents have the potential affected. In house review of the cresident population with catheters ensure catheter tubing is attaches secure device to prevent tension possible injury to the resident. Caleg straps provided and secured identified residents by June 14, 2 Staff Development Coordinator peducation to licensed nurses and nursing assistants on the Indwellic Catheter policy with a focus on eithe leg strap securement is secure	I to be current s to d to a and atheter for 022. rovided certified ing insuring re and	
	and needed extensiv	e to total assistance for all elp of one to two persons.		the indwelling catheter is attacher residents with indwelling catheter	d for all	

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022	
NAME OF PE	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP C	CODE	05/24/2022	
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SIGNATUR	E HEALTHCARE OF KIN	NSTON					
			KINSTON, NC 28501				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 690	Continued From page	e 63	F 6	90			
	The care plan dated an indwelling urinary interventions included document refusal. On 5/15/22 at 4:04 Pl His catheter bag was draining. The Nursing removed the bed cover permission, and there attached to Resident tubing was not attach supposed to be attach supposed to be attach nurse. On 5/17/22 at 5:30 Pl removed the cover to The catheter tubing we device.	M Resident #56 was in bed. covered, and urine was Assistant (NA) #14 er, with Resident #56's was a securing device #56's leg, but the catheter ed. The NA stated it was hed and she would tell the with the NA #14 again view the securing device.		June 20, 2022. Newly adn with indwelling catheters w to ensure a catheter is sec indwelling catheter attache education will be included orientation for all licensed nursing assistants. 3. Ongoing audits to include observations will be compled to securement device in place indwelling catheter is attacked indwelling catheter in place indwelling catheter i	rill be reviewed ured with the ured with the d. This in new hire nurses and de resident eted by DON, to validate the atheters have a e and the hed to the audits will be week, weekly x. All data will be d to the facility formance withly by the s or trends d by the QAPI		
F 692 SS=D	5/19/22 at 4:15 PM, tl	ne facility Administrator on the Administrator stated the to the attached and secure.	e be revised to ensure continued		nued nmittee or, DON, nator, tehabilitation , and Director nembers may hould arise. director of mplementing table plan of on to be	6/21/22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345365	B. WING _		C 05/24/2022
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	03/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 692	(Includes naso-gastriboth percutaneous e percutaneous endosenteral fluids). Base comprehensive asseensure that a resider §483.25(g)(1) Mainta of nutritional status, sesirable body weigh balance, unless their demonstrates that the preferences indicate §483.25(g)(2) Is offer maintain proper hydrological status, sesident growider orders and the This REQUIREMENT by: Based on record reversely Registered Dietician address Registered I for 1 of 1 resident (Redietary needs. Findings included: Resident #68 was ad 3/23/18 with multiple diabetes and dementing the series of the	nutrition and hydration. ic and gastrostomy tubes, indoscopic gastrostomy and copic jejunostomy, and d on a resident's ssment, the facility must int- ains acceptable parameters such as usual body weight or it range and electrolyte resident's clinical condition is is not possible or resident otherwise; red sufficient fluid intake to ation and health; red a therapeutic diet when problem and the health care rapeutic diet. T is not met as evidenced riew, resident, staff, and interview the facility failed to Dietician recommendations resident #68) reviewed for Imitted to the facility on diagnoses that included tia.	F 6	F692 1.Dietary recommendation for Res#68 has been addressed. 2.All residents have the potential taffected. Dietary recommendation reviewed for all in house residents May 2022. Dietary recommendation addressed will be executed for all identified residents by June 20, 20 Regional Dietary Manager provide	to be us s since ons not 022.
	Review of Resident # revealed a weight of	#68's medical record 188.3 on 3/1/22 and a weight		education to the Registered Dietic May 19, 2022. This education incl	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345365	B. WING			C 05/24/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	Z-#ZVZZ
				9(07 CUNNINGHAM ROAD		
SIGNATURE HEALTHCARE OF KINSTON			K	INSTON, NC 28501			
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 692	Continued From page	÷ 65	F	692			
		imum Data Set (MDS)			providing the Administrator, DON, and Dietary Manager with a hard copy of recommendations and the completion of		
	Resident #68 was coo	-			an exit conference at every facility visit Staff Development Coordinator provide additional education to the Director of		
	1	progress note dated 5/10/22 g health shakes three times elp halt weight loss.			Nursing and Unit Manager on timely execution of dietary recommendations once received from RD by June 20, 20. This education will be included in new leads to the control of the control o		
	Record review reveale shakes.	ed no order for health			orientation for DONs and Unit Manager 3.Ongoing audits via observation and		
	During an observation on 5/15/22 at 1:05 PM there was no health shake on Resident #68's tray.				record reviews will be completed by DC and/or Unit Managers to validate timely execution of dietary recommendations. These audits will be completed during the second reviews and the second recompleted during the second recompleted by DC and	′	
		17/22 at 8:33 AM revealed esident #68's breakfast tray.			Clinical Morning Meeting. Audits will be conducted 2 x weekly x 4 weeks, and the monthly x 3 months. All data will be		
	During an interview with the Director of Nursing (DON) on 5/17/22 at 9:07 AM she stated when the registered dietician made recommendations for a resident, they were emailed to her and the				summarized and presented to the facili Quality Assurance and Performance Improvement meeting monthly by the DON or Assistant Director Of Nursing.	ty	
		pordinator. She reported the party and the physician are I the order was then			Any issues or trends identified will be addressed by the QAPI committee as t arise, and the plan will be revised to ensure continued compliance. The QAI		
	Dietician (RD) on 5/17 when she has recommended to the DON and Coordinator. She reported and contacted to	ducted with the Registered 7/22 at 2:01 PM who stated mendations, she sends an If the Staff Development orted the DON placed the the physician. The RD stated for recommendation was not			committee consists of the Administrator DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Direct of Social Services. Other members mabe assigned as the need should arise.	or	
	followed. No further w for Resident #68.	veights had been obtained			4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of		

		(1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
345365		B. WING _	B. WING		C 05/24/2022		
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		0012412022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	5/17/22 at 4:35 PM w of an order for health After checking her em Registered Dietician's #68 which was dated During an interview w Coordinator on 5/17/2 she was not in the fact sent and did not recal her email, she located email dated 5/10/22 d During an interview w 5/18/22 at 11:30 AM is expectation staff mem recommendations from Sufficient Nursing State CFR(s): 483.35(a)(1)(1) §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and more sident safety and at practicable physical, it well-being of each respectation of the facility accordance with the facility accordance with the facility sufficient numbers types of personnel on	ducted with the DON on ho stated she was unaware shakes for Resident #68. nail, she located the semail discussing Resident 5/10/22. With the Staff Development 22 at 4:40 PM she reported bility the day the email was all the email. After checking the Registered Dietician's discussing Resident #68. With the Administrator on the stated it was his subers follow up on the Registered Dietican. Wiff (2) Staff. Sta	F 7	correction. Corrective action to be completed by June 21, 2022.	ne	6/21/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345365	B. WING		C 05/24/2022	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 107 CUNNINGHAM ROAD KINSTON, NC 28501	03/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 725	this section, licensed (ii) Other nursing per limited to nurse aide §483.35(a)(2) Excepparagraph (e) of this designate a licensed nurse on each tour of This REQUIREMEN by: Based on record refacility failed to proviwith Activities of Dail residents (Residents who were dependen This affected 5 of 8 is staffing. Findings included: This citation is cross F677 Based on record reversident interviews the Activities of Daily Livesidents. This occu (Resident #53, #17, for ADL care. Review of the daily second to the second reversident interviews the Activities of Daily Livesidents. This occu (Resident #53, #17, for ADL care. Review of the daily second reversidents (NA) school 1:00pm shift for apple 1-4-22 documentation of the daily second reversidents.	ved under paragraph (e) of d nurses; and resonnel, including but not s. It when waived under section, the facility must I nurse to serve as a charge of duty. T is not met as evidenced view, and staff interviews the de sufficient staffing to assist by Living (ADL) care for #53, #17, #46, #52 and #270) t on facility staff for ADL care residents reviewed for	F 725	F725 1. Activities of Daily Living (ADL) care has been provided for Resident #53, #46, and #52. Resident #270 has been discharged. 2. All residents have the potential to be affected. The facility will utilize staffing agencies and continues to recruit nurse to provide sufficient staffing to assist we ADL care for dependent residents. Nursing staffing will be reviewed daily the morning meeting, by the CEO, DO and facility centralized scheduler to include days, nights and weekends. Education provided to licensed nurses completed by 6/20/22 to contact the Administrative Nurse On Call if they're not able to meet the needs of the residents due to staffing. 3. DON, Administrator, and facility scheduler will continue to review staffing schedules M-F during the morning stameeting to ensure sufficient staffing. Tadministrator and/ DON will interview.	et17, n e g ses vith at N e ffing The	

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CODE		33/24/2022	
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SIGNATUR	RE HEALTHCARE OF KIN	NSTON		KINSTON, NC 28501			
	0.11.41.45.4.57.4.67.	ATEMENT OF REFIGIENCIES					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE				
F 725	Continued From page	e 68	F 7	25			
	on 1-18-22 the daily s NAs were scheduled for approximately 73 in The facility's daily star reviewed and showed the 7:00am to 3:00pm residents. A phone interview wa 2:54pm with the facility scheduler stated there were only 3-4 NAs so facility. She stated sh from the agencies and there was not any hel During an interview w 5-19-22 at 5:35pm, th was unaware there w only 3-4 NAs working	eximately 78 residents and staffing sheet revealed 4 for the 7:00am to 3:00pm residents. If the fing sheet for 4-26-22 was at 4 NAs were scheduled for a shift for approximately 76 seconducted on 5-20-22 at the scheduler. The ewere days when there heduled for the entire ewould attempt to find help defacility staff but somedays		residents to validate ADL care had provided 5x a week for two weeks weekly for two weeks, weekly for weeks and monthly for three more ensure sufficient staffing to safely the needs of our residents. All discummarized and presented to the Quality Assurance and Performa Improvement meeting monthly by Administrator. Any issues or trenidentified will be addressed by the committee as they arise, and the be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DC Development Coordinator, MDS coordinator, Admission Coordinated Rehabilitation Manager, Medical Director of Social Services, and Environmental Services. Other may be assigned as the need shearise.	random staff and interview/observe five residents to validate ADL care has been provided 5x a week for two weeks, twice weekly for two weeks, weekly for two weeks and monthly for three months to ensure sufficient staffing to safely meet the needs of our residents. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should		
F 726 SS=J	Competent Nursing S CFR(s): 483.35(a)(3)(F 7	correction. Corrective action to be completed by June 21, 2022.)	6/21/22	
	the appropriate comp provide nursing and re- resident safety and at	vices e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		05/24/2022	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	1 00/2-11/2022	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 726	Continued From page well-being of each re	e 69 sident, as determined by	F 73	26		
	and considering the r diagnoses of the facil	s and individual plans of care number, acuity and lity's resident population in facility assessment required				
	licensed nurses have and skill sets necess needs, as identified to	cility must ensure that e the specific competencies ary to care for residents' hrough resident escribed in the plan of care.				
