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

AUG 1 3 2013

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 07/19/2013

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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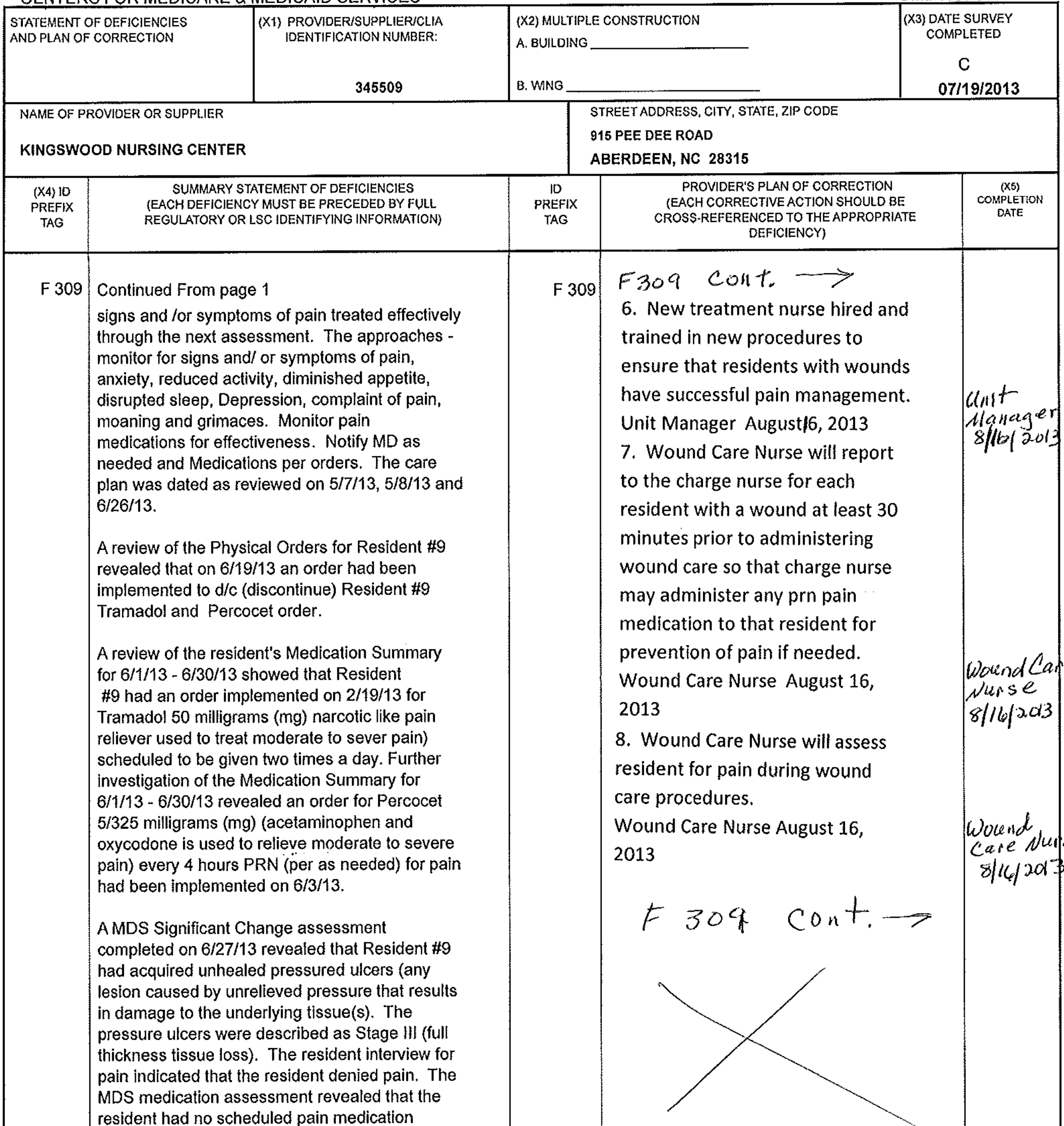
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and document review, the facility failed to provide pain management interventions for 1 of 3 residents (Resident #9). Findings included: Resident #9 was readmitted on 3/12/13, with diagnoses including Atrial Fibrillation, Osteoarthritis and Dementia. The Minimum Data Set (MDS) Quarterly assessment dated 5/5/13 revealed Resident #9 had an impairment for short and long term memory. Cognitive skills were moderately impaired; decisions poor and cues were required. The resident interview for pain indicated that the resident denied pain. The MDS medication assessment indicated that the resident had a scheduled pain medication regimen. A review of the care plan dated 2/22/13 revealed that Resident #9 had a potential for the problem of pain. The risk was related to generalized pain, movement and pressure ulcer sacrum (5/10/13). The goals listed were - Resident will have all	F 309	**309** 1. All residents with pain are potentially at risk. 2. Resident #9 was placed under Hospice care and Hospice pain management protocols were initiated. July 20, 2013 3. LPN #1 and LPN#2 were in-serviced on how to assess for pain and the proper steps to take to ensure residents pain is managed successfully. Staff Development Coordinator July 22, 2013 4. All residents with wounds to be audited for presence of pain medication. Any resident without prn pain medication will have MD notified for order for prn medication. Unit Manager and Wound Nurse August 16, 2013 5. All nursing staff will be in-serviced on reviewing resident's Care Plans, recognizing the signs and symptoms of pain, proper procedure for reporting of resident's pain, and steps to follow to ensure that resident's pain is managed successfully. Staff Development Coordinator August 16, 2013	Hospice 7/20/2013 Staff Development Coordinator 7/22/2013 Unit Manager Wound Nurse 8/16/2013 Staff Development Coordinator 8/16/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Reba Juanita Frazier — TITLE: Administrator — (X6) DATE: 8/9/2013

