DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 345509 | MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ JAN 17 | DATE SURVEY COMPLETE: 12/1/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER KINGSWOOD NURSING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC | | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| F 247 | 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE |

A resident has the right to receive notice before the resident's room or roommate in the facility is changed.

This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interviews, the facility failed to notify two (2) of two (2) residents (Resident #69, Resident #90) of a new roommate. The findings included:

1. Resident #69 was admitted to the facility on 12/21/2009. A quarterly Minimum Data Set (MDS) assessment dated 10/14/2011 indicated that Resident # 69 was cognitively intact.

On 11/29/2011 at 10:18 AM, Resident #69 stated she was not notified when she got a new roommate. She stated she came back from lunch and her roommate was already moved in. No one from the facility introduced her to her new roommate.

A review of Resident #69's medical record revealed no documentation regarding notification of a new roommate.

On 12/1/11 at 8:42 AM, Administrative staff #4 stated the facility notified the family/resident if oriented before we move that resident to another room. Generally, if it was an alert and oriented resident, the facility let them know that they are going to get a roommate prior to the new resident coming to the room. However, they did not always let them know when they were getting a new/ another roommate. It also would be documented in the social worker notes but was not documented every time.

2. Resident # 90 was admitted to the facility on 04/28/201. A quarterly MDS dated 10/31/2011 indicated that Resident # 90 was cognitively intact.

On 11/29/2011 at 9:36 AM, Resident # 90 indicated he was not notified when he was getting a new roommate.

A review of Resident #90's medical record revealed no documentation regarding notification of a new roommate.

On 12/1/11 at 8:42 AM, Administrative staff #4 stated the facility notified the family/resident if oriented before we move that resident to another room. Generally, if it was an alert and oriented resident, the facility let them know that they are going to get a roommate prior to the new resident coming to the room. However, they did not always let them know when they were getting a new/ another roommate. It also would be documented in the social worker notes but was not documented every time. She further indicated she was not at work when Resident #90 got his last roommate which was November 25, 2011.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345509 | A. BUILDING _____ B. WING _____ | C 12/01/2011 |

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

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| F 000 | INITIAL COMMENTS<br><br>2567 amended 1/5/2012 to correct F 274--resident number changed to #9 from #5. | F 000 | This plan of correction shall not be construed as an admission of fault nor agreement with the findings of non-compliance. The plan of correction is provided pursuant of Federal requirements which require an acceptable plan of correction as a condition of continued certification. | |
| F 156 SS=B | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered | F 156 | **483.10- F156**<br><br>1. All residents are potentially at risk for this issue.<br>2. All Denial Letters will be completed to include the date of and reason for denial.<br>3. Social Services will mail Denial Letters to residents' RP, certified mail with return receipt, or give to the resident if he/she is their own RP, as well as verbally informing RP. Denial Letters will be sent 5 days prior to their Last Date of Coverage.<br><br>F 156 Continued → | Social Services Administrator 12-09-11 |

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

Rebecca Jennette Rogers Administrator 1-11-2012

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.

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| F 156 | Continued From page 1<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.<br><br>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This | F 156 | 4. Social Services will be responsible for the completion of all Denial letters including the reason for termination. Social Services is also responsible for logging the Denial Letter in on the **Notice of Medicare Non-Coverage** Log.<br>5. The Log, as well as a copy of all letters, will be reviewed in the Medicare Meeting weekly.<br>6. The Administrator will review the log weekly x4, monthly x3, and quarterly thereafter.<br>7. The reviews of the Medicare Denial letters will be addressed in monthly QA meeting.<br><br>Social Services Administrator 12/29/11 | |

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| F 156 | Continued From page 2<br>includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to issue the reason for denial on Medicare benefits for 1 of 3 sampled residents (Resident # 92) and failed to provide written notice more than 2 days in advance of loss of benefits for 2 of 3 sampled residents (Residents # 51 & # 84).<br><br>The findings include:<br><br>1. Resident #92 was admitted to the facility on 9/1/11. On 11/30/11, a record review was conducted which revealed that on 11/21/11, Administrative Staff #4 prepared a Notice of Medicare Non-Coverage. On the form, it recorded that she met with the resident and told her that her coverage would end on 11/25/11. The form did not record a reason for non-coverage. | F 156 | | |

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| F 156 | Continued From page 3<br>On 11/30/11 at 9:45 am, Administrative Staff #4 stated that she spoke to Resident #92 in person. She shared that she doesn't always write a reason why the the coverage was denied on the form, however in the case of Resident #92 it was because she would not participate in therapy.<br><br>2. Resident #51 was admitted to the facility on 5/26/11. On 11/30/11, a record review was conducted which revealed that on 6/8/11, the MDS (Minimum Data Set) nurse prepared a Notice of Medicare Non-Coverage. On the form, it recorded that she left a phone message for the representative payee (RP) and relayed that Resident #51 would be denied coverage on 6/13/11 because her condition had improved.<br><br>On page 2 of the notice, was instructions for the receiver to "Please sign below to indicate that you have received this notice." It was left blank.<br><br>The notice also had a section that read, "I have been notified by telephone that the services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my Quality Improvement Organization (QIO) no later than noon of the day before the effective date of this notice," and it was left blank.<br><br>On 11/30/11 at 9:00 am, the MDS nurse was interviewed. She stated that she used to coordinate the Notices of Medicare Non-Coverage until September, when the Social Worker took over the task. She shared that she recalled calling the RP to notify her of the denial of services but did not send her a copy of the notice in the mail because she did not know that it was a required action. | F 156 | | |

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| F 156 | Continued From page 4<br><br>3. On 6/10/11, Resident #84 was admitted to the facility. On 11/30/11 a record review was conducted which revealed that on 7/25/11, the MDS (Minimum Data Set) nurse prepared a Notice of Medicare Non-Coverage. On the form, it recorded that she spoke with the representative payee (RP) and relayed that Resident #84 was denied coverage on 7/24/11 because her condition had improved and that she would be returning to assisted living.<br><br>On 11/30/11 at 9:00 am, the MDS nurse was interviewed. She stated that she used to coordinate the distribution of the Notices of Medicare Non-Coverage letters until the Social Worker took over the task in September. She shared that her expectations was for the notification to be done five days prior to the last day of coverage. Regarding Resident #84, she recalled that she had attempted several phone calls to the RP before successfully reaching him on 7/25/11. She stated that the RP was already aware that Resident #84 would be transferred to an assisted living bed, however, she did not send him a copy of the notice by mail, because she did not know that it was a required action. | F 156 | | |
| F 159 SS=B | 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS<br><br>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.<br><br>The facility must deposit any resident's personal funds in excess of $50 in an interest bearing | F 159 | F 159 please see next page | |

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| F 159 | Continued From page 5<br>account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)<br><br>The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br><br>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br><br>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br><br>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.<br><br>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.<br><br>This REQUIREMENT is not met as evidenced | F 159 | **F 159**<br>1. All residents are potentially at risk.<br>2. Residents #6 and #29 have been given the most recent monthly statement for their respective trust funds.<br>Completed 12-29-2011<br>3. Audit conducted to determine if there are any other alert and oriented residents that should receive their statement.<br>Completed 1-06-2012 For those identified, the Trust Fund statement for December was presented to them by the BOM.<br>Completed 1-06-2012-. The BOM is responsible for mailing out or personally presenting all Resident Trust Fund statements.<br>4. Monthly Trust Fund statements for Non alert/oriented residents will continue to be mailed to residents RP monthly by the BOM.<br>5. Alert and oriented residents will be requested to sign a second copy for their personal file.<br>6. Program results will be reviewed by Administrator 1 x each month.<br>7. Results will be presented to QA meeting quarterly for 1 year. | 12-29-11 BOM<br>Social Services BOM 1-6-12<br>12-29-11 BOM<br>BOM 1-6-11<br>Adm 12-29-11<br>BOM 12-29-11 |

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| F 159 | Continued From page 6 | F 159 | | |

by:
Based on record review, resident and staff interviews, the facility failed to issue quarterly financial bank statements to two (2) of three sampled residents (Resident #6, Resident #29) with resident trust fund accounts who were cognitively intact and independent in decision-making. The findings included:

1. Resident #6 was admitted to the facility on 4/29/2009. A quarterly Minimum Data Set (MDS) dated 10/26/2011 indicated Resident #6 was cognitively intact.

On 11/29/2011 at 9:26 AM, Resident #6 stated he had a resident trust funds account but did not receive any statements. Resident #6 stated if he asked how much money was in his account, the facility would tell him.

On 12/1/2011 at 10:45 AM, Administrative staff # 5 stated she provided monthly statements to responsible parties (RP) but only provided alert and oriented residents statements when they requested one. She further indicated she gave residents a receipt when they obtained money from their account.

2. Resident # 29 was admitted to the facility on 12/20/2009. A quarterly MDS dated 9/23/2011 indicated Resident #29 was cognitively intact.

A review of Resident #29's trust funds account revealed that Resident #29 opened her account on 12/20/2009.

On 11/29/2011 at 2:03 PM, Resident #29 stated she had a personal funds account but did not

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| F 159 | Continued From page 7<br>receive a bank statement. She indicated that the facility would tell her how much was in the account if she asked them.<br><br>On 12/1/2011 at 10:45 AM, Administrative staff # 5 stated she provided monthly statements to responsible parties (RP) but only provided alert and oriented residents statements when they requested one. She further indicated she gave residents a receipt when they obtained money from their account. | F 159 | | |
| F 226 SS=B | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on policy review, personnel records review and staff interviews, the facility failed to verify licensure and certification for 3 of 5 new employees, prior to hire.<br><br>The findings include:<br><br>The facility's Administrative Policies and Procedures: titled Screening, dated 3/11/2004 was reviewed. It read, "It is the policy of this facility that all potential employees be screened to run out a history of abuse, neglect or mistreatment of residents. This facility will not knowlingly hire individuals who have been found guilty, by a court of law, or abusing, mistreating, or neglecting residents, or who have any finding | F 226 | **F226**<br>1. The referred to 3 employees' licenses and or certifications were verified, retrieved and placed in their files. Completed 12-29-2011 Conducted an audit of all current licensed and certified employees for verification. Completed 12-29-2011 The SDC is responsible for verifying all licenses/certification of all new perspective employees before hiring any employee.<br>2. A **Pre-Employment/Pre-Orientation Checklist** will be attached to all perspective employees applications and forwarded to the DON.<br>3. The **Pre-Employment/Pre-Orientation Checklist** will be completed and verified by both the DON and SDC prior to Orientation.<br>F226 Continued → | SDC 12-29-11<br>SDC 12-29-11<br>DON SDC 12-29-11 |

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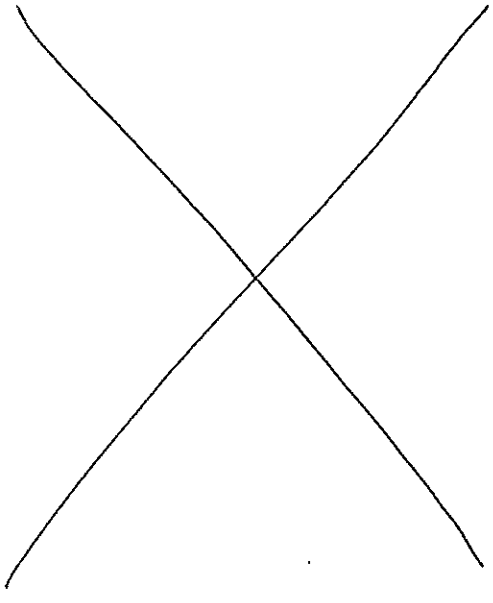
| F 226 | Continued From page 8<br>entered into the State Nurse Aides Registry concerning abuse, mistreatment or neglect."<br><br>Procedure: "A verification of the current license or certification status, including the Nurses Aide registry will be obtained to include whether any disciplinary action was been taken against them."<br><br>1. Nurse #3 was hired on 10/26/11 as a Licensed Practical Nurse. On 12/1/11, a review was conducted of Nurse #3's personnel file. It revealed that at the time of her hire, there was no evidence that her license was verified, as part of the pre-hire screening. A document from the North Carolina Board of Nursing, dated 11/30/11 was in her file, with a license expiration date of 1/31/2013.<br><br>On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed. She shared that the employee who normally conducted the pre-employment screening was on a leave of absence and unavailable for interview. She did not know the reason why the license was verified after the date of hire.<br><br>2. Nurse #4 was hired on 9/29/11 as a Registered Nurse. On 12/1/11, a review was conducted of Nurse #4's personnel file. It revealed that at the time of her hire, there was no evidence that her license was verified as part of the pre-hire screening. A document from the North Carolina Board of Nursing, dated 11/30/11 was in her file, with a license expiration date of 7/13/2012.<br><br>On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed. She shared that the employee who normally conducted the pre-employment | F 226 | 4. A copy of the license or certification and the Criminal Background Check will be stapled to the **Pre-Employment/Pre-Orientation Checklist** and it will be filed in the employees permanent employee file.<br>5. A Log of all new hires will be maintained by the SDC. The SDC will monitor weekly x4, monthly x3, and quarterly thereafter. The results will be presented to the QA Committee 1 x each month x 12 months.<br><br>  | SDC 12-21-11<br>SDC 12-21-11<br>SDC 12-29-11 |

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| F 226 | Continued From page 9<br>screening was on a leave of absence and unavailable for interview. She did not know the reason why the license was verified after the date of hire.<br><br>On 12/1/11 at 1:10 pm, Administrative Staff #1 was interviewed. She stated that she searched records contained in the staff development department and found another license verification for Nurse #4's license; it was dated 10/7/11.<br><br>3. Nurse Aide #1 was hired on 10/26/11. On 12/1/11, a review was conducted of Nurse Aide #1's personnel file. It revealed that at the time of her hire, there was no evidence that her certification was verified, as part of the pre-hire screening. A document from the North Carolina Nurse Aide I Registry, dated 10/31/11 was in her file, with a certification expiration date of 1/13/2013.<br><br>On 12/1/11 at 10:50 am, Administrative Staff #5 was interviewed. She shared that the employee who normally conducted the pre-employment screening was on a leave of absence and unavailable for interview. She did not know the reason why the certification was verified after the date of hire. | F 226 | | |
| F 253 SS=B | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by: | F 253 | F 253 = See next page | |

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| | 345509 | A. BUILDING _____ B. WING _____ | 12/01/2011 |

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

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| F 253 | Continued From page 10<br>Based on observation and resident interviews the facility had closet doors and dresser drawer fronts in disrepair on four (4) of four (4) halls and more than 2/3 of resident rooms. Findings included:<br><br>Review of the hand written document titled Room Furniture Facings, dated 7/20/11, revealed there were 55 rooms in the facility (excluding room 407 which was not listed) and of these there were 10 resident rooms where the furniture facings were listed as real bad, 25 where they were listed as bad and 18 where they were listed as fair (Room 210 was listed under both bad and fair). There was one room where the furniture facings had been repaired already (Room 103) and two rooms that did not indicate any damage (Room 215 and Room 216). The total percentage of rooms with furniture facings in real bad or bad condition was 63 percent. The total percentage of rooms with real bad, bad or fair furniture facings was 94 percent. Eleven (11) of the rooms with very bad or bad furniture facings were on 100 hall (out of 14 rooms), 12 were on 200 hall (out of 16 rooms), 1 was on 300 hall (out of 8 rooms) and 9 were on 400 hall (out of 17 rooms). Room 407 was not listed).<br><br>On 11/30/11 at 2:47 PM a tour of the facility revealed 34 rooms that had damaged veneer on the closet doors and/or drawer fronts. Resident rooms with closed doors were not entered at this time. Damage included: small cracks in the veneer, small chips of veneer missing, larger cracks and missing areas of veneer, small to large areas of veneer pulling away from/peeled back from the door/drawer front, the entire sheet of veneer barely hanging on the door/drawer front, or veneer already completely off exposing | F 253 | **F253**<br>1. A complete inventory of all furniture in need of repair will be completed by maintenance and logged on the **Maintenance Furniture Audit.** Completed 12-23-2011<br>2. Maintenance Staff will begin refinishing all furniture, logging completion date for each room **on Furniture Repair Completion Log.**<br>3. Furniture will be checked on daily rounds by the department heads and other key personnel. Any problems will be reported to maintenance by entering a work request on the Maintenance Log located at each nurses station. Department Heads were in-serviced on this program by the Administrator. Completed 12-20-2011 Anticipated completion of furniture is 01-31-2012..<br>4. Maintenance will complete a weekly audit of each room and furniture. Rooms #101,102,103,104,105,106,107,108,109,110,111,112,113,114,201,202,203,204,205,206,207,208,,301,302,306, 307,and308 have been completed. Completed 1-11-2012 | |

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| F 253 | Continued From page 11<br>the particle board beneath. In several rooms the kick plate for the closet and/or dresser was also damaged and/or the bedside table drawer/door fronts had damaged veneer also.<br><br>On 12/1/11 at 11 AM, interview with Administrative Staff #3 revealed that she was aware of the state of disrepair of the closet doors and dresser drawer fronts and that it was a problem in almost every resident room in the facility. She indicated that one set of drawer/door fronts had been replaced in the last few months and that her plan was to start replacing one set per month.<br><br>On 12/1/11 interview with Administrative Staff #6 at 11:10 AM revealed he had been working in the facility for 6 months and during that time replaced one room's closet and drawer fronts (Room 103). He stated that more would be replaced in future but he did not know when. In addition, he provided the inventory he completed titled Room Furniture Facings dated 7/20/11 (See above). | F 253 | Anticipated completion of rooms#210,211,212,213,214,215,216,303,307,401,402,403,404,405,406,408,409,410,411,412,413,414,415,416,417 and 418 will be 1-31-2012.<br>5. Audits will be monitored by the Administrator weekly x4, monthly x3, and quarterly thereafter.<br>6. Results of audits will be presented to the QA Committee 1 x each month x 12 months. | |
| F 272 SS=C | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine; | F 272 | F 272 see next page | |

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| F 272 | Continued From page 12<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff interview, the facility failed to assess residents regarding discharge plans and return to community on their admission MDS (Minimum Data Set) assessments for 4 (residents # 92, #85, #114 & # 6) of 4 sampled residents. The findings include:<br><br>1. Resident #92 was admitted to the facility on 09/01/11 with multiple diagnoses including Left femoral fracture. The admission MDS | F 272 | **F272**<br>1. All residents are potentially at risk.<br>2. All identified residents (#92,#85,#114,#6) section Q of their MDS was corrected. Completed 12-29-2012<br>3. The facility's MDS Coordinator contacted the software company to inform them of the problem. The problem was corrected 11-30-2011. All in-house MDS will be audited by the MDS/Care Plan Coordinator and Social Services. Completed 1-13-2012.<br>4. Each upcoming MDS will be reviewed for completion of Section Q in the daily Administrative Nurse meeting. Administrative nurses are DON, ADON, SDC, MDS and Clinical Coordinator.<br>6. Results of monitoring will be presented 1 x month x 12 months to QA Committee. | SS MDS 12-29-11<br>MDS 11-30-11<br>MDS SS 1-13-12<br>Clinical Coordinator MDS DON ADON SDC 12-29-11 |

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| F 272 | Continued From page 13<br>assessment dated 09/13/11 indicated that Resident #92's cognitive status was intact. The section of the MDS for the discharge plan and return to community was blank.<br><br>The social worker's notes dated 09/01/11 revealed that the resident was admitted for short term rehab (rehabilitation) and to return home where she resides with her daughter. The resident is to receive PT (Physical Therapy)/OT (Occupational Therapy). The plan is to return home once goals are met. The notes dated 09/15/11 indicated that the resident would like to go home and is discussing a day with her daughter. Discussed home health options which resident states she has had. Resident also states her daughter generally cares for her at home.<br><br>On 11/30/11 at 8:40 AM, the MDS Nurse was interviewed. She stated that the social worker was responsible in completing the section regarding discharge plan and the return to community.<br><br>On 11/30/11 at 8:45 AM, the social worker was interviewed. She stated that she was not completing the section under discharge plan and return to community because the computer would not accept any response. She further stated that the facility had a lot of MDS assessments rejected from the state because of incomplete information. She also indicated that it has something to do with the software the facility was using.<br><br>2. Resident #85 was admitted to the facility on 3/16/10, then readmitted on 9/1/11 with multiple | F 272 | | |