	limited to assessing,	ing care includes but is not evaluating, planning and nt care plans and responding				
	to demonstrate comp techniques necessar needs, as identified the assessments, and de	ure that nurse aides are able betency in skills and y to care for residents'				
	Based on record rev Physician interview, to orient new agency no competency to delive the resident's assess Assistant (NA) #1 wa for determining reside in the NA feeding a re 5-11-22 to a resident enteral feedings (nuti the digestive system order to be nothing b	iew, staff interviews, and the facility failed to train and ursing staff and verify or care in accordance with ed care needs. Nursing is not oriented to the protocol ents' dietary orders resulting egular textured meal on (Resident #369) who had rition delivered by a tube into as a liquid) and a physician's y mouth (NPO). Resident was hospitalized for 5 days.		 Nurse Aide #1 was provided a orientation immediately after the by the Staff Development Coordi Nurse Aide #1 no longer works a facility. All residents have the potentia affected. The staffing agencies heen provided a copy of the ager orientation guide on 5/12/22. Ed provided on the Agency Orientati 	incident nator. t the I to be nave ncy ucation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345365	B. WING			05/	24/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				9	07 CUNNINGHAM ROAD			
SIGNATUI	RE HEALTHCARE OF	KINSTON		K	INSTON, NC 28501			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 726	Continued From page	age 70	F	726				
	NA #1 also provide	ed a regular textured meal tray			Checklist was provided to all staff			
		t (Resident #61) who had			including the agency staff which includ	es		
		nd a physician's order to be			nursing processes as well as emergen			
		gh likelihood of serious harm.			preparation was provided to agency s			
		2 of 2 residents (Resident #369			by 5/18/2022 by the Director of Nursing			
	and Resident #61)	reviewed for enteral feedings.			and the Unit Managers. Additionally, n	ew		
					agency staff will receive access to the			
	Immediate Jeopare	dy for example #1 began on			facility's electronic medical prior to the	first		
	5-11-22 when NA #	#1 fed Resident #369, who was			day working in the facility and providing	g		
		al feedings, a regular textured			resident care. Any staff, to include age	ncy		
		eopardy for example #2 began			staff, who were not educated by			
		NA #1 provided Resident #61,			5/18/2022 will receive education prior t	.О		
		l on enteral feedings, a regular			working. This education has been			
		nediate Jeopardy was removed			included in orientation for all staff			
		he facility provided and			including agency staff.			
		cceptable credible allegation of			2. Ongoing gudita will be completed vi	_		
		dy removal. The facility			Ongoing audits will be completed via interviews and review of the Agency	1		
		npliance at a lower scope and no actual harm with the potential			Orientation binders to validate agency			
		mal harm that is not Immediate			staff in the facility have completed the			
		plete education and ensure			Agency Orientation Guide prior to work	cina .		
		s put into place are effective.			an assignment in the facility. Additiona			
	monitoring cycloni	o par into piaco aro encenvo.			audits via staff interviews will be	•		
	Findings included:				conducted to validate staff have acces	s to		
					the facility's electronic medical record.			
	a. Resident #369 v	was admitted to the facility on			These audits will be conducted 5 x we	ekly		
		ole diagnoses that included			x 2 weeks, weekly x 2 weeks, and mor			
	gastrostomy status	_			x 3 months. All data will be summarize	d		
					and presented to the facility Quality			
	The quarterly Minii	mum Data Set (MDS) dated			Assurance and Performance			
	4-13-22 revealed F	Resident #369 was severely			Improvement meeting monthly by the			
	cognitively impaire	ed and required total assistance			DON or Assistant Director Of Nursing.			
		r feeding. The MDS also coded			Any issues or trends identified will be			
		receiving 51% or more of her			addressed by the QAPI committee as	hey		
		feeding and 501 cubic			arise, and the plan will be revised to			
	centimeters (cc) or	r more water per day.			ensure continued compliance. The QA			
					committee consists of the Administrato	•		
		ive physician's orders included			DON, ADON, SDC, MDS Coordinator,			
	∟an order for Recid	ent #360 to be NPO and to	1		Admissions Coordinator Rehabilitation	1	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022	
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		03/24/2022	
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SIGNATUR	RE HEALTHCARE OF KI	NSTON		KINSTON, NC 28501			
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F 726	Continued From page	÷ 71	F 7	26			
	per hour continuously	itional supplement at 55cc through enteral feedings.		Manager, Medical Director, and of Social Services. Other member assigned as the need should	bers may		
		e care plan as of 5-10-22 he would remain free of					
	complications related The interventions for head of the bed eleval distention, lung sound Resident #369 had a would remain stable. goal were in part resident flushes per order. A nursing progress no by Nurse #2 document Resident #369's room nurse. Nurse #2 document resident with her eyes (physical touch) stimut blood-tinged fluid. The	to the use of a feeding tube. the goal were in part keep ited, observe for abdominal ds and check for residual. second goal that her weight The interventions for the dent is NPO, diet as tional supplement and water of dated 5-11-22 at 9:15am inted she was called into in by the Wound Care (WC) imented she observed the sopen, alert to tactile dili and coughing up de documentation indicated		4. The Administrator and Direct Nursing is responsible for imple and maintaining the acceptable correction. Corrective action to completed by June 21, 2022.	ementing plan of		
	that Resident #369 w emergency room for 6 The emergency room 5-11-22 revealed a di food. A CT scan (seri- ordered which showe pneumatosis (increas colon due to vomiting The hospital records of Resident #369 receiv intravenous antibiotic	hospital records dated agnosis of aspiration of es of x-ray images) was d Resident #369 also had ed gastric pressure in the along the right colon. dated 5-16-22 indicated ed intravenous fluids, and was restarted on her resident was discharged					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		COMPLETED
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	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STAT 907 CUNNINGHAM ROAD KINSTON, NC 28501	E, ZIP CODE	I GOIL-WEGEL
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F 726	7-6-11 with multiple gastrostomy status. The May 2022 active Resident #61 was to a fortified nutritional centimeter (cc) per henteral feedings. The quarterly Minimus 5-9-22 revealed Rescognitively impaired with one person for ealso coded for tube for more of her calories of water per day. Resident #61's active revealed a goal that signs and symptoms her feeding tube. The were in part administ resident is NPO and 30-35 degrees while During a phone interfect at 1:31pm, the NA exiday working at the facility. She discussed trays on 5-11-22 and the status of	admitted to the facility on diagnoses that included be physician's orders indicated be NPO and was to receive supplement at 45 cubic four continuously through and Pata Set (MDS) dated ident #61 was severely and required total assistance eating. Resident #61 was eeding acquiring 51% or per day with 501cc or more e care plan as of 5-10-22 she would not exhibit overt of complications related to e interventions for the goal ter feedings as ordered, elevate the head of the bed	F 7		FICIENCY)	
	meal trays (one for F Resident #61) from o dietary staff provided trays with eggs, Fren	ne kitchen and requested 2 Resident #369 and one for dietary staff. She said the I her 2 regular textured meal nch toast with apples, range juice. NA #1 stated she				

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		345365	B. WING			C 05/24/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	13/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 726	on the tray table a where she began the eggs and oran #369 began to turn trouble breathing, her side and retrie in a meeting. She nurses on the unit approximately 1 m she had received computer access p stated she saw the Resident #369 but since she did not he check the resident resident was NPO feed Resident #61 could have tried to the meal tray in the The Director of Nu on 5-17-22 at 2:25 not aware if NA #1 training/orientation assignment. The Development Coothe education. During an interview Coordinator (SDC SDC confirmed she orientation/training working at the faci revealed she had education/orientat after the incident wexplained NA #1 series.	nit, placed Resident #61's tray and proceeded to Resident #369 to feed Resident #369 some of ge juice. She stated Resident in red in the face and had so she turned the resident on ved help from a nurse that was explained she did not see any and had left the resident for a number of the face and had left the resident for a number of the face and had left the resident for a number of the face and had left the resident for a number of the face and had left the resident for a number of the face and had left the computer to the face and had left the said another staff member of the face and had left the resident since she left the resident's room.	F7	726			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		00/2-4/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 726	provide the orientatic access. The SDC stadid not have long ter indicated NA #1 wouknow what her assig were or what their cahaving orientation. Tagency staff schedul did not receive trainitheir assignment. Sh for the residents' we to correct the proble only a problem for a received scheduled their first shift. The Medical Director telephone on 5-19-2 Director stated she was training or orientation have the education to facility. The Administrator was 5:35pm. The Administrator was	to pull NA #1 off the floor to con/education and computer ated she was unaware NA #1 off the floor to con/education and computer ated she was unaware NA #1 off care experience. She all do not have been able to oned residents' diet orders are needs were without the SDC also discussed new died off hours and weekends ang/orientation prior to starting the added she was concerned all-being but did not know how off. She also said this was gency staff as facility staff corientation prior to beginning or was interviewed by 2 at 3:35pm. The Medical was not involved in the of staff but expected staff to one care for the residents in the assinterviewed on 5-19-22 at estrator stated he expected all and oriented in the care at stated of Immediate 2 at 12:56pm.	F7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '		(X3) DATE SURVEY COMPLETED		
