PRINTED: 12/04/2012
FORM APPROVED
OMB NO. 0938-0391

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
	346509	A. BUILDING _____ B. WING _____	C 11/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	916 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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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. 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. 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 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	F 156 1. All residents are potentially at risk. 2. Resident # 59 is no longer a resident of the facility. 3. When a resident is due to be discharged from the Medicare program depending on whether the resident has completed Medicare goals through the Therapy or Nursing department, an MDS or Therapy Discharge Communication Form will be presented to the Social Services Director. The MDS or Therapy Communication Form will be prepared by the Therapy Director or the Minimum Data Set Coordinator 7 days prior to discontinuing services. The Therapy and or/ MDS Discharge Communication form includes name of resident, Medicare discharge date, reason for discharge and the date the next payer source begins. The form is prepared and signed by the MDS Coordinator or the Therapy Director. The form	12/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Reba Quantin Rogers	Administrator	12-31-2012

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 A description of the manner of protecting personal funds, under paragraph (c) of this section; 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. 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. 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	is given to the Social Services Director 7 days prior to ending Medicare services by either the MDS Coordinator or the Therapy Director. The Liability Notice for Medicare Benefits Non-Coverage form will be prepared by the Social Services Director and mailed to the resident representative or the alert and oriented resident by Certified Return Receipt 5 days in advance of loss of benefits. The Social Services Director will provide the alert and oriented resident with a copy of the Liability Notice for Medicare Benefits Non-Coverage form and discuss with them what their plans are at that time. The original Notice for Medicare Benefits Non-Coverage form will be sent certified return receipt. The original will be delivered to the alert and oriented resident by the Activities Department through their mail service program. The Social Services Director will keep a record of when she has received the Communication Form, when	12/14/12

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F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with residents, family and staff, the facility failed to give advance notice of Medicare non-coverage for 1 of 3 residents (Resident #59); failed to post current state agency contact information and failed to ensure residents are knowledgeable about their resident rights. The findings include: 1. On 11/16/12 a record review was conducted of the Liability Notices for Medicare Benefits Non-Coverage. It revealed that Resident # 59 was admitted to the facility on 7/26/12. On 8/17/12, the Administrative Staff #5 informed her that on 8/16/12 her Medicare services ended due to meeting therapeutic goals. The form had a signature from Resident #59, dated 8/17/12.	F 156	she sent the Liability Letter and the date she receives the green certified receipt on a log. This log will be presented to the Administrator1 x per week for auditing purposes. The Administrator will confirm the correctness of the log and make notes on the log of audit findings. This will serve as our audit tool. 4. Social Services Director will present audit results to the Quality Assurance Committee 1 x per month for 3 months and then quarterly thereafter. 5. The corrected state contact information has been enlarged and posted at a level that wheelchair residents can read. The administrator will mark her calendar for the first Friday of each month to be the day the Administrator will walk through the building to review all posted	12/14/12

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F 156	Continued From page 3 On 9/24/12, Resident #59 received a 2nd notice from Administrative Staff #5 that her current Medicare services would end on 9/24/12 due to meeting therapeutic goals. She signed the form on 9/24/12. The Administrative Staff #5 was interviewed on 11/16/12 at 4:06 pm. She stated that she was not aware of how many days in advance that she was required to give the liability notice to residents or responsible parties (RP). She stated that generally the therapy department told her 3 to 5 days in advance of coverage ending, due to therapeutic goals being met. She stated that she attempts to call the RP and if they are unreachable after 2 to 3 calls, she sent out a certified letter through mail. If she was aware that the resident was alert and oriented, then she went directly to the resident for a signature. She shared that when she contacted the RP for Resident #59 initially, he expressed that he didn't want Resident #59 to be approached due to recent sudden death in their family. After some thought, he gave the Administrative Staff #5 permission to make direct contact with Resident #59, who signed the form, the day after service ended. 2. On 11/13/12 at 12:18 pm, the state agency contact information was found on a bulletin board across from the nurse's station. The information was last revised 02/07 and listed the state agency as The Division of Facility Services, with an outdated phone number and mailing address. The information provided for the Complaints Branch, was outdated as well.	F 156	information for correctness. The Administrator will present the audit results to the Quality Assurance Committee 1 x per month x 12 months. 6. The Activity Director had written up a Grievance Form concerning Resident #13 missing angels. She called the resident's family member who explained that mom is always moving her angels, hiding her angels or even giving them away and doesn't remember what she did with them. The Activity Director added this information to the completed grievance form and turned it into Social Services 11-27-12. The Activity Director then took a blank Grievance form down to resident #13 to explain the facility's process for resolving grievances including searching a resident's room, sometimes searching neighboring resident's rooms and talking to staff and family about what could have happened. Two days later the	12/14/12

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F 156	Continued From page 4 On 11/13/12 at 5:00 pm, during a family interview for a newly admitted resident, the daughter inquired where she could find the state agency information in the event; she needed to contact the agency. She was given the location of the bulletin board and informed that the information would be updated by the facility later in the week. On 11/14/12 at 11:30 am, the state contact information from 2007 remained on the bulletin board. The Administrative Staff #1 was contacted on 11/14/12 at 11:37 am. She stated that she was ultimately responsible for monitoring the state resources board for accuracy, but was unaware that their form was not current. She removed the old information and shared that she would make sure that the form was updated, printed larger and lowered to eye level for residents who may sit in wheelchairs. On 11/15/16 at 4:30 pm, the bulletin board listed current state contact information. On 11/17/12 at 3:40 pm, the Administrative Staff #8 was interviewed. She stated that she facilitated the monthly resident council meetings and did not discuss in the meetings, how a resident could contact the state agency if there were concerns. She also acknowledged that she did not know the name of the state agency that regulated nursing homes but would inquire with other staff if a resident inquired. 3. On 11/17/12 at 3:30 pm, an interview was held with the Resident Council President, Resident #13. She stated that she had lived at the facility	F 156	Administrator visited with resident #13 and noticed that the angels were back in resident's room. 7. The Administrator in-serviced the Activity Director and the Social Services Director on the importance of discussing residents rights and the location of the facility Survey Results during each resident Council Meeting. The Social Services Director is responsible for presenting at least 2 resident rights for discussion and the location of the facility Survey Results during each meeting. During the Resident Council Meeting for December, all Resident Rights were discussed. The Social Services Director will track which resident rights have been discussed each month to assure that all resident rights have been discussed throughout the year. 8. The Activity Director will include a description of the council's discussion of the resident's right and which	12/12/12

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F 156	Continued From page 5 for many years and in the past, the Social Worker would attend their meetings and discuss resident rights, but that hadn't happen for a long time. She stated that at their monthly resident council meetings, no one reviewed Resident Rights. Resident #13 reported that she alerted staff recently that she had some missing property, and although her room was searched, nothing else happened. She commented that she was unclear what the expectations should be, after reporting stolen property. The Administrative Staff #8 was interviewed on 11/17/12 at 3:35 pm. She stated that she had been involved with the Resident Council meetings for two years and does not discuss resident rights at the meetings. She also shared, that the social worker does not attend the meetings to present resident rights to the residents in attendance.	F 156	ones were discussed in the minutes of the resident council meeting. This will be presented to the Quality Assurance Committee 1 x monthly x 12 months.	12/14/12
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS 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. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing 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.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest	F 159	F159 1. All residents are potentially at risk. 2. After the Resident Trust Fund Account was reconciled, the interest was calculated for all residents with resident trust funds. Our Business Office Manager has a program that automatically calculates the interest once the information in entered by the Business Office Manager. The interest amounts were calculated and posted to the appropriate	12/14/12

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F 159	Continued From page 6 bearing account, interest-bearing account, or petty cash fund. 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. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to apply monthly interest since March, 2012 to 3 of 3 sampled residents (Residents # 6, #33 and #124) with resident trust fund accounts. The findings include:	F 159	resident accounts. Residents # 6, #33 and #124 had the interest posted to their accounts and then checks were processed for the full amount owed. Checks for residents #6,33 and 124 were mailed out to the appropriate parties by the Business Office Manager.. 3. Each month after the Resident Trust Fund Account is reconciled by the Business Office Manager, the interest for each individual account will be posted to their accounts. This process should be completed by the Business Office Manager by the 10th of each month. 4. Each week the Business Office Manager will run a summary report of the Resident Trust Fund Accounts showing individual balances and the total balance for all accounts. This summary will be presented to the Administrator to audit for monthly interest postings, refunds for deceased residents and to verify that the total is not	12/14/13

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F 159	Continued From page 7 1. On 11/15/12, a record review was conducted of resident trust fund account files. It revealed that Resident #124 had an account balance of $140.30 and received her last interest payment of $0.12 on 2/29/12, when her balance was $2,281.12. The Administrative Staff # 6 was interviewed on 11/16/12 at 9:50 am. She shared that she was hired into her position during February, 2012 and was still receiving ongoing training for business office procedures. She confirmed that interest have been suspended since 2/29/12 because she didn't know how to divide it and post it for the residents. She commented that she was still waiting for her corportrate trainer to give her direction on posting interest payments to the resident trust fund account. 2. On 11/15/12, a record review was conducted of resident trust fund account files. It revealed that Resident #33 had an account balance of $1354.32 and had not received any interest since her initial deposit on 7/19/12. The Administrative Staff # 6 was interviewed on 11/16/12 at 9:50 am. She shared that she was hired into her position during February, 2012 and was still receiving ongoing training for business office procedures. She confirmed that interest have been suspended since 2/29/12 because she didn't know how to divide it and post it for the residents. She commented that she was still waiting for her	F 159	more than our surety bond covers. This summary will serve as the Administrator's audit tool. 5. The Business Office Manager will report audit results to the Quality Assurance Committee 1 x per month for 12 months.	12/14/12