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| F 272 | Continued From page 14<br>diagnoses including seizures and Alzheimer's disease. The admission MDS assessment dated 09/13/11 indicated that Resident #85's cognitive status was impaired. The section of the MDS for the discharge plan and return to community was blank.<br><br>On 11/30/11 at 8:40 AM, the MDS Nurse was interviewed. She stated that the social worker was responsible in completing the section regarding discharge plan and the return to community.<br><br>On 11/30/11 at 8:45 AM, the social worker was interviewed. She stated that she was not completing the section under discharge plan and return to community because the computer would not accept any response. She further stated that the facility had a lot of MDS assessments rejected from the state because of incomplete information. She also indicated that it has something to do with the software the facility was using.<br><br>3. Resident #6 was admitted to the facility on 5/31/01, then readmitted on 5/31/11 with multiple diagnoses including spinal cord Injury and diabetes mellitus II. The annual MDS assessment dated 2/3/11 indicated that Resident #6's cognitive status was intact. The section of the MDS for the discharge plan and return to the community was blank.<br><br>On 11/30/11 at 8:40 AM, the MDS Nurse was interviewed. She stated that the social worker was responsible in completing the section regarding discharge plan and the return to | F 272 | | |

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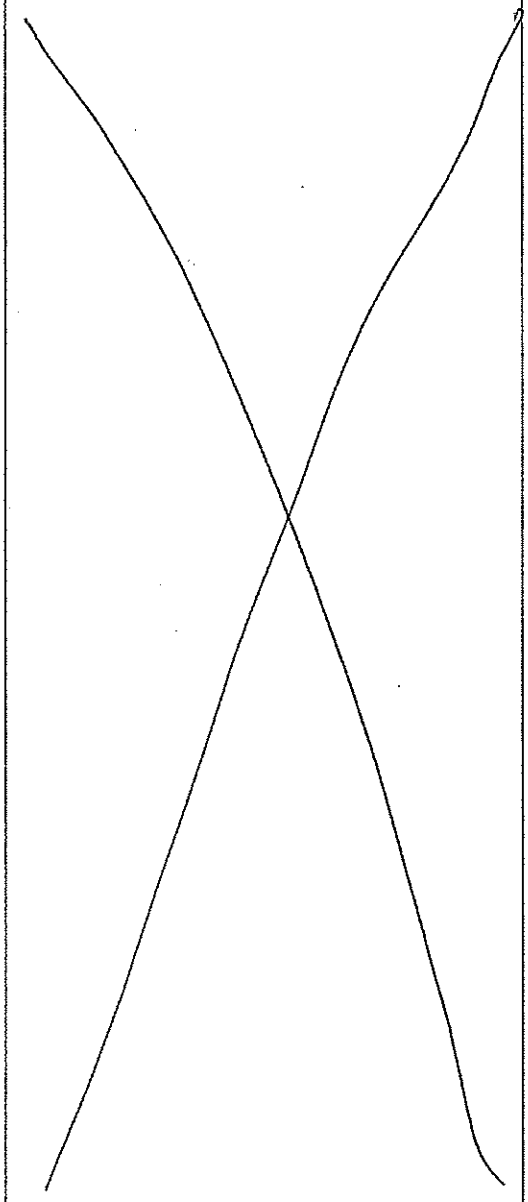
| F 272 | Continued From page 15<br>community.<br><br>On 11/30/11 at 8:45 AM, the social worker was interviewed. She stated that she was not completing the section under discharge plan and return to community because the computer would not accept any response. She further stated that the facility had a lot of MDS assessments rejected from the state because of incomplete information. She also indicated that it has something to do with the software the facility was using.<br><br>4. Resident # 114 was admitted to the facility 10/28/2011 and discharged home 11/11/11. Diagnoses included: Hypertension, Diabetes, failure to thrive and gastroesophageal reflux disease.<br><br>The Admission Minimum Data Set (MDS) dated 11/4/11 indicated resident had mild cognitive impairment. Resident required limited assistance with locomotion on the unit, extensive assistance with bed mobility, transfers, and toilet use. Total assistance was required with locomotion off the unit, dressing, personal hygiene and bathing. The section of the MDS for the discharge plan and return to the community was blank.<br><br>On 11/30/2011 at 8:45 AM, the MDS nurse was interviewed. She stated that the social worker was responsible for completing the section regarding discharge plan and the return to the community.<br><br>On 11/30/2011 at 8:45 AM, Administrative staff #4 was interviewed. She stated she was not | F 272 |  | |

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| F 272 | Continued From page 16<br>community.<br><br>On 11/30/2011 at 8:45 AM, Administrative staff #4 was interviewed. She stated she was not completing the section under discharge plan and return to the community because the computer would not accept any response. She further stated that the facility had a lot of MDS assessments rejected from the stated because of incomplete information. She also indicated that it had something to do with the software that the facility was using. | F 272 | | |
| F 274 SS=B | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to complete a significant change in status MDS assessment for 2 (Residents #45 & # 9) of 2 sampled residents triggered for a significant change in status assessments. The | F 274 | **F274**<br>1. All residents are potentially at risk.<br>2. Significant change assessments were completed for residents #45 and #9. Completed 1-06-2012<br>3. All in-house residents MDS were assessed for possible need for Significant Change Assessments by a committee consisting of the MDS Coordinator, Rehab Director, Social Services and DON. Completed 12-30-2011 Significant Change Assessments were completed for those determined to need one. Completed 1-06-2012 The MDS Nurse was in-serviced on the Plan of Care for residents #4 and #9 and the Plan of Correction. Completed 12-20-2011 | MDS 1-6-12<br>DON MDS Rehab SS 12-30-2011<br>MDS 1-6-12<br>DON 12-20-11 |

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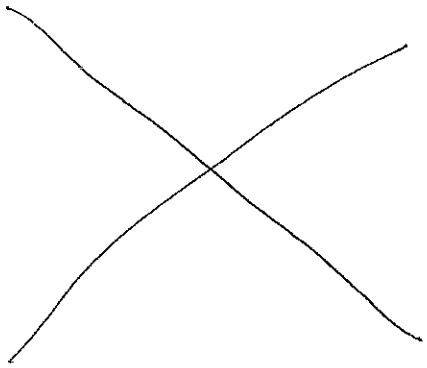
| F 274 | Continued From page 17<br>Alzheimer's Disease. The annual MDS assessment dated 08/12/11 indicated that Resident #45 had memory and decision making problems and needed limited assistance with one person physical assist with bed mobility, dressing, toilet use and personal hygiene. The quarterly Minimum Data Set assessment dated 11/11/11 indicated that Resident #45 had memory and decision making problems and needed extensive assistance with one person assist with bed mobility, dressing, toilet use and personal hygiene.<br><br>Based on the annual MDS assessment and the quarterly MDS assessment, Resident #45 had declined in 4 areas of ADLs (activities of daily living), bed mobility, dressing, toilet use and personal hygiene from limited assistance to extensive assistance.<br><br>On 12/01/11 at 1:23 PM, the MDS Nurse was interviewed. She stated that she understood that 3 or more changes (decline or improvement) in ADL functions would trigger a significant change in status assessment. She also stated that she did not compare the last assessment with the current assessment for any changes. The MDS Nurse further revealed that when a resident was scheduled to have a quarterly assessment, she completes the quarterly assessment even though the resident was triggered for a significant change.<br><br>2. Resident # 5 was originally admitted to the facility on 07/03/06 with multiple diagnoses including Hypertension, Anxiety, Chronic Kidney | F 274 | 4. All future Quarterly assessments will be compared to the residents previous Annual assessment to identify any areas of decline and/or improvement that would trigger a significant change assessment.<br>5. If a significant change is required, the Quarterly MDS will be changed to a Significant Change MDS.<br>6. Residents who trigger for a Significant change MDS will be discussed in daily Administrative Nurse meeting.<br>7. Monthly Log of residents requiring a Significant Change MDS will be presented 1 x monthly to the QA Committee x 12 months.. The DON is responsible for monitoring this program.<br><br>  | MDS 12-29-11<br>MDS 12-29-11<br>MDS 12-29-11 |

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| F 274 | Continued From page 18<br>Disease, and Osteoporosis. The annual MDS assessment indicated that Resident #5's cognitive status was intact and she was independent with ambulation in room and needed supervision with ambulation in corridor. The assessment also indicated that she needed supervision with bathing. The quarterly MDS assessment dated 09/08/11 indicated that Resident #5 had moderate cognitive impairment and ambulation in room and in corridor did not occur during entire 7 days. The assessment further indicated that she needed extensive assistance with bathing.<br><br>Based on the annual and quarterly MDS assessments, Resident #5 had declined in 2 areas, ambulation and bathing.<br><br>On 12/01/11 at 1:23 PM, the MDS Nurse was interviewed. She stated that she understood that 3 or more changes (decline or improvement) in ADL functions would trigger a significant change in status assessment. She also stated that she did not compare the last assessment with the current assessment for any changes. The MDS Nurse further revealed that when a resident was scheduled to have a quarterly assessment, she completes the quarterly assessment even though the resident was triggered for a significant change. | F 274 | | |
| F 278 SS=B | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate | F 278 | F 278 - see next page | |

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| F 278 | Continued From page 19<br>participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview, the facility failed to accurately assess one (2) of eleven (11) sampled residents (Resident # 90) for speech and (Resident #45) for antipsychotic medication and failed to complete RN signature for Care Area Assessment and care planning for eleven (11) of thirteen (13) sampled residents (Resident #6, #9, #45, #51, #75, #85, #90, # 92, #93, #111 and # 114). The findings included:<br><br>1a. Resident #90 was admitted to the facility | F 278 | F278<br>1. All residents are potentially at risk.<br>2. Residents #90 and #45 MDS coding errors were corrected 12-29-2011. Residents #90, #45, #6, #9, #51, #75, #85, #92, #93, #111, #114 MDS signatures were corrected 12-29-2011. All in-house residents MDS will be audited at time of next scheduled MDS and any errors corrected. These MDS will be added to MDS log to show corrections completed and date.<br>All annual admission and significant change assessments completed as of 9-1-2011 pulled and signatures completed. 1-3-2012<br>3.MDS nurse will visit daily with residents who are in MDS look back period to assist in assessment.<br>4. After completion of MDS, MDS coordinator will review assessment for accuracy.<br>5. MDS Coordinator will bring all completed MDS to the daily Department Head meeting for completion of all signatures. | MDS 12-29-11<br>MDS 1-3-12<br>MDS 12-29-11<br>MDS 12-29-11<br>MDS 12-29-11 |

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| | 345509 | A. BUILDING _____ B. WING _____ | 12/01/2011 |

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| F 278 | Continued From page 20<br>4/28/2010. Cumulative diagnoses included: Cerebrovascular accident with hemiplegia and Aphasia.<br><br>An Annual Minimum Data Set (MDS) assessment dated 5/2/2011 indicated resident had clear speech, was understood and understands. Resident was alert and oriented. Communication did not trigger on the MDS.<br><br>On 11/29/2011 at 9:36 AM., an interview was conducted with Resident #90. Resident #90 used gestures, sounds and a communication board to express himself and answer questions during the interview.<br><br>A Social work note dated 8/2/11 indicated Resident #90 expressed himself with gestures, garbled words and sound board.<br><br>An Activity progress note dated 10/31/11 revealed that Resident #90 could not speak.<br><br>On 11/30/11 at 9:45 AM., the MDS nurse reviewed the MDS for 5/2/2011 and stated that it was incorrect information regarding speech clarity and that Resident #90 was understood. She stated she had no idea why she had documented it that way and it was a mistake. She knew Resident #90 did not talk.<br><br>1b. Resident #90 was admitted to the facility 4/28/2010. Cumulative diagnoses included: Cerebrovascular accident with hemiplegia and Aphasia.<br><br>An Annual Minimum Data Set (MDS) assessment dated 5/2/2011 was reviewed. No signature was | F 278 | 6. The DON will sign all MDS for completion and all Annual and Significant Change MDS and new admissions in the areas of VB1 and the MDS Coordinator will sign the VC1 section.<br>7. All MDS will be logged onto MDS log and checked for accuracy and signatures daily in Daily Administrative Nurse meeting.<br>8. The DON is responsible for monitoring this program. The MDS Log will be reviewed 1 x monthly x 12 months in the QA Committee meeting . | DON 12-31-11<br>MDS 12-31-11<br>DON 12-31-11 |

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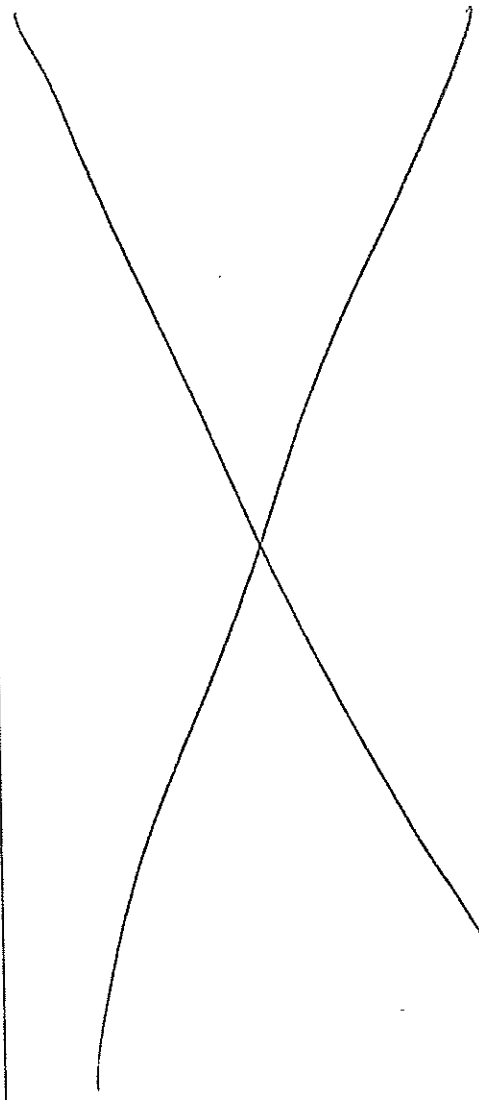
| F 278 | Continued From page 21<br>noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).<br><br>On 11/30/2011 at 9:45 AM., the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.<br><br>On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility consultant had not told them those areas needed to be completed and signed.<br><br>2. Resident #93 was admitted to the facility 4/29/2010. Cumulative diagnoses included: Advanced Multiple Sclerosis, Osteomyelitis and Osteoporosis.<br><br>An Annual MDS dated 5/6/2011 was reviewed. No signature was noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).<br><br>On 11/30/11 at 9:45 AM, the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.<br><br>On 11/30/11 at 1:45 PM., Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility consultant had not told them those areas needed to be completed and signed. | F 278 |  | |

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| F 278 | Continued From page 22<br>3. Resident #111 was admitted to the facility 9/27/2011. Cumulative diagnoses included: Coronary Artery Disease, Hypertension, Congestive Heart Failure and Diabetes.<br><br>An Admission MDS dated 11/2/11 was reviewed. No signature was noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).<br><br>On 11/30/11 at 9:45 AM, the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.<br><br>On 11/30/11 at 1:45 PM, Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility consultant had not told them those areas needed to be completed and signed.<br><br>4. Resident # 114 was admitted to the facility 10/28/2011. Diagnoses included: Hypertension, Diabetes, Failure to thrive and Gastroesophageal Reflux Disease.<br><br>An Admission MDS dated 11/4/11 was reviewed. No signature was noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).<br><br>On 11/30/11 at 9:45 AM, the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.<br><br>On 11/30/11 at 1:45 PM, Administrative staff #1 | F 278 | | |

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| F 278 | Continued From page 23<br>stated she did not know she needed to sign those areas. The Administrator also said the facility consultant had not told them those areas needed to be completed and signed.<br>5a. Resident #75 was admitted to the facility on 01/29/09 with multiple diagnoses including Alzheimer's Disease. The quarterly MDS assessment dated 11/01/11 indicated that Resident #75 had memory and decision making problems and was on antianxiety and antidepressant medications.<br><br>Review of Resident #75's medications revealed that she was on Risperdal 0.25 mgs (milligrams) at bedtime twice a week starting 08/19/11<br><br>On 12/01/11 at 1:34 PM, the MDS Nurse was interviewed. She stated that she did not know why she did not code the antipsychotic medication for the use of Risperdal.<br><br>5b. Resident # 75 was admitted on 01/29/09. Review of the annual MDS assessment dated 02/03/11 revealed that the section under Care Area Assessment (CAA) Summary was not signed by an RN (Registered Nurse) coordinator for CAA Process and the person completing the care plan.<br><br>On 12/01/11 at 1:23 PM, the MDS Nurse was interviewed. She stated that the section under Care Area Assessment Summary has not been signed since she started working as an MDS Nurse. She indicated that she did not know that this section needed to be signed. | F 278 | | |

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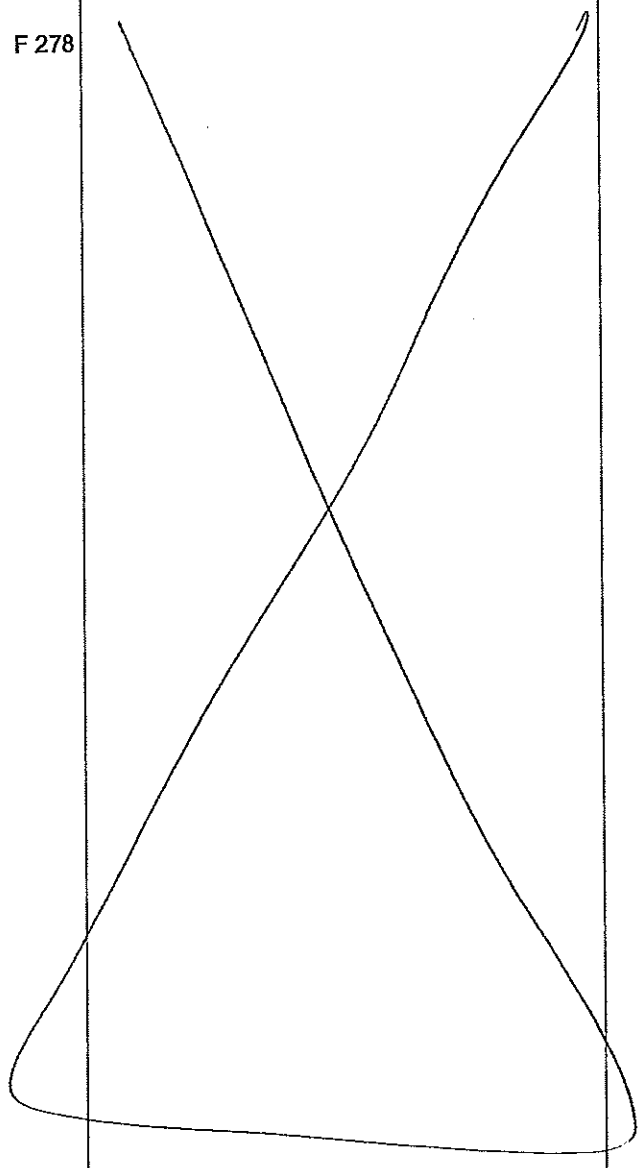
| F 278 | Continued From page 24<br>6. Resident #51 was admitted to the facility on 05/26/11. Review of the admission MDS assessment dated 06/03/11 revealed that the section under Care Area Assessment (CAA) Summary was not signed by an RN (Registered Nurse) coordinator for CAA Process and the person completing the care plan.<br><br>On 12/01/11 at 1:23 PM, the MDS Nurse was interviewed. She stated that the section under Care Area Assessment Summary has not been signed since she started working as an MDS Nurse. She indicated that she did not know that this section needed to be signed.<br><br>7. Resident # 92 was admitted to the facility on 09/01/11. Review of the admission MDS assessment dated 09/13/11 revealed that the section under Care Area Assessment (CAA) Summary was not signed by an RN (Registered Nurse) coordinator for CAA Process and the person completing the care plan.<br><br>On 12/01/11 at 1:23 PM, the MDS Nurse was interviewed. She stated that the section under Care Area Assessment Summary has not been signed since she started working as an MDS Nurse. She indicated that she did not know that this section needed to be signed.<br><br>8. Resident #5 was originally admitted to the facility on 07/03/06. Review of the annual MDS assessment dated 06/09/11 revealed that the section under Care Area Assessment (CAA) Summary was not signed by an RN (Registered Nurse) coordinator for CAA Process and the | F 278 |  | |