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(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
residents and was p textured meals from Manager. At approx #1 delivered a break room. Nurse Aide #1 sat do Shortly thereafter, resome difficulty and Norange juice. Resident Was Aide #1 turned called out for nursing reported resident be (vomit). Staff called was sent to the hosp am, while alert and cand treatment. At no breathing or lose con Resident #61 was possible table. The noto Resident #61. The from Resident #61. The from Resident #61. The from Resident #61 was possible table. The noto Resident #61 was possible table was not fed, and bedside table. The noto Resident #61 was possible table was possible table. The noto Resident #61 was possible table was possible table. The noto Resident #61 was possible table was possible table was possible table. The noto Resident #61 was possible table was possible table was possible table. The noto Resident #61 was possible table was possible table was possible table.	rovided trays with regular the Dietary Assistant kimately 8:40 am, Nurse Aide kfast tray to Resident #369's own to feed Resident #369. Sesident appeared to have Nurse Aide #1 gave her ent's color appeared red. dresident on her side and grassistance. Arriving nurse agan to vomit bloody emesis MD and 911 and the resident oriented, for further evaluation or time did Resident #369 stop ensciousness during event. Trovided a meal tray. Resident dresident was not accessible are meal tray was removed aroom as soon as staff were 1 had placed a tray in the event, administrative staff ented the process of dietary od tray without the resident in the census diet report audit erious adverse outcome from grant Additionally, dietary staff	F 726				
	ROVIDER OR SUPPLIER RE HEALTHCARE OF K SUMMARY S (EACH DEFICIEN REGULATORY OF REGULA	RE HEALTHCARE OF KINSTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 75 residents and was provided trays with regular textured meals from the Dietary Assistant Manager. At approximately 8:40 am, Nurse Aide #1 delivered a breakfast tray to Resident #369's room. Nurse Aide #1 sat down to feed Resident #369. Shortly thereafter, resident appeared to have some difficulty and Nurse Aide #1 gave her orange juice. Resident's color appeared red. Nurse Aide #1 turned resident on her side and called out for nursing assistance. Arriving nurse reported resident began to vomit bloody emesis (vomit). Staff called MD and 911 and the resident was sent to the hospital at approximately 9:40 am, while alert and oriented, for further evaluation and treatment. At no time did Resident #369 stop breathing or lose consciousness during event. Resident #61 was provided a meal tray. Resident #61 was not fed, and the meal tray was left on the bedside table. The meal tray was removed from Resident #61's room as soon as staff were aware Nurse Aide #1 had placed a tray in the room. Upon review of this event, administrative staff immediately implemented the process of dietary staff not issuing a food tray without the resident name being listed on the census diet report audit sheet to prevent a serious adverse outcome from occurring or recurring. Additionally, dietary staff	ROVIDER OR SUPPLIER RE HEALTHCARE OF KINSTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 75 residents and was provided trays with regular textured meals from the Dietary Assistant Manager. At approximately 8:40 am, Nurse Aide #1 delivered a breakfast tray to Resident #369's room. Nurse Aide #1 sat down to feed Resident #369. Shortly thereafter, resident appeared to have some difficulty and Nurse Aide #1 gave her orange juice. Resident's color appeared red. Nurse Aide #1 turned resident on her side and called out for nursing assistance. Arriving nurse reported resident began to vomit bloody emesis (vomit). Staff called MD and 911 and the resident was sent to the hospital at approximately 9:40 am, while alert and oriented, for further evaluation and treatment. At no time did Resident #369 stop breathing or lose consciousness during event. Resident #61 was provided a meal tray. Resident #61 was not fed, and the meal tray was left on the bedside table. The meal tray was removed from Resident #61's room as soon as staff were aware Nurse Aide #1 had placed a tray in the room. 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Additionally, dietary staff in the coreum of a recipient of the control of the coreum of the process of dietary staff not issuing a food tray without the resident name being listed on the census diet report audit sheet to prevent a serious adverse outcome from occurring or recurring. Additionally, dietary staff not sexing a food tray without the resident name being listed on the census diet report audit sheet to prevent a serious adverse outcome from occurring or recurring. Additionally, dietary staff	

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	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CO 907 CUNNINGHAM ROAD KINSTON, NC 28501		05/24/2022 ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 726	Quality Assurance & (QAPI) meeting for the Interdisciplinary Regional Nurse Consconsists of the Admin Director, Director of In Development Coordin Projects DON, Intering Regional Nurse Consconsists of the Admin Projects DON, Intering Regional Nurse Consconsists of the Admin Regional Nurse Consconsists of the following: Now Intering Regional Nurse Consconsists of the following: Now Intering Regional Nurse Consconsists of the following: Now Intering Regional Nurse Aide #1 saccess to the following: Now Intering Regional Re	otified, and in-depth ad hoc Performance Improvement his event held 5/11/2022, with Feam, Medical Director and sultant. The QAPI committee histrator, the Medical Nursing (DON), Staff nator (SDC), Special m Unit Manager, and sultant. Root cause was determined lurse Aide #1's first day was 5/11/2022 and she on or training prior to working d no long-term care ailure to orient prior to contributed to the deficiency. Y failed to validate Nurse he electronic medical record. To the physician's orders or at the diet orders were. To validate residents' diet for to requesting a meal tray etary Assistant Manager olicy to validate the tray card cult with the dietary manager rese to determine if there was lents' diet order prior to fixing esidents (Residents #369 and	F 72	26				
	Nurse Aide #1's last	day was 5/11/2022. Nurse						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345365	B. WING		C 05/24/2022
	ROVIDER OR SUPPLIER	INSTON	9	TREET ADDRESS, CITY, STATE, ZIP CODE 07 CUNNINGHAM ROAD KINSTON, NC 28501	1 00/24/2022
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F 726	reportable on 5/11/2 was substantiated, a summary was submared. All residents are at a practice. Plan developed: 1) The facility has p a copy of the agency of the agency of the agency station and the permitted to orientation material number to the on-cate ach nurse's station this education over agency orientation geach nurse's station. Team Member rotat Director of Nursing, Development Coordinated to staff to assistance as need arrive to the facility completed, the agency contact the on-call profession that the facility at the beavailable on off hour collect the agency sthe start of the shift	ubmitted to the state as a 2022. The allegation of neglect and the final investigative	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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SIGNATUR	RE HEALTHCARE OF KI	INSTON		K	INSTON, NC 28501		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 726	Continued From pag	e 78	F.	726			
	· -	I be responsible to collect the					
		ion paperwork at the start of					
		s previously established, or					
		aff in contacting the on-call					
		r to complete the orientation					
		al Team will be responsible to					
		daily, specifically on the					
		termine who will be an					
		working at the facility for the					
		Il need to have validation of					
		et being completed prior to					
		ust be done on site prior to					
		uties. Education will also					
		n residents who are NPO					
		Additional education was					
	-	ctor of Nurses and Unit					
	Manager for the nurs	sing staff, going over the list					
	of residents who are	NPO, and adding list to the					
		book located at each nurse's					
	station. Centralized	scheduling has been					
	educated by Clinical	Information Technology					
	Nurse Technologist of	on providing agency staff					
	access to the electro	nic medical record prior to					
	arrival to the facility.	If the access is not obtained					
	prior to arrival, the a	gency staff will call the on-call					
	phone number and a	ccess will be provided along					
	with steps to access	the system. Validation will					
	be completed that ele	ectronic medical record					
	access is successful	prior to the staff working					