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F 159	Continued From page 8 corportrate trainer to give her direction on posting interest payments to the resident trust fund account. 3. On 11/15/12, a record review was conducted of resident trust fund accounts. It revealed that Resident #6 had an account balance of $778.00 and had not received any interest since her initial deposit on 10/4/12. The Administrative Staff # 6 was interviewed on 11/16/12 at 9:50 am. She shared that she was hired into her position during February, 2012 and was still receiving ongoing training for business office procedures. She confirmed that interest have been suspended since 2/29/12 because she didn't know how to divide it and post it for the residents. She commented that she was still waiting for her corportrate trainer to give her direction on posting interest payments to the resident trust fund account.	F 159		
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to convey funds for 2 of 3 expired	F 160	F160 1. All residents are potentially at risk. 2. Each month after the Resident Trust Fund Account is reconciled, the interest is calculated for all residents with resident trust funds by the Business Office Manager. The calculated interest amounts are posted to the	12/14/12

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F 160	Continued From page 9 residents (Residents #124 and # 33) within thirty days of their deaths. The findings include: 1. On 11/15/12, a record review was conducted in the business office, along with Administrative Staff # 6. It revealed that Resident #124 was admitted to the facility on 10/5/10 and expired on 6/6/12. At the time of her death, she had $3534.24 in her resident trust fund account. An account statement, showing transactions from 1/1/12 to 11/16/12, illustrated that the facility deducted three additional personal medical liability payments from the trust account, after her death, leaving a balance on 11/15/12 of $140.30. There was also a $10.00 withdrawal for June cable service. The Administrative Staff #6 was interviewed on 11/15/12 at 9:30 am. She stated that Resident #124 still had money in her account because she planned to take the personal medical liability out that was owed on the account, then send her refund to the clerk of courts. On 11/16/12 at 9:11 am, the Administrative Staff #6 further explained that she was hired earlier this year and was still receiving training on how to manage the resident trust fund. She commented that she knew that she was over the thirty days time limit, but she only received training from the corporate office once a month, and that they were behind in catching up on the trust accounts. The Administrative Staff #7 added that they normally refund money to the clerk of courts within thirty days of death unless there is money owed on the	F 160	appropriate accounts by the Business Office Manager. Residents #6, #33 and #124 had the interest posted to their accounts and then checks were processed for the full amount owed. Checks for residents #6,#33 and #124were mailed to the appropriate parties by the Business Office Manager. 3. Each week the Business office Manager will run an account summary report of the Resident Trust Fund Accounts showing individual balances for all accounts. This summary will be presented to the administrator weekly. The administrator will use this tool to audit the monthly interest postings, refunds for deceased residents and to verify that the account total does not exceed our Surety Bond amount. During the weekly audit, if the need for a refund to a deceased resident is found, the paperwork, etc. needed	12/14/12

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F 161	Continued From page 11 The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide sufficient coverage for the resident trust fund account. The findings include: On 11/15/12, a record review was conducted in the business office, regarding the resident trust fund accounts. The Administrative Staff #6 was interviewed at 9:30 am and asked to produce a copy of the surety bond. The surety bond was reviewed and revealed that it was in effect from 1/15/12 to 1/15/13, and protected the resident trust fund account up to $40,000. The Administrative Staff #6 produced a balance report, dated 11/15/12, representing all funds in the resident trust fund account, which totaled $68,014.36. She acknowledged that she hadn't deducted payments yet for the personal medical liabilities, which would reduce the balance. On 11/15/12 at 9:45 am, the Administrative Staff #1 was informed that the surety bond had insufficient coverage for the resident trust fund account. She stated that she would contact the corporate office and make sure that the bond was increased.	F 161	F161 1. All residents with Resident Trust Funds are potentially at risk. 2. A Surety Bond for $70,000.00 was received by the Administrator. 3. Each week the Business Office Manager will run a summary of the Resident Trust Fund accounts showing individual balances and the total balance for all resident accounts. The summary will be presented to the Administrator weekly. The Administrator will use this tool to audit and monitor monthly interest postings, refunds for deceased residents and to verify that the account total does not exceed our Surety Bond amount. 4. The Business Office Manager will present the audit results to the Quality Assurance Committee 1 x per month for 12 months.	12/14/12

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	345309	A. BUILDING _____ B. WING _____	C 11/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 161	Continued From page 12 On 11/16/12 at 11:45 am, the Administrative Staff #1 produced an email document from the corporate office which reflected that the bond had been increased to $70,000. The balance of the resident trust fund acount had been lowered to $27,271.04 after payments had posted.	F 161		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to ensure that residents were knowledgeable about the location of the state survey results. The findings include: On 11/15/12, the resident council minutes were reviewed from July, 2012 through Novemeber, 2012. The notes did not reflect any discussion of the location of survey results for the alert and oriented residents in attendance. The minutes reflected that Resident #13, the council president was present at each meeting.	F 167	F167 1. All residents are potentially at risk. 2. The Activity Director spoke with resident #13 and informed her where the location of the Facility Survey results are posted. 3. The Administrator in-serviced the Activity Director and the Social Services Director on the importance and requirement of discussing residents rights and the location of the Facility Survey results at each Resident Council Meeting each month.	12/14/12

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F 167	Continued From page 13 On 11/17/12 at 3:30 pm, Resident #13 was interviewed about the monthly resident council meetings. She stated that attended regularly and that she was aware of the kind of the information that was contained in a survey results book but she did not know where the book was located in the facility. On 11/17/12 at 3:40 pm, the Administrative Staff # 8 was interviewed. She shared that she had been in her position for two years and facilitated the monthly resident council minutes. She stated that she does not review the location of the state survey results book with the residents attending the council meetings.	F 167	4. The Administrator will each month review the meeting minutes to determine if these issues are being discussed each month. 5. The Activity Director will include in the meeting minutes a description of the council's discussion of these issues and present to the Quality Assurance Committee 1 x monthly x 12 months.	12/14/12
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to obtain a national criminal background check for 1 of 1 staff (NA #9) known to reside out of state, and failed to determine if a national criminal background check was required prior to employment for 5 of 5 staff (NA # 5, NA #6, NA #7, NA #8, NA #10): The findings included:	F 226	F 226 1. All residents are potentially at risk 2. NA #9 sent home on 11/15/12. Fingerprints obtained and resubmitted to North Carolina State Bureau of Investigation for National Criminal Background Check on 11/16/12. Employee #9 has not returned to work at this time and will be allowed to return to work as soon as National Criminal Background Check results returned with no issues identified. 3. NA # 5, #6, #7, #8, and #10 all had completed 5 year address history completed on 11/16/12.	12/14/12

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F 226	Continued From page 14 1. Review of the facility document dated as modified 5/4/09 and titled "Administrative Policies and Procedures Background Checks" revealed "At present this state law requires only State Wide background check for all employees working in a Long Term Care facility." There was also a hand written note that read "5 yrs or < (years or less) In State must obtain fingerprint cards, for federal check". Review of the employee file for NA #9 revealed the current residence address on her application was an out of state address (South Carolina). There was no information in her employee file to indicate she had lived in the State of North Carolina for the 5 years prior to hire at the facility. Interview with Administrative Staff #7 on 11/15/12 at 11 AM revealed she was aware that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years prior to the date of hire and acknowledged NA #7 ' s South Carolina address indicated a national background check should have been done. She stated that she recalled NA #7 submitting finger print cards prior to hire but she did not know what had happened to it and did not have the results of the national background check. She indicated that NA #7 would not work further shifts until a national background criminal history check was completed. 2. Review of the facility document dated as modified 5/4/09 and titled ' Administrative Policies and Procedures Background Checks " revealed " At present this state law requires only State Wide background check for all employees	F 226	4. All new applicants will complete a 5 year address history with application by Staffing Coordinator 5. Director of Nursing or Assistant Director of Nursing when conducting Interview will go over each applicant's addresses for the last 5 years to confirm address history upon interview of each perspective employee. 6. Any perspective employee who meets the criteria for requiring a National check will be given a fingerprint card and application will be held until card is returned. Fingerprint card will then be sent off for Background check by Staffing Coordinator 7. No one will be hired until acceptable Criminal Background Check is received and approved by the Administrator. 8. Human Resources will audit applications and Criminal Background Information sent to State Bureau of Investigation and report findings in Quality Assurance Meeting. Audits will be	12/14/12

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F 226	Continued From page 15 working in a Long Term Care facility. " There was also a hand written note that read " 5 yrs or < (years or less) in State must obtain fingerprint cards, for federal check ". a. Review of the employee file for NA #5, a recent hire at the facility revealed the staff member ' s current address was listed on application and was in North Carolina but no address history for the previous 5 years was listed. Also there was no information to indicate whether or not NA #5 resided in North Carolina for less than 5 years prior to the date of hire. On 11/15/12 at 11 AM interview with Administrative Staff #7 revealed she was aware that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years prior to the date of hire. She acknowledged that the employee file for NA #5 did not have any information that indicated whether or not these recent hires had resided in North Carolina for the past 5 years of not. She stated that she would obtain this information by asking them each to provide a 5 year address history. On 11/16/12 at 9 AM Administrative Staff #7 reported that NA #5 had completed a five year address history and had all resided in North Carolina for the past 5 years. On 11/16/12 at 3:30 PM during interview with Administrative Staff #2 she acknowledged that by only asking for current address prior to hire the facility has no way of knowing whether or not potential employees meet the State criteria for having a national criminal background check.	F 226	done weekly x4 weeks, monthly x 3months, and quarterly thereafter and reviewed by the Director of Nursing in monthly Quality Assurance meeting.	12/14/12