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 309	Continued From page 1 signs and /or symptoms of pain treated effectively through the next assessment. The approaches - monitor for signs and/ or symptoms of pain, anxiety, reduced activity, diminished appetite, disrupted sleep, Depression, complaint of pain, moaning and grimaces. Monitor pain medications for effectiveness. Notify MD as needed and Medications per orders. The care plan was dated as reviewed on 5/7/13, 5/8/13 and 6/26/13. A review of the Physical Orders for Resident #9 revealed that on 6/19/13 an order had been implemented to d/c (discontinue) Resident #9 Tramadol and Percocet order. A review of the resident's Medication Summary for 6/1/13 - 6/30/13 showed that Resident #9 had an order implemented on 2/19/13 for Tramadol 50 milligrams (mg) narcotic like pain reliever used to treat moderate to sever pain) scheduled to be given two times a day. Further investigation of the Medication Summary for 6/1/13 - 6/30/13 revealed an order for Percocet 5/325 milligrams (mg) (acetaminophen and oxycodone is used to relieve moderate to severe pain) every 4 hours PRN (per as needed) for pain had been implemented on 6/3/13. A MDS Significant Change assessment completed on 6/27/13 revealed that Resident #9 had acquired unhealed pressured ulcers (any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). The pressure ulcers were described as Stage III (full thickness tissue loss). The resident interview for pain indicated that the resident denied pain. The MDS medication assessment revealed that the resident had no scheduled pain medication	F 309	F309 Cont. → 6. New treatment nurse hired and trained in new procedures to ensure that residents with wounds have successful pain management. Unit Manager August 16, 2013 7. Wound Care Nurse will report to the charge nurse for each resident with a wound at least 30 minutes prior to administering wound care so that charge nurse may administer any prn pain medication to that resident for prevention of pain if needed. Wound Care Nurse August 16, 2013 8. Wound Care Nurse will assess resident for pain during wound care procedures. Wound Care Nurse August 16, 2013 F 309 Cont. →	Unit Manager 8/16/2013 Wound Care Nurse 8/16/2013 Wound Care Nurse 8/16/2013