	their shift. The on- c	all clinical team member or					
		rill be responsible for the				ĺ	
		on as stated above for the				ĺ	
	agency orientation pr					ĺ	
		3/2022. Any staff, to include					
	agency staff, who we	<u> </u>					
	5/18/2022 will receive on the floor.	e education prior to working					
		Johnsont Coordinates Married					
		elopment Coordinator, Wound all Nurse Consultant will					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C)5/24/2022	
	ROVIDER OR SUPPLIER	INSTON		STREET ADDRESS, CITY, STATE, ZIP CO. 907 CUNNINGHAM ROAD KINSTON, NC 28501	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	medical records syst their first assigned worth on- call clinical to manager will be responding to the floor after 5/16/2 electronic medical record manager will be responding to the electronic medical record for the electronic medical record for the clinical Team Medical responsible to according to use the medical record for reagency staff are also care delivery guides resident's care need floor. 3) The Agency Orient reviewed by the Reg 5/18/22 and approve agency staff and is of the start of the shift forientation checklist well as emergency publication of Nursing and Unit I guide located at eaccontains resident die include agency staff, 5/18/2022 will receive on the floor.	access to the electronic tem prior to the beginning of ork shift as of 5/16/2022. eam member or weekend consible for the EMR access above for the agency No nursing staff will work on 022 without access to the accords system. Orientation dical record will be agency staff by the facility evelopment coordinator, aurse consultant. The Agency t includes education on how accords system. In addition, ember or Weekend Manager	F 7:	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUC	(X3) DATE SURVEY COMPLETED		
						(С
		345365	B. WING				24/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE		
OLONIATU.	DE 11541 THOADS OF	KINGTON		907 CUNNIN	IGHAM ROAD		
SIGNATU	RE HEALTHCARE OF	KINSTON		KINSTON, I	NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	The guides were p 5/17/2022. The stat the Regional Nurse Nurse on the place guides at each nur resource. Any staff were not educated education prior to 6) Agency staff will report cards locate include the resider definition of NPO (Director of Nursing Coordinator, and the beginning 5/17/202 staff will work on the education has bee 7) Staff were proviof what could happ provided a diet that physician and coul outcomes by the Development Coordination has agency staff will wountil education has Alleged date of IJ I The facility's credit Jeopardy was valid through interviews nursing staff as we The staff verbalize starting their shift i education docume were reviewed. Note that the staff verbalize starting their shift i education docume were reviewed. Note that the place of the staff verbalize starting their shift i education docume were reviewed. Note that the place of the staff verbalize starting their shift i education docume were reviewed.	an as an additional resource. laced at the nurses on iff have been re-educated by consultant and Director of ement of the agency orientation ses' station as an accessible f, to include agency staff, who by 5/18/2022 will receive working on the floor. I be educated on the CNA care d at each nurse's station to ats' current diet orders and the nothing by mouth) by the g, Staff Development he Regional Nurse Consultant 22. No staff including agency he floor after 5/17/2022 until he received. ded education on the severity hen to a resident if they were t was not ordered by the d result in serious adverse hirector of Nursing and the Staff dinator. No staff including bork on the floor after 5/17/2022	F	726			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345365	B. WING			1	C 24/2022
	ROVIDER OR SUPPLIER	NSTON	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE 07 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 727 SS=E	use of the resident care information inclusivere observed using located at the nursing resident's diets and severified with nursing stray from the kitchensissues with residents Signage with contact the time clock and boreminding nursing stacare until obtaining a electronic medical rethe Orientation Checursing staff and a rerevealed new agency to the facility's electrorientation checklist if first day working in thresident care. The facility's date of it of 5-19-22 was validated RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1) §483.35(b)(1) Except paragraph (e) or (f) of must use the service least 8 consecutive he §483.35(b)(2) Except paragraph (e) or (f) of grangraph (e) or (f) or (f) of grangraph (e) or (f) or (f	ding resident care, and the are guides to locate resident uding diets. Nurse aides resident care guides, g station, to confirm stated resident diets were staff before requesting a diet. Meal audits indicated no receiving the correct diets. information was posted at oth nursing stations aff not to provide resident cocess to the facility's cord system and receiving klist. Interviews with the eview of staffing audits of staff were receiving access onic medical records and the information prior to or on the die facility and providing stated. Full Time DON -(3) and nurse to when waived under of this section, the facility is of a registered nurse for at a cours a day, 7 days a week.		726			6/21/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345365	B. WING _			1	24/2022
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	Z-1/2022
				90	07 CUNNINGHAM ROAD		
SIGNATUR	RE HEALTHCARE OF KIN	NSTON			INSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 727	Continued From page	e 82	F 7	727			
		ector of nursing may serve					
		ly when the facility has an					
	This REQUIREMENT	ncy of 60 or fewer residents. is not met as evidenced					
	by:	and at off intermitation that			F707		
		ew and staff interviews, the ule a Registered Nurse			F727		
	ı ` ,	nsecutive hours a day for 12			1. The facility has scheduled a Registe	red	
	of 60 days (10-31-21,				Nurse (RN) for at least 8 consecutive		
		12-18-21, 1-2-22, 1-1-22,			hours a day.		
		-22 and 5-7-22) reviewed for					
	staffing.				2. All residents have the potential to be		
	Findings included:				affected. Nursing staffing will be review		
	Findings included:				daily during the morning staffing meetir by the CEO, DON and facility centralize		
	Review of the facility's				scheduler to include days, nights and		
		ot an RN scheduled for at			weekends to validate a RN is schedule	d	
		ours on the following dates:			for 8 consecutive hours each day.		
	10-31-21, 10-30-21, 1				Education provided to the centralized		
		l-2-22, 1-1-22, 4-17-22,			scheduler to contact the administrator a		
	5-15-22, 5-8-22 and 5)- <i>1-</i> 22.			DON if she is unable to schedule a RN 8 consecutive hours each day. This	ior	
	A phone interview occ	curred with the centralized			education was provided by the Director	of	
		r on 5-20-22 at 9:02am. The			Nursing (DON) by June 20, 2022. This		
		the facility switched to			education will be included in new hire		
		g 4-25-22 and she did not			orientation for facility schedulers.		
		chedules prior to 4-25-22.					
		7-22, 5-8-22 and 5-15-22			3. Ongoing auditing will be completed t		
		duled for 8 hours but had			validate the provision of a RN for at lea		
	only worked 7.5 hours	s each day.			8 consecutive hours a day. Audits will be	Эе	
	During a phone interv	vious with the facility's			completed 5 x weekly for two weeks,	nth	
	During a phone interv	at 9:50am, the scheduler			weekly x 2 weeks, and monthly x 3 monthly the Administrator and/or the Directo		
	confirmed she would				Nursing. All data will be summarized a		
	schedule an RN on 10				presented to the facility Quality Assurat		
		12-19-21, 12-18-21, 1-2-22,			and Performance Improvement meeting		
		She stated some days she			monthly by the Administrator. Any issue	_	
		to work, and she said she			or trends identified will be addressed by		
		had to work 8 consecutive			the QAPI committee as they arise, and	•	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION		E SURVEY PLETED
		345365	B. WING				C / 24/2022
	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE OF CUNNINGHAM ROAD INSTON, NC 28501	1 03/	24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757 SS=D	hours. The Administrator was 5:35pm. The Administ difficulty getting RN's unaware there had not full 8 hours. Drug Regimen is Free CFR(s): 483.45(d)(1): §483.45(d) Unnecess Each resident's drug unnecessary drugs. drug when used- §483.45(d)(1) In exceed duplicate drug therap §483.45(d)(2) For exceeding the state of	e from Unnecessary Drugs e from Unnecessary Drugs (6) eary Drugs-General. regimen must be free from An unnecessary drug is any essive dose (including y); or cessive duration; or at adequate monitoring; or at adequate indications for its oresence of adverse indicate the dose should be		727	the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Direct Director of Social Services, and Environmental Services. Other member may be assigned as the need should arise. 4. The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	tor, or, rs f	6/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING		0,	C 5/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO		J/L-4/2022	
				907 CUNNINGHAM ROAD			
SIGNATUI	RE HEALTHCARE OF	KINSTON		KINSTON, NC 28501			
(X4) ID	SUMMAR	/ STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)	
PREFIX TAG		EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETION DATE	
F 757	Continued From p	age 84	F 7	57			
	stated in paragrap section.	r combinations of the reasons ths (d)(1) through (5) of this					
		ENT is not met as evidenced					
		review and staff interviews the dress a recommendation from		F757			
	,	ant for 1 of 6 residents		1. Resident #269 has been	discharged		
		cessary medications (Resident		1. Resident #203 has been	discriarycu.		