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F 226	Continued From page 16 b. Review of the employee file for NA #6, a recent hire at the facility revealed the staff member's current address was listed on application and was in North Carolina but no address history for the previous 5 years was listed. Also there was no information to indicate whether or not NA #6 resided in North Carolina for less than 5 years prior to the date of hire. On 11/15/12 at 11 AM interview with Administrative Staff #7 revealed she was aware that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years prior to the date of hire. She acknowledged that the employee file for NA #6 did not have any information that indicated whether or not these recent hires had resided in North Carolina for the past 5 years of not. She stated that she would obtain this information by asking them each to provide a 5 year address history. On 11/16/12 at 9 AM Administrative Staff #7 reported that NA #6 had completed a five year address history and had all resided in North Carolina for the past 5 years. c. Review of the employee file for NA #7, a recent hire at the facility revealed the staff member's current address was listed on application and was in North Carolina but no address history for the previous 5 years was listed. Also there was no information to indicate whether or not NA #7 resided in North Carolina for less than 5 years prior to the date of hire. On 11/15/12 at 11 AM interview with	F 226		

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F 226	Continued From page 17 Administrative Staff #7 revealed she was aware that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years prior to the date of hire. She acknowledged that the employee file for NA #7 did not have any information that indicated whether or not these recent hires had resided in North Carolina for the past 5 years of not. She stated that she would obtain this information by asking them each to provide a 5 year address history. On 11/16/12 at 9 AM Administrative Staff #7 reported that NA #7 had completed a five year address history and had all resided in North Carolina for the past 5 years. On 11/16/12 at 3:30 PM during interview with Administrative Staff #2 she acknowledged that by only asking for current address prior to hire the facility has no way of knowing whether or not potential employees meet the State criteria for having a national criminal background check. d. Review of the employee file for NA #8, a recent hire at the facility revealed the staff member ' s current address was listed on application and was in North Carolina but no address history for the previous 5 years was listed. Also there was no information to indicate whether or not NA #8 resided in North Carolina for less than 5 years prior to the date of hire. On 11/15/12 at 11 AM interview with Administrative Staff #7 revealed she was aware that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years	F 226		

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F 226	Continued From page 18 prior to the date of hire. She acknowledged that the employee file for NA #8 did not have any information that indicated whether or not these recent hires had resided in North Carolina for the past 5 years of not. She stated that she would obtain this information by asking them each to provide a 5 year address history. On 11/16/12 at 9 AM Administrative Staff #7 reported that NA #8 had completed a five year address history and had all resided in North Carolina for the past 5 years. On 11/16/12 at 3:30 PM during interview with Administrative Staff #2 she acknowledged that by only asking for current address prior to hire the facility has no way of knowing whether or not potential employees meet the State criteria for having a national criminal background check. e. Review of the employee file for NA #10, a recent hire at the facility revealed the staff member ' s current address was listed on application and was in North Carolina but no address history for the previous 5 years was listed. Also there was no information to indicate whether or not NA #10 resided in North Carolina for less than 5 years prior to the date of hire. On 11/15/12 at 11 AM interview with Administrative Staff #7 revealed she was aware that State law required a national criminal background check for any new employee that had not resided in North Carolina for the five years prior to the date of hire. She acknowledged that the employee file for NA #10 did not have any information that indicated whether or not these recent hires had resided in North Carolina for the	F 226		

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F 226	Continued From page 19 past 5 years of not. She stated that she would obtain this information by asking them each to provide a 5 year address history. On 11/16/12 at 9 AM Administrative Staff #7 reported that NA #10 had completed a five year address history and had all resided in North Carolina for the past 5 years. On 11/16/12 at 3:30 PM during interview with Administrative Staff #2 she acknowledged that by only asking for current address prior to hire the facility has no way of knowing whether or not potential employees meet the State criteria for having a national criminal background check.	F 226		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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	F 278	F278 1. All residents are potentially at risk. 2. MDS assessments for residents #4, #24, #30, #36, #37, and #41 corrected and resubmitted by the Minimum Data Set Coordinator. 3. All Minimum Data Set Assessments audited by Minimum Data Set Coordinator, Director of Nursing, Assistant Director of Nursing, and Clinical Care Coordinator using Minimum Data Set Audit tool. Inaccuracies corrected by Minimum Data Set Coordinator.	12/14/12

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F 278	Continued From page 20 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to accurately code Minimum Data Sets (MDS's) for 6 (Residents #4, #24, #30, #36, #37 and #41) of 27 residents. The findings included: 1. Resident #37 was readmitted to the facility on 4/27/12 with bilateral, unstageable pressure ulcers on her heels. The left heel ulcer was resolved on 7/27/12 but the right continued. The "Weekly Pressure Ulcer Progress Report" revealed that on 10/5/12, 10/25/12 and 10/31/12, the resident's pressure ulcer was unstageable. The quarterly MDS dated 10/18/12 listed Resident #37 with one stage 2 pressure ulcer. During an interview on 11/15/12 at 3:34 PM, Administrative Staff #4 indicated she coded the MDS's based on the "Skin/Wound QI Log", a form that was updated weekly by the treatment nurse. To demonstrate, Administrative Staff #4 revealed the Skin/Wound QI Log dated 10/31/12 on which Resident #37 was listed as having a stage 2 pressure ulcer. During an interview on 11/15/12 at 5:45 PM, the	F 278	4. Minimum Data Set Coordinator nurse in-serviced by the Director of Nursing on proper coding of restraints versus enablers. 5. Treatment nurse in-serviced by Director of Nursing on proper staging of wounds and how to complete the weekly wound report and documentation. 6. Social Services Coordinator in-serviced on proper coding of Minimum Data Set assessment for behaviors by Director of Nursing including review of nurses notes for documentation in look back period. 7. Audit of 30% of Minimum Data Set assessments completed each week up to 5 Minimum Data Set assessments per week will be done weekly x4 weeks, then monthly x3 months, then quarterly by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Clinical Care	12/14/12

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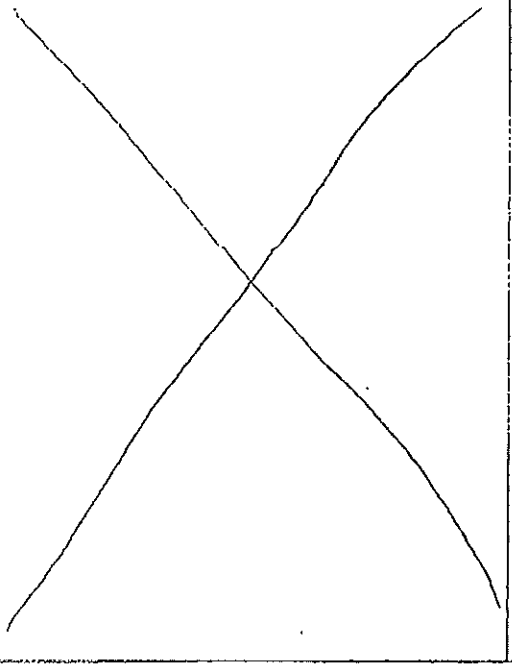
F 278	Continued From page 21 Treatment Nurse indicated she made an error and Resident #37's pressure ulcer should have been listed as unstageable on the Skin/Wound QI Log. During an interview on 11/17/12 at 9:27 AM, Administrative Staff #2 stated she expected the log to reflect what was recorded on the resident's Weekly Pressure Ulcer Progress Report. She added that the MDS nurse and physician rely on the data recorded on the log. 2. Resident #36 was admitted to the facility on 10/12/12. Diagnoses included urinary tract infection. Nurse's notes dated 10/13/12 at 6AM indicated Resident #36 was confused, refused care and medications, and was physically and verbally combative towards nursing assistants. The admission Minimum Data Set (MDS) dated 10/19/12 was coded to indicate Resident #36 had no behavioral symptoms or rejection of care from 10/13/12 - 10/19/12. During an interview on 11/16/12 at 2:55 PM, Administrative Staff #5 stated she normally reviewed nurse's notes prior to coding MDS's, and acknowledged that she had coded Resident #36's behaviors incorrectly. 3. Resident #30 was admitted to the facility on 5/9/07. Diagnoses included a hip fracture. The quarterly Minimum Data Set (MDS) dated 11/4/12, was coded to indicate the resident used bed rails as a restraint and a chair that prevents	F 278	Coordinator, or any appropriate staff appointed by the Director of Nursing. Minimum Data Set assessment Quality Assurance audit tool will be completed by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or Clinical Care Coordinator. B. Results of MDS audit will be presented in Quality Assurance meeting monthly x 3months then quarterly thereafter by the Director of Nursing 	12/14/12

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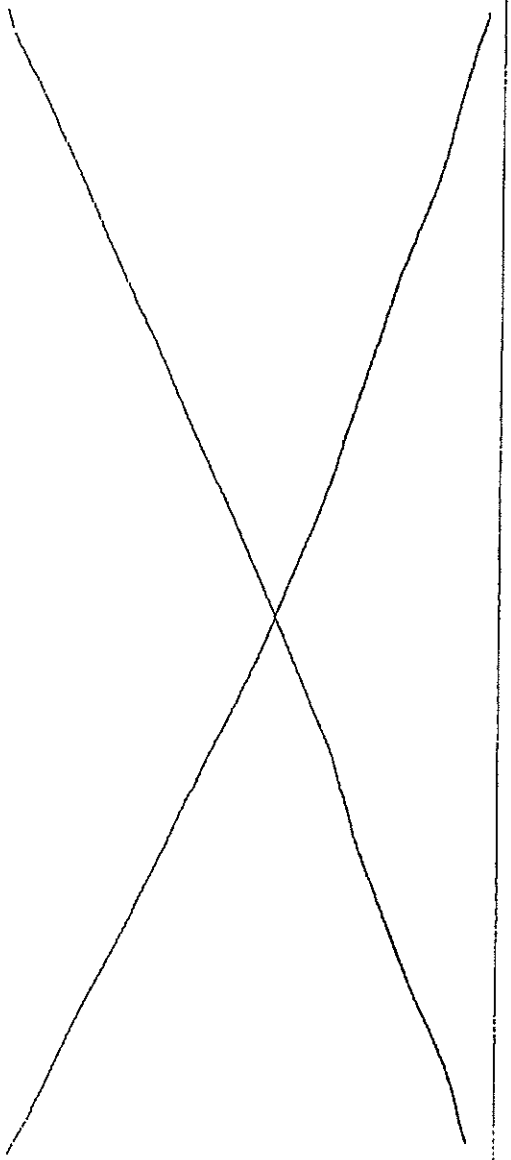
F 278	Continued From page 23 During interview with Administrative Staff #2 on 11/16/12 at 3:30 PM she stated that the half rails on Resident #24 ' s bed were not a restraint as she just used them as an enabler for turning with her good arm and did not try to get out of bed. She added that the seatbelt in Resident #24 ' s chair was not a restraint as the resident could undo it and in addition it was put on her chair at her request several years ago. During interview with Administrative Staff #4 on 11/16/12 at 4 PM she indicated that she coded all side rails and wheelchair seat belts as restraints because there was no other place to include them on the MDS. She further indicated she was not aware it was incorrect to code these devices as a restraint, if that was not their function, but that she clarified in the Care Area Assessment that these devices were not physical restraints and therefore did not proceed to care plan. 5. Resident #4 was admitted to the facility on 3/28/12. Diagnoses included cardiovascular accident. The quarterly Minimum Data Set (MDS) dated 8/29/12, revealed the resident was cognitively intact. The MDS was coded to indicate the resident used bed rails as a restraint. During an interview on 11/14/12 at 10:36 AM, Nursing Nurse #3 indicated that Resident #4 was not capable of getting out of bed on her own and never tried to get out of bed on her own. She added that the half rails on the bed were enablers for turning and repositioning. During interview with Administrative Staff #2 on	F 278		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346609	A. BUILDING _____ B. WING _____	C 11/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	916 PEE DEE ROAD ABERDEEN, NC 28315