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F 309	Continued From page 2 regimen. A Nursing Note dated 7/8/13 at 10:50 AM read in part: Resident in bed sleeping. Resident continues to hurt when moved. Resident overall health continues to be poor. Review of the Resident #9 MAR (Medications Administration Records) for 7/1/13 - 7/31/13 showed no evidence of a pain medication being administered prior to the wound treatment on 7/17/13. Further investigation on the MAR for 7/1/13 - 7/31/13 revealed that Resident #9 had no pain medication ordered for scheduled or PRN. Review of the Resident #9 MAR for July, 2013 showed no evidence of a pain medication being administered prior to the wound treatment on 7/17/13. Further investigation on the MAR for July, 2013 revealed that Resident #9 had no pain medication ordered for scheduled or PRN. On 7/17/13 at 10:46 AM, an observation of the wound care treatment for Resident #9 was conducted. LPN#2 with the assistance of NA(Nurse Aide) #1 provided the treatment care. LPN#2 reported that the resident had received schedule pain medication prior to treatment. Resident #9 showed signs and symptoms of pain by facial grimacing, moaning and crying each time the resident was moved during the treatment care. The resident kept repeatedly asking the LPN#2, "Are you finished yet?". When asked by LPN #2 if she could finish the treatment, Resident #9 would smile and nod her head. Resident #9 was observed to raise her hand and tried to hit at LPN#2 during the treatment care. When asked about the resident behaviors, LPN #2 stated "she always acts like that". The	F 309	F309 Cont. → 9. Any staff member that notices a resident displaying signs or symptoms of pain, or that receives a complaint of pain from a resident, will immediately report this to the charge nurse for that resident. Charge Nurse will check to see if resident has an order for prn pain medication. If resident does not have a prn pain medication, the charge nurse will call the Physician and inform him/her of resident's pain, level of pain, and any scheduled pain medication that resident is on so that Physician can order pain mediation for that resident. Charge Nurse August 16, 2013 10. Care Plans will be updated daily by MDS (Minimum Data Set) Coordinator during the daily Clinical Meeting after review of new Physician Orders. Unit Manager will Audit Care Plans weekly to ensure Care Plans are updated. Audits will be given to Director of Nursing for presentation in monthly QA x 3 months or until compliance is achieved. Director of Nursing August 16, 2013 F309 CONT. →	Charge Nurse 8/16/2013 Director of Nursing 8/16/[illegible]

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FORM APPROVED
OMB NO. 0938-0391

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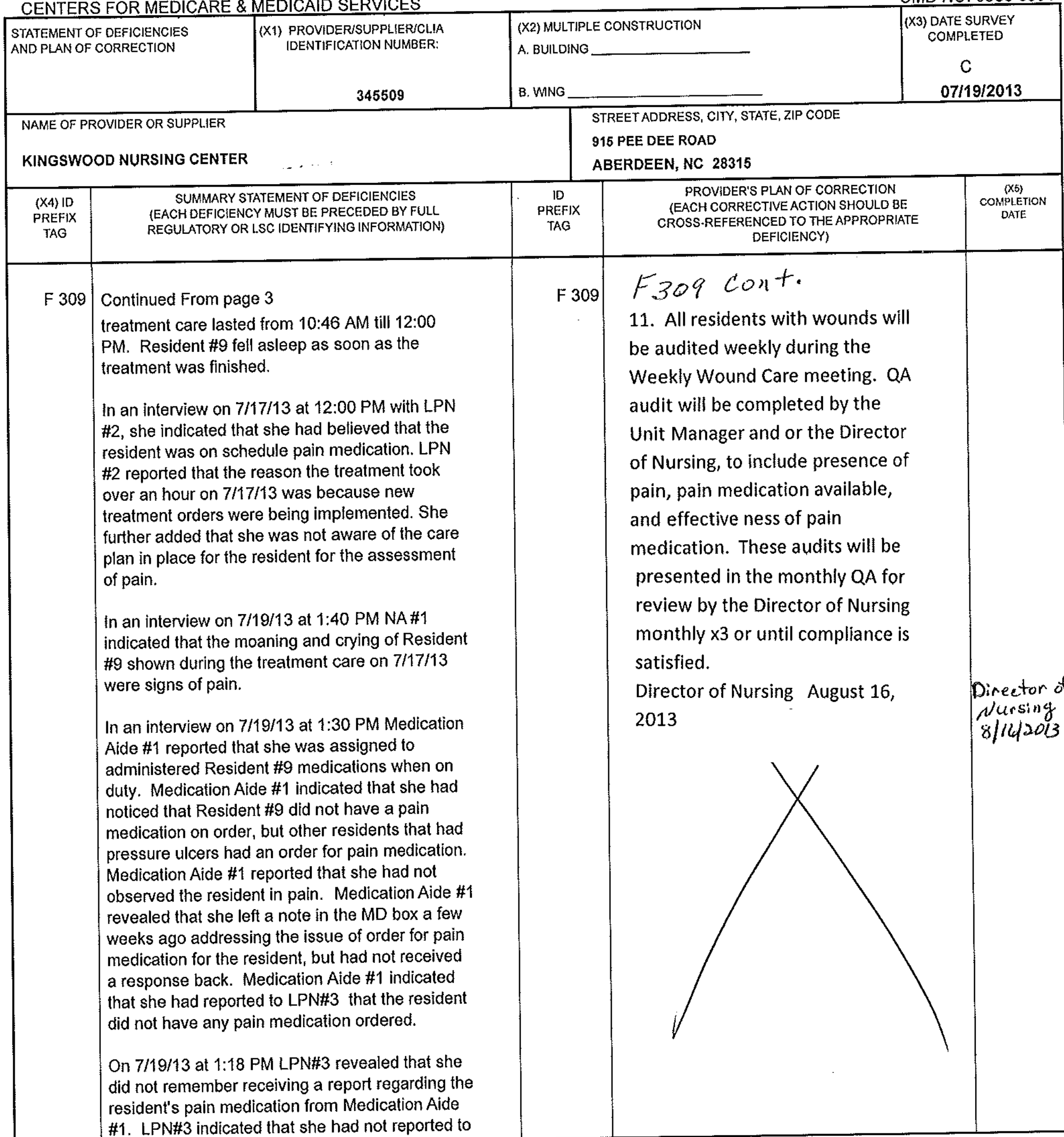