	#269).	occoury modications (recolacing		2. All residents have the po	tential to be		
				affected. In house review to			
	The findings include	ded:		on current resident populati	•		
				that each residents□ medic			
	Resident #269 wa	s admitted to the facility on		is free from unnecessary m	-		
	2/17/22 with diagn	oses that included a cerebral		physician orders are followed	∍d. Physician		
	infarction (stroke).	He discharged on 4/18/22.		orders from resident appoint reviewed for each resident to			
		an orders revealed an order		going forward to validate im			
		Amantadine (a medication to		of physician orders. Outsta			
	treat movement di	sorders) 10 milliliters by mouth		physician orders will be imp			
	twice a day.			the identified residents by J Education on unnecessary			
		om neurology dated 3/3/22 read		and the importance of follow			
		ne was started presumably for		orders will be provided for			
		s. Given the patient no longer		nurses by the Staff Develop			
		and is having difficulty sleeping		Coordinator by June 20, 20			
	at night will stop A			training will also be included orientation for licensed nurs			
		tion Administration record for					
		pril 2022 revealed Amantadine		3. Ongoing audits will be co			
		twice daily until discharge.		Director of Nursing, SDC, a Manager for review of new	orders/		
		conducted with Resident #269 s		pharmacy recommendation	•		
		5/16/22 at 1:26 PM who stated		Clinical Whiteboard and we			
		#269 at his neurologist		Meeting. These audits will be			
		3/22 and was aware his		days per week for two week			
		discontinued. She reported she		for two weeks, then monthly			
		en continued when she was		months. All data will be sur			
	∣ reviewing his discl	harge medications.		presented to the facility Qua	ality Assurance		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345365	B. WING _				C 24/2022
	ROVIDER OR SUPPLIER	NSTON		90	TREET ADDRESS, CITY, STATE, ZIP CODE 07 CUNNINGHAM ROAD INSTON, NC 28501		- 11-4
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	Records Director on 8 stated she is respons reports from outside a She reported she did after Resident #269 ' 3/3/22. She stated sh reports after appointment of the state of	ducted with the Medical 5/18/22 at 11:49 AM who ible for ensuring consult appointments are received. not receive a consult report is neurology appointment on the has had difficulty receiving ments with the provider. Who stated Medical islible for getting the coutside appointments. She is unaware of any issues with its. The DON stated had she dent #269's neurologist had action it would have been support Personnel (b) Hoy sufficient staff with the incies and skills sets to carry the food and nutrition service, ion resident assessments, the and the number, acuity facility's resident population the facility assessment (c).		757	and Performance Improvement meeting monthly by the DON or ADON. Any issues or trends identified will be addressed by the QAPI committee as the arise, and the plan will be revised to ensure continued compliance. The QAI committee consists of the Administrator DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Direct of Social Services. Other members mate assigned as the need should arise. 4. The Administrator and Director of Nursing are responsible for maintaining compliance. Compliance achieved by June 21, 2022.	hey PI r, or y	6/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022	
NAME OF D	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE		05/24/2022	
NAME OF T	NOVIDER OR SOLT EIER			, , ,			
SIGNATUR	RE HEALTHCARE OF KII	NSTON		907 CUNNINGHAM ROAD			
				KINSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 802	Continued From page	≥ 86	F 8	02			
	(2)(ii). This REQUIREMENT	articipate on the as required in § 483.21(b)					
	facility failed ensure to competent to carry or and nutrition service is dietary orders. The laprovided Nursing Assistextured meal for 2 residents (and on enteral feeding tube into the digestive continuously resulting and being hospitalized Immediate Jeopardy Dietary Assistant Martrays for 2 residents (seedings. The Immediate Jeopardy Premains out of compliscope/severity of a "Expotential for more that immediate jeopardy) ensure monitoring systems included: a. The May 2022 activities and nutrition in the diagram of the complete state of the co	at the functions of the food in accordance with residents' Dietary Assistant Manager istant (NA) #1 with a regular was a liquid) in Resident #369 aspirating in Resident #369 aspirating in Resident #369 and Resident istant and on continuous enteral istant jeopardy was removed facility provided and interpretable credible allegation of removal. The facility istance at a lower of the complete education and istems put into place are impetent dietary staff.		1. The assistant dietary manager longer employed at the facility. 2. All residents have the potential affected. Education provided to distaff that providing a diet not orderesident could result in serious adoutcomes. This education was proby the Director of Nursing and the Regional Dietary Manager on 5/18 dietary staff will work after 5/18/20 education has been completed. The education will be included in new orientation for all dietary staff. 3. Ongoing audits will be completed Dietary Manager and/or the Region Dietary Manager via staff interview observations to validate dietary standerstanding of resident diets, the and restrictions. Additionally, diet will be able to state the process to they are unsure about a residents. These audits will be completed we weeks and monthly x 3months. All will be summarized and presented facility Quality Assurance and Performance Improvement meeting monthly by the DON or Assistant Of Nursing. Any issues or trends identified will be addressed by the committee as they arise, and the	to be ietary red for a verse ovided 3/22. No 0/22 until his hire ed by the onal ws and aff extures, early staff o follow if diet. eekly x 2 I data d to the eng Director e QAPI		
	and to receive a fortif	ied nutritional supplement at cc) per hour continuously		be revised to ensure continued compliance. The QAPI committee			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			1	C 24/2022	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	Z-4/2022	
					7 CUNNINGHAM ROAD			
SIGNATU	RE HEALTHCARE OF KII	NSTON			INSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 802	Continued From page	2 87	F8	302				
	through enteral feedin b. The May 2022 acti indicated Resident #6 to receive a fortified r	ngs. ve physician's orders s1 was to be NPO and was utritional supplement at 45 per hour continuously			consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Direct of Social Services. Other members ma be assigned as the need should arise.	or		
	at 1:31pm, the NA disbreakfast trays on 5-#369 and Resident # tray. The NA stated s requested 2 meal tray Resident #61 from didietary staff provided with eggs, French to a patty and orange juice dietary staff had not residents were NPO. enteral feeding pump was and since she did computer to check the unaware the resident she did not feed Resistaff member could his ince she left the mean difference and had troughter to the country she fed Resident #36. The NA stated Resident the face and had troughter that was in a magent to the emergence 5 days. A telephone interview.	11-22 and realized Resident 61 had not received a meal he went to the kitchen and ys for Resident #369 and etary staff. She said the her 2 regular meal trays ist with apples, sausage e and commented the			4. The Administrator and Dietary Mana is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	ger		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(>	X3) DATE : COMPL	
		345365	B. WING _			05/2	24/2022
	ROVIDER OR SUPPLIER	INSTON	,	STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	E	(X5) COMPLETION DATE
F 802	working at the facility received the new entered the tray card print of the tray card print of the computer. He start and the computer is the computer in the tray card print of the computer is the computer. He start and the computer is the computer in th	anager explained he had been a for "a few weeks" but had aployee training that included ats and how to verify orders in ated Nursing Assistant (NA) en on 5-11-22 during the requested meal trays for Resident #61. He discussed orders in the electronic of the residents and saw they received enteral feedings but ing to switch the residents as on he provided a regular of eggs, French toast with the ty and orange juice for both Resident #61 to the NA. The mager stated he could only ary order in the computer. He times the orders were not attronic medical record before but, so he did not know if there order to switch the residents and should have asked the the nursing staff before or (DM) was interviewed on The DM explained he was seen NA #1 requested 2 meal and Resident #61 on the Dietary Assistant Manager to but received new employee on the tray card print outs and ders in the computer. He said at Manager should have found order with the nurse prior to	F	302			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022
	ROVIDER OR SUPPLIER	NSTON	'	STREET ADDRESS, CITY, STATE, ZIP O 907 CUNNINGHAM ROAD KINSTON, NC 28501	ODE	1 00/2 H 2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD B THE APPROPRIA	DATE