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F 278	Continued From page 24 11/16/12 at 3:30 PM she stated that the half rails on Resident #4 ' s bed were not a restraint as she just used them as an enabler for turning with her good arm and did not try to get out of bed. She added that Resident #4 did not like to get out of bed and would agree to get up with assistance only about once a month. During interview with Administrative Staff #4 on 11/16/12 at 4 PM she indicated that she coded all side rails as restraints because there was no other place to include them on the MDS. She further indicated she was not aware it was incorrect to code these devices as a restraint, if that was not their function, but that she clarified in the Care Area Assessment that these devices were not physical restraints and therefore did not proceed to care plan. 6. Resident #41 was admitted to the facility on 9/5/11 with osteoporosis and cerebral vascular accident. On the quarterly Minimum Data Set (MDS), 8/27/12, she was coded as having disorganized thinking, needing extensive assistance with transfers and had no activity of walking in her room or on the corridor. The MDS also listed her as having no falls and stated that bed rails were used daily as a physical restraint, as well as a chair, that prevented rising. On 11/13/12 at 10:00 am, Resident #41 was observed sitting in a reclined wheelchair, eating breakfast. She made no attempts to get up unassisted. On 11/14/12 at 2:00 pm, she was observed sitting in her reclining wheelchair, never attempting to get up. The Administrative Staff #2 was interviewed on	F 278		

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F 278	Continued From page 25 11/16/12 at 3:00 pm, and stated that Resident #41 cannot ambulate independently or with assistance. She further stated that she hadn't tried to stand or propel herself in her wheelchair. She added that she was in a reclining wheelchair for comfort and that it should not have been coded as a restraint. Regarding the bed rails used for Resident #41, she stated that they do not prevent her from rising and that she does not attempt to get out of bed, in fact, she laid very still in bed. She shared that the rails are used an enabling device and should not be coded as a physical restraint.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 needs that are identified in the comprehensive assessment. 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).	F 279	F 279 1. All residents are potentially at risk. 2. Care Plans for residents # 29 and #30 corrected by Minimum Data Set Coordinator. 3. All Dialysis resident's Care Plans audited by Clinical Care Coordinator on 12/13/12. Fluid restrictions and checking of shunt for thrill and brult added as well as no B/P in arm with shunt (specific arm identified on each one) and added to the Kardex for CNA staff by Clinical Care Coordinator.	12/14/12

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F 279	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and a nursing reference, the facility failed to develop comprehensive care plans for 2 (Residents #29 and #30) of 27 residents. The findings included: 1. During an interview on 11/16/12 at 9:13 AM, Administrative Staff #2 indicated the facility did not have a policy that addressed securing or anchoring indwelling catheters. She said for care issues for which the facility had no policy, staff used the "Lippincott Manual" as a standard of nursing practice. The "Lippincott Manual of Nursing Practice", 9th Edition, included the following under care of suprapubic catheters: "Nursing Action: Secure drainage tubing to lateral abdomen with tape. Rationale: Prevents undue tension on the catheter." Resident #30 was admitted to the facility on 5/9/07. Diagnoses included benign prostatic hypertrophy with urinary retention, and suprapubic catheter. The resident's care plan, last reviewed 10/3/12, included a problem of catheter use. Interventions included encourage hydration, change suprapubic catheter weekly, irrigate with normal saline as needed. There was no physician order or care plan intervention for securing the catheter. On 11/15/12 at 8:11 AM and 11/17/12 at 9:33 AM, the suprapubic catheter was observed unsecured.	F 279	4. All Care Plans of all residents with catheters audited by Clinical Care Coordinator on 12/13/12 and intervention to secure catheter added to each Care Plan and Kardex by Clinical Care Coordinator. 5. All Care Plans will be brought to daily Department head meeting along with new orders from the previous day and Care Plans will updated by Minimum Data Set Coordinator, Director of Nursing, Assistant Director of Nursing and Clinical Care Coordinator. b. 20% of all Care Plans will be audited monthly by Director of Nursing, Assistant Director of Nursing, Clinical Care Coordinator, and Staff Development Coordinator for accuracy using the Care Plan Quality Assurance Audit tool. Results of these audits will be reviewed in Quality Assurance meeting monthly x 3 months	12/14/12

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F 279	Continued From page 27 During an interview on 11/17/12 at 9:33 AM, Nursing Assistant #3 stated she had not been told to secure the resident's catheter. During an interview on 11/17/12 at 5:25 PM, Administrative Staff #4 stated that she did not include securing the catheter on the care plan because that was part of routine catheter care and staff was expected to know to secure the catheter. #2. Resident #29 was admitted to the facility on 9/9/12. Cumulative diagnoses included: end stage renal disease on hemodialysis, Diabetes Mellitus and Hypertension. An Admission Minimum Data Set (MDS) dated 9/13/12 indicated Resident #29 received dialysis treatment. A Care plan dated 9/28/12 indicated Resident #29 was at risk for fluid overload related to renal failure. Goals included: will receive dialysis as ordered through next assessment; will have no signs and/or symptoms of fluid overload through next assessment. Interventions included: assess for signs and/or symptoms of fluid overload; labs per physician orders; assist resident to get ready for dialysis; encourage adequate rest periods; monitor lower extremities for edema. The Care plan did not address the assessment of the dialysis site (access site was a shunt located in the left upper arm) and Resident #29's fluid restriction.	F 279	and quarterly thereafter by the Director of Nursing. 7. Minimum Data Set Coordinator and care plan team in-serviced by Director of Nursing on 12/14/12 on how to do individualized resident care plans.	12/14/12

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F 279	Continued From page 28 A physician's order dated 9/30/12 was noted for fluid restriction 1000 cubic centimeters (cc) per twenty-four (24) hours. Physician's orders for November 2012 revealed an order to check thrill and bruit at shunt site every shift. On 11/16/12 at 2:33 PM., Administrative staff #4 stated she created the care plan from information that was in the computer. If Resident #29 had a different need or changes needed to be made to the care plan, Administrative staff #4 would make the changes as needed. Administrative staff #4 stated the care plan for Resident #29 should have included the location of the shunt, monitoring of the shunt for thrill and bruit, not to take blood pressure in Resident #29's left arm, and the fluid restriction of 1000 cc. per twenty-four (24) hours. On 11/16/12 at 2:40 PM., Administrative staff #2 stated the care plan for any dialysis resident including Resident #29 should include monitoring of shunts for thrill and bruit and blood pressure restrictions for shunt site. Fluid restriction should also be addressed on the dialysis care plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	F 280 1. All residents are potentially at risk. 2. Resident #37 Care Plan corrected to reflect Multipodis Boot discontinued by the Clinical Care Coordinator on 11/16/12. Kardex updated to inform with direct care staff.	12/14/12

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F 280	Continued From page 29 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to review and revise care plans for 1 (Residents #37) of 27 residents. The findings included: Resident #37 was readmitted to the facility on 4/27/12. Diagnoses included subarachnoid hemorrhage, rib fractures, pelvic pain, coronary artery disease and peripheral artery disease. The Admission Minimum Data Set (MDS) dated 5/4/12 indicated Resident #37 had memory problems, severe impairment of cognitive skills for daily decision making, did not reject care, required extensive assistance of 2 for bed mobility, and had 2 unstageable pressure ulcers with suspected deep tissue injury. Physician orders dated 5/23/12 included "multipodus boots for heel decubitis". Review of monthly Physician Orders revealed the order for the multipodus boots was still active through November 2012.	F 280	3. All resident's Care Plans audited for accuracy by Minimum Data Set Coordinator, Director of Nursing, Assistant Director of Nursing, and Clinical Care Coordinator with audit completed on 12/14/12. Kardex for each resident updated to reflect Care Plan for CNA's and all Direct care staff by Clinical Care Coordinator on 12/14/12 with updated Kardex placed in CNA documentation books to ensure communication of changes to all direct care staff. 4. 20% of all Care Plans will be audited monthly by Director of Nursing, Assistant Director of Nursing, Clinical Care Coordinator, and Staff Development Coordinator for accuracy using the Care Plan Quality Assurance Audit tool. Results of these audits will be reviewed in Quality Assurance meeting monthly x 3 months and quarterly thereafter by the Director of Nursing.	12/14/12