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F 309	Continued From page 3 treatment care lasted from 10:46 AM till 12:00 PM. Resident #9 fell asleep as soon as the treatment was finished. In an interview on 7/17/13 at 12:00 PM with LPN #2, she indicated that she had believed that the resident was on schedule pain medication. LPN #2 reported that the reason the treatment took over an hour on 7/17/13 was because new treatment orders were being implemented. She further added that she was not aware of the care plan in place for the resident for the assessment of pain. In an interview on 7/19/13 at 1:40 PM NA #1 indicated that the moaning and crying of Resident #9 shown during the treatment care on 7/17/13 were signs of pain. In an interview on 7/19/13 at 1:30 PM Medication Aide #1 reported that she was assigned to administered Resident #9 medications when on duty. Medication Aide #1 indicated that she had noticed that Resident #9 did not have a pain medication on order, but other residents that had pressure ulcers had an order for pain medication. Medication Aide #1 reported that she had not observed the resident in pain. Medication Aide #1 revealed that she left a note in the MD box a few weeks ago addressing the issue of order for pain medication for the resident, but had not received a response back. Medication Aide #1 indicated that she had reported to LPN#3 that the resident did not have any pain medication ordered. On 7/19/13 at 1:18 PM LPN#3 revealed that she did not remember receiving a report regarding the resident's pain medication from Medication Aide #1. LPN#3 indicated that she had not reported to	F 309	F309 Cont. 11. All residents with wounds will be audited weekly during the Weekly Wound Care meeting. QA audit will be completed by the Unit Manager and or the Director of Nursing, to include presence of pain, pain medication available, and effective ness of pain medication. These audits will be presented in the monthly QA for review by the Director of Nursing monthly x3 or until compliance is satisfied. Director of Nursing August 16, 2013	Director of Nursing 8/16/2013