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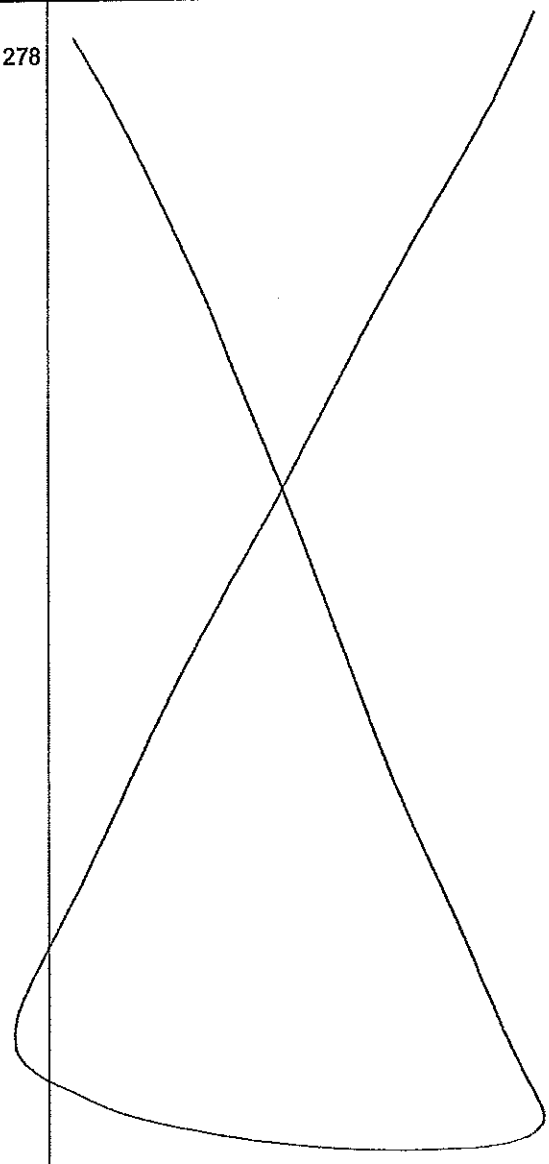
| F 278 | Continued From page 25<br>person completing the care plan.<br><br>On 12/01/11 at 1:23 PM, the MDS Nurse was interviewed. She stated that the section under Care Area Assessment Summary has not been signed since she started working as an MDS Nurse. She indicated that she did not know that this section needed to be signed.<br><br>9. Resident #45 was admitted to the facility on 08/02/10. Review of the annual MDS assessment dated 08/12/11 revealed that the section under Care Area Assessment (CAA) Summary was not signed by an RN (Registered Nurse) coordinator for CAA Process and the person completing the care plan.<br><br>On 12/01/11 at 1:23 PM, the MDS Nurse was interviewed. She stated that the section under Care Area Assessment Summary has not been signed since she started working as an MDS Nurse. She indicated that she did not know that this section needed to be signed.<br>10. Resident #85 was admitted to the facility 9/1/11. Cumulative diagnoses included: Alzheimer's disease and seizures.<br><br>An Admission MDS dated 9/13/11 was reviewed. No signature was noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).<br><br>On 11/30/11 at 9:45 AM, the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments. | F 278 |  | |

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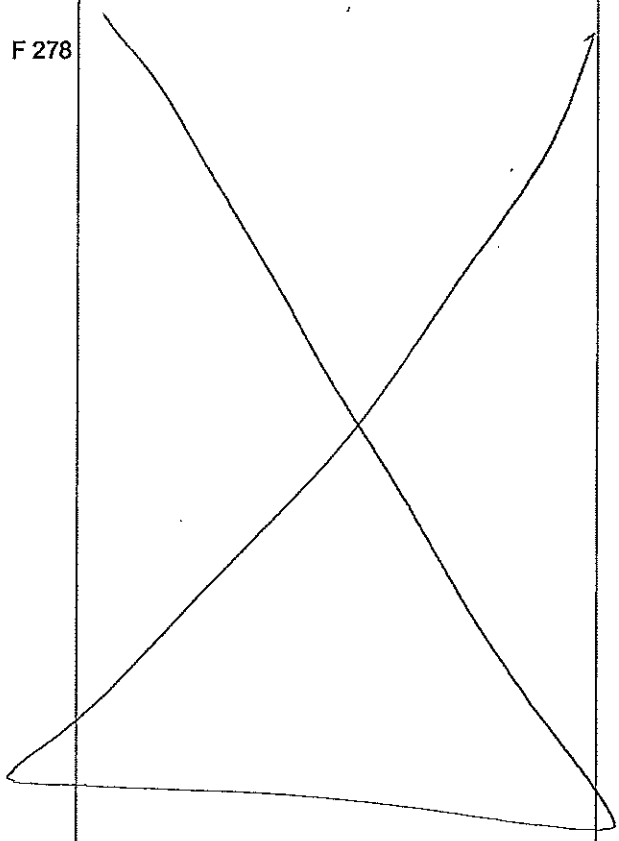
| F 278 | Continued From page 26<br>On 11/30/11 at 1:45 PM, Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility consultant had not told them those areas needed to be completed and signed.<br><br>11. Resident #6 was admitted to the facility 5/31/11. Cumulative diagnoses included: spinal cord injury, neurogenic bladder and diabetes mellitus II<br><br>An Annual MDS dated 2/3/11 was reviewed. No signature was noted at signature of RN coordinator for CAA (Care Area Assessment) process (VB1) and signature of person completing the care plan (VC1).<br><br>On 11/30/11 at 9:45 AM, the MDS nurse stated that VB1 and VC1 had never been completed and signed on any assessments.<br><br>On 11/30/11 at 1:45 PM, Administrative staff #1 stated she did not know she needed to sign those areas. The Administrator also said the facility consultant had not told them those areas needed to be completed and signed. | F 278 |  | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial | F 279 | F 279 - See next page | |

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| F 279 | Continued From page 27<br>needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to review and revise the care plan for 3 (Residents #45, #67 & #59)of 13 sampled residents. The findings include:<br><br>1. Resident # 45 was admitted to the facility on 08/02/10 with multiple diagnoses including Alzheimer's Disease. The quarterly (MDS) Minimum Data Set assessment dated 11/11/11 indicated that Resident #45 had memory and decision making problems and had falls since admission and prior assessments. The care plan for falls dated 11/15/11 was reviewed. The approaches included restorative program for ambulation, non skid foot wear when ambulation, keep floors free of clutter, keep personal items within reach and keep call light within reach.<br><br>Review of the nurse's notes and incident reports revealed that Resident #45 had falls on 11/15/11 and 11/20/11 (twice). On 11/15/11, the report indicated that Resident #45 was found on the | F 279 | F279<br>1. All residents are potentially at risk<br>2. The care plans for residents #45, #67 and #59 were reviewed and corrected. Completed 12-02-2011 All in-house resident Care Plans Are being reviewed and revised through the following procedures.<br>3. All Administrative Nurses will meet daily to review new MD orders, any falls or incidents, any resident issues from the previous day.<br>4. Any revisions to resident Care Plans will be made by the MDS nurse at this time.<br>5. Care Plans will be brought to Standards of Care meeting weekly and updated by the MDS Nurse.<br>6. Care Plans will be kept together in a binder at each nurse's station for easy access and review by nurses, CNA's, and MD's as needed.<br>7. The DON is responsible for monitoring this program daily using the **Admin Nurses Meeting Form** and during the Administrative Nurses meeting. Results of the monitoring will be presented to the QA Committee 1 x each month x 12 months. | MDS 12-29-11<br>clinical coord. SDC DON ADON MDS 12-29-11<br>MDS 12-29-11<br>MDS 12-29-11<br>MDS 12-29-11<br>DON 12-29-11 |

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floor and the RFA (restraint free alarm in bed) did not sound. The intervention was to check RFA for malfunction. This intervention (RFA) was not included on the care plan approaches for falls. On the 11/20/11 at 2:45 PM, the report indicated that Resident #45 fell from the bed. The intervention was to monitor the resident in the common area by the staff. This intervention was not added to the care plan approaches for falls. On 11/20/11 at 7:30 PM, the report revealed that Resident #45 fell from the chair. The interventions were RFA in wheelchair and PT (Physical Therapy) to evaluate and treat. These interventions were not added to the care plan.

On 12/01/11 at 1:23 PM, the MDS Nurse was interviewed. She stated that every morning the administrative staff members have a stand up meeting and they talked about falls. She acknowledged that Resident #45 had several falls but she did not go back and revised the care plan for falls.

3. Resident #59 was admitted 3/26/07 and had cumulative diagnoses that included hypertension, dementia, Parkinson ' s disease and depression. The quarterly Minimum Data Set (MDS) dated 8/3/11 indicated she was cognitively impaired and had an injury fall (not a major injury) since her last quarterly assessment.

Review of the Incident/Accident report dated 9/16/11 at 3:15 PM revealed " Resident noted on floor beside bed lying on her back with her feet on the wall and head pointed to foot of bed. " The report indicated Resident #59 sustained a 1 centimeter abrasion on her back from the fall. The action taken to prevent reoccurrence was " shorten string on personal bed alarm to sound

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alarm sooner. " This intervention was not added to the care plan.

The Falls Investigation Overview Plan of Action dated 9/17/11 revealed the resident had been in bed prior to the fall. No corrective actions were checked off. Under the referrals section, referral to PT/OT (Physical Therapy/Occupational Therapy) was checked and dated 9/19/11. This intervention was not added to the care plan.

Review of the care plan for Resident #59 last updated on 11/8/11 revealed she was at risk for falls related to cognitive impairment, impaired safety, poor judgement, poor hearing, osteoperosis, dementia, arthritis, Parkinsons and related to being on fall risk medications (seroquel and remeron were listed). The approaches listed were: remind resident to use assistive device, wheelchair, remind resident to ask for assistance, RFA (restraint free alarm) to bed, RFA to chair, keep personal items within reach, ½ rails when in bed to increase mobility.

Review of the Incident/Accident report dated 11/13/11 at 1:10 PM revealed " Resident found on floor in bathroom. States she was trying to go to bathroom." The report indicated Resident #59 was not injured from the fall. There was nothing listed in the section regarding steps taken to prevent reoccurrence.

The Falls Investigation Overview Plan of Action dated 11/14/11 revealed the resident had been attempting to go to the bathroom prior to the incident. No corrective actions were checked off. Under the referrals section, referral to PT/OT (Physical Therapy/Occupational Therapy) was

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345509 | A. BUILDING _____ B. WING _____ | 12/01/2011 |

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

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| F 279 | Continued From page 30 | F 279 | | |

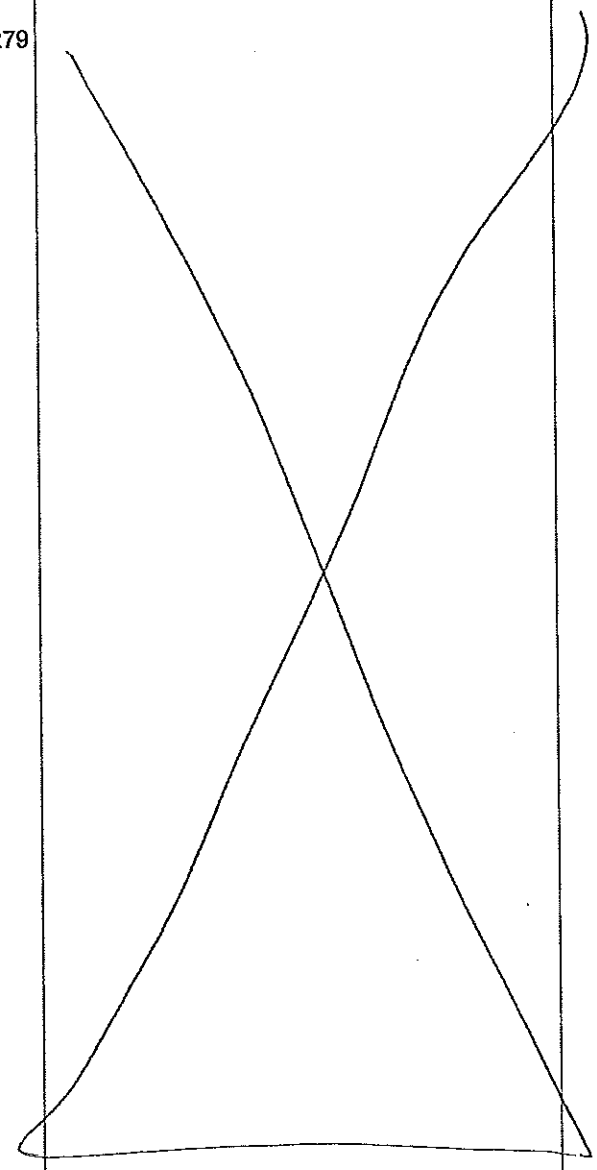
checked and dated 11/14/11. This intervention was not added to the care plan.

Review of the Incident/Accident report dated 11/27/11 at 4:30 PM revealed " CNA (Nursing Assistant) was pushing rsdt (resident) out of BR (bathroom) when rsdt slammed forward and fell out of w/c (wheelchair) landing on floor on her right side. " The report indicated Resident #59 was not injured from the fall. The action taken to prevent reoccurrence was " reiterate to resident to use call bell for assistance. " This intervention was not added to the care plan although the care plan did include the approach to " remind resident to ask for assistance. "

The Falls Investigation Overview Plan of Action dated 11/28/11 revealed the resident was being pushed in her wheelchair by an NA when she fell. No corrective actions were checked off. Under the referrals section, referral to PT/OT (Physical Therapy/Occupational Therapy) was checked and dated 11/28/11. This intervention was not added to the care plan.

2. Resident #67 was originally admitted to the facility 1/2/2009. She was readmitted to the facility 8/3/2011 following an overnight hospitalization. Cumulative diagnoses included: Alzheimer's Disease, Hypertension, Diabetes and Anemia.

An Admission Minimum Data Set (MDS) dated 8/10/2011 indicated Resident # 67 displayed short term and long term memory impairment with poor decision-making abilities. Extensive assistance was required with bed mobility, transfers, dressing, bathing, toileting and



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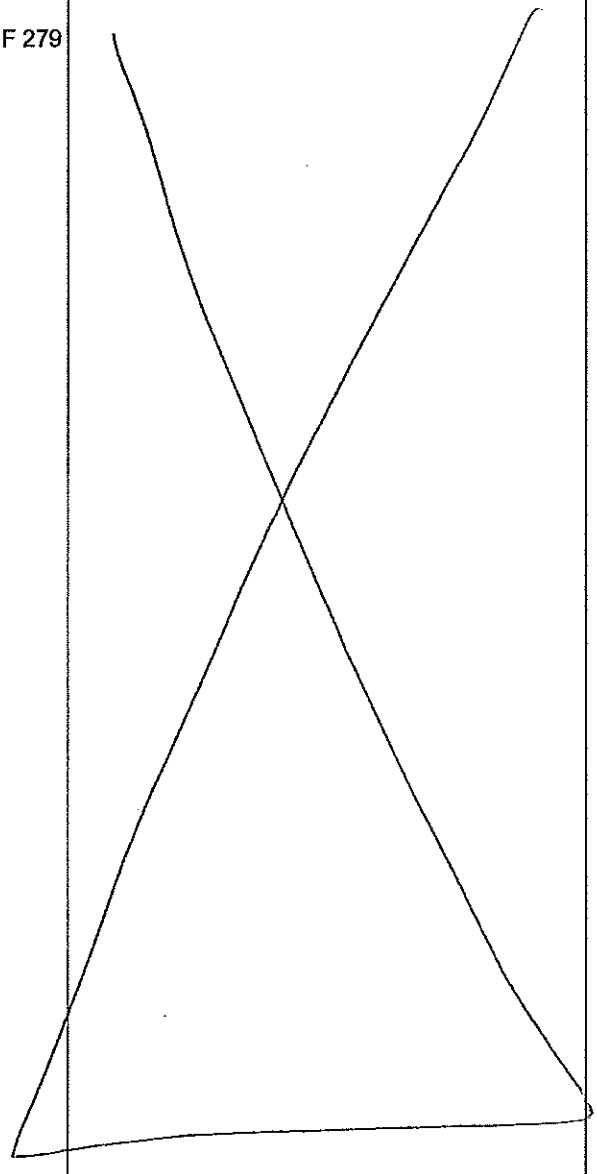
| F 279 | Continued From page 31<br>personal hygiene.<br><br>A physician's progress notes dated 6/29/11 indicated Resident #67 had two episodes of rectal bleeding (5/27/2011 and 6/15/2011). Hemoglobin ranged from 9.2-9.7. Resident #67, because of religious beliefs, refused blood transfusions<br><br>A monthly physician's progress note dated 8/1/2011 stated that Resident #67' hemoglobin has dropped to 7.4 as of 7/29/2011.<br><br>A physician' progress note dated 8/4/2011 indicated that Resident #67 was scheduled for an outpatient colonoscopy due to recent episodes of rectal bleeding. A rectal tumor was found on the colonoscopy. Family opted for no surgery, chemotherapy or radiation therapy.<br><br>A Care Plan dated 8/15/11 did not address resident's bleeding, recent diagnosis of cancer and/or comfort care measures for Resident #67.<br><br>On 12/1/11 at 10:00 AM., Administrative Staff #1 reviewed the medical record and indicated she did not find a care plan for rectal bleeding, resident's religious preferences, diagnosis of cancer or a care plan for comfort measures.<br><br>On 12/1/2011 at 1:13 PM., the MDS Nurse stated care plan meetings are held quarterly. She also stated she made changes to the care plan and/or updated the care plan. The MDS Nurse stated the staff had a standup meeting every morning and discussed any changes that needed to be made. She would then revise the care plan. She did not know why the care plan for Resident #67 did not indicate the problem of rectal bleeding, | F 279 |  | |

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| F 279 | Continued From page 32<br>religious preferences and diagnosis of cancer or comfort measures. | F 279 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to follow doctor's orders for 4 (Residents # 92, #75, #45 & #100) of 10 sampled residents. The findings include:<br><br>1. Resident # 45 was admitted to the facility on 08/02/10 with multiple diagnoses including Alzheimer's Disease. The annual MDS assessment dated 08/12/11 indicated that Resident #45 had memory and decision making problems.<br><br>Review of the telephone orders dated 09/21/11 revealed that Resident #45 had a doctor's order for Amitiza 24 mcg (microgram) by mouth twice a day for constipation.<br><br>The doctor's progress notes dated 09/21/11 indicated " more lethargic and constipated. Add Amitiza as no BM (bowel movement) on protocol x (for) 8 days " .<br><br>The MARs (Medication Administration Record) were reviewed. Amitiza was transcribed to the September, 2011 MAR and was administered from 09/21 thru 09/31, 2011. On the October and November, 2011 MARs, Amitiza was not | F 281 | F281<br>1. All residents are potentially at risk<br>2. MD orders have been clarified and corrected on the MARs for residents #92, #75, #45, #100. Completed 12-29-2011 All in-house resident medical records will be audited through the following procedures.<br>3. A selected Nurse from each Hall will be assigned at the end of each month for checking of new MAR's for the upcoming month. These same nurses will do MAR checks every month.<br>4. First check of new MAR's will be done using the chart and going back thru 3 months of MD orders to ensure accuracy.<br>5. The second check on all New MAR' will be done using the resident's current MAR.<br>6. The selected nurses will be trained on the new MAR check procedure. Completed 12-26-2011<br><br>F281 - continued → | DON 12-28-11<br>DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11<br>SDC 12-26-2011 |