F 802	dietary staff to follow clarification from mar questions before provesident. The Administrator was Jeopardy on 5-18-22. Resident #369's diet Resident #61's diet of On 5/11/2022 during Nurse Aide #1 recognand #61 had not receto the kitchen and recresidents and was protextured meals from Manager. At approxi #1 delivered a breakt room. Nurse Aide #1 sat do Shortly thereafter, resome difficulty and Norange juice. Resident Worange juice. Resident was sent to the hospam, while alert and of and treatment. At no breathing or lose con Resident #61 was provided the sident #61 was pro	strator stated he expected dietary orders and seek nagement if there are any viding a meal tray to any as notified of Immediate at 1:55pm. order: NPO order: NPO breakfast meal tray delivery nized that Residents #369 eived meal trays. She went quested meal trays for both ovided trays with regular the Dietary Assistant mately 8:40 am, Nurse Aide fast tray to Resident #369's own to feed Resident #369. Sident appeared to have urse Aide #1 gave her ent's color appeared red. It resident on her side and assistance. Arriving nurse gan to vomit bloody emesis MD and 911 and the resident ital at approximately 9:40 riented, for further evaluation of time did Resident #369 stop isciousness during event.	F	302		
	bedside table. The m	the meal tray was left on the leal tray was not accessible e meal tray was removed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345365	B. WING		0:	C 5/ 24/2022		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			,	STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		1 33/2 1/222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 802	from Resident #61's aware Nurse Aide # room. Post event: - Medical director in Quality Assurance & (QAPI) meeting for the Interdisciplinary Regional Nurse Corconsists of the Adm Director, Director of Development Coord Projects DON, Inter Regional Nurse Corcipiects DON, Inter Regional Nurse Corci	otified, and in-depth ad hock Performance Improvement this event held 5/11/2022, with Team, Medical Director and Insultant. The QAPI committee inistrator, the Medical Nursing (DON), Staff Ilinator (SDC), Special im Unit Manager, and Insultant. Root cause was determined to Insultant. Ro	F 802					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		,	C 5/24/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		3/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 802	Plan developed: - Dietary staff educa ordered for a resider adverse outcomes be the Regional Dietary dietary staff will workeducation has been - Dietary manager resport (a roster of resulting the dietary staff and validation process to food/drinks on 5/17/2 refer to the census of meal tray to a reside after 5/18/2022 until completed Dietary manager will dietary staff to ensure dietary staff to ensure diets, texture, and reside after 5/18/2022 until completed Dietary manager will dietary staff to ensure diets, texture, and reside after 5/18/2022 until completed Dietary manager will dietary staff to ensure dietary staff to ensure dietary staff to ensure dietary conversion I diet or meal plan), and diet level and Consist panel will be posted. This validation was set 5/17/2022. The info	e as a reportable on ation of neglect was ne final investigative litted on 5/18/2022. Sisk for the current deficient litted that providing a diet not not could result in serious by the Director of Nursing and Manager on 5/18/2022. No cafter 5/18/2022 until completed. Eviewed the census diet in serious litter and diet orders) with re-education provided on the profolow prior to giving out any 2022. The dietary staff will liter with a side of the literary report prior to issuing a litt. No dietary staff will work	F 8	02			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 5/24/2022	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON				STREET ADDRESS, CITY, STATE, ZIP COD 907 CUNNINGHAM ROAD KINSTON, NC 28501		5) 24) 2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 802	the resident name be report audit sheet. Deducated by the Reg consult with the dieta licensed nurse if add warranted. The license correct diet by using record. The dietary recorrect diet by using system. This action of Alleged date of IJ remarks and alleged date of IJ remarks are reviewed. All resident with the correducation including the resident with the correducation documents were reviewed. All residents with residents Dietary staff education including the resident diet list to colorify resident diet list to colorify resident diets on urse as needed. Die dietary list was printed when nursing staff residents, and a list of mouth (NPO) diets, in terminology conversidysphagia diet levels	t issue a food tray without sing listed on the census diet bietary staff has been ional Dietary Manager to ary manager and/or the itional diet clarification is sed nurse will validate the the electronic medical manager will validate the the electronic meal tracking was completed 5/18/2022. Inoval: 5/19/2022. allegation of Immediate ted onsite on 5-24-22 ith facility staff including tary staff verbalized receipt of the importance of providing ect diet as ordered. The staff ation, audits and monitoring sident diets were audited for meal audits indicated no receiving the correct diets. In included the use of onfirm a resident's diet and to with the dietary manager or etary staff stated resident and daily and referenced to quested diet trays for of residents with nothing by esident diet list, diet on list and national were posted in the kitchen information. Daily meal issues with residents	F8	02			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345365	B. WING				24/2022	
	ROVIDER OR SUPPLIER	NSTON		9	TREET ADDRESS, CITY, STATE, ZIP CODE 07 CUNNINGHAM ROAD (INSTON, NC 28501	1 001	L-4/ ZUZZ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 802 F 812 SS=E	of 5-19-22 was validade Food Procurement, Str. CFR(s): 483.60(i)(1)(2) §483.60(i) Food safetted The facility must - §483.60(i)(1) - Procure approved or consider state or local authoritic (i) This may include for from local producers, and local laws or regulation food local laws or regulation food from using progradens, subject to consider safe growing and food (iii) This provision does from consuming food from consuming food from consuming food standards for food setting REQUIREMENT by: Based on observation facility failed to label and discard expired for in 2 of 2 kitchen refriguence food in the potential to affect residents. Findings included:	mmediate jeopardy removal ted. core/Prepare/Serve-Sanitary (2) by requirements. re food from sources ed satisfactory by federal, ies. cod items obtained directly subject to applicable State ulations. Is not prohibit or prevent roduce grown in facility compliance with applicable d-handling practices. Is not preclude residents is not procured by the facility. In prepare, distribute and ince with professional rivice safety. In is not met as evidenced In and staff interviews, the land date left over food items available for use perators. This practice had the food served to 58 of 70		812	F812 1. Leftover food items have been labeled and dated. Expired food items have be discarded. 2. All residents had the potential to be affected. Completed inspection of the kitchen was made by the Registered Distriction to answer deficient areas are seen.	ed en	6/21/22	
	kitchen with Dietary A	a.m. the initial tour of the ide (DA) #1 revealed the not labeled, dated or expired			Dietician to ensure deficient areas removed corrected. This was completed by Jur 20, 2022. Education on the Food			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345365	B. WING		C 05/24/2022
NAME OF P	ROVIDER OR SUPPLIER	0.000	 	STREET ADDRESS, CITY, STATE, ZIP CODE	05/24/2022
NAME OF T	TO VIDER OR OUT FIER				
SIGNATUR	RE HEALTHCARE OF KI	NSTON		907 CUNNINGHAM ROAD	
				KINSTON, NC 28501	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 812	Continued From page	94	F 81	2	
	in the refrigerators:			Procurement/ Storage/ Preparation was conducted with the Dietary St	aff by
	From the reach-in ref			June 20, 2022 by the Regional Die	
		s with no label or date.		Manager. This training will also be	
	These were discarded	•		provided to all Dietary Staff upon h	nire
		dated open on 3/22/2022		during orientation.	
		's expiration date on the			
	container was discard	•		3. Ongoing audits by the Administr	
		iner ½ full of cooked field date was discarded by DA		Registered Dietician and Dietary N will be conducted for observation a	•
	#1.	date was discarded by DA			
	#1.			review to the facility is storing, pre distributing and serving food in	pailing,
	From the walk-in refri	gerator:		accordance with professional stan	darde
		powls with non-sealing cup		for food service safety. These aud	
		omatoes and peaches with		be conducted 5 x weekly for two w	
	no label or date were			weekly for two weeks and monthly	
		breast wrapped in plastic		three months. All data will be	101
	wrap with no label or			summarized and presented to the	facility
	5/10/2022 was discar			Quality Assurance and Performance	
		breast with a cut in the		Improvement meeting monthly by	
	-	osing the turkey breast to the		Administrator. Any issues or trends	
		0/2022 was discarded by DA		identified will be addressed by the	
	#1.	•		committee as they arise, and the p	olan will
	- Four large unop	pened containers of		be revised to ensure continued	
	Horseradish with exp	iration dates 12/29/2021		compliance. The QAPI committee	
	were discarded by DA	\ #1.		consists of the Administrator, DON	I, Staff
	- Pears in a stora	age container dated		Development Coordinator, MDS	
	5/10/2022 were disca	irded by DA #1.		coordinator, Admission Coordinato	The state of the s
				Rehabilitation Manager, Medical D	irector,
		5 a.m. in an interview with		Director of Social Services, and	
		od items were covered,		Environmental Services. Other me	
		en placed in the kitchen		may be assigned as the need show	uld
		d items were good for three		arise.	