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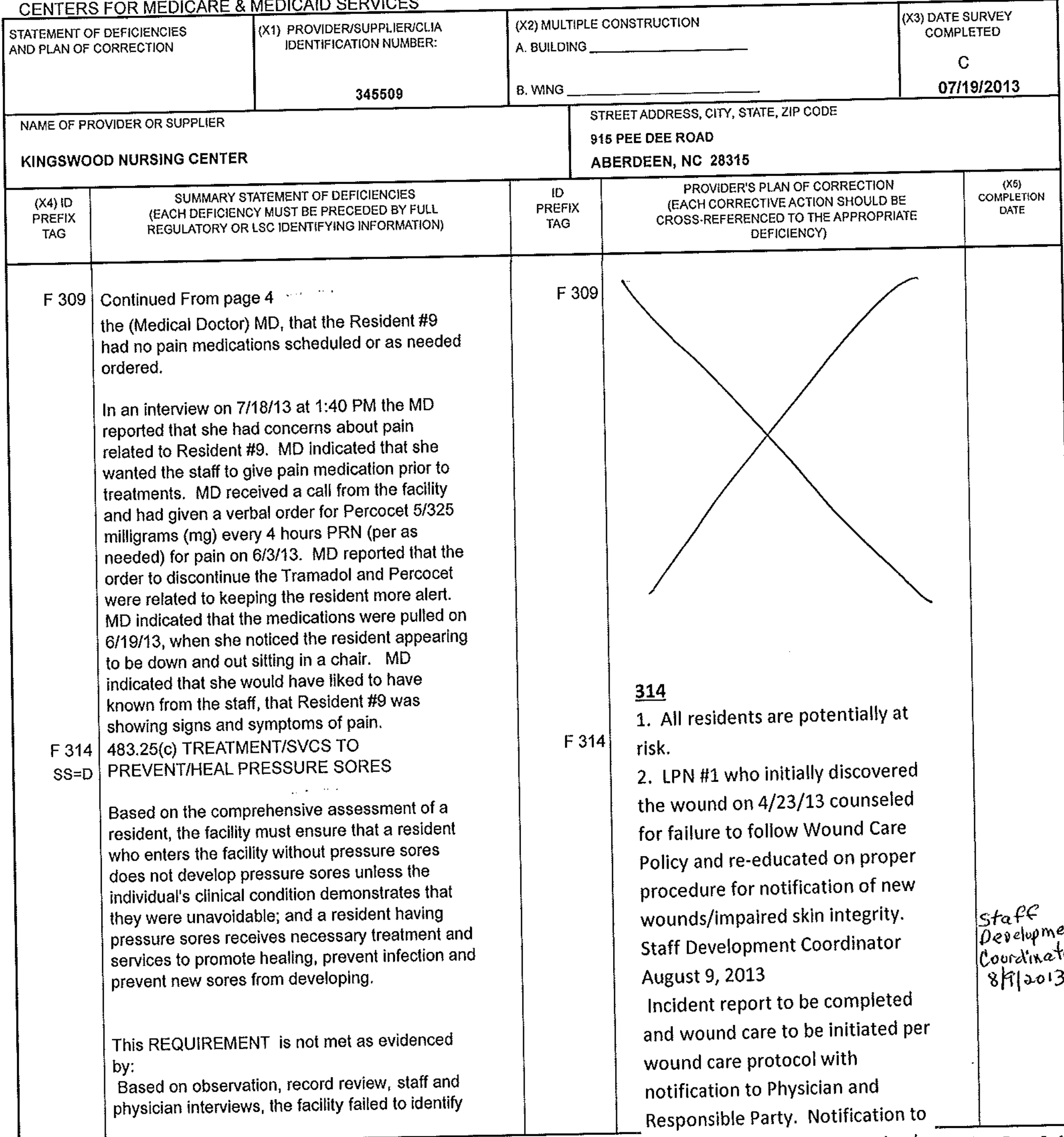

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F 309	Continued From page 4 the (Medical Doctor) MD, that the Resident #9 had no pain medications scheduled or as needed ordered. In an interview on 7/18/13 at 1:40 PM the MD reported that she had concerns about pain related to Resident #9. MD indicated that she wanted the staff to give pain medication prior to treatments. MD received a call from the facility and had given a verbal order for Percocet 5/325 milligrams (mg) every 4 hours PRN (per as needed) for pain on 6/3/13. MD reported that the order to discontinue the Tramadol and Percocet were related to keeping the resident more alert. MD indicated that the medications were pulled on 6/19/13, when she noticed the resident appearing to be down and out sitting in a chair. MD indicated that she would have liked to have known from the staff, that Resident #9 was showing signs and symptoms of pain.	F 309	X	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician interviews, the facility failed to identify	F 314	**314** 1. All residents are potentially at risk. 2. LPN #1 who initially discovered the wound on 4/23/13 counseled for failure to follow Wound Care Policy and re-educated on proper procedure for notification of new wounds/impaired skin integrity. Staff Development Coordinator August 9, 2013 Incident report to be completed and wound care to be initiated per wound care protocol with notification to Physician and Responsible Party. Notification to be placed on 24 hour Supervisor's Report Sheet for review in morning Clinical meeting. Shift Supervisor August 16, 2013 F 314 cont. →	Staff Development Coordinator 8/9/2013 Shift Supervisor 8/16/2013