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| F 281 | Continued From page 33<br>transcribed and therefore was not administered to the resident.<br><br>On 12/01/11 at 11:10 AM, Nurse #1 was interviewed. Nurse #1 reviewed the chart and stated that Amitiza was not transcribed to the October and November MARs. She stated that 2 nurses had checked the new MARs against the last month's MARs and missed the order for Amitiza.<br><br>On 12/01/11 at 12:05 PM, administrative staff #1 was interviewed. She stated that she had problems with the nurses checking the MARs. She stated that she had new nurses now to check the MARs.<br><br>2. Resident # 100 was admitted to the facility on 09/20/10. Review of the telephone orders dated 09/06/11 revealed a doctor's order for Lacrilube ointment ½ inch to both eyes for dry eyes. On 09/07/11, there was a new doctor's order to discontinue Lacrilube and to start Artificial Tears ointment to both eyes for dry eyes.<br><br>The MARs were reviewed. Lacrilube was transcribed to the October, November and December, 2011 MARs and was administered in October and November, 2011.<br><br>On 12/01/11 at 11:10 AM, Nurse #1 was interviewed. Nurse #1 reviewed the chart and stated that Lacrilube was transcribed to the October and November, 2011 MARs. She stated that 2 nurses were checking the new MARs against the last month's MARs and missed the order to discontinue the Lacrilube. | F 281 | 7. MD orders will be reviewed in daily Admin Nurses meeting and then checked to ensure all orders were transcribed to the MAR's and TAR's for accuracy.<br>8. The Clinical Care Coordinator is responsible for the monitoring when labs are drawn and if results are in charts. All facility pink copies of labs drawn will be placed in Lab Scheduling Notebook until lab results come in to ensure that all labs have been obtained.<br>9. Clinical Coordinator will check pink copies against returned lab results daily to ensure all labs results are received. The Clinical Care Coordinator is responsible for the monitoring of this program.<br>10. The ADON and SDC will also complete a daily **New Order QA monitor** and initial that orders have been checked.<br>11. The nursing staff was in-serviced on this procedure by the SDC. Completed 12-29-2011<br>12. Monitoring results off **New Order QA monitor** will be presented to the QA Committee 1 x month x12 months. | DON 12-29-11<br>Clinical Coord. 12-29-11<br>Clinical Coord 12-29-11<br>ADON SDC 12-29-11<br>SDC 12-29-11<br>DON 12-29-11 |

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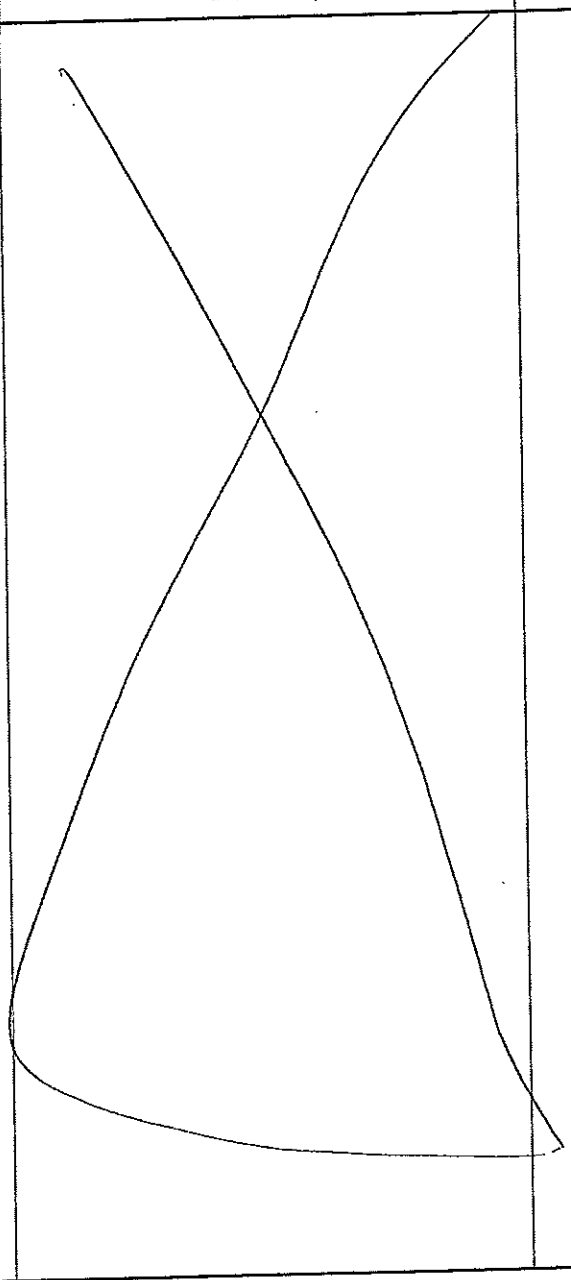
| F 281 | Continued From page 34<br><br>On 12/01/11 at 12:05 PM, administrative staff #1 was interviewed. She stated that she had problems with the nurses checking the MARs at the end of the month. She stated that she had new nurses now to check the MARs.<br><br>3. Resident # 75 was admitted to the facility on 01/29/09. Review of the physician's orders for November, 2011 revealed an order for Risperdal 0.25 mgs at bedtime twice a week on Friday and Saturday for Senile Dementia with Depressive features.<br><br>The MARs were reviewed. In September, 2011, Risperdal was transcribed to the MAR to be given twice a week (Friday and Saturday) but was initialed by the nurses daily indicating that Risperdal was administered daily. In October, 2011, Risperdal was transcribed to be given twice a week (Friday and Saturday) but was initialed by the nurses daily from October 3 thru October 7, 2011 indicating that it was administered daily. The October, 2011 MAR also had no nurse's initials for 10/15 (Saturday), 10/21 (Friday) and 10/28 (Friday) indicating that Risperdal was not administered. The November, 2011 MAR revealed that Risperdal was transcribed to be given twice a week on Friday and Saturday but it was initialed by the nurses from 11/1 thru 11/5 indicating that it was administered daily.<br><br>On 11/30/11 at 10:50 AM, Nurse #1 was interviewed. She stated that the nurses checking the MARs at the end of the month should have put boxes on the days the medications are scheduled to be given. | F 281 |  | |

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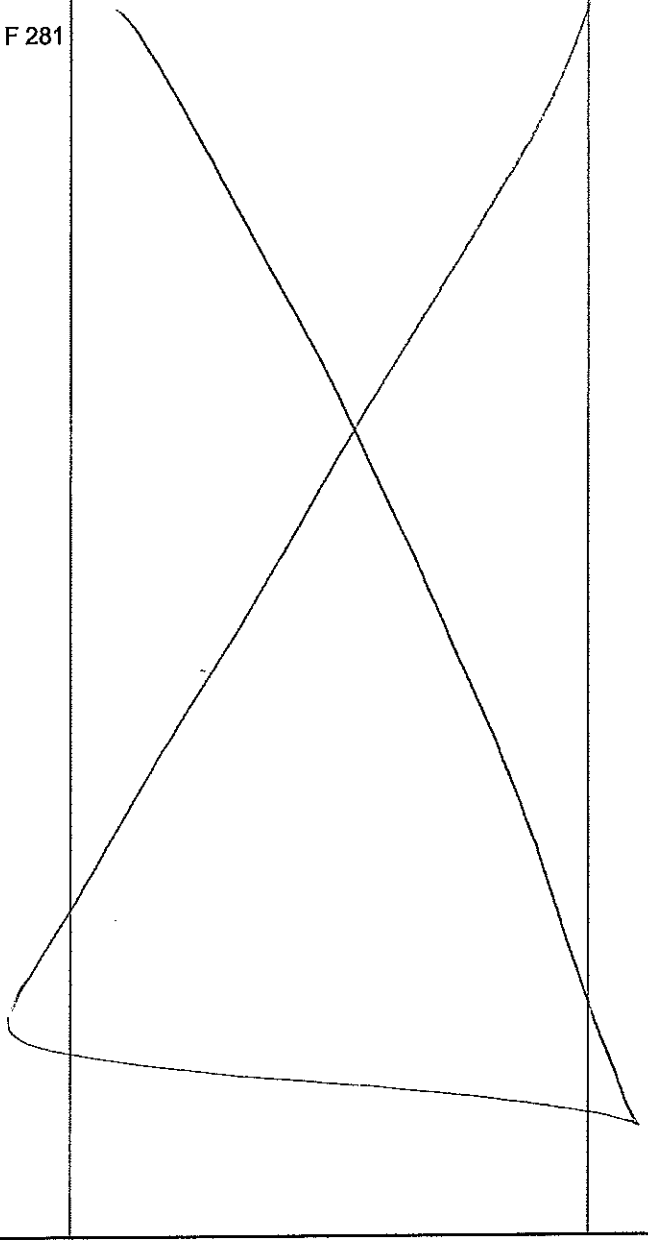
| F 281 | Continued From page 35<br><br>On 12/01/11 at 12:05 PM, administrative staff #1 was interviewed. She stated that she had problems with the nurses checking the MARs at the end of the month. She stated that she had new nurses now to check the MARs. She also indicated that she expected the nurses to read the order before giving the medications.<br><br>4. Resident #92 was admitted to the facility on 09/01/11 with multiple diagnoses including Left femoral fracture. The admission MDS assessment dated 09/13/11 indicated that Resident #92's cognitive status was intact.<br><br>Review of the telephone orders revealed a doctor's order dated 11/16/11 for ESR (erythrocyte sedimentation rate), CBC (complete blood count) and PT(prothrombin time)/PTT (partial thromboplastin time).<br><br>The doctor's progress notes dated 11/16/11 revealed " pt.(patient) with chronic left knee pain but now some increase in swelling/erythema of knee and thigh. Left knee osteoarthritis flare versus overlap cellulitis".<br><br>Review of the laboratory reports revealed that ESR and PT/PTT were drawn on 11/17/11 with the results in the chart but there was no CBC report.<br><br>On 12/01/11 at 12:05 PM, the administrative staff #1 stated that the laboratory request was completed for ESR, CBC and PT/PTT to be drawn on 11/17/11. She stated that she was not aware that ESR and PT/PTT were drawn but not | F 281 |  | |

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| F 281 | Continued From page 36<br>the CBC. She stated that she would have it drawn today. | F 281 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to make a follow up call with the attending physician regarding the abnormal Dilantin level for 1 (Resident # 45) of 10 sampled residents resulting to a delay in changing the course of treatment or plan of care. The finding includes:<br><br>Resident # 45 was admitted to the facility on 08/02/10 with multiple diagnoses including Seizure Disorder. The quarterly (MDS) Minimum Data Set assessment dated 11/11/11 indicated that Resident #45 had memory and decision making problems.<br><br>Review of the physician's orders for November, 2011 revealed that Resident #45 was on Dilantin (150 mgs) 6 ml (milliliter) by mouth twice a day at 8 AM and 4 PM.<br><br>Review of the laboratory reports revealed a Dilantin level of 25.6 ( normal 10-20) dated | F 309 | F309<br>1. Resident #45---------- All residents are potentially at risk.<br>2. All abnormal lab results will be faxed to the MD as well as a call placed to MD.<br>3. Nurse will report to the Clinical Coordinator any abnormal labs received. These results will be placed on the Supervisors clipboard as well as the report sheet for that hall.<br>4. If MD is has not responded to call regarding abnormal labs by the end of that shift, the nurse is to notify the Nursing Supervisor/Clinical Coordinator.<br>5. The Nursing Supervisor/Clinical Coordinator should immediately notify the DON..<br>6. The DON will follow up and notify the Administrator immediately. The Administrator will attempt to contact MD as well. If Administrator cannot locate MD then a call will be made to the<br><br>F 309 - see next page | ADON 12-29-11<br>ADON 12-29-11<br>DON 12-29-11<br>DON 12-29-11<br>12-29-11 DON<br>DON 12-29-11 |

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| F 309 | Continued From page 37<br>11/18/11. The report was not initialed by the physician or Nurse Practitioner to indicate that they had been reviewed.<br><br>The nurse's notes dated 11/18/11 at 12 Noon read " lab (laboratory) called with Dilantin level of 25.6. Notified MD (medical doctor) of results, awaiting new order " .<br>Further review of the nurse's notes for November 19 and November 20, 2011, there were no notes to indicate that a follow up call was made with the MD regarding the abnormal Dilantin level.<br><br>The MARs for November, 2011 were reviewed. On November 19 and November 20, there were nurse's initials for 8 AM and 4 PM doses indicating that Dilantin was administered to Resident #45.<br><br>On 11/30/11 at 2:35 PM, Nurse #1 was interviewed. She stated that she was the nurse on duty when the laboratory called for the abnormal Dilantin level. She indicated that she had called the MD's office and was told that the MD will call back. She also stated that she had faxed the laboratory report to MD. Nurse #1 indicated that she left work at 3 PM and the MD had not returned her call. She indicated that she had informed the nurse on 3-11 shift to make a follow up call to MD. She further revealed that she came back to work on 11/21/11. The resident was lethargic and had been falling, so she called the MD to get an order for a stat Dilantin level.<br><br>The Dilantin level on 11/21/11 was 22.1, the MD had ordered to hold the Dilantin for 24 hours and to recheck the level on 11/22/11. The Dilantin | F 309 | facility Medical Director for advise and direction.<br>7. Any high levels of meds will be held until MD can be reached.<br>8. Nursing staff was in-serviced on procedure by SDC. Completed 12-29-2011<br>9. Clinical Coordinator will bring all labs to the daily Admin Nurse meeting for review.<br>10. Results of Lab review will be documented on **Admin Nurses Meeting Form. Monitoring results will be presented to the QA Committee 1 x month x 12 months ongoing.** | ADON 12-29-11<br>SDC 12-29-11<br>CC 12-29-11<br>ADON 12-29-11 |

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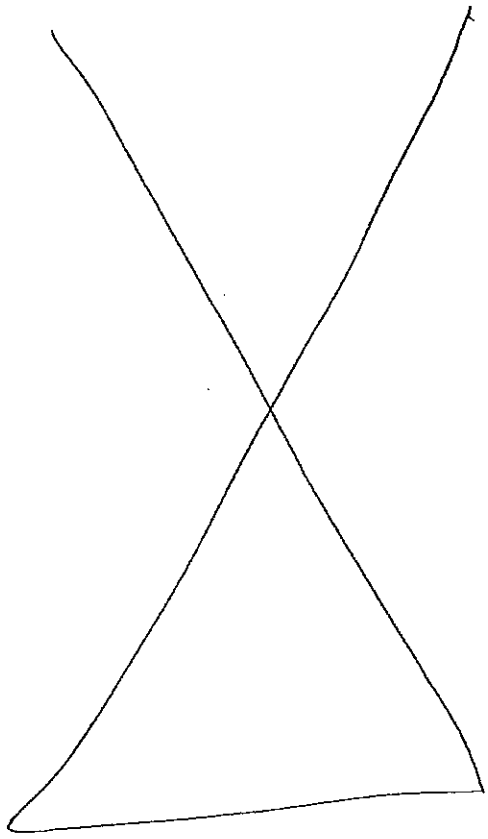
| F 309 | Continued From page 38<br>level on 11/22/11 was 25.1. The MD ordered to give Dilantin infatabs 100 mgs every 12 hours.<br><br>On 12/01/11 at 2:55 PM, the administrative staff #1 was interviewed. She stated that her expectation was for the nurses to keep calling the doctor until he calls back and to hold the medication (Dilantin). She stated that the facility had no policy on notification of MD of abnormal lab reports. She also stated that she had investigated this incident and found out that the nurse on the 7-3 shift had reported the abnormal Dilantin level to the nurse on 3-11 shift and the nurse on the 3-11 shift failed to inform the nurse on 11-7 shift and to hold the Dilantin. Administrative staff #1 revealed that the nurse on 11-7 shift was no longer employed by the facility.<br><br>On 12/01/11 at 3:22 PM, Nurse #2 (nurse on 3-11 shift) was interviewed. She stated that she was aware of the abnormal Dilantin level and withheld the 4 PM dose of Dilantin on 11/18/11. She indicated that she could not remember if she had followed up the call to the MD office. She also indicated that if she did not document it on the nurse's notes she might have not called. Nurse #2 indicated that she had informed the nurse on 11-7 shift about the abnormal Dilantin level. | F 309 |  | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | See next page | |

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| F 323 | Continued From page 39<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview and document review, the facility failed to evaluate risks and implement interventions to prevent falls for one 1 (Resident #59) of 3 sampled residents with fall risk and failed to maintain electrical equipment in safe operating condition for one 1 (Resident #77) of 1 sampled resident. Findings include:<br><br>1. Resident #59 was admitted 3/26/07 and had cumulative diagnoses that included hypertension, dementia, Parkinson's disease and depression. The quarterly Minimum Data Set (MDS) dated 8/3/11 indicated she was cognitively impaired and had an injury fall (not a major injury) since her last quarterly assessment.<br><br>Review of the Incident/Accident report dated 9/16/11 at 3:15 PM revealed " Resident noted on floor beside bed lying on her back with her feet on the wall and head pointed to foot of bed. " The report indicated Resident #59 sustained a 1 centimeter abrasion on her back from the fall. The action taken to prevent reoccurrence was " shorten string on personal bed alarm to sound alarm sooner. "<br><br>The Falls Investigation Overview Plan of Action dated 9/17/11 revealed the resident had been in bed prior to the fall. The safety device checked off as having been in place was a personal alarm. There was no documentation of whether it had alarmed when she fell. Low bed mat and half side rails were not checked. No possible causes | F 323 | **F323**<br>1. Residents #59 was reviewed again. The string on her alarm was shortened so it would alarm sooner and she was moved to a room closer to the nurses station for closer observation. Resident #77 reevaluated. Resident had acute episode which is now resolved. Current interventions are appropriate. He has had no further falls.<br>2. Nurses were in-serviced on how to complete incident reports, including interventions to prevent further falls. The in-service was done by the SDC. Completed 12-29-2011<br>3. All incident reports will be brought to Daily Admin Nurse meeting and Department Head meeting for review and evaluation. The ADON is responsible for verifying that interventions were initiated.<br>4. Any new interventions will be decided at this time and initiated.<br>5. **Accident Incident Log** will be reviewed by the ADON and DON weekly x4, monthly x3, and quarterly there after. Monitoring results will be presented to the QA Committee monthly.<br>F 323 see next page | ADON 12-29-11<br>SDC 12-29-11<br>ADON 12-29-11<br>ADON 12-29-11<br>ADON 12-29-11 |

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| | 345509 | A. BUILDING _____ B. WING _____ | 12/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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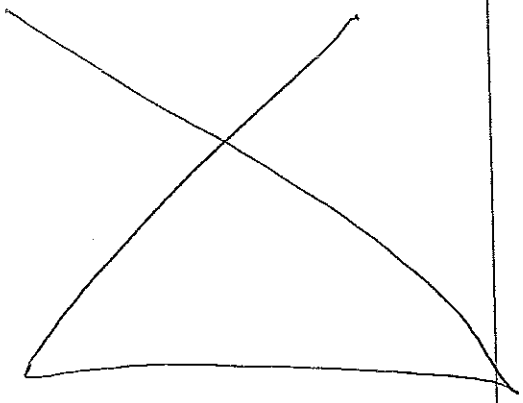
| F 323 | Continued From page 40<br>for the incident were checked off. No corrective actions were checked off. Under the referrals section, referral to PT/OT (Physical Therapy/Occupational Therapy) was checked and dated 9/19/11.<br><br>Review of the care plan for Resident #59 last updated on 11/8/11 revealed she was at risk for adverse reactions to psychotropic medications (seroquel, remeron and lexapro were listed) and one of the approaches listed was " monitor medications for adverse effects). The care plan also indicated Resident #59 was at risk for falls related to cognitive impairment, impaired safety, poor judgement, poor hearing, osteoporosis, dementia, arthritis, Parkinsons and related to being on fall risk medications (seroquel and remeron were listed).<br><br>Review of the Incident/Accident report dated 11/13/11 at 1:10 PM revealed " Resident found on floor in bathroom. States she was trying to go to bathroom. " The report indicated Resident #59 was not injured from the fall. There was nothing listed in the section regarding steps taken to prevent reoccurrence.<br><br>The Falls Investigation Overview Plan of Action dated 11/14/11 revealed the resident had been attempting to go to the bathroom prior to the incident. The safety device checked off as having been in place was a personal alarm. There was no documentation of whether it had alarmed when the resident fell. There was no documentation of what footwear the resident was wearing at the time of the fall. There was no documentation of when the resident was last assisted with incontinent care of toileting. No | F 323 | 6. All resident rooms will be monitored daily on Admin rounds for any potential safety hazards.<br><br>7. Any problems noted will be reported to Maintenance and to the Administrator on **Department Head Daily Rounds** form or noted on the maintenance logs at each nurses station.<br>8. A log of all identified problems will be kept by maintenance on the Maintenance Log at each nurses station.<br>9. Administrator will review log weekly x4, monthly x3, and quarterly thereafter.<br>10. Potential Hazards and Safety issues will be addressed monthly in QA meeting.<br><br>  | All 12-29-11<br><br>ADM 12-29-11<br><br>maint. 12-29-11<br><br>ADM 12-29-11 |