		aced in the refrigerators or		4. The Administrator and the Dist	
	the expiration date.			4. The Administrator and the Dieta	-
	On El40/0000 -4 5 00	man in an independent state at .		Manager is responsible for implem	_
		p.m. in an interview with the		and maintaining the acceptable pla	111 OI
	refrigerators were to b	ed food items in the kitchen be labeled, dated and		correction. Corrective action to be completed by June 21, 2022.	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345365	B. WING		05/24/2022
	ROVIDER OR SUPPLIER	NSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	1 00/24/2022
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 812			F 8	12	
	reach-in and walk-in items daily, and the conformer checking the refrigure expired on Saturday opened and prepared labeled and dated who items to be seen to be seen and prepared labeled and dated who items to be seen and the s	refrigerators for expired food dietary cook was responsible gerators for food items and Sunday. He stated d food items were to be nen placed in refrigerators ren days or the marked			
F 835 SS=J	Dietary Cook #1, he seresponsible for check stored in the reach-in the beginning of the setated food items were and dated when oper the refrigerators. He secheduled on 5/15/20 checking the food items and labeling Administration	king the date on food items a and walk-in refrigerators at shift for expired foods. He are to be covered, labeled aned or cooked and placed in stated he was the cook and did not recall and in the refrigerators for	F 8	35	6/21/22
	enables it to use its re efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on record rev facility failed to provide	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial		Nurse Aide #1 and the Assistant Dietary Manager are no longer emploat the facility.	oyed

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C 05/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2 1/2022	
				907 CUNNINGHAM ROAD		
SIGNATUI	RE HEALTHCARE OF K	INSTON		KINSTON, NC 28501		
(X4) ID	·		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
F 835	Continued From pag	e 96	F 83	5		
	training, orienting, ar	nd verifying competencies for				
	new agency staff wh	ich resulted in Nursing		2. All residents have the potential to	be	
		oviding a regular meal tray to		affected. Administration staff, consis		
	l	ent #369 and Resident #61)		of the Administrator, Director of Nurs	ing,	
		nothing by mouth (NPO) and		Staff Development Coordinator, and		
		enteral feedings (nutrition		Regional Nurse Consultant reviewed		
	-	nto the digestive system as a		facility's protocol for orienting, trainin		
	liquid).			and verifying competencies of new s		
	Immediate Joonardy	bagan an E 11 22 when the		prior to allowing staff to work on the t		
		began on 5-11-22 when the re NA #1 was trained,		Education was provided on 5/18/22 b	by trie	
		ent to care for residents who		Regional Nurse Consultant to the Administrator pertaining to the regula	aton/	
	I -			requirement that a facility must be	itory	
	were NPO and on enteral feedings. Immediate Jeopardy was removed on 5-19-22 when the			administered in a manner that enable	e it	
		implemented an acceptable		to use its resources effectively and	50 K	
		Immediate Jeopardy		efficiently to attain or maintain the high	nhest	
		remains out of compliance at		practicable physical, mental, and	,	
	-	ty of an "D" (no actual harm		psychosocial well-being of each resid	dent.	
		more than minimal harm that		This education will be included in new		
	is not Immediate Jed	ppardy) to complete		orientation for all administrators.		
	education and ensur	e monitoring systems put into				
	place are effective.			4. Ongoing audits will be completed	by the	
				administrator to validate that residen	ts are	
	Findings included:			receiving diets as order by the physic		
				agency staff are receiving orientation		
	This tag is cross refe	erenced to:		the Agency Orientation Guide prior to		
				working a shift, agency staff will have		
	F726			access to the electronic medical reco		
	D d d	:		prior to working a shift, and dietary s		
		iew, staff interviews, and the facility failed to train and		will not provide meal trays for resider	11.5	
		the facility falled to train and ursing staff and verify		without validating the correct diet is prepared. These audits will be comp	leted	
		er care in accordance with		5 x weekly x 2 weeks, weekly x 2 we		
		sed care needs. Nursing		and monthly x 3 months. All data will		
		as not oriented to the protocol		summarized and presented to the fac		
		ents' dietary orders resulting		Quality Assurance and Performance		
		egular textured meal on		Improvement meeting monthly by the		
	_	(Resident #369) who had		DON or Assistant Director Of Nursing		
	enteral feedings (nutrition delivered by a tube into			Any issues or trends identified will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP C 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	0012412022	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 835	the digestive system order to be nothing b #369 aspirated and v NA #1 also provided to another resident (fenteral feedings and NPO creating a high This occurred for 2 o and Resident #61) resident for 2 or and 3 or	as a liquid) and a physician's y mouth (NPO). Resident was hospitalized for 5 days. a regular textured meal tray Resident #61) who had a physician's order to be likelihood of serious harm. f 2 residents (Resident #369 eviewed for enteral feedings. As interviewed on 5-19-22 at strator discussed it was the coordinators (SDC) position staff were trained and ing their shift and the DON) was to oversee the con was complete as well as my questions the agency staff inistrator stated the accility were agency/contract ack of consistency and poor as notified of Immediate at 2:51pm. Order: NPO breakfast meal tray delivery inized that Residents #369 evived meal trays. She went quested meal trays for both ovided trays with regular	F8	addressed by the QAPI corarise, and the plan will be rensure continued complian committee consists of the ADON, ADON, SDC, MDS CAdmissions Coordinator, RManager, Medical Director, of Social Services. Other mbe assigned as the need state of the Administrator is respinglementing and maintain acceptable plan of correction action to be completed by a	evised to ce. The QAPI Administrator, coordinator, ehabilitation and Director nembers may nould arise. consible for ing the on. Corrective		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED	
		345365	B. WING		C 05/24/2022		
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		05/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 835	Nurse Aide #1 sat do Shortly thereafter, re some difficulty and Norange juice. Reside Nurse Aide #1 turned called out for nursing reported resident be (vomit). Staff called was sent to the hosp am, while alert and cand treatment. At no breathing or lose cor Resident #61 was pr #61 was not fed, and bedside table. The m to Resident #61. The from Resident #61's aware Nurse Aide #1 room.	be 98 bown to feed Resident #369. sident appeared to have lurse Aide #1 gave her ent's color appeared red. d resident on her side and g assistance. Arriving nurse gan to vomit bloody emesis MD and 911 and the resident bital at approximately 9:40 briented, for further evaluation of time did Resident #369 stop hisciousness during event. Tovided a meal tray. Resident of the meal tray was left on the heal tray was not accessible he meal tray was removed room as soon as staff were had placed a tray in the	F8	35			
	Quality Assurance & (QAPI) meeting for the Interdisciplinary Regional Nurse Conconsists of the Admin Director, Director of Development Coording Projects DON, Intering Regional Nurse Con-Plan developed. Repetite the following: Nurse the facility was 5/2 orientation or training She had no long-terminal to orient prior	petified, and in-depth ad hoc Performance Improvement his event held 5/11/2022, with Team, Medical Director and sultant. The QAPI committee histrator, the Medical Nursing (DON), Staff hator (SDC), Special m Unit Manager, and sultant. hoot cause was determined to see Aide #1's first day working hi/2022 and she received no g prior to working on the floor. In care experience and the to working on the floor ficiency. In addition, the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION B	COMPLETED	
		345365	B. WING		C 05/24/2022
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	05/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 835	facility failed to valid the electronic mediaccess to the physise what the diet of failed to validate reprior to requesting a Dietary Assistant M policy to validate the consult with the dielicensed nurse to do in the residents' dietray for two residents. All residents are at practice. - Administration standaministrator, Direct Consultant, immediate protocol for orienting competencies of nestaff to work on the review completed a consistent in complorientation at the standard potential for signiffication at the standard potential for signification at the standard potential for signifi	ge 99 date Nurse Aide #1's access to cal record. She had no cian's orders or care plans to reders were. Nurse Aide #1 sidents' diet with charge nurse a meal tray from dietary. The anager failed to follow the e tray card system, and to tary manager and/or a etermine if there was a change to order prior to fixing a meal ts (Residents #369 and #61). Trisk for the current deficient aff, consisting of the ctor of Nursing, Staff tor, and Regional Nurse ately reviewed the facility's g, training, and verifying aw staff prior to allowing the floor. Root Cause Analysis and determined staff were not eting new agency staff art of their shift, leaving the ant issues to arise with each on this review, it was nal oversite was required with administrative team is one to attain and maintain the the revised plan to ensure eted and competencies of agency staff's initial shift in the staff working on the floor. as fully implemented on	F 83		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	COMPLETED		