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F 314	Continued From page 5 and implement interventions for pressure ulcers 1 of 3 residents for a period of three weeks following the identification of an open area (Resident #9). Findings included: Resident #9 was readmitted from the hospital on 3/12/13 with diagnoses including Atrial Fibrillation, Osteoarthritis and Dementia. A review of Resident #9's Treatment Administration Record (TAR) showed that on 1/24/13 an order was implemented for Dermagran-B Wound Dressing Ointment (a pH balance skin protectant) - apply twice daily and as needed after each incontinent episode. On 2/8/13, a Pressure Ulcer Risk Evaluation Form rated the resident at high risk for the development of a pressure ulcer. (Any lesion caused by unrelieved pressure, results in damage to the underlying tissue(s). A review of the care plan initiated 2/18/13 revealed that Resident #9 had a risk for impaired skin integrity/pressure ulcers due to decreased mobility, incontinence. The first documentation of a skin concern was in a weekly skin assessment dated 4/23/13 and it was described as open areas on bottom. There was no documentation in the medical record of any treatment initiated for the open areas. LPN #1 (Licensed Practical Nurse) was interviewed on 7/17/13 at 2:45 PM. She shared that a NA (Nurse Aide), whose name she could not recall, came to her on 4/23/13 and informed her that the resident had open areas on her bottom. She believed a treatment was in place for the resident. LPN #1 revealed that she did not leave a note for the	F 314	F314 Cont. → 3. All Nursing Staff rein-serviced on correct policy and procedure for reporting of new wounds/impaired skin integrity. Staff Development Coordinator August 16, 2013 4. Complete skin audits on all residents completed to monitor for any new wounds/skin areas. Director of Nursing August 16, 2013 5. Weekly skin audits will be reviewed by Ward Secretary daily x 30 days. Any noted changes or discrepancies will be reported to the Unit Manager/Director of Nursing for follow up. Results of weekly audits will be addressed in Monthly QA meeting x 3 months or until compliance achieved. Director of Nursing August 16, 2013	Staff Development Coordinator 8/16/2013 Director of Nursing 8/16/2013 Director of Nursing 8/16/2013

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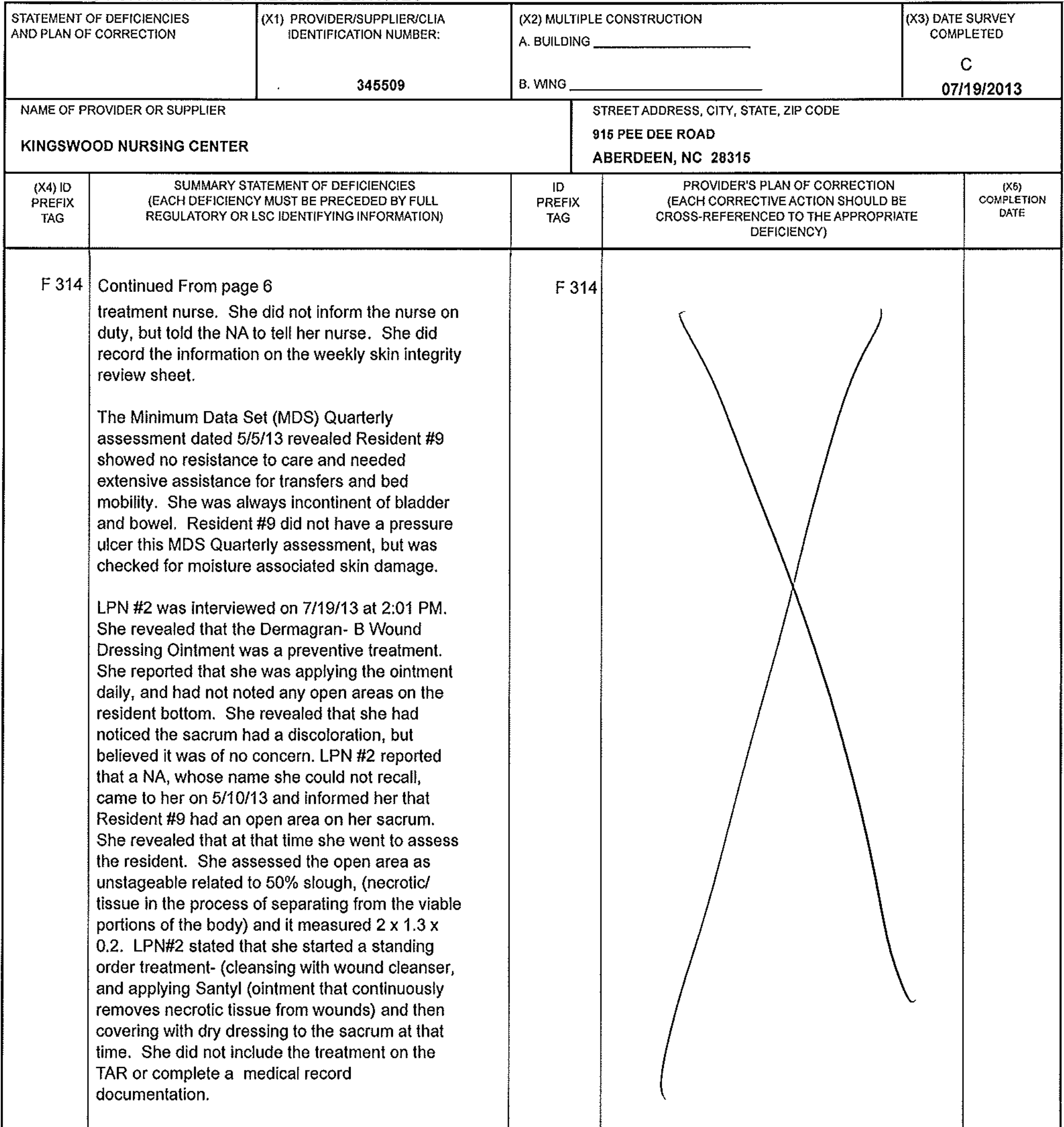
F 314	Continued From page 6	F 314		