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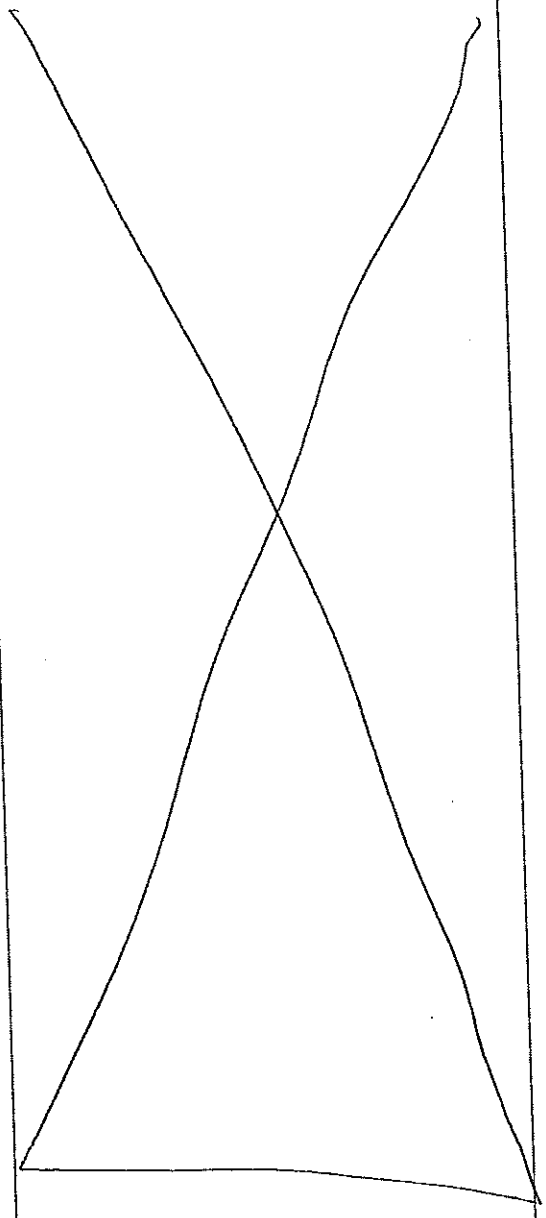
| F 323 | Continued From page 41<br>possible causes for the incident were checked off. No corrective actions were checked off. Under the referrals section, referral to PT/OT (Physical Therapy/Occupational Therapy) was checked and dated 11/14/11.<br><br>Review of the Incident/Accident report dated 11/27/11 at 4:30 PM revealed " CNA (Nursing Assistant) was pushing rsdt (resident) out of BR (bathroom) when rsdt slammed forward and fell out of w/c (wheelchair) landing on floor on her right side. " The report indicated Resident #59 was not injured from the fall. The action taken to prevent reoccurrence was " reiterate to resident to use call bell for assistance. " The resident's vital signs were present on the form. There was no further health assessment documented and " was a resident seen by a physician " was checked " no ". The attached statement from the NA dated 12/27/11 read " I was pushing (name of resident) from bathroom to her bed. She looked to me as if she passed out. She fell out of her chair onto the floor on her right side."<br><br>The Falls Investigation Overview Plan of Action dated 11/28/11 revealed the resident was being pushed in her wheelchair by an NA when she fell. The safety device checked off as having been in place was a personal alarm. No possible causes for the incident were checked off. No corrective actions were checked off. Under the referrals section, referral to PT/OT (Physical Therapy/Occupational Therapy) was checked and dated 11/28/11. There was no indication that the NA had been asked to demonstrate how the incident occurred to determine if issues requiring reeducation were involved. There was no indication that the resident's medications or | F 323 |  | |

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| F 323 | Continued From page 42<br>health status had been reviewed in relation to the fall or the NA's written statement that the resident " looked as if she passed out " .<br><br>Interview with the Administrative Staff #7 on 12/1/11 at 1:30 PM revealed physical therapy was already working with Resident #59 when she fell on 9/16/11 and had been continuing to work with her so the referrals to PT/OT were not adding, or contributing, anything new that PT wasn't already working on with the resident.<br><br>During interview with Administrative Staff #1 and #3 on 12/1/11 at 4 PM they indicated that reminding a cognitively impaired resident to use the call bell was not a sufficient intervention to prevent falls on its own; and that it did not make sense in a situation where the staff member had been pushing the resident in a wheelchair when the fall occurred. They both also indicated that a more thorough investigation of the resident's falls should have been conducted so appropriate interventions could be put in place.<br><br>2. Resident #77 was admitted on 9/8/11 with diagnoses including Alzheimer's disease and Diabetes. The Admission MDS dated 9/14/11 revealed Resident #77 was moderately cognitively impaired and independent in locomotion, walking, transferring, eating and toileting but required limited assistance for dressing and hygiene. Resident #77 was on contact isolation throughout the survey.<br><br>On 12/1/11 at 8:30 AM, the resident was observed in his room sitting in his wheelchair. The air-conditioning and heating unit on the far wall of his room, under the window, was observed | F 323 | | |

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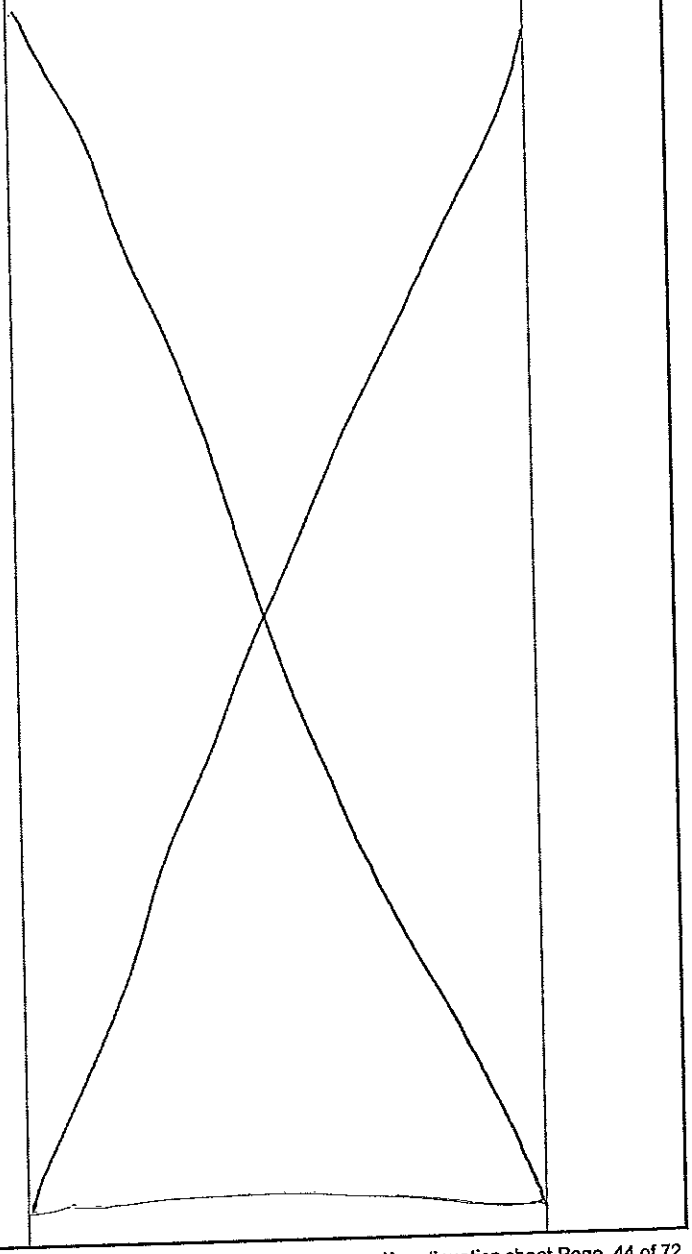
| F 323 | Continued From page 43<br>to be unplugged from the electrical wall outlet. The outlet cover was off and sitting on the windowsill. Beside the outlet cover was a box containing what appeared to be a new outlet. The electrical outlet in the wall was blackened and burnt looking. The plug-in end of the power supply cord extending from the air-conditioning and heating unit was blackened and burnt looking.<br><br>Interview with resident #77 on 12/1/11 at 2:30 PM revealed he did not find the temperature in the room uncomfortable. When he was asked if there was a problem with the unit he said " it wore out. "<br><br>Interview with Administrative Staff #6 (Admin #6) on 12/1/11, at 9 AM, revealed he did not have any requisitions or reports of items needing repair in Resident #77's room (#103). He then observed the room and recalled that he had been painting it recently, after the previous resident moved out. He stated that while he was painting the room he unplugged the air-conditioning and heating unit and discovered the blackened areas. Admin #6 said that he had intended to fix the outlet and power supply cord at that time, which was why the outlet cover was off and the new outlet was in the room. He went on to add that he ended up having to order a new cord for the unit and he had decided to wait to do the repair until he had all the materials. He said the room had been empty at the time and that since then, Resident #77 moved in. Admin #6 added that he did not inform anyone that the air-conditioning and heating unit was not working or that the electrical outlet was damaged and the room should not be used until it was fixed. He further added that the | F 323 |  | |

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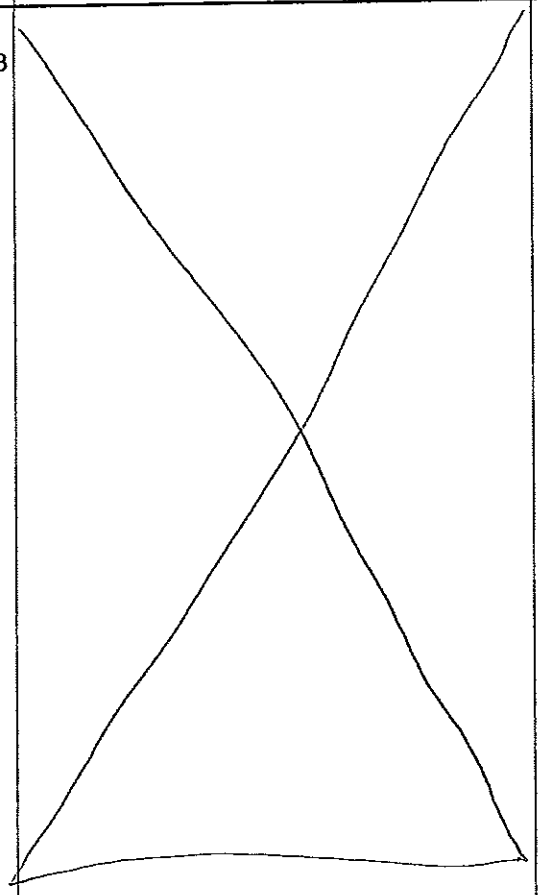
| F 323 | Continued From page 44<br>power supply cord had probably arrived by now and he would fix both items immediately.<br><br>Interview with Administrative Staff #2 on 12/1/11 at 9:10 AM revealed Resident #77 was transferred into Room #103 on 11/22/11.<br><br>On 12/1/11 at 10 AM review of the invoice provided by Admin #6 revealed the power supply cord had been ordered on 11/18/11.<br><br>On 12/1/11 at 10:30 AM Administrative Staff #3 was interviewed and indicated that she had not been aware of any problems with the air-conditioning and heating unit or the electrical outlet in Resident #77 ' s room. She indicated that this was a comfort issue for the resident and a potential safety hazard. She further stated that it was her expectation that she be informed of such hazards and that residents would not be admitted to a room with a non functioning air-conditioning and heating unit, or a damaged electrical outlet or power cord.<br><br>On 12/1/11 at 11:10 PM the electrical outlet and power supply cord in Room 103 was observed to have been repaired. | F 323 |  | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any | F 329 | F329<br>1. All residents are potentially at risk<br>2. All residents with psychoactive medications will be identified. Identified residents' behaviors were added to behavior monitoring sheets. Completed 12-2-2011<br>F329 continued | DDN<br>12-2-11 |

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| F 329 | Continued From page 45<br>combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to monitor the behaviors or to indicate specific target behaviors on the behavior monitoring sheets for 4 (Residents # 92, #9, #75 & #37 ) of 8 sampled residents on antipsychotic and/or antianxiety medications. The findings include:<br><br>1. Resident #92 was admitted to the facility on 09/01/11 with multiple diagnoses including Psychosis. The admission MDS assessment dated 09/13/11 indicated that Resident #92's cognitive status was intact.<br><br>Review of the physician's orders for November, 2011 revealed that Resident #92 was on Seroquel 100 mgs at bedtime for Psychosis. | F 329 | 3. All residents with psychoactive medications will have a Behavior Monitor sheet completed with target behaviors identified monthly with the end of the month MARs audit.<br>4. Nurses will be in-serviced on how to complete Behavior Monitor Sheets by SDC. Completed 12-29-2011<br>5. Nurses assigned to complete monthly checks on New MAR's will be in-serviced on how to fill out Behavior Monitor Sheets with Target Behaviors identified. The SDC provided the training. Completed 12-26-2011<br>6. Behavior Monitor Sheets will be audited each night by the night shift for completion.<br>7. Audits will be reviewed by the DON or her designee daily and discussed in monthly QA meeting. | ADON 12-29-11<br>SDC 12-29-11<br>DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11 |

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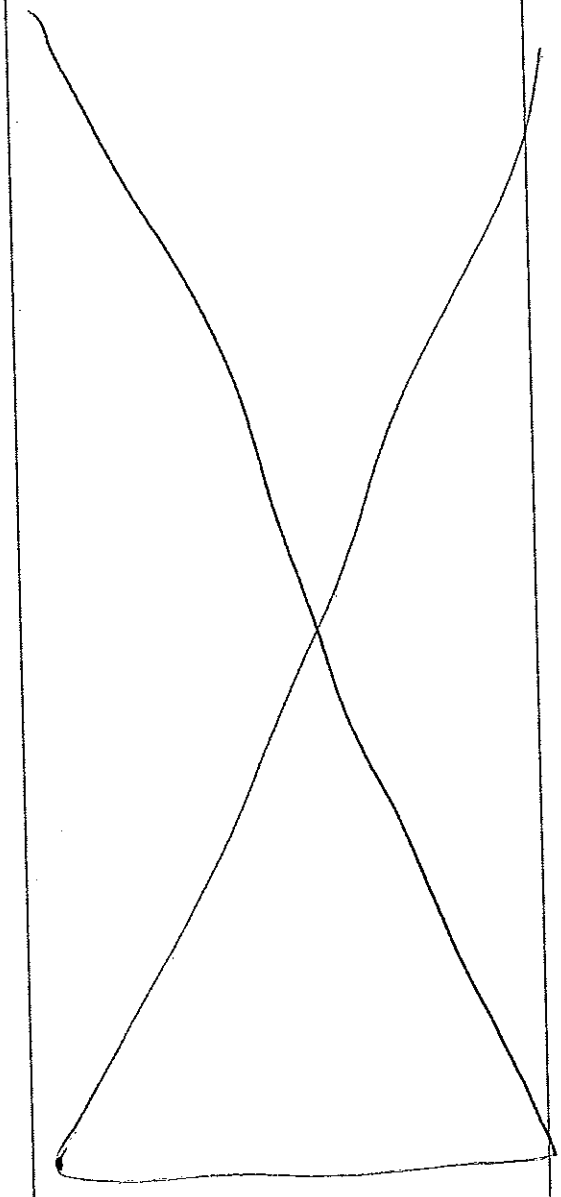
| F 329 | Continued From page 46<br><br>On 11/30/11 at 2:35 PM, Nurse #1 was interviewed. She stated that the facility had a behavior monitoring form used to document resident's behaviors.<br><br>The behavior monitoring forms were reviewed. Resident #92 had no behavior monitoring form for the month of November, 2011. The October and September, 2011 monitoring forms had no specific target behaviors listed.<br><br>On 12/01/11 at 11:10 AM, Nurse #1 was interviewed. She stated that she did not know why Resident #92 had no behavior monitoring form for November, 2011. She further stated that the behavior monitoring forms should have target behaviors listed and the nurses checking the MARs at the end of the month were responsible for writing the target behaviors on the forms.<br><br>On 12/01/11 at 12:05 PM, the administrative staff #1 was interviewed. She stated that target behaviors should be listed on each behavior monitoring forms. She stated that she had in-serviced the nurses on the use of the behavior monitoring form before but there was a big turn over of nurses lately. She indicated that she would schedule an in-service for all the nurses regarding the behavior monitoring forms.<br><br>2. Resident # 9 was originally admitted to the facility on 07/03/06 with multiple diagnoses including Anxiety. The quarterly MDS assessment dated 09/08/11 indicated that Resident #9 had moderate cognitive impairment. | F 329 |  | |

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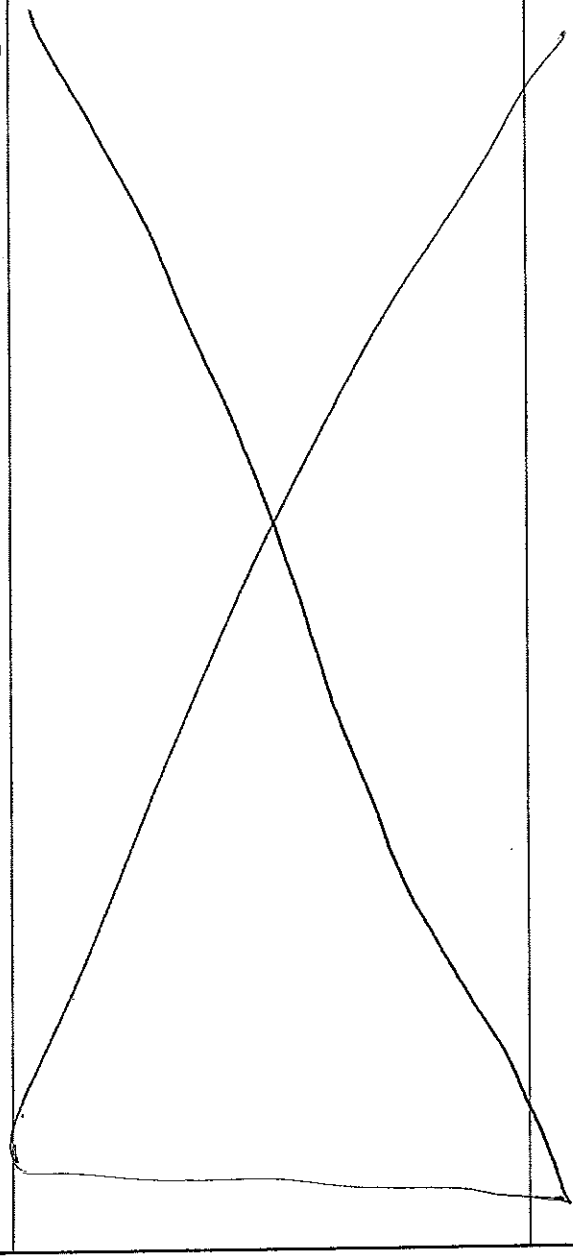
| F 329 | Continued From page 47<br><br>Review of the physician's order for November, 2011 revealed that Resident #9 was on Xanax 0.25 mgs at bedtime for Anxiety.<br><br>On 11/30/11 at 2:35 PM, Nurse #1 was interviewed. She stated that the facility had a behavior monitoring form used to document resident's behaviors.<br><br>The behavior monitoring forms were reviewed. Resident #9 had no behavior monitoring form for the month of November, 2011. The October and September, 2011 monitoring forms had no target behaviors listed.<br><br>On 12/01/11 at 11:10 AM, Nurse #1 was interviewed. She stated that she did not know why Resident #9 had no behavior monitoring form for November, 2011. She further stated that the behavior monitoring forms should have target behaviors listed and the nurses checking the MARs at the end of the month were responsible for writing the target behaviors on the forms.<br><br>On 12/01/11 at 12:05 PM, the administrative staff #1 was interviewed. She stated that target behaviors should be listed on each behavior monitoring forms. She stated that she had in-serviced the nurses on the use of the behavior monitoring form before but there was a big turn over of nurses lately. She indicated that she would schedule an in-service for all the nurses regarding the behavior monitoring forms.<br><br>3. Resident #75 was admitted to the facility on 01/29/09 with multiple diagnoses including | F 329 |  | |