		345365	B. WING		C	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501	05/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 835	Regional Nurse Coreviewing thorough Administration from Operations Manual the regulatory requiadministered in a mesources effective maintain the highest and psychosocial was Alleged date of IJ manual through interviews nursing staff and different consultar of education prior to facility. The staff education prior to facility. The staff education great types of diand the importance diets, and these top re-education of the education also incluvalidate resident's of dietary manager or with meals educated the nursing staff incorect resident physician diet order administrative team included administrative team included administrate expected practices as necessary on the	rovided on 5/18/22 by the insultant to the administrator by F835 at §483.70 and Appendix PP of the State. This education focused on irrement that a facility must be inanner that enables it to use its by and efficiently to attain or st practicable physical, mental, well-being of each resident. The staff verbalized receipt of starting their shift in the flucation documentation, audits are reviewed. The dietary and added to so fresident to starting their shift in the flucation documentation, audits are reviewed. The dietary and dated 5/11/2022 included etcs, nothing by mouth (NPO) and the accuracy of resident bottonics were included in the dietary staff. Dietary staff used use of resident diet list to diet and confirmation with nurse as needed. Assistance on conducted on 5/11/2022 to cluded checking meal tray card and diet and verifying	F 83	5		

	(X3) DATE SURVEY COMPLETED	
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	24/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 835 Continued From page 101 providing resident care before receiving access to the facility's electronic resident record and the orientation checklist information. Staffing audits and interviews revealed centralized scheduling or management staff were providing the orientation checklist and access to the facility's electronic medical record prior to the agency staff reporting to work and prior to providing resident care. Nursing staff were using resident care guides for resident care information including diet orders and were verifying resident diets with the assigned nurse before requesting a diet tray from the kitchen, and dietary staff used the daily printed resident diet list, NPO list, dietary manager and nurse to confirm resident's diet. Daily meal audits indicated residents were receiving diets as ordered. The facility's date of immediate jeopardy removal of 5-19-22 was validated. F 880 Infection Prevention & Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. \$483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: \$483.80(a)(1) A system for preventing, identifying,	6/21/22	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED		
		345365	B. WING _			C 05/24/2022
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501			03/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	reporting, investigating and communicable distaff, volunteers, visit providing services unarrangement based us conducted according accepted national states §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveit possible communication infections before they persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and trant to be followed to preven (iv) When and how is communicable including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employed disease or infected state of the provided in the contact will transmit to the contact will transmit to the provided in disease or infected in disease or infected in the provided in the	ig, and controlling infections is eases for all residents, ors, and other individuals der a contractual upon the facility assessment to §483.70(e) and following indards; In standards, policies, and ogram, which must include, allance designed to identify ole diseases or a can spread to other is meaning in possible incidents of se or infections should be insmission-based precautions arent spread of infections; olation should be used for a at not limited to: attion of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct is or their food, if direct the disease; and procedures to be followed rect resident contact.	F8	380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022	
NAME OF PE	ROVIDER OR SUPPLIER		- 	STREET ADDRESS, CITY, STATE, ZIP CODE		05/24/2022	
	10115211 011 001 1 21211			907 CUNNINGHAM ROAD			
SIGNATURE HEALTHCARE OF KINSTON			KINSTON, NC 28501				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 103	F 8	80			
	corrective actions tak	en by the facility.					
		lle, store, process, and s to prevent the spread of					
	IPCP and update the This REQUIREMENT by: Based on observation facility failed to follow and Prevention (CDC protective equipment precautions when Numering Resident #3 protection and wearing instead of an N95 mask when exiting R Transportation Aide waring a disposable N95 mask also failed face mask for 2 of 2 sinfection control practite COVID-19 pander	ir program, as necessary. T is not met as evidenced an and staff interviews, the the Centers for Disease C) guidelines for personal (PPE) for enhanced droplet arse #1 was observed 19's room without eye and a disposable face mask ask and failed to remove esident 319's room and the was observed exiting after retrieving a meal tray after mask instead of an to discard the disposable staff members observed for tices. This occurred during		F880 1. Nurse #1 and the Transports have been provided education Centers for Disease and Preve (CDC) guidelines for personal equipment (PPE) for enhanced precautions by June 20, 2022. 2. All residents had the potential affected by the deficient practic Auditing being completed by the Development Coordinator of the resident population requiring edroplet precautions will be to we proper eye wear and N95 mas being worn by facility staff. Sta	on the ention protective d droplet all to be ces. The ne current inhanced ralidate if observed		
	stated, "Approved recrespirators) should be CDC recommendation transmission-based prequiring eye protection be worn by Stakeh	9 policy updated 3/18/22 spirators (such as N95 e used in accordance with one in appropriate precaution settings and ion (face shield or goggles) holders (in addition to masks) re areas should be based on		without proper PPE will receive spot 1:1 educations, progressi disciplinary actions, and subsetermination of employment. The provide education to all staff of Control as it pertains to wearin the proper PPE when entering a resident's room requiring endended in the provided in negative spot and the provided in n	ve equent ne SDC will n Infection ng / using and exiting nance 2022. This		

		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345365	B. WING			C 05/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/24/2022	
				907 CUNNINGHAM ROAD			
SIGNATUR	RE HEALTHCARE OF K	INSTON		KINSTON, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pag	e 104	F 88	00			
	requirements by loca			orientation for all staff.			
		ordance with CDC, state		onentation for all stair.			
	and/or federal regula			3.Ongoing auditing to include			
				observations of facility staff to va	alidate		
	Based on the CDC D	ata Tracker website on		donning proper PPE when provi			
		nity transmission level at the		for residents requiring enhanced	•		
	time of the survey wa			precaution will be completed by			
				Director of Nursing and/or SDC.	These		
	An interview was cor	nducted with the interim		audits and observations will be	conducted		
	Director of Nursing o	n 5/15/22 at 12:00 PM and		5 days a week for 2 weeks, 2 x	weekly for		
	she stated there were no staff or resident			2 weeks, weekly for 2 weeks an			
	COVID-19 positive c	ases at the facility.		monthly x 3 months. Any incider			
				non-compliance with Infection C			
		00 PM, Nurse #1 was		guidelines as it relates to failure			
	_	esident #319's room wearing		proper PPE when providing care	e for		
		osable face mask, and no		residents on enhanced droplet	- 41		
		age for enhanced droplet		precautions will be addressed a	-		
	•	ed on Resident #319's door o wear gown, gloves, eye		arise. All data will be summarize presented to the facility Quality			
		95 mask before entering the		and Performance Improvement			
	room.	95 mask before entering the		monthly by the Administrator. A	-		
	TOOM.			or trends identified will be addre			
	At 1:05 PM on 5/15/3	22, Nurse #1 was observed		the QAPI committee as they aris			
		9's room wearing the same		the plan will be revised to ensur			
		1 had removed her gown and		continued compliance. The QAF			
		kited the room and sanitized		committee consists of the Admir			
		way using the wall hand		DON, Staff Development Coord			
	sanitizer.	, ,		MDS Coordinator, Admission Co	oordinator,		
				Rehabilitation Manager, Medica	l Director,		
	An interview was cor	nducted with Nurse #1 on		Director of Social Services, and			
		When she was asked if she		Environmental Services. Other			
		y a new mask after exiting		may be assigned as the need sl	nould		
		n on enhanced droplet		arise.			
		ted she was supposed to get			_		
		flustered and forgot. Nurse		4. The Administrator and Director			
	#1 stated she was su			Nursing is responsible for imple			
	· ·	ering a room on enhanced		and maintaining the acceptable			
	droplet precaution bu	ut sne forgot.		correction. Corrective action to b	oe		
			1	completed by June 21, 2022.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345365	B. WING _			C 05/24/2022	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF KINSTON			STREET ADDRESS, CITY, STATE, ZIP COD 907 CUNNINGHAM ROAD KINSTON, NC 28501	•	03/24/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	b. On 5/18/22 at 1:05 was observed exiting wearing goggles and carrying a meal tray at the food cart located observed sanitizing his sanitizer in the hallway precaution sign on the gloves, eye protection before entering the roobservation the Transishe needed to remove a new mask when exipprecaution room and stated she just forgot. An interview was confined in the stated staff edroplet precautions significantly gloves, N95 mask, and stated a new mask she those rooms. On 5/19/22 at 4:25 PI conducted with the Advanced in the stated staff edroplet precautions significantly gloves.	PM, the Transportation Aide Resident #28's room a disposable face mask and placing the meal tray on in the hallway. She was er hands using the wall hand y. The enhanced droplet e door instructed gowns, and N-95 mask be worn om. At the time of the sportation Aide was asked if the her mask and replace with ting an enhanced droplet she stated "Yes". She ducted with the interim se on 5/19/22 at 2:00 PM intering rooms on enhanced mould be wearing a gown, and eye protection. She mould be put on when exiting	F8	80			