treatment nurse. She did not inform the nurse on duty, but told the NA to tell her nurse. She did record the information on the weekly skin integrity review sheet.

The Minimum Data Set (MDS) Quarterly assessment dated 5/5/13 revealed Resident #9 showed no resistance to care and needed extensive assistance for transfers and bed mobility. She was always incontinent of bladder and bowel. Resident #9 did not have a pressure ulcer this MDS Quarterly assessment, but was checked for moisture associated skin damage.

LPN #2 was interviewed on 7/19/13 at 2:01 PM. She revealed that the Dermagran- B Wound Dressing Ointment was a preventive treatment. She reported that she was applying the ointment daily, and had not noted any open areas on the resident bottom. She revealed that she had noticed the sacrum had a discoloration, but believed it was of no concern. LPN #2 reported that a NA, whose name she could not recall, came to her on 5/10/13 and informed her that Resident #9 had an open area on her sacrum. She revealed that at that time she went to assess the resident. She assessed the open area as unstageable related to 50% slough, (necrotic/ tissue in the process of separating from the viable portions of the body) and it measured 2 x 1.3 x 0.2. LPN#2 stated that she started a standing order treatment- (cleansing with wound cleanser, and applying Santyl (ointment that continuously removes necrotic tissue from wounds) and then covering with dry dressing to the sacrum at that time. She did not include the treatment on the TAR or complete a medical record documentation.