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F 280	Continued From page 30 Resident #37 care plan, last reviewed on 11/2/12, included pressure ulcers as a problem but use of a multipodus boot was not included as an intervention. During an interview on 11/15/12 at 3:34 PM, Administrative Staff #4 indicated that it was an oversight not to include the multipodus boot on the care plan.	F 280	5. Care Plan Team - Minimum Data Set Coordinator, Activities Director, Social Services Coordinator, Dietary Manager, and Willow Springs Unit Coordinator - In-serviced by Director of Nursing on 12/14/12 on how to do individual resident care plans.	12/14/12
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to follow the care plan for pressure ulcers by not performing weekly pressure ulcer skin assessments for two (2) of three (3) residents with pressure ulcers (Resident # 91 and #93). Findings included: 1. Resident #91 was admitted to the facility 4/29/10. Cumulative diagnoses included: multiple sclerosis, sacral decubitus and urinary incontinence. A Quarterly Minimum Data Set (MDS) indicated Resident # 91 had a stage four (4) pressure ulcer at the time of the assessment. The pressure ulcer had been present on the prior assessment dated 7/22/12.	F 282	F 282 1. All residents are potentially at risk. 2. Pressure ulcer weekly documentation sheets completed on residents # 91 and #93 with accurate staging and description of wound by Clinical Care Coordinator. 12/7/12 3. Treatment nurse in-serviced by the Director of Nursing on proper staging of wounds and how to complete the weekly wound report. 4. Complete audit of Treatment records along with MD orders to be completed and clarification orders written as needed by the Treatment nurse.	12/29/12

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F 282	Continued From page 31 A Pressure Ulcer Risk form dated 10/23/12 indicated a score of eleven (11) which made Resident #91 a high risk for pressure ulcers. A Care Plan dated 8/24/12 indicated Resident #91 was at risk for impaired skin integrity/ pressure ulcers due to fragile skin, decreased mobility and incontinence. Goal included: Resident will have all skin breakdown and pressure ulcers show improvement through next assessment. Interventions included, in part, monitor and measure wound weekly for improvement and/or decline; change treatment as needed; notify MD as needed. A review of the Weekly wound/ pressure ulcer progress reports revealed no documentation of the pressure ulcer was recorded for the month of August, 2012 and the first week in September 2012. Documentation of the pressure ulcer was noted on 7/31/12 with the next entry being on 9/19/12. On 11/16/12 at 9:40 AM., the Treatment nurse stated she had been doing the wound care for one month so did not know why nothing was documented for August and the first week in September. On 11/17/12 at 9:24 AM, Administrative staff #2 stated the wound care nurse (treatment nurse) should document on the Weekly wound/ pressure ulcer progress report sheets after the standards of care meeting which was held every Thursday. She indicated she expected the Weekly wound/ pressure ulcer progress report for Resident #91 to be done weekly and reflect the actual wound	F 282	5. Treatment Administration Records will be brought to weekly Standards of Care meeting (with Director of Nursing, Assistant Director of Nursing, Administrator, Therapy Manager, Minimum Data Set Coordinator, Clinical Care Coordinator, Dietary Manager, and Willow Springs unit Coordinator) by Treatment Nurse for review of wounds. Treatment nurse will document weekly treatment notes at this time to include wound healing progress and that wound was reviewed in Standards of Care meeting. All TAR's will be brought to weekly Standards of Care meeting and weekly treatment nurses notes will be documented there.	12/24/12

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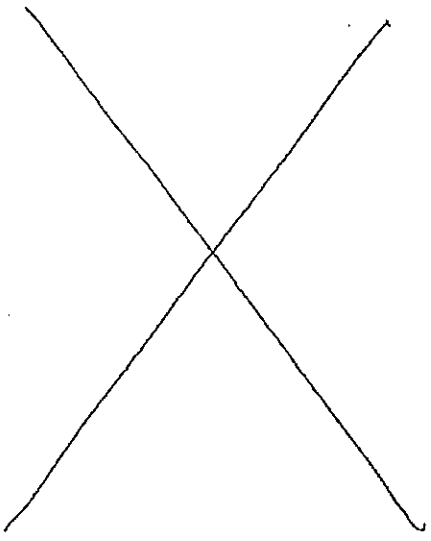
F 282	Continued From page 32 stage and measurements. 2. Resident #93 was admitted to the facility 8/14/12. He was discharged to the hospital 8/19--8/24/12 following a fall resulting in a fracture of the right hip. Other diagnoses included: Alzheimer's disease and Diabetes Mellitus. A Pressure Ulcer Risk form dated 8/14/12 revealed a total score of nine (9) which indicated Resident #93 was at high risk for pressure ulcers. An Admission Minimum Data Set (MDS) dated 8/31/12 indicated Resident #93 was at risk for pressure ulcers. During the assessment period, Resident #93 had two (2) unstageable pressure ulcers (known but not stageable due to the presence of slough and/or black tissue covering the wound bed). A Care Plan dated 8/31/12 indicated Resident #93 was at risk for impaired skin integrity/ pressure ulcers. Goals included: Resident will have all skin breakdown/ pressure areas show improvement through next assessment. Interventions included, in part, monitor and measure wound weekly for improvement and/or decline. A review of the medical record revealed there was not an initial pressure ulcer wound assessment or any Weekly wound/ pressure ulcer progress reports. On 11/16/12 at 5:03 PM., Administrative staff #2 stated documentation of pressure ulcer areas are completed on the Weekly Pressure Ulcer	F 282	6. Monthly audit of wound documentation, Treatment Administration Records, Physicians Orders, and visualization of the wound by Director of Nursing, Assistant Director of Nursing or Clinical Care Coordinator will be completed and documented on Wound Quality Assurance Audit Tool. Results of Audit will be addressed in Quality Assurance by the Director of Nursing monthly x3 and quarterly thereafter. 	12/26/12

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F 282	Continued From page 33 documentation form by the wound care (treatment) nurse until all areas are healed. Administrative staff #2 indicated she expected to see a note regarding the progress and/or decline of the wound on the pressure ulcer documentation form. On 11/16/12 at 5:35 PM., the Treatment nurse stated she could not say where the pressure ulcer documentation was for the sacrum area and indicated it should have been in the wound care book.	F 282		
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 record review and staff interview, the facility failed to assess and treat a leg wound for 1 (Resident #36) of 4 residents reviewed for wound care. The findings included: Resident #36 was admitted to the facility on 10/12/12. Diagnoses included hip contusion and venous ulcer of the left calf. Orders from the wound clinic dated 10/16/12 revealed an order for daily medihoney calcium alginate dressing to the left lower leg wound.	F 309	F309 1. All residents with orders for wound treatments are potentially at risk. 2. Resident #36 was discharged from the facility prior to survey, unable to correct for this resident as she is no longer here. 3. Complete Audit of treatment orders and Treatment Administration Record to ensure all wound care medications present and available completed by Assistant Director of Nursing with all medications found to be present. 4. Treatment nurse in-serviced by the Director of Nursing on all aspects of the wound care program including MD notification of any issues such as ordered	12/20/12

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F 309	Continued From page 34 Review of treatment notes revealed: 10/17/12, "Resident refused treatment as ordered." On 10/18/12: "Explained to resident and daughter that we were waiting for the medihoney to perform with dressing change to left lower leg." 10/19/12: "Performed treatment to left lower leg as ordered without problems." Review of the Treatment Administration Record (TAR) revealed initial treatment to the left leg wound was 10/18/12 by the Treatment Nurse. The record had no documentation of an assessment of the wound including size, appearance, drainage or odor. During an interview on 11/16/12 at 10:07 AM, the Treatment Nurse indicated that the resident refused the treatment on 10/17/12 because she thought the physician was supposed to remove the skin graft on her leg. On 10/18/12 the resident was willing to receive the treatment but the medihoney calcium alginate had not come from the pharmacy. The Treatment Nurse indicated that she made Administrative Staff #2 aware that the medihoney calcium alginate had not come in, but did not notify the physician of the delay in treatment or ask if an alternate treatment was advisable until the medihoney calcium alginate was available. During an interview on 11/17/12 at 4:53 PM, Administrative Staff #2 stated she had been in contact with the pharmacy daily to obtain the medihoney calcium alginate. She added that she would have expected the Treatment Nurse to notify the physician, and to document initial and weekly descriptions of any wounds including	F 309	treatment not available, wound assessment, documentation of wound assessment, doing wound care as ordered, and notifying Clinical Care Coordinator if she has any problems with obtaining ordered wound treatment supplies. 5. Director of Nursing spoke with Pharmacist and arranged to have 2 tubes of medihoney kept in stock in the Director of Nursing Office. Pharmacy will flag company account to send medihoney when ordered - as this is an OTC medication it was on the list of do not send medications. 6. Monthly audit of wound documentation, Treatment Administration Records, Physicians Orders, and visualization of the wound by Director of Nursing, Assistant Director of Nursing or Clinical Care Coordinator will be completed and documented on Wound Quality Assurance Audit Tool. Results of Audit will be addressed in Quality Assurance by the Director of Nursing monthly x3 and quarterly thereafter.	12/14/12

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	345509	A. BUILDING _____ B. WING _____	C 11/17/2012

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KINGSWOOD NURSING CENTER	916 PEE DEE ROAD ABERDEEN, NC 28315

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F 309	Continued From page 35 measurements, appearance, drainage and the periwound appearance.	F 309		
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, staff interview and record review, the facility failed to assess and implement interventions as ordered for the treatment of pressure ulcers for 3 (Residents #37, #91 and #93) of 3 residents. The findings included: Resident #37 was readmitted to the facility on 4/27/12. Diagnoses included subarachnoid hemorrhage, rib fractures, pelvic pain, coronary artery disease and peripheral artery disease. The Admission Minimum Data Set (MDS) dated 5/4/12 indicated Resident #37 had memory problems, severe impairment of cognitive skills for daily decision making, did not reject care, required extensive assistance of 2 for bed mobility, and had 2 unstageable pressure ulcers with suspected deep tissue injury. The May Treatment Administration Record (TAR)	F 314	F314 1. All residents are potentially at risk. 2. Order obtained for resident #37 to discontinue Multipodis boots on 11/16/12. Care Plan and Kardex updated by Clinical Care Coordinator. 3. Clinical Care Coordinator spoke with Resident #91 MD regarding wound clinic appointment and need for authorization. Resident #91 refused Wound Care Clinic and informed Clinical Care Coordinator that she will not go. Order obtained to discontinue previous order for Wound Care Clinic by Clinical Care Coordinator on 12/13/12. 4. Clarification order for resident #93 obtained to change order to Bunny boots bilaterally by Clinical Care Coordinator on 12/14/12 and Care Plan, Kardex, and Treatment Administration Record updated.	12/29/12