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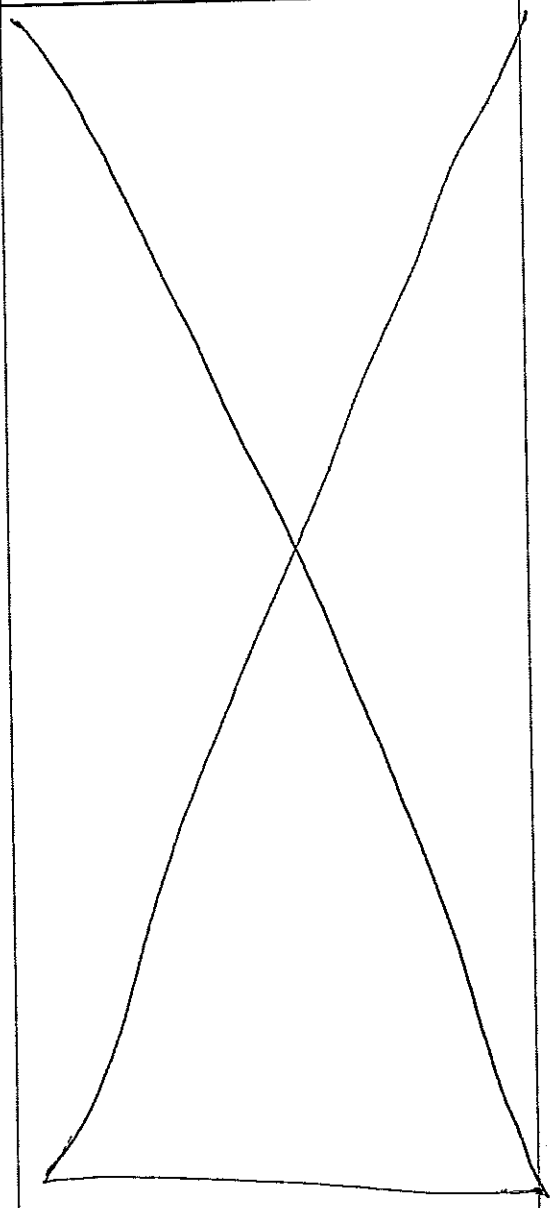
| F 329 | Continued From page 48<br>Alzheimer's Disease. The quarterly MDS assessment dated 11/01/11 indicated that Resident #75 had memory and decision making problems.<br><br>Review of the physician's orders for November, 2011 revealed That Resident #75 was on Risperdal 0.25 mgs at bedtime twice a week on Friday and Saturday for Senile Dementia with Depressive features.<br><br>On 11/30/11 at 2:35 PM, Nurse #1 was interviewed. She stated that the facility had a behavior monitoring form used to document resident's behaviors.<br><br>The behavior monitoring forms were reviewed. Resident #75 had no behavior monitoring form for the month of November, 2011. The October and September, 2011 monitoring forms had no target behaviors listed.<br><br>On 12/1/11 at 11:10 AM, Nurse #1 was interviewed. She stated that she did not know why Resident #75 had no behavior monitoring form for November, 2011. She further stated that the behavior monitoring forms should have target behaviors listed and the nurses checking the MARs at the end of the month were responsible for writing the target behaviors on the forms.<br><br>On 12/01/11 at 12:05 PM, the administrative staff #1 was interviewed. She stated that target behaviors should be listed on each behavior monitoring forms. She stated that she had in-serviced the nurses on the use of the behavior monitoring form before but there was a big turn over of nurses lately. She indicated that she | F 329 |  | |

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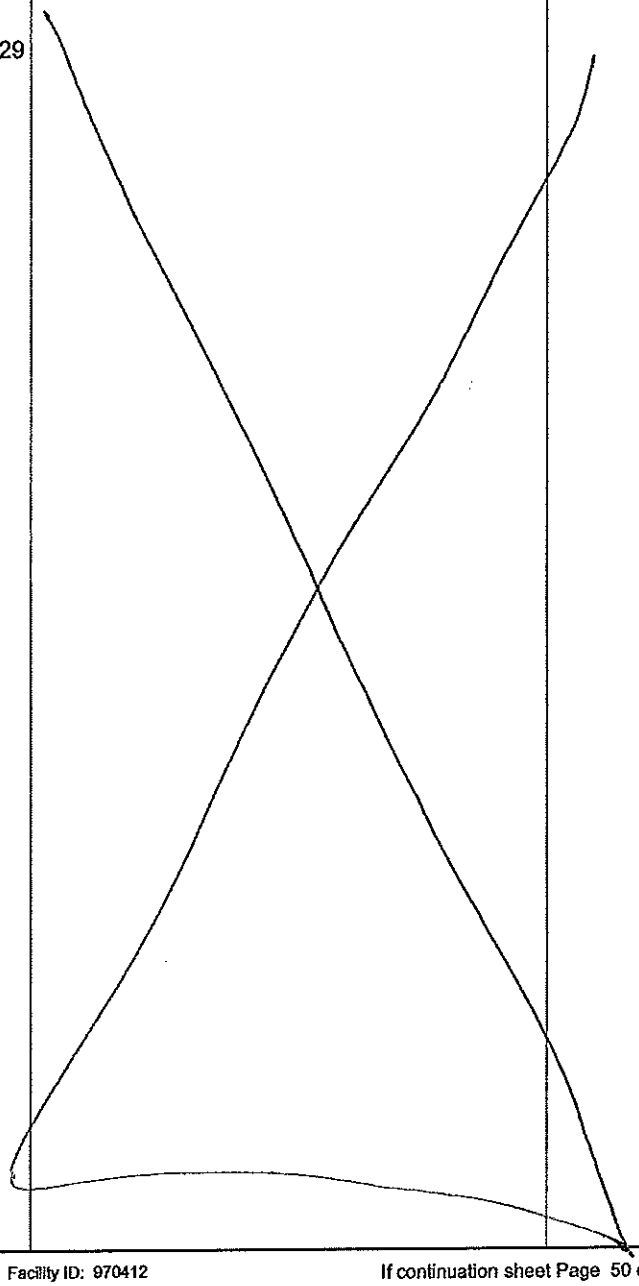
| F 329 | Continued From page 49<br>would schedule an in-service for all the nurses regarding the behavior monitoring forms.<br><br>4. Resident #37 was admitted to the facility on 9/4/07 with diagnoses including hypertension; anxiety; depression with history of suicidal ideation; and vascular dementia with delusions. The annual MDS assessment dated 8/27/11 indicated that Resident #37 was moderately cognitively impaired.<br><br>Review of the physician's orders revealed the resident was on seroquel 12.5 mg 4 times per week and ativan 0.5 mg twice a day.<br><br>On 11/30/11 at 2:35 PM, Nurse #1 was interviewed. She stated that the facility had a behavior monitoring form used to document resident's behaviors.<br><br>The behavior monitoring forms were reviewed. The November and October monitoring forms for ativan and seroquel had no target behaviors listed.<br><br>On 12/1/11 at 10 AM, Nurse #5 was interviewed and stated that target behaviors should be listed and she did not know why they were not. She reviewed the forms and noted that some staff appeared to be writing a zero in the form and their initials on a shift when the resident was not having any behaviors. She went on to add that she had been taught that behaviors were to be documented as they occurred and that target behaviors should be listed to be able to do that. Nurse #5 also indicated that Resident #37 sometimes exhibits paranoia but this was not listed on the form. | F 329 |  | |

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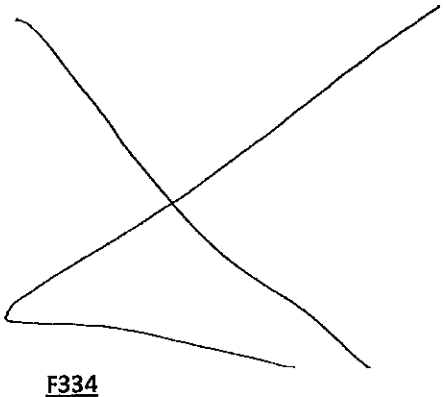
| F 329 | Continued From page 50<br><br>On 12/01/11 at 12:05 PM, the administrative staff #1 was interviewed. She stated that target behaviors should be listed on each behavior monitoring forms. She stated that she had in-serviced the nurses on the use of the behavior monitoring form before but there was a big turn over of nurses lately. She indicated that she would schedule an in-service for all the nurses regarding the behavior monitoring forms. | F 329 |  | |
| F 334 SS=B | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>The facility must develop policies and procedures that ensure that –<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical | F 334 | **F334**<br>1. All residents are potentially at risk<br>2. Facility Policy for Influenza administration has been updated to include that each resident and or Responsible Party will receive education prior to administration of Vaccine. Completed 12-02-2011 The ADON is responsible for providing the information prior to administration of Vaccine.<br>3 Each resident and/or RP will sign a consent form that includes acknowledgement of education of benefits and side effects of the Flu Vaccine during their admission meeting and prior to administration of the Vaccine.<br><br>F334 Continued | 12-29-11<br>ADON 12-29-11<br>ADON 12-29-11 |

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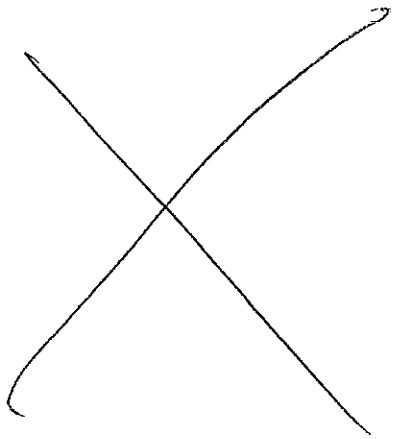
| F 334 | Continued From page 51<br>contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. | F 334 | 4. A log will be maintained of all Flu Vaccines administered to include residents name, date of education, a copy of education material used for that year, date consent signed, and date vaccine administered. The ADON is responsible for maintaining the log.<br>5. Flu Vaccine Log will be reviewed by the DON or her designee monthly during Flu Season.<br>6. Progress of Vaccine administration and Log will be reviewed in monthly QA.<br>7. All nurses will be in-serviced on this procedure. Completed 12-29-2011<br>  | ADON 12-29-11<br>ADON 12-29-11<br>ADON 12-29-11<br>ADON 12-29-11 |

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| F 334 | Continued From page 52<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide education regarding the benefits and potential side effects of the influenza immunization before offering the immunization to 5 (Residents # 45, #99, #59, #85 & # 55) of 5 sampled residents. The findings include:<br><br>The facility's policy and procedure for Influenza Vaccination (undated) was reviewed. The policy read in part " Residents are protected from the influenza virus by receiving the vaccine annually " . The policy did not indicate that education will be provided prior to the offering of the influenza vaccine.<br><br>1. Resident # 45 was admitted to the facility on 08/02/10 with multiple diagnoses including Alzheimer's Disease. The quarterly (MDS) Minimum Data Set assessment dated 11/11/11 indicated that Resident #45 had memory and decision making problems.<br><br>Review of the Immunization Record revealed that Resident #45 had received Influenza Vaccine on 11/15/11. There was no evidence in the chart that education regarding benefits and potential side effects of influenza immunization was provided to the resident/RP (responsible party) prior to the immunization.<br><br>On 11/30/11 at 4:50 PM, the administrative staff #2 was interviewed. She stated that the resident or the RP should have been educated of risk/benefits of the vaccine prior to offering. She acknowledged that the education was not documented in the resident's records. | F 334 | | |

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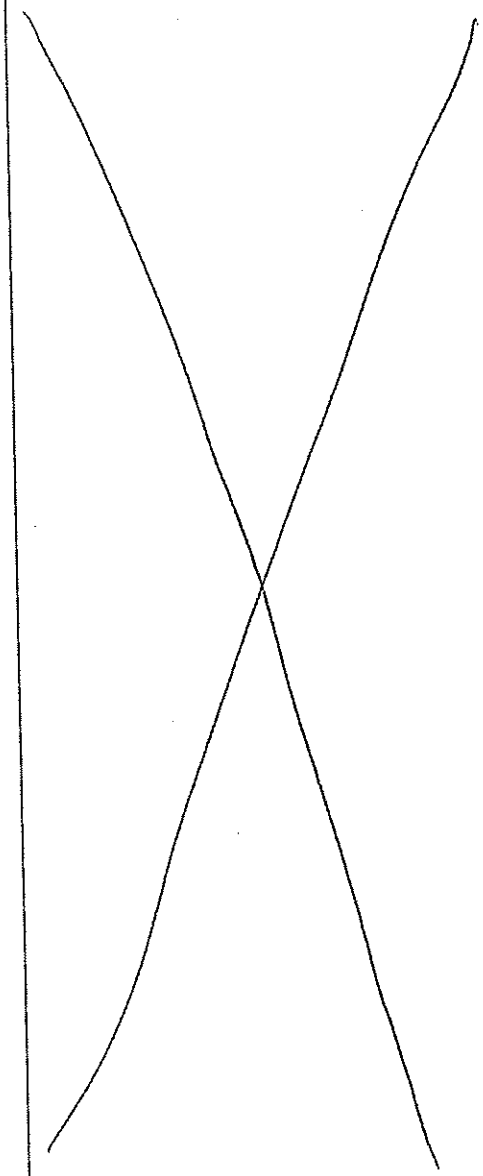
| F 334 | Continued From page 53<br><br>On 12/01/11 at 9:35 AM, the administrative staff#2 stated that the education and the consent for the influenza and pneumococcal vaccines were given to the RP during admission and not yearly.<br><br>2. Resident # 99 was admitted to the facility on 01/31/11. The quarterly MDS assessment indicated that Resident #99 had memory and decision making problems.<br><br>Review of the Immunization Record revealed that Resident #99 had received Influenza Vaccine on 11/15/11. There was no evidence in the chart that education regarding benefits and potential side effects of influenza immunization was provided to the resident/RP (responsible party) prior to the immunization.<br><br>On 11/30/11 at 4:50 PM, the administrative staff #2 was interviewed. She stated that the resident or the RP should have been educated of risk/benefits of the vaccine prior to offering. She acknowledged that the education was not documented in the resident's records.<br><br>On 12/01/11 at 9:35 AM, the administrative staff #2 stated that the education and the consent for the influenza and pneumococcal vaccines were given to the RP during admission and not yearly.<br><br>3. Resident #85 was admitted to the facility on 09/01/11. The admission MDS assessment revealed that Resident # 85 had memory and | F 334 |  | |

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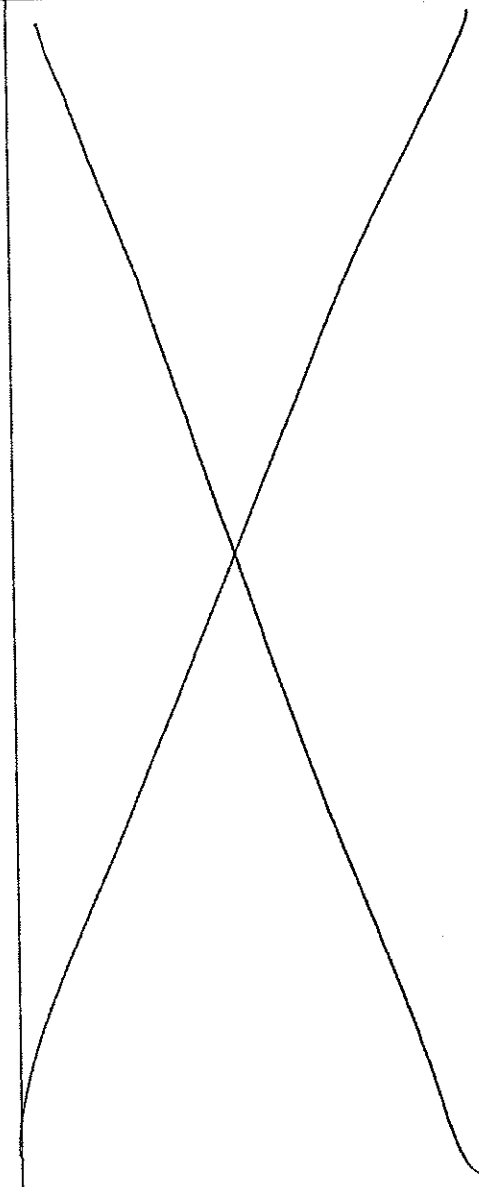
| F 334 | Continued From page 54<br>decision making problems.<br><br>Review of the Immunization Record revealed that Resident #85 had received Influenza Vaccine on 10/18/11. There was no evidence in the chart that education regarding benefits and potential side effects of influenza immunization was provided to the resident/RP (responsible party) prior to the immunization.<br><br>On 11/30/11 at 4:50 PM, the administrative staff #2 was interviewed. She stated that the resident or the RP should have been educated of risk/benefits of the vaccine prior to offering. She acknowledged that the education was not documented in the resident's records.<br><br>On 12/01/11 at 9:35 AM, the administrative staff #2 stated that the education and the consent for the influenza and pneumococcal vaccines were given to the RP during admission and not yearly.<br><br>4. Resident # 59 was admitted to the facility on 03/26/11. The quarterly MDS assessment revealed that Resident #59 had severe cognitive impairment.<br><br>Review of the Immunization Record revealed that Resident #59 had received Influenza Vaccine on 11/11/11. There was no evidence in the chart that education regarding benefits and potential side effects of influenza immunization was provided to the resident/RP (responsible party) prior to the immunization.<br><br>On 11/30/11 at 4:50 PM, the administrative staff | F 334 |  | |

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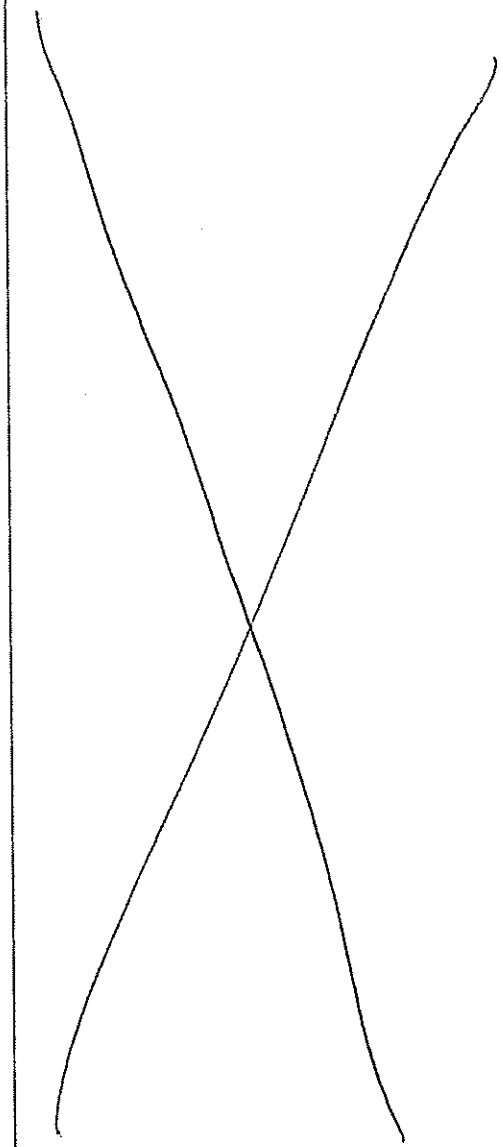
| F 334 | Continued From page 55<br>#2 was interviewed. She stated that the resident or the RP should have been educated of risk/benefits of the vaccine prior to offering. She acknowledged that the education was not documented in the resident's records.<br><br>On 12/01/11 at 9:35 AM, the administrative staff #2 stated that the education and the consent for the influenza and pneumococcal vaccines were given to the RP during admission and not yearly.<br><br>5. Resident # 55 was admitted to the facility on 11/20/06. The annual MDS assessment revealed that Resident #55 had memory and decision making problems.<br><br>Review of the Immunization Record revealed that Resident #55 had received Influenza Vaccine on 10/13/11. There was no evidence in the chart that education regarding benefits and potential side effects of influenza immunization was provided to the resident/RP (responsible party) prior to the immunization.<br><br>On 11/30/11 at 4:50 PM, the administrative staff #2 was interviewed. She stated that the resident or the RP should have been educated of risk/benefits of the vaccine prior to offering. She acknowledged that the education was not documented in the resident's records.<br><br>On 12/01/11 at 9:35 AM, the administrative staff #2 stated that the education and the consent for the influenza and pneumococcal vaccines were given to the RP during admission and not yearly. | F 334 |  | |