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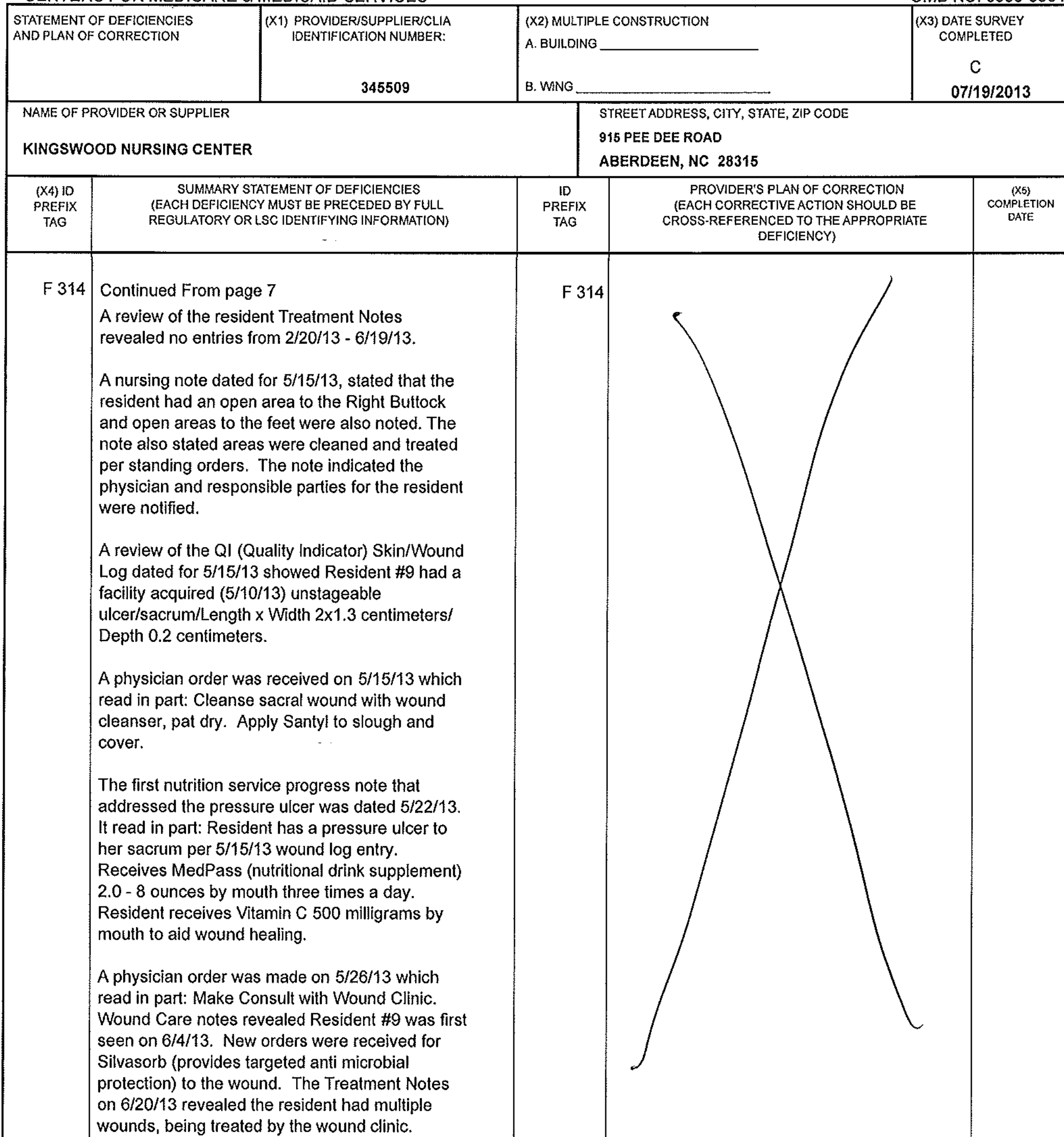

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F 314	Continued From page 7 A review of the resident Treatment Notes revealed no entries from 2/20/13 - 6/19/13. A nursing note dated for 5/15/13, stated that the resident had an open area to the Right Buttock and open areas to the feet were also noted. The note also stated areas were cleaned and treated per standing orders. The note indicated the physician and responsible parties for the resident were notified. A review of the QI (Quality Indicator) Skin/Wound Log dated for 5/15/13 showed Resident #9 had a facility acquired (5/10/13) unstageable ulcer/sacrum/Length x Width 2x1.3 centimeters/ Depth 0.2 centimeters. A physician order was received on 5/15/13 which read in part: Cleanse sacral wound with wound cleanser, pat dry. Apply Santyl to slough and cover. The first nutrition service progress note that addressed the pressure ulcer was dated 5/22/13. It read in part: Resident has a pressure ulcer to her sacrum per 5/15/13 wound log entry. Receives MedPass (nutritional drink supplement) 2.0 - 8 ounces by mouth three times a day. Resident receives Vitamin C 500 milligrams by mouth to aid wound healing. A physician order was made on 5/26/13 which read in part: Make Consult with Wound Clinic. Wound Care notes revealed Resident #9 was first seen on 6/4/13. New orders were received for Silvasorb (provides targeted anti microbial protection) to the wound. The Treatment Notes on 6/20/13 revealed the resident had multiple wounds, being treated by the wound clinic.	F 314		

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F 314	Continued From page 8 On 7/17/13 at 10:46 AM, an observation of the sacrum ulcer wound care for Resident #9 revealed the area appeared as red in color, with brown loose tissue in the middle. A moderate amount of drainage was present. LPN#2 indicated that the sacrum pressure ulcer was a stage three (full thickness tissue loss, slough may be present but does not obscure the depth of tissue loss). In an interview on 7/18/13 at 1:40 PM with the MD (Medical Doctor), she expressed that she was concerned about the wound care of Resident #9 and had referred her to the Wound Clinic. She indicated that she was in close contact with the wound specialist regarding the resident's condition. She indicated that she expected to be notified when there were any skin condition changes involving her residents.	F 314		