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F 314	Continued From page 36 included Skin Prep to bilateral heels daily. Physician orders dated 6/23/12 included "multipodus boots (a protective orthosis that minimizes the risk of pressure on the heel) for heel decubitis". The June TAR revealed the order was changed from Skin Prep to a hydrogel product to both heels daily until ulcers were resolved. The June TAR also indicated Resident #37 used the multipodus boots on the 3-11 shift except for 1 refusal on 6/26/12. The July TAR revealed the treatment to the right heel was changed to an enzyme ointment on 7/18/12. The left heel wound was resolved on 7/27/12. The July TAR listed the multipodus boots for heel decubitis as a treatment but handwritten in was "FYI". The TAR lacked documentation that the boots were actually used. TAR's from August through November indicated the enzyme treatment for the right heel was continued daily, and the multipodus boot remained listed as an FYI without documentation of actual use. Right heel pressure ulcer measurements included: 5/9/12: unstageable 2 by 3 cm (centimeter), area dark red; 8/31/12: 3 by 4.2 by 0.2 cm; 10/5/12: 4 by 3 cm, unstageable due to wound bed covered with yellow slough; 10/25/12 and 10/31/12: 3 by 3 cm, unstageable with wound bed red and moist; 11/8/12 and 11/14/12: 3 by 3 cm, unstageable with wound bed yellow slough. On 11/16/12 at 8:35 AM, Resident #37 was	F 314	5. Complete audit of Treatment records along with MD orders to be completed. MD notified of any clarification orders received and written as needed by the Treatment nurse. 6. Clinical Care Coordinator will review all new treatment/wound care orders daily with the Treatment nurse to include new treatments, consultation orders, and preventive equipment orders. Both the Clinical Care Coordinator and the Treatment nurse will sign off on the orders noting that they have been checked, and will then pass them to the MDS nurse to update the Care Plan. 7. Monthly audit of wound care program to include Treatment Administration Records, consults, preventive devices, and wound documentation will be completed and documented on Wound Quality Assurance Audit Tool by Director of Nursing, Assistant	12/09/12

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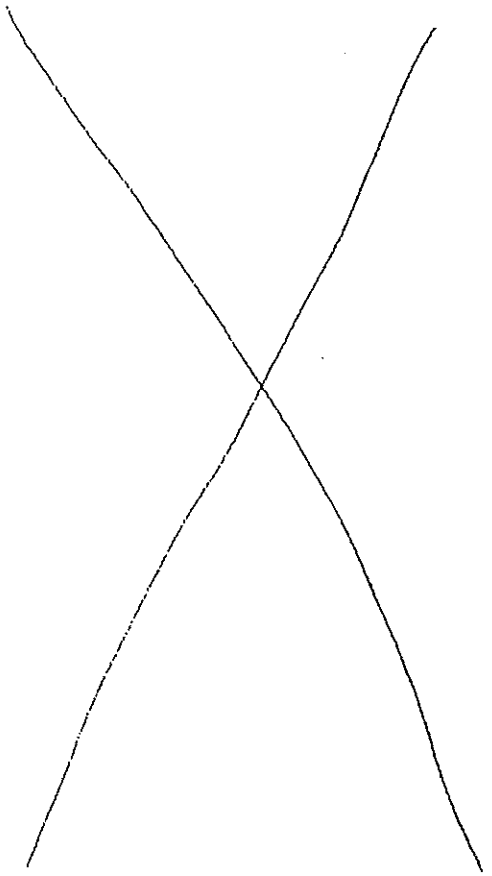
F 314	Continued From page 37 observed in her wheelchair. Her right foot had a dressing and paper bootie to cover the foot. The resident ' s foot was resting on the wheelchair foot rest. There was no visible source of pressure to her heel. At 2:35 PM, Resident #37 was observed in bed lying on her back. A pillow was under her knees and lower legs but her heels were resting on the bed. The multipodus boot was lying on her dresser. During an interview on 11/15/12 at 2:35 PM, Nursing Assistant (NA) #1 stated she did not know what the multipodus boot was and she had never put it on the resident. During an interview on 11/15/12 at 5:30 PM NA #2 stated she frequently took care of Resident #37 on the 3-11 shift but was never told to put the multipodus boot on her. During an interview on 11/16/12 at 1:48 PM, Administrative Staff #2 said she expected the multipodus boot to be worn when the resident was in bed. #2 Resident #91 was admitted to the facility 4/29/10. Cumulative diagnoses included: multiple sclerosis, sacral decubitus and urinary incontinence. A Quarterly Minimum Data Set (MDS) indicated Resident #91 had a stage four (4) pressure ulcer at the time of the assessment. The pressure ulcer had been present on the prior assessment dated 7/22/12. A physician's progress note dated 7/18/12	F 314	Director of Nursing, Clinical Care Coordinator. Results of audit will be addressed by Director of Nursing in Quality Assurance meeting monthly x3 and quarterly thereafter. 	12/29/14

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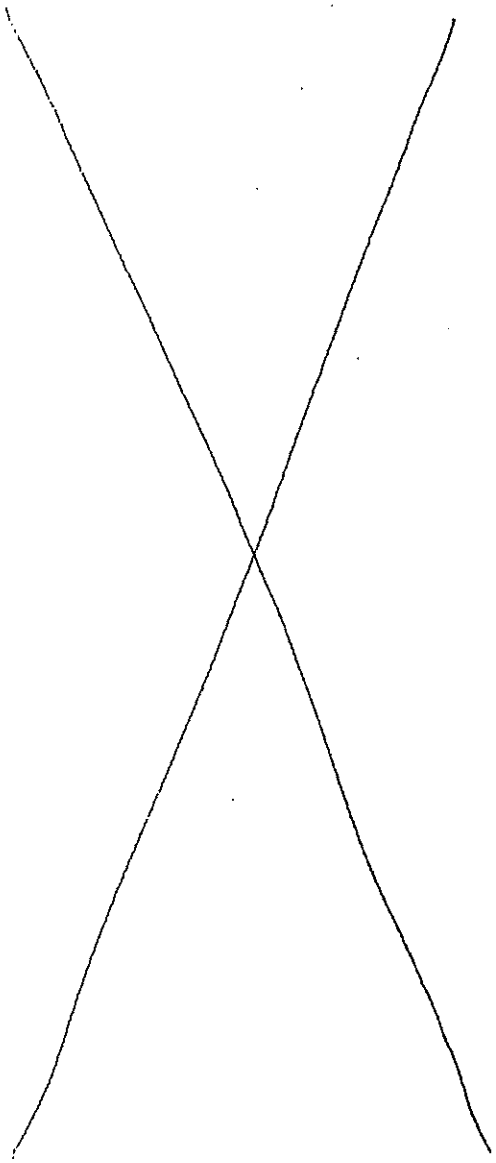
F 314	Continued From page 38 indicated Resident #91 had a slow decline but the stage IV (4) decubitus had been stabilized with wound care. Resident #91 had agreed to go to the wound clinic. A review of the medical record revealed no consultation from the wound clinic from July 2012 through November 2012. On 11/17/12 at 9:34 am, ward clerk #1 stated Resident #91 had a type of insurance that required the physician to obtain authorization for a wound clinic appointment. She stated the physician had written an order in July and asked her to make the appointment. She said she notified the clinical coordinator that the physician had to get the authorization and she had not been asked again to obtain an appointment for Resident #91. On 11/17/12 at 10:00AM., Administrative staff #2 stated the physician had not written an order for the wound care clinic and must have verbally spoken to nursing staff about making the appointment. She did not know if an appointment had been made. On 11/17/12 at 10:50 AM., Nurse #1 stated she was the one who called regarding the wound care appointment in July because the physician had asked her to find out about obtaining authorization for the wound clinic. Nurse #1 said she and ward clerk #1 talked about who would do the authorization but never came to a conclusion as to who would obtain the authorization. Nurse #1 stated nothing was done after that conversation to obtain authorization and the appointment with the wound clinic was never	F 314		

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F 314	Continued From page 39 made. #3 Resident #93 was admitted to the facility 8/10-8/14/12. He was discharged to the hospital 8/10--8/24/12 following a fall resulting in a fracture of the right hip. Other diagnoses included: Alzheimer's disease and Diabetes Mellitus. A physician's order dated 8/30/12 indicated Resident #93 was to wear a right boot to prevent hip internal rotation and to decrease heel pressure and a left boot to decrease heel pressure. An observation on 11/14/12 at 3:24 PM. revealed Resident #93 in bed. Resident #93 was wearing a boot on the left foot. There was not a boot on the right foot. On 11/16/12 at 3:30 PM., NA #2 stated Resident #93 had pressure relief boots for his feet--a fluffy boot on one foot and a boot with a support on it on the other foot. When asked how she knew what equipment was used for Resident #93, she stated she would ask another nursing assistant or the nurse on the hall. It was also noted in the care plan book for nursing assistant in the kardex at the nursing station. An observation on 11/16/12 at 3:42 PM. revealed Resident #93 sleeping in bed. He was not wearing any boots at that time. A pressure relief boot was noted in the chair. A review of the Kardex for Resident #93 revealed there were no boots listed to be applied for Resident #93.	F 314		