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| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors.<br><br>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview, the facility failed to record accurate information on the daily nursing staff posting, as | F 356 | **F356**<br>1. Staffing information will be posted outside of the DON's office daily on the **Daily Staffing Sheet.**<br>2. Staffing Coordinator, Clinical Coordinator, Administrative Staff, and all Nursing Supervisors have been in-serviced on the form and how to complete and adjust daily. The SDC provided the in-servicing. Completed 12-29-2011<br>3. Staffing Sheets will be completed at the beginning of each shift with the appropriate information by the shift Supervisor.<br>4. Staffing Sheets will be maintained in the DON's office.<br>5. Copies of Staffing Sheets will be provided to Administrator for monitoring purposes daily. The Administrator will provide monitoring results of this program to the QA Committee each month on-going. | DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11 |

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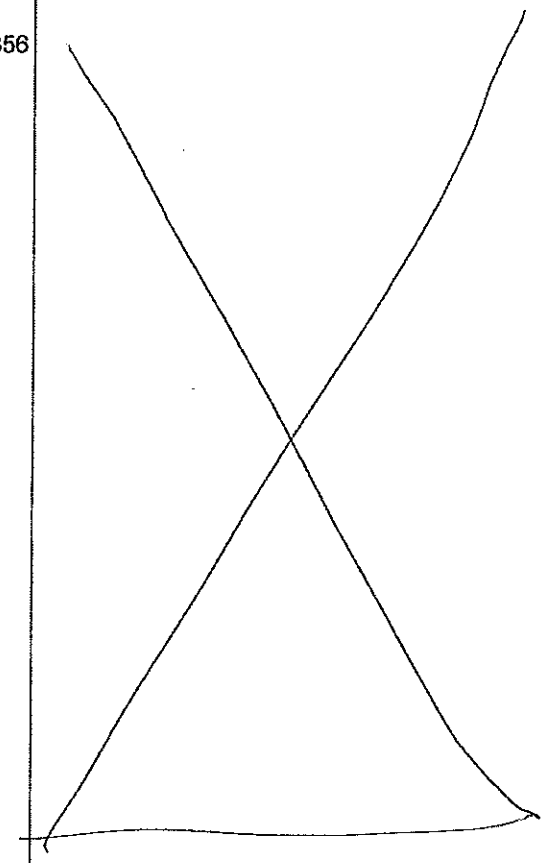
| F 356 | Continued From page 57<br>required.<br><br>The findings include:<br><br>On 11/29/11 at 4:00 pm, a review was conducted of daily nursing assignments from 11/13/11 to 11/27/11 to determine sufficient staffing. The form did not contain resident census updates per shift and it did not record the working hours for certified nurse aides II. There were errors with the number of staff working, which skewed the actual number of working hours per discipline. Nurse aides, who were being oriented were listed under staff working hours.<br><br>On 11/29/11 at 4:45 pm, the Administrative Staff #1 was interviewed. She shared that the staff who normally completed the form was on leave and would not be available for interview.<br><br>On 11/30/11 at 9:25 am, the Administrative Staff #3 was interviewed. She wasn't aware that the daily staffing assignment had been completed incorrectly. She shared a willingness, to correct the information on the form and would in-service her staff, upon her return from a leave of absence. | F 356 |  | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. | F 428 | See next page | |

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| F 428 | Continued From page 58<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff interview, the facility's pharmacist failed to report drug irregularities to the attending physician or the Director of Nursing for 5 (Residents # 45, # 75, # 100, # 9 & #92) of 10 sampled residents. The findings include:<br><br>1. Resident # 45 was admitted to the facility on 08/02/10 with multiple diagnoses including Alzheimer's Disease. The annual MDS assessment dated 08/12/11 indicated that Resident #45 had memory and decision making problems.<br><br>Review of the telephone orders dated 09/21/11 revealed that Resident #45 had a doctor's order for Amitiza 24 mcg (microgram) by mouth twice a day for constipation.<br><br>The MARs (Medication Administration Record) were reviewed. Amitiza was transcribed to the September, 2011 MAR and was administered from 09/21 thru 09/31, 2011. On the October and November, 2011 MARs, Amitiza was not transcribed and therefore was not administered to the resident.<br><br>The DRRs (drug regimen review) were reviewed and revealed that the pharmacist had reviewed the resident's chart on 10/13/11 and 11/17/11. The notes did not mention of irregularities | F 428 | F428<br>1. All residents are potentially at risk. Residents #45,75,100,9,92 orders were clarified 12/1/11<br>2. Pharmacy Manager was contacted by DON and informed of citation. Date12-19-2011<br>3. Consultant Pharmacist did a complete and thorough audit of all residents and their records. Completed 12-29-2011<br>4. Pharmacist will meet with DON each month at the conclusion of his visit to review documented findings for the month. The DON is responsible for monitoring the Consulting Pharmacists monthly review and documentation. Chart audits are performed monthly with the end of the month MAR audit.<br>5. Results of Pharmacists monthly review will be discussed in QA meeting monthly. | DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11 |

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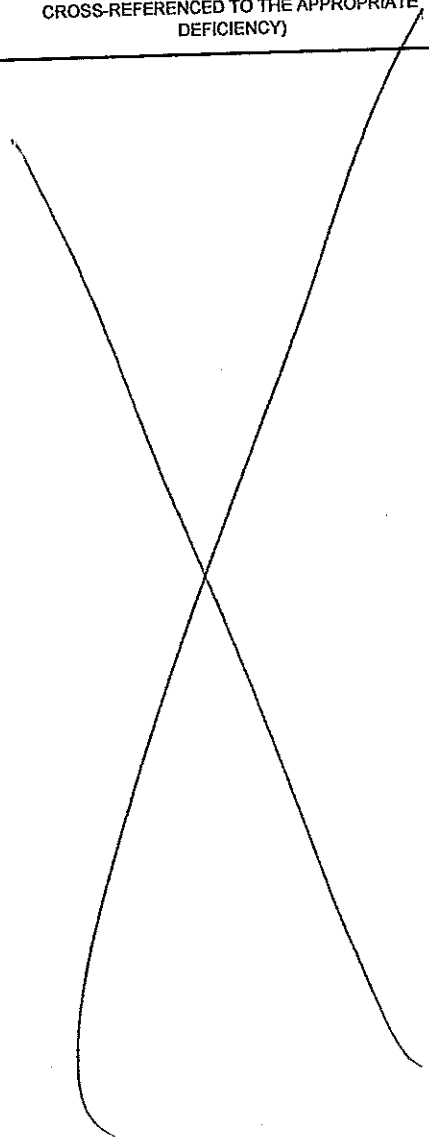
| F 428 | Continued From page 59<br>regarding the Amitiza.<br><br>On 12/01/11 at 11:50 AM, the pharmacist was interviewed. He stated that he could not remember the recommendation he had made during his drug regimen reviews for Resident #45 but he indicated that the DON had copies of his recommendations.<br><br>Copies of the pharmacist's recommendations to the attending physician and/or DON for October and November, 2011 were reviewed. There were no recommendations or report of drug irregularities for Resident #45 regarding the Amitiza.<br><br>2. Resident # 100 was admitted to the facility on 09/20/10 with multiple diagnoses including Alzheimer's Disease. The quarterly MDS assessment dated 08/05/11 indicated that Resident #100 had memory and decision making problems.<br><br>Review of the telephone orders dated 09/06/11 revealed a doctor's order for Lacrilube ointment ½ inch to both eyes for dry eyes. On 09/07/11, there was a new doctor's order to discontinue Lacrilube and to start Artificial Tears ointment to both eyes for dry eyes.<br><br>The MARs were reviewed. Lacrilube was transcribed to the October and November, 2011 MARs and was administered in October and November, 2011. | F 428 |  | |

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| | 345509 | A. BUILDING _____ B. WING _____ | 12/01/2011 |

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

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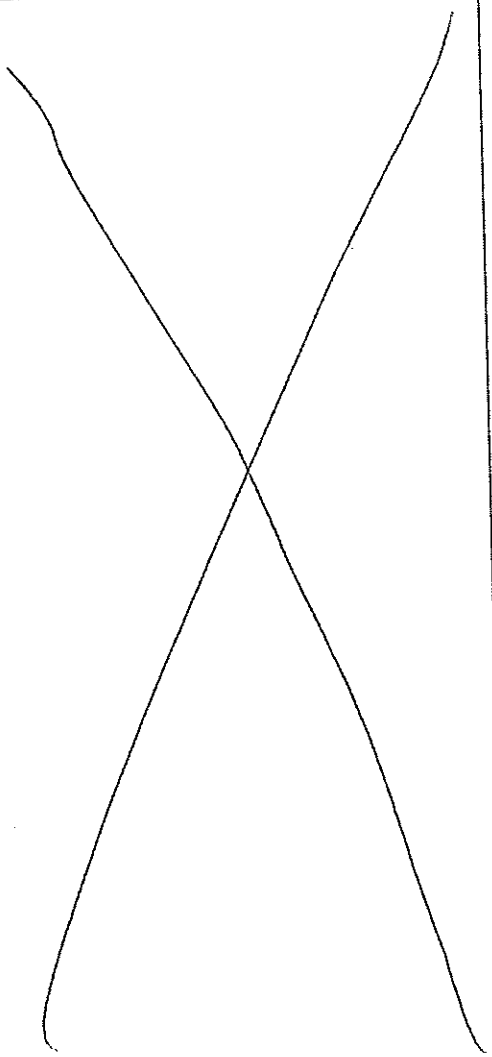
| F 428 | Continued From page 60<br>On 12/01/11 at 11:10 AM, Nurse # 1 was interviewed. Nurse #1 reviewed the chart and stated that Lacrilube was incorrectly transcribed to the October and November, 2011 MARs. She stated that 2 nurses were checking the new MARs against the last month's MARs and missed the order to discontinue the Lacrilube.<br><br>The DRRs (drug regimen review) were reviewed and revealed that the pharmacist had reviewed the resident's chart on 10/13/11 and 11/16/11. The notes did not mention of irregularities regarding the Lacrilube.<br><br>On 12/01/11 at 11:50 AM, the pharmacist was interviewed. He stated that he could not remember the recommendation he had made during his drug regimen reviews for Resident #100 but he indicated that the DON had copies of his recommendations.<br><br>Copies of the pharmacist's recommendations to the attending physician and/or DON for October and November, 2011 were reviewed. There were no recommendations or report of drug irregularities for Resident #100 regarding the Lacrilube.<br><br>3a. Resident #75 was admitted to the facility on 01/29/09 with multiple diagnoses including Alzheimer's Disease. The quarterly MDS assessment dated 11/01/11 indicated that Resident #75 had memory and decision making problems.<br><br>Review of the physician's orders for November, | F 428 |  | |

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| F 428 | Continued From page 61<br>2011 revealed That Resident #75 was on Risperdal 0.25 mgs at bedtime twice a week on Friday and Saturday for Senile Dementia with Depressive features.<br><br>The MARs were reviewed. In September, 2011, Risperdal was transcribed to the MAR to be given twice a week (Friday and Saturday) but was initialed by the nurses daily indicating that Risperdal was administered daily. In October, 2011, Risperdal was transcribed to be given twice a week (Friday and Saturday) but was initialed by the nurses daily from October 3 thru October 7, 2011 indicating that it was administered daily. The October, 2011 MAR also had no nurse's initials for 10/15 (Saturday), 10/21 (Friday) and 10/28 (Friday) indicating that Risperdal was not administered. The November, 2011 MAR revealed that Risperdal was transcribed to be given twice a week on Friday and Saturday but it was initialed by the nurses from 11/1 thru 11/5 indicating that it was administered daily.<br><br>The DRRs (drug regimen review) were reviewed and revealed that the pharmacist had reviewed the resident's chart on 9/14/11, 10/13/11 and 11/16/11. The notes did not mention of irregularities regarding the Risperdal.<br><br>On 12/01/11 at 11:50 AM, the pharmacist was interviewed. He stated that he could not remember the recommendation he had made during his drug regimen reviews for Resident #75 but he indicated that the DON had copies of his recommendations.<br><br>Copies of the pharmacist's recommendations to the attending physician and/or DON for October | F 428 | | |

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| F 428 | Continued From page 62<br>and November, 2011 were reviewed. There were no recommendations or report of drug irregularities for Resident #75 regarding the Risperdal.<br><br>3b. Resident #75 was admitted to the facility on 01/29/09 with multiple diagnoses including Alzheimer's Disease. The quarterly MDS assessment dated 11/01/11 indicated that Resident #75 had memory and decision making problems.<br><br>Review of the physician's orders for November, 2011 revealed That Resident #75 was on Risperdal 0.25 mgs at bedtime twice a week on Friday and Saturday for Senile Dementia with Depressive features.<br><br>On 11/30/11 at 2:35 PM, Nurse #1 was interviewed. She stated that the facility had a behavior monitoring form used to document resident's behaviors.<br><br>The behavior monitoring forms were reviewed. Resident #75 had no behavior monitoring form for the month of November, 2011. The October and September, 2011 monitoring forms had no target behaviors listed.<br><br>The DRRs (drug regimen review) were reviewed and revealed that the pharmacist had reviewed the resident's chart on 9/14/11, 10/13/11 and 11/16/11.<br><br>Copies of the pharmacist's recommendations to the attending physician and/or DON for | F 428 | | |

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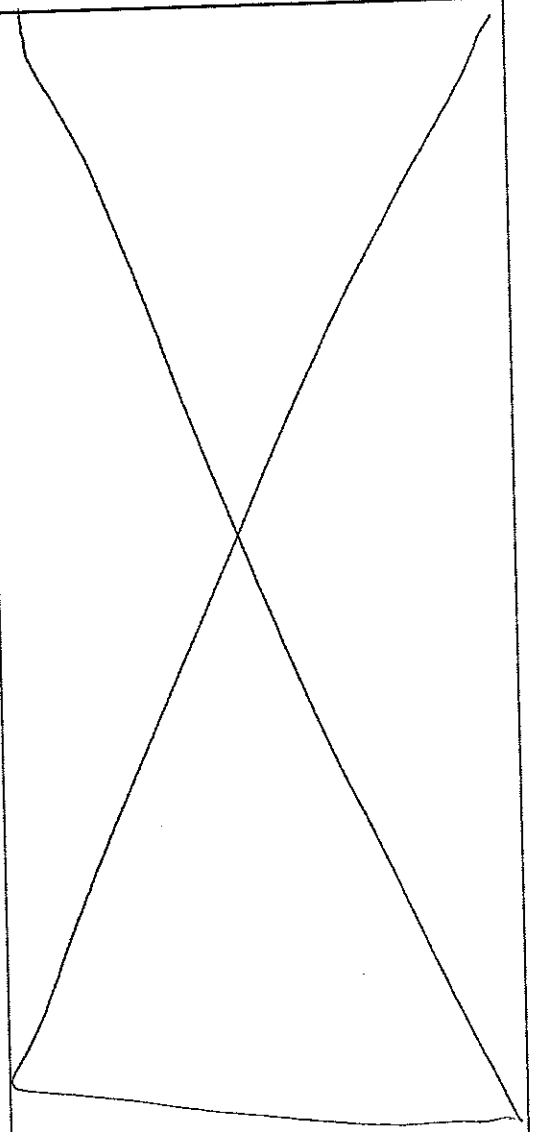
| F 428 | Continued From page 63<br>September, October and November, 2011 were reviewed. There were no recommendations or report of irregularities for Resident #75 regarding the monitoring of behaviors.<br><br>On 12/01/11 at 11:50 AM, the pharmacist was interviewed. He stated that he could not remember the recommendation he had made during his drug regimen reviews for Resident #75 but he indicated that the DON had copies of his recommendations. The pharmacist also indicated that he did not look at the behavior monitoring sheets much during his visits.<br><br>On 12/01/11 at 12:05 PM, the administrative staff #1 was interviewed. She stated that target behaviors should be listed on each behavior monitoring forms. She stated that she had in-serviced the nurses on the use of the behavior monitoring form before but there was a big turn over of nurses lately. She indicated that she would schedule an in-service for all the nurses regarding the behavior monitoring forms.<br><br>4. Resident # 9 was originally admitted to the facility on 07/03/06 with multiple diagnoses including Anxiety. The quarterly MDS assessment dated 09/08/11 indicated that Resident #9 had moderate cognitive impairment.<br><br>Review of the physician's order for November, 2011 revealed that Resident #9 was on Xanax 0.25 mgs at bedtime for Anxiety. | F 428 |  | |

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| F 428 | Continued From page 64<br><br>On 11/30/11 at 2:35 PM, Nurse #1 was interviewed. She stated that the facility had a behavior monitoring form used to document resident's behaviors.<br><br>The behavior monitoring forms were reviewed. Resident #9 had no behavior monitoring form for the month of November, 2011. The October and September, 2011 monitoring forms had no target behaviors listed.<br><br>The DRRs (drug regimen review) were reviewed and revealed that the pharmacist had reviewed the resident's chart on 9/14/11, 10/13/11 and 11/16/11.<br><br>Copies of the pharmacist's recommendations to the attending physician and/or DON for September, October and November, 2011 were reviewed. There were no recommendations or report of irregularities for Resident #9 regarding the monitoring of behaviors.<br><br>On 12/01/11 at 11:50 AM, the pharmacist was interviewed. He stated that he could not remember the recommendation he had made during his drug regimen reviews for Resident #9 but he indicated that the DON had copies of his recommendations. The pharmacist also indicated that he did not look at the behavior monitoring sheets much during his visits.<br><br>5. Resident #92 was admitted to the facility on 09/01/11 with multiple diagnoses including Psychosis. The admission MDS assessment | F 428 | | |

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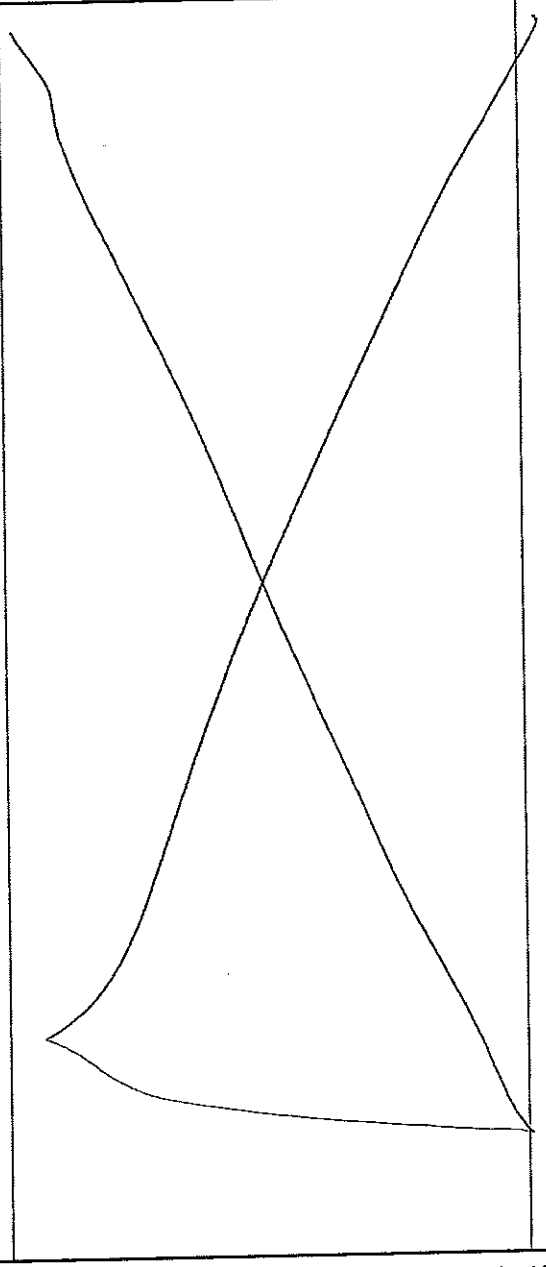
| F 428 | Continued From page 65<br>dated 09/13/11 indicated that Resident #92's cognitive status was intact.<br><br>Review of the physician's orders for November, 2011 revealed that Resident #92 was on Seroquel 100 mgs at bedtime for Psychosis.<br><br>On 11/30/11 at 2:35 PM, Nurse #1 was interviewed. She stated that the facility had a behavior monitoring form used to document resident's behaviors.<br><br>The behavior monitoring forms were reviewed. Resident #92 had no behavior monitoring form for the month of November, 2011. The October and September, 2011 monitoring forms had no target behaviors listed.<br><br>The DRRs (drug regimen review) were reviewed and revealed that the pharmacist had reviewed the resident's chart on 10/13/11 and 11/16/11.<br><br>On 12/1/11 at 11:10 AM, Nurse #1 was interviewed. She stated that she did not know why Resident #92 had no behavior monitoring form for November, 2011. She further stated that the behavior monitoring forms should have a target behavior listed and the nurses checking the MARs at the end of the month were responsible of writing the target behaviors on the forms.<br><br>Copies of the pharmacist's recommendations to the attending physician and/or DON for September, October and November, 2011 were reviewed. There were no recommendations or report of irregularities for Resident #92 regarding the monitoring of behaviors. | F 428 |  | |