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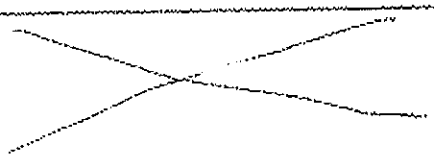
F 314	Continued From page 40 ON 11/17/12 at 10:00 AM., Administrative staff #2 stated she expected staff to follow physician's orders and Resident # 93 should wear bilateral pressure relief boots as ordered by the physician.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and nursing reference, the facility failed to secure a urinary catheter for 1 (Resident #30) of 2 residents. The findings included: During an interview on 11/16/12 at 9:13 AM, Administrative Staff #2 indicated the facility did not have a policy that addressed securing or anchoring indwelling catheters. She said for care issues for which the facility had no policy staff used the Lippincott Manual as a standard of nursing practice. The "Lippincott Manual of Nursing Practice", 9th Edition, included the following under care of suprapubic catheters: "Nursing Action: Secure drainage tubing to lateral abdomen with tape.	F 315	F315 1. All residents are potentially at risk. 2. Resident # 30's catheter was secured to his abdomen with tape and this was added to the TAR, Kardex, and Care plan by Clinical Care Coordinator on 12/11/12 3. Care plans and Kardex's for all residents with Supra Public catheters audited by Clinical Care Coordinator using Catheter Audit tool and corrected to include securing of catheters to the abdomen. 4. All residents with Supra Public catheters will have secure catheter tubing to the abdomen added to the Treatment Administration Record by the Treatment Nurse to be checked and documented by the nurse each shift.	12/14/12

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F 315	Continued From page 41 Rationale: Prevents undue tension on the catheter." Resident #30 was admitted to the facility on 5/9/07. Diagnoses included benign prostatic hypertrophy with urinary retention, and suprapubic catheter. The resident's care plan, last reviewed 10/3/12, included a problem of catheter use. Interventions included encourage hydration, change suprapubic catheter weekly, irrigate with normal saline as needed. There was no physician order or care plan intervention for securing the catheter. On 11/15/12 at 8:11 AM the suprapubic catheter was observed unsecured. During an interview on 11/16/12 at 9:13 AM, Administrative Staff #2 stated that they had tried using adhesive securing devices but the resident just picked them off. She could not recall attempting any alternative measures that did not involve adhesive to the skin. On 11/17/12 at 8:32 AM, Administrative Staff #2 stated the facility had just received some new leg straps for securing catheter tubing. The leg straps fastened with Velcro and thus adhesive was not required. On 11/17/12 at 9:33 AM, Resident #30's suprapubic catheter was observed unsecured. Nursing Assistant (NA) #3 stated that she had not been told to secure the catheter. This was her first week-end to take care of him. During an interview on 11/17/12 at 5:25 PM,	F 315	5. Licensed and non-licensed Nursing staff will be in-serviced on the procedure for securing Supra Public catheter tubing to the abdomen by the Clinical Care Coordinator or Director of Nursing using an employee roster to ensure all staff are in-serviced. Nursing staff will be in-serviced as they return to work until all Nursing staff has received in-service. 6. Catheter Audit tool will be completed by the Clinical Care Coordinator or Director of Nursing weekly x4, monthly x3, and quarterly thereafter and discussed in Quality Assurance meeting by the Director of Nursing.	12/14/12

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F 315	Continued From page 42 Administrative Staff #4 stated that she did not include securing the catheter on the care plan because that was part of routine catheter care and staff was expected to know to secure the catheter.	F 315		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. 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: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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.	F 356	F 356 1. All residents are potentially at risk. 2. Staffing information will be posted at nurses station each shift by the shift supervisor. 3. Shift Supervisor's will be In-serviced by the Director of Nursing on how to complete the Daily Staffing Sheet including deduction of HFA beds fro the total census, counting only direct care staff, and deducting time spent providing care to HFA residents from the total number of direct care hours. 4. Staffing sheets will be completed at the beginning of each shift by the Shift Supervisor including the number of staff working, total hours worked by each	12/14/12

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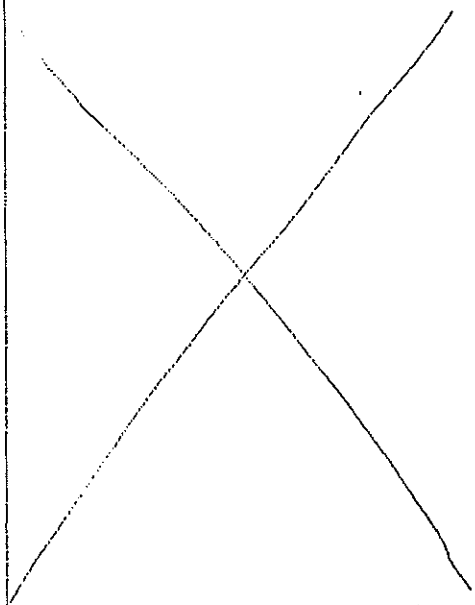
F 356	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to record accurate information on the daily staff posting. The findings include: On 11/13/12 at 12:19 pm, the daily staff posting was observed on a wall next to the Greenbrier hallway, which was across from the nurse's station. On the form, the daily staff posting for 11/7/12 hung on the wall. No actual hours were recorded for any of the nursing staff. On 11/14/12 at 9:45 am, the daily staff posting from 11/13/12 hung on the wall, across from the nurse's station. No actual hours were recorded for any of the nursing staff. The Administrative Assistant was interviewed on 11/15/12 at 11:45 am. She stated she was responsible for handling the daily staff posting with the exception of weekends. At the beginning of her work day, she explained that she filled out the data for registered nurses (RN), licensed practical nurses (LPN), nurse aides (NA), medication aides (MA) and resident census. Then she stated that it was the responsibility of the charge nurse to update the changes with staff and census per shift. She shared that she included residents in the rest homes in the census count for the residents receiving skilled nursing care. Also, she stated that she was instructed by the Director of Nursing (DON) to list the Assistant Director of Nursing	F 356	discipline, and the total census for that shift (minus the Assisted Living beds) and signed by the person completing the form. 5. Staffing sheets will be monitored daily x4 weeks, weekly x3 months, and monthly thereafter using Staffing Sheet Audit Tool by the Director of Nursing with results reported in Quality Assurance meeting by the Director of Nursing. 	12/14/12

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F 356	Continued From page 44 (ADON) under her Registered Nurses (RN) count, although she was aware that the ADON was not on a medicine cart or giving patient care. The Administrative Assistant acknowledged that they were not capturing the total actual hours worked for the RN, LPN, NA and MA, per shift. She was unable to offer an explanation why the daily staffing hadn't been changed and posted for six days, even though she worked weekdays during this time period. She was unsure why the staff posting was not posted at the beginning of yesterday's shift, as well. The Director of Nursing was interviewed on 11/15/12 at 3:20 pm. She commented that she believed that she was required to post a RN on duty, at least once a day on the daily staffing since the facility actively had more then 60 residents. Therefore, she instructed the Administrative Assistant to post her ADON usually under the hours for the RN. She did add that on the weekends, the ADON was called to the floor and was actually working with residents, therefore she felt it was accurate to record her hours then. She shared that the Administrative Assistant was on leave earlier in the year and another employee helped to complete the daily staff posting. Since her return, she stated that the two staff members sometimes got confused whose responsibility it was to update the daily staff posting, which was probably the reason why it was overlooked from 11/7/12 to 11/13/12. The DON stated that she would make changes to	F 356		

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	345509	A. BUILDING _____ B. WING _____	C 11/17/2012

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 356	Continued From page 45 the form, to include the actual hours worked per discipline, omit counting the rest home residents in the census, re-orientate her staff on the proper instructions to complete the staffing and assign just one employee to complete the task moving forward.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to (1) refrigerate soy sauce and salsa after opening, (2) date items when opened and (3) ensure hands and gloves were clean prior to handling food. The findings included: 1. During the initial tour of the kitchen on 11/13/12 at 10:45 AM, a bottle of soy sauce dated as opened 11/1/11 and a container of chunky salsa dated as opened 3/21/11 were observed stored in the dry storage room. Both were labeled, "Refrigerate after opening". The Dietary Manager said during an interview on 11/17/12 at 10:45 AM that she had seen the soy sauce and salsa in the dry storage area and	F 371	F371 1. All resident are potentially at risk. 2. The undated items that needed refrigeration were immediately discarded. The opened but undated items in the walk-in cooler were discarded or dated appropriately immediately. 3. A mandatory meeting was called so that ALL Dietary Staff were in attendance and in-serviced on reading each item they open for storage instructions for any left over amounts and the proper way to date and store items after opening. Dietary staff will store foods according to label instructions. The in-service also included information on how and when to change gloves when handling food. Cook #1 received 1-1 in-servicing through our disciplinary process. This in-service was done by our Dietary Manager and our Registered Dietician.	12/14/12

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F 371	Continued From page 46 thought they were unopened. She added that she immediately discarded both items on 11/13/12 when she became aware that they were opened. 2. During the initial tour of the kitchen on 11/13/12 at 10:45 AM, the following were observed opened but undated in the walk-in cooler: 1 jar of jam, 1 container of honey mustard dressing, 1 container of pimento cheese spread, 1 container of ranch dressing and 1 container of cottage cheese. On 11/13/12 at 10:45 AM the Dietary Manager stated that items should be dated when opened. She discarded the honey mustard dressing and cottage cheese, and dated the other items. 3a. On 11/17/12 at 10:25 AM, Cook #1, while wearing gloves, was observed to drop a bag of bread on the floor. She picked up the bag and set it on the counter. She next tore a piece of aluminum foil and laid it on the counter next to the bag of bread. She then removed the bread from the bag and wrapped the bread in the foil. She did not remove the gloves during this process. The cook was interviewed and stated she should have removed the gloves and washed her hands after picking up the bag from the floor. During an interview on 11/17/12 at 10:30 AM, the Dietary Manager acknowledged she had witnessed the above. She indicated the cook should have changed her gloves after handling the bag that had fallen on the floor. #3 b. On 11/13/2012 at 12:15 PM., NA#1 was observed taking a bread roll out of the plastic bag	F 371	4. The Dietary Manager and the afternoon cook are auditing the storage areas each day to see that items are stored, dated and labeled the correct way. Results of their audits are documented daily on a new auditing tool. The results will be presented to the Quality Assurance Committee 1 x month x 12 months. 5. All nursing and Department Head Staff In-serviced on 12-7-12 by the Director of Nursing regarding procedure for passing trays and infection control in the dining room including sanitizing of tables, washing hands between residents if handling food is involved and sanitizing hands between handling trays. Director of Nursing and Clinical Care Coordinator will continue to In-service until all nursing and Department Head Staff have been In-serviced.	12/14/12

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F 371	Continued From page 47 and, with her ungloved hand, she placed the roll on the resident's dinner plate. She sat down with the resident and was assisting the resident with her meal when another resident entered the dining room. Without washing her hands, NA #1 obtained the resident's food tray, removed the bread roll from the plastic bag with her ungloved hand and placed the roll on the plastic bag. On 11/13/2012 a 12:15 PM., NA #1, when asked regarding hand washing, stated she should wash her hands prior to handing out the food trays. She stated the facility did not want gloves worn when passing out the trays. NA #1 further stated there was no hand sanitizer available in the dining room, only a soap dispenser. An observation revealed two hand sanitizers in the dining room. Both hand sanitizers contained sanitizing agents and were functioning properly. On 11/15/12 at 4:58 PM., Administrative staff #2 stated nursing staff should wash/sanitize their hands before passing food trays and between tasks. She said they should wash their hands after passing a tray to a resident and before and after touching food items.	F 371	c. At least one meal service per day will be audited by Department Heads and Nursing Supervisors with results recorded on Dining Service Quality Assurance audit tool and turned into the Director of Nursing. Every meal (Breakfast, Lunch, and Dinner) will be audited at least twice per week. Audits will be completed daily x4 weeks, then weekly thereafter. Results of audit will be addressed by the Director of Nursing in monthly Quality Assurance meeting.	12/14/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425	F425 1. All residents are potentially at risk. 2. Resident #36 discharged from the facility prior to survey. 3. "Please Send" will be documented on each order for	12/14/12

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F 425	Continued From page 48 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacist interview, the facility failed to obtain wound treatment medication in a timely manner for 1 (Resident #36) of 4 residents. The findings included: Resident #36 was admitted to the facility on 10/12/12. Diagnoses included hip contusion and venous ulcer of the left calf. Orders from the wound clinic dated 10/16/12 revealed an order for daily medihoney calcium alginate dressing to the left lower leg wound. Review of treatment notes revealed: 10/17/12, "Resident refused treatment as ordered." 10/18/12: "Explained to resident and daughter that we were waiting for the medihoney to perform with dressing change to left lower leg." 10/19/12: "Performed treatment to left lower leg as ordered without problems." Review of the Treatment Administration Record	F 425	wound care products sent to the pharmacy by the Treatment Nurse or Nurse Supervisor. 4. Medihoney added to stock wound supplies by Director of Nursing and kept in the Director of Nursing office as of 12/10/12 5. Nurses will be in-serviced on ordering of wound care supplies to include adding "Please Send" if the medication is an Over the Counter medication by the Clinical Care Coordinator using Employee roster to ensure all nurses are in-servised.. 6. To ensure timeliness of initiation of wound care orders, all orders from the previous day will be checked daily by the Clinical Care Coordinator, Director of Nursing, Assistant Director of Nursing, and Treatment nurse to ensure new orders are placed on the Treatment Administration Record, Care Plan, and Kardex as needed.	12/14/12

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F 425	Continued From page 49 (TAR) revealed initial treatment with medihoney calcium alginate to the left leg wound was on 10/19/12 by the Treatment Nurse. During an interview on 11/16/12 at 10:07 AM, the Treatment Nurse indicated that the resident refused the treatment on 10/17/12 because she thought the physician was supposed to remove the skin graft on her leg. On 10/18/12 the resident was willing to receive the treatment but the medihoney calcium alginate had not come from the pharmacy. The Treatment Nurse indicated that she made Administrative Staff #2 aware that the medihoney calcium alginate had not come in. During a telephone interview on 11/17/12 at 3:12 PM, the pharmacist stated that the original order for medihoney calcium alginate was faxed to the pharmacy on 10/16/12 with a medication order. The pharmacist indicated he believed the technician was unaware that the pharmacy had an agreement with the facility to fill orders for wound care products and therefore did not enter it into the computer. On 10/17/12 the pharmacy received a faxed order to refill the medihoney calcium alginate. The pharmacy responded that no refill could be issued since no original order was on file. On 10/18/12 the pharmacy received the original order and the medihoney calcium alginate was sent to the facility that night. During an interview on 11/17/12 at 4:53 PM, Administrative Staff #2 stated she had been in contact with the pharmacy daily to obtain the medihoney calcium alginate.	F 425	6. Monthly audit of treatment orders, Treatment Administration Records, and wound documentation will be completed and documented on Wound Quality Assurance Audit Tool by Director of Nursing, Clinical Care Coordinator, and Assistant Director of Nursing. Results of Wound Quality Assurance Audit Tool monitor will be addressed in Quality Assurance meeting by the Director of Nursing monthly x3 and quarterly thereafter.	12-11-12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 50 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. 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. 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. 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 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to remove expired medications from	F 431	F431 1. All residents potentially at risk. 2. All expired medications removed from Medication Storage Room on 11/16/12 by Clinical Care Coordinator. 3. All medications in medication storage room, including E-box from pharmacy, refrigerated medications, and stock medications will be checked by the Director of Nursing, Assistant Director of Nursing, Clinical Care Coordinator, Shift Supervisors, and Supply Clerk weekly x4 weeks and monthly thereafter to rotate stock and remove any medications about to expire. 4. Medication carts will be audited twice weekly by Third shift nurses using Medication Cart Audit. Any medications that have expired or close to expiration date will be removed.	12/14/12

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F 431	Continued From page 51 the emergency drug box in 1 of 2 medication rooms (medication room for 100, 200 and 300 halls). The findings included: On 11/16/12 at 11 AM the following expired medications were observed in the emergency supply box of the medication room for 100, 200 and 300 hall: Hydroxyzine Pamoate 25 mg cap expired 10/12 Penicillin expired 10/12 Nitro Patch expired 8/12 Arithromycin tab 250 expired 10/12 Nurse #4 was present at this time and indicated that the medications in the emergency box should not be expired. She stated that pharmacy was responsible for checking the emergency supply box to ensure medications were current. Nurse #4 then placed the above expired medications in the return to pharmacy box and said she would order replacement stock.	F 431	5. Any medications that have expired or within one month of expiration will be removed and destroyed or returned to pharmacy as required by Director of Nursing, Assistant Director of Nursing, Clinical Care Coordinator, and Shift Supervisors 6. Pharmacy will audit E-boxes monthly and remove all medications that expire the next month. 7. Results of audits will be presented by the Director of Nursing monthly Quality Assurance meeting.	12/14/12

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	345509	A. BUILDING 01 - MAIN BUILDING 01 JAN 28 2013 B. WING	01/04/2013

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K045 1. All residents are potentially at risk. 2. The original lighting has been changed to a new lighting fixture. The new lighting fixture contains the required 2 lighting system. 3. The Maintenance Supervisor has formalized a Preventative Maintenance Program which has just been finished this month. The Preventative Maintenance Program includes maintenance items that his department checks weekly, monthly, quarterly, semi-annually or yearly. 4. Checking both internal and external exit lighting will be added to his Preventative Maintenance Program. These items will be check on a weekly basis. 5. The Maintenance Supervisor will provide to the Administrator a copy of his audit each week for monitoring purposes. 6. The Maintenance Supervisor will report his Audit Results to the Quality Assurance Meeting each month x 12 months.	1/29/2013 Maint. Supervisor
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area.(100 and 200 hall) NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 1/18/2013 CW

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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K 045	Continued From page 1 42 CFR 483.70(a)	K 045		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: smoking areas do not have self-closing metal container which eshtrays can be emptied.	K 066	K066 1. All residents are potentially at risk. 2. The non-compliant containers have been replaced with self-closing metal containers in which ashtrays can be emptied. The containers have been painted red and the following instructions will be stenciled on each container. "Cigarette Butts Only" 3. Staff will be in-serviced about the purpose of the cigarette butt containers and the need to use the containers and ashtrays correctly. 4. The Maintenance Supervisor will add 5 x per week monitoring of the smoking areas to his Preventative Maintenance Program. 5. The Maintenance Supervisor will provide the Administrator with a copy of his monitoring results so the Administrator can monitor the program. 6. The Maintenance Supervisor will provide the Quality Assurance Committee with results of his monitoring system 1 x per month x 12 months.	1/22/2013 Maint. Supervisor

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K 066	Continued From page 2 42 CFR 483.70(a)	K 066		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: at time of survey, found empty oxygen cylinder tank mix in with full ones(oxygen storage room across from nurse station). 42 CFR 483.70(a)	K 076	K076 1. All residents are potentially at risk. 2. Red signs with black lettering that say "Full Oxygen Tanks Only" or "Empty Oxygen Tanks Only" will be attached to the entrance doors of the empty and full oxygen rooms for better visibility. An additional red and black lettered sign will be placed above the empty or full oxygen tank storage areas. 3. The nursing staff have been in-serviced on the proper procedure for Full or Empty Oxygen Tank storage. 4. The Maintenance Supervisor will add monitoring of the oxygen rooms to his Preventative Maintenance Program. 5. The Maintenance Supervisor will provide a copy of his 3 x per week audit of the oxygen rooms to the Administrator 1 x per week so the Administrator can monitor his program. 6. The Maintenance Supervisor will report his audit results to the Quality Assurance Committee 1 x per month for 12 months.	1/30/2013 Maintenance Supervisor