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| F 428 | Continued From page 66<br>On 12/01/11 at 11:50 AM, the pharmacist was interviewed. He stated that he could not remember the recommendation he had made during his drug regimen reviews for Resident #92 but he indicated that the DON had copies of his recommendations. The pharmacist also indicated that he did not look at the behavior monitoring sheets much during his visits. | F 428 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to | F 431 | **F431**<br>1. All expired medications removed from Medication Storage Room on 11/31/11.<br>2. Central Supply will check all stock medications in medication room weekly to rotate stock and remove any medications about to expire.<br>3. Medication carts will be audited twice weekly by night nurses to check for any medications that have expired or close to expiration date.<br>4. Any medications that have expired or within 14 days of expiration will be removed and destroyed or returned to pharmacy as required.<br>5. DON and or her designee will do a second audit on medication carts and medication room weekly.<br>6. All audits will be recorded on the **Medication Storage QA Monitor.**<br>7. Results of the audit will be reviewed by the DON weekly x4, and monthly thereafter in QA. | DON 12-29-11<br>DON 12-29-11<br>DON 12-29-11<br>Central Supply 12-29-11<br>DON 12-29-11<br>DON 12-29-11 |

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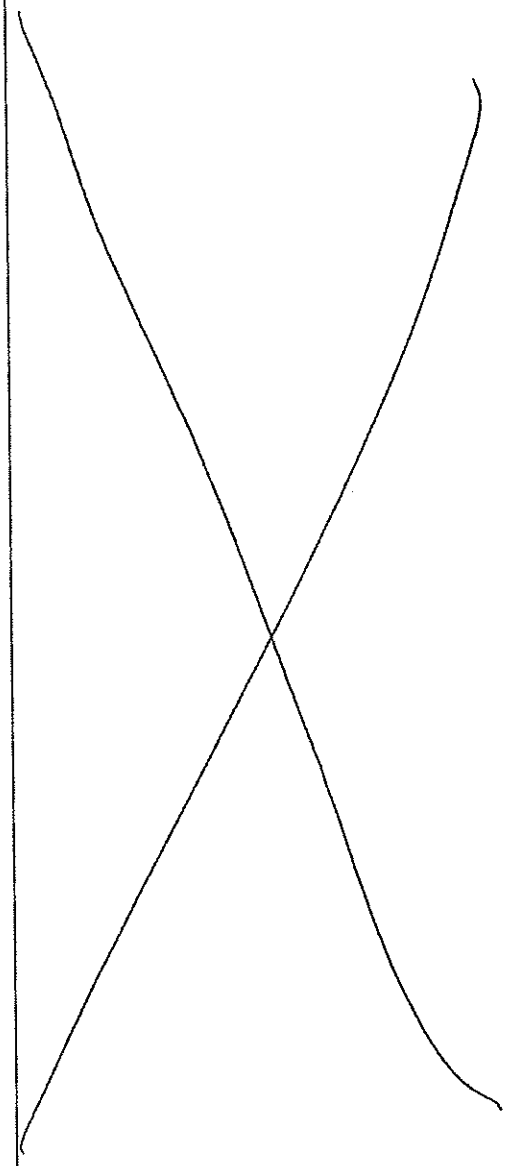
| F 431 | Continued From page 67<br>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to discard expired medications from one (1) of two (2) medication rooms. Findings include:<br><br>On 12/1/11 at 2:30 PM, the medication room on 200 hall was observed. In the stock medication cupboard the following stored expired medications were observed: calcium oyster shell 500 mg (milligrams) in an unopened 100 tablet container (expiration date 1/11), two unopened containers of zinc sulphate 200 mg (expiration dates 10/11 and 11/11), Vitamin E 400 IU (International Units) 100 soft gels (unopened with an expiration date of 10/11), three 100 tablet containers of vitamin B 100 mg (all expired on 10/11), folic acid 800mg elixir 16 ounces (unopened with an expiration date of 9/11), mucinex 600mg 20 tabs (expiration date 9/11). In the refrigerator the following stored expired medication was observed: 4 unopened vials of pneumococcal vaccine (all expired 29 January, 2011).<br><br>In interview with Administrative Staff #1 on 12/1/11 at 4 PM, she indicated it was her expectation that medication rooms were checked for and free of expired medications. | F 431 |  | |
| F 441 | 483.65 INFECTION CONTROL, PREVENT | F 441 | See next page | |

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| F 441 SS=D | Continued From page 68<br>SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | F441<br>1. All residents are potentially at risk.<br>2. All current nurses including night and weekend nurses were educated on the process for disinfection of glucometers by the SDC.. Completed 12-03-2011<br>3. All new nurses will be trained on the procedure for disinfection of glucometers in orientation. The SDC will provide the in-service training.<br>4. Each medication cart will have 2 glucometers.<br>5. Glucometers will be sanitized between each use ,using Sani-wipes to wipe down glucometer and then being wrapped in Sani-wipe for 2 minutes per manufacturers instructions.<br>6. DON or her designee will do random audits of nurses having them demonstrate the procedure and explain how often to disinfect machines 2 x each month.<br>7. Results of audits will be reviewed by DON or designee biweekly x4 and then monthly. Monitoring results will be presented in QA meeting 1 x month x 6 months. | SDC 12-3-11<br>SDC 12-31-11<br>Central Supply 12-31-11<br>DON 12-31-11<br>DON 12-31-11<br>DON 12-31-11 |

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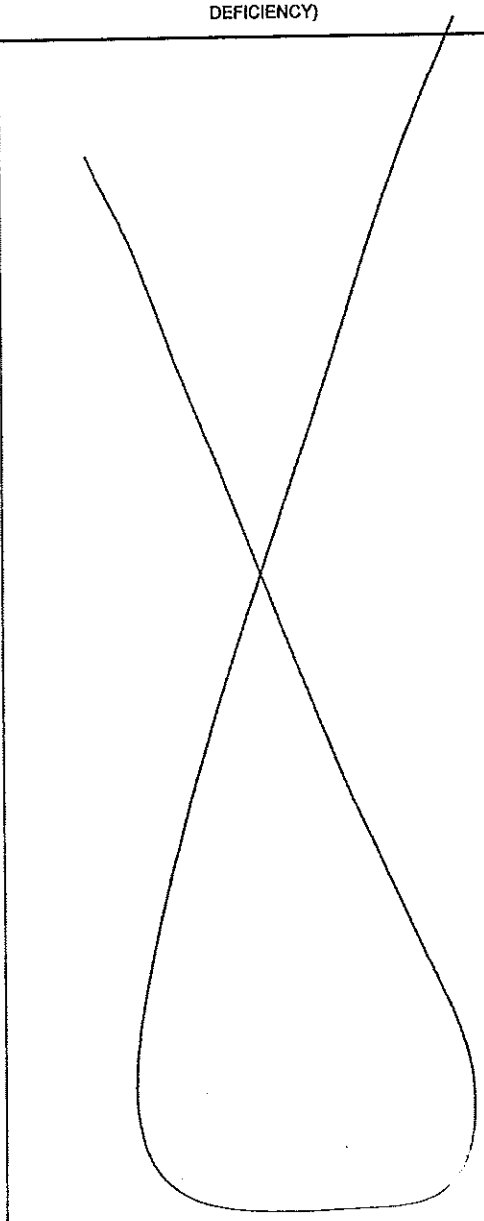
| F 441 | Continued From page 69<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and document review, one (1) of three (3) nurses failed to properly disinfect a glucometer. Findings included:<br><br>Review of the document titled ' Glucometer Manufacturers ' Cleaning/Disinfecting Procedures (undated) revealed, in part, for the glucometer used at the facility, " Disinfecting - 1:10 dilution of water and bleach (or bleach wipe), dampen a paper towel and thoroughly wipe down the meter or use Super Sani-Cloth® & Sani-Cloth® HB Germicidal disposable wipes. "<br><br>Review of the document titled ' Cleaning/Disinfecting Glucometers ' (dated 4/30/10) from the " Administrative Policies & Procedures " provided by the facility read, in part:<br>" Multi Use Glucometers "<br>" Be free of visible soil by use of water and detergents - wipe with a cloth dampened with soap and water to remove any visible soil. "<br>" Be infection free at the low to highest level by the use of disinfectants which would eliminate bacteria, fungi, viruses and bacteria spores. If no visible soil is present, disinfect the exterior surfaces after each use following the manufacturer direction or wipe with a cloth dampened with EPA (Environmental Protection Agency) registered detergent/disinfectant. "<br><br>On 11/30/11 at 4:25 PM Nurse #6 was observed using the glucometer to test the blood sugar of Resident #12. She used a lancet to obtain a drop of blood for the test strip that was inserted into | F 441 |  | |

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| KINGSWOOD NURSING CENTER | 915 PEE DEE ROAD ABERDEEN, NC 28315 |

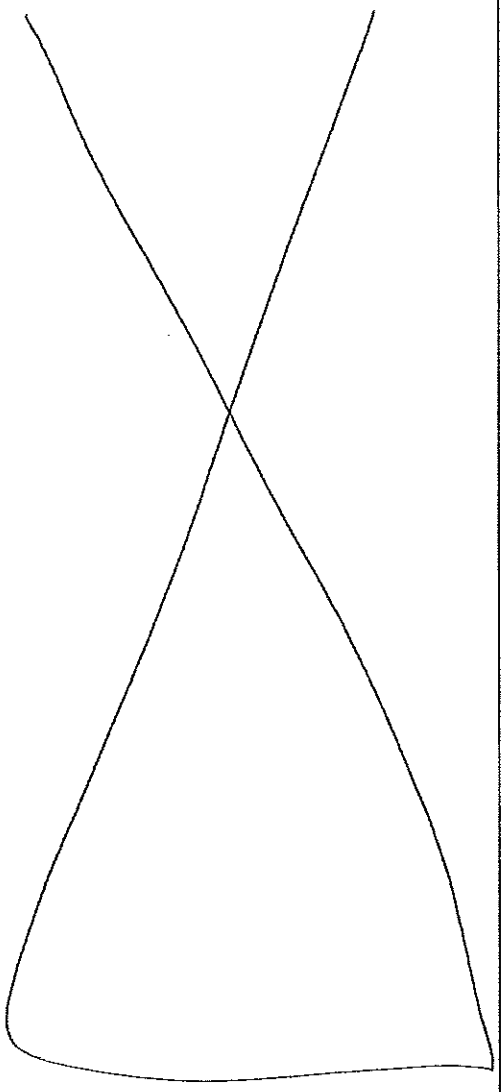
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 70 | F 441 | | |

the glucometer. After using the glucometer she wiped the opening where the test strip was inserted with an alcohol swab. She then exited the room, disposed of the test strip, alcohol swab and lancet (in the sharps container) and placed the glucometer inside the medication cart. Nurse #6 then gave Resident #12 the required insulin dosage. She disposed of the syringe in the sharps container. Throughout the process she wore gloves when required and performed hand hygiene as needed.

On 11/30/11 at 4:36 Nurse #6 was observed dispensing medications into a medication cup for Resident #92. She then retrieved the glucometer from the medication cart. After locking the cart she put on gloves and gathered up the glucometer with a test strip, along with alcohol swabs, a lancet, a cup of water and the medication cup and then she moved towards Resident #92 ' s room. At that time Nurse #6 was asked to stop for a moment. She then placed the supplies on top on the medication cart.

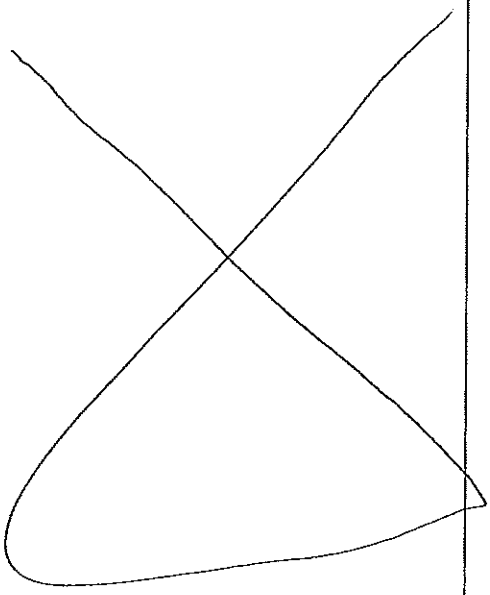
On 11/30/11 at 4:38 Nurse #6 was interviewed and was asked if there was something she had forgotten to do before testing Resident #92 ' s blood glucose. Nurse #6 did not think she had forgotten anything. When she was asked if there were any special wipes she was supposed to use to clean the glucometer between uses, she said she was a new nurse and she had been taught in Nursing school that the glucometer could be cleaned with an alcohol swab; like she did when she was in Resident #12 ' s room.

On 11/30/11 at 4:40 PM interview with Administrative Staff #2 (Admin #2) and Nurse #6



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345509 | A. BUILDING _____ B. WING _____ | 12/01/2011 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 71<br>revealed that Admin #2 expected staff to clean the glucometers using the sani wipes on the medication carts. She also stated that this was taught in staff orientation and annual updates. The instructions on the sani-wipes were reviewed by Admin #2 and indicated the item that was being cleaned needed to remain wet for 5 minutes. Admin #2 provided education to Nurse #6 regarding the cleaning technique and expectation that glucometers were cleaned after each use. Nurse #6 stated that she would clean the glucometer as instructed.<br><br>On 11/31/11 at 4 PM interview with Administrative Staff #1 and Administrative Staff #3 revealed that the facility was in the process of reviewing the requirements for disinfecting glucometers with all their licensed nurses, and medication technicians, prior to their next shift on the medication cart. | F 441 |  | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

This plan of correction shall not be construed as an admission of fault nor agreement with the findings of noncompliance. The plan of correction is provided pursuant of Federal Requirements which require an acceptable plan of correction as a condition of continued certification.

RINTED: 12/19/2011
FORM APPROVED
MB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | ) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345509 | A. BUILDING _____ B. WING _____ | 12/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET A |
|---|---|
| KINGSWOOD NURSING CENTER | 815 PE ABERI |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | 3E ATE | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 029 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: kitchen dry storage room door failed to close and latch for smoke tight seal.<br><br>42 CFR 483.70(a) | K 029 | | |
| K 038 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at | K 038 | | |

K 029

1. The kitchen dry storage door was fixed immediately.
2. All residents are at risk for potential harm.
3. Maintenance Supervisor will perform a weekly documented audit of all facility doors 1 x week for 1 month and then 1 x month through out year.
4. Each documented audit will be reviewed by the administrator..
5. Results of audits will be presented at each QA meeting for review and recommendations.

Maintenance Supervisor 1/20/2012

K038 - Next Page

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Admin | 1/3/2012 |

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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

This plan of correction shall not be construed as an admission of fault nor agreement with the findings of noncompliance. The plan of correction is provided pursuant of Federal Requirements which require an acceptable plan of correction as a condition of continued certification.

PRINTED: 12/19/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | ) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345509 | A. BUILDING _____ B. WING _____ | 12/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET A |
|---|---|
| KINGSWOOD NURSING CENTER | 915 PE ABERI |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | 3E ATE | (X6) COMPLETION DATE |
|---|---|---|---|---|
| K 029 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: kitchen dry storage room door failed to close and latch for smoke tight seal.<br><br>42 CFR 483.70(a) | K 029 | | |
| K 038 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at | K 038 | | |

K 029

1. The kitchen dry storage door was fixed immediately.
2. All residents are at risk for potential harm.
3. Maintenance Supervisor will perform a weekly documented audit of all facility doors 1 x week for 1 month and then 1 x month through out year.
4. Each documented audit will be reviewed by the administrator..
5. Results of audits will be presented at each QA meeting for review and recommendations.

Maintenance Supervisor 1/20/2012

K038 - Next Page

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

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.

GW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345509 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 12/15/2011 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 038 | Continued From page 1<br>approximately 8:30 am onward, the following items were noncompliant, specific findings include: there was not a wiring diagram and system components location map adjacent to fire alarm panel for the special locking in Special care unit.<br><br>42 CFR 483.70(a) | K 038 | K038 cont. →<br>K 038<br>1. All residents are at risk for potential harm.<br>2. The company that originally installed the Special Unit locking system has been contacted.<br>3. The wiring diagram and systems component map will be provided to the facility by the company that originally install the special locking system and then placed adjacent to the fire alarm panel.<br>4. The administrator will monitor the process for completion.<br>5. Results will be reported to the QA Committee.<br><br>K047 next page | Maintenance Supervisor Adm. 1/20/2012 |
| K 047<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: kitchen did not have Exit or directional signs displayed with continuous illumination. | K 047 | | |
| K 051<br>SS=F | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of | K 051 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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|---|---|---|---|
| | 345509 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 12/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINGSWOOD NURSING CENTER | 918 PEE DEE ROAD<br>ABERDEEN, NC 28315 |

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|---|---|---|---|---|
| K 038 | Continued From page 1<br>approximately 8:30 am onward, the following items were noncompliant, specific findings include: there was not a wiring diagram and system components location map adjacent to fire alarm panel for the special locking in Special care unit. | K 038 | K038 Previous page | |
| K 047<br>SS=F | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: kitchen did not have Exit or directional signs displayed with continuous illumination. | K 047 | K 047<br>1. All residents are at risk for potential harm.<br>2. The 2 required Exit or Directional signs were immediately ordered.<br>3. A certified electrician was contacted and Exit or directional signs were installed in required locations.<br>4. Maintenance Supervisor or designee will provide Administrator with a documented monitor of all Exit signs 1 x per month.<br>5. Results of monitoring will be presented to QA Committee each month. | |
| K 051<br>SS=F | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of | K 051 | K051 Next page. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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|---|---|---|---|
| | 345509 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 12/15/2011 |

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

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|---|---|---|---|---|
| K 051 | Continued From page 2<br>nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: fire alarm filed to activity when tested on battery back up.<br><br>42 CFR 483.70(a) | K 051 | K 051<br>1. All residents are at risk for potential harm.<br>2. Fire Alarm Company (Diebold) was again contacted and 2 more back up batteries were brought to the facility and installed.<br>3. After another 24 hrs. for new batteries to charge, the alarm system was tested with positive results.<br>4. Maintenance Supervisor or designee will test alarm system 1 x per month for 3 months and then quarterly thereafter.<br>5. Results will be presented to the QA Committee monthly. | Maintenance Supervisor 1/20/2012 |
| K 056 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water | K 056 | K056 next page | |

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|---|---|---|---|
| | 345509 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 12/15/2011 |

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|---|---|---|---|---|
| K 056 | Continued From page 3<br>supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: facility had no documentation on 5 year test of obstruction on system. Also accelerator valves were not supervised.<br><br>42 CFR 483.70(a) | K 056 | K 056<br>1. All residents are at risk for potential harm.<br>2. Sunland Fire Protection has been contacted. They have the paperwork show-that our test of obstruct-tion is not due until April but we have scheduled it to occur before 1/20/2012.<br>3. Both the accelerated valves and the obstruction test will be completed before 1/20/2012.<br>4. Results of tests will be pre-sented to the QA Committee. | Maintenance Supervisor 1/20/2012 |
| K 069<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: the facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specifically, the automatic fire extinguishing system does not comply with UL 300 standard in accordance with NFPA 96 7-2.2. Additionally, all necessary components of the system were not subjected to hydrostatic pressure tests at intervals not | K 069 | K 069<br>1. All residents are at risk for potential harm.<br>2. The deep fat fryer was moved so that it is located under the hood system.<br>3. Sunland Fire Protection has been contacted.<br>4. All components of the system will be subjected to a hydrostatic pressure test prior to 1/20/12.<br>5. Results of tests will be presented to QA Committee for review and recom-mendations. | Maintenance Supervisor 1/20/2012 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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|---|---|---|---|
| | 345509 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 12/15/2011 |

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

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|---|---|---|---|---|
| K 069 | Continued From page 4<br>exceeding 12 years.<br>42 CFR 483.70(a) | K 069 | | |