STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345609	A. BUILDING _____ B. WING _____	C 11/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to treat 1 of 1 resident (Resident #1) capable of urinary continence, with dignity, when requesting assistance with toileting. The findings included: Resident #1 was admitted to the facility on 10/17/13 after a weeklong stay in the hospital for pneumonia, lung cancer and cardiomyopathy. Resident #1 was not interviewed since she was discharged to the hospital on 10/27/13, and then later placed on Hospice. The admission Minimum Data Set (MDS) assessment was not available due to the length of her stay in the facility, however, on the FL-2, a form used by professionals to determine a patient ' s level of care needs for a skilled nursing environment, dated 10/16/13, it determined that Resident #1 had constant mental orientation to person, place and time. She was continent of bowel and bladder but required extensive assistance for ambulation, transfers and toileting. A written statement from Nurse #2, dated 10/27/13 (7am to 7 pm shift) revealed that Resident #1 reported to a nurse aide (unknown) at the beginning of the shift that she had not been	F 241	F241 1. Resident #1 cleaned and dried by 7am-7pm NA on 10/27/13. 2. Director of Nursing (DON) and Staff Development Coordinator (SDC) interviewed alert and oriented residents on 10/28/13 and asked if staff met their needs and requests on the night of 10/26/13. All interviewed residents expressed that staff was attentive to their needs and requests with no noted complaints. 3. NA assigned to resident on 7pm-7am shift 10/26/13 disciplined by DON on 11/8/13 for not providing for the resident's dignity by toileting resident as requested by resident and resident having an un-necessary episode of incontinence and call light not being within reach so that she could call for help. Discipline included education on providing for the dignity of all residents including but not limited to ADL needs and requests. 4. Nursing Supervisor (Nurse #3) disciplined by DON on 11/6/13 for	NA 10/27/13 DON SDC 10/25/13 DON 11/8/13 DON 11/6/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dyanita Frazier LSS	Administrator	11/27/13

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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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 241	Continued From page 1 changed all night. The nurse went into the room to talk with Resident #1 and she stated, " look at my gown and bed. " She wrote that the gown and bed was soaking wet with a brown ring under the resident. The Resident also stated to her that she was told by a female staff to go ahead and wet the bed and we will try to get back to you. Nurse #2 found the Resident ' s entire gown and bed was very cold. A phone interview was conducted with Nurse #2 on 11/1/13 at 11:15 am. She stated that last Sunday, she was called to the room of Resident #1 and found her soiled in urine and was told that she had been wet, all night long. The Resident told her that she hadn ' t been touched all night long and her gown and sheets were wet. She stated that the Resident was cognitively intact. She continued by stating that the night shift staff had already left, but she brought her concerns to the attention of Administrative Nurse #3. She also mentioned that when she entered the room, she noticed that Resident #1 ' s call bell cord was hanging down next to her bed, but she was uncertain if she had used her call bell during the night. The nurse said that Nurse Aide #1 was one of the aides working that morning who came to the room to clean Resident #1 up. Nurse #2 then went to speak to Nurse #3, who worked on the hall the night of 10/26/13. The nurse told her that she was unaware that Resident #1 was soiled all night long. She assured Nurse #2 that she had toileted Resident #1, using the bedpan, the night before, while her family was present.	F 241	failing to ensure accommodation of resident's dignity in regards to request for care. Discipline included re-education on providing for the dignity of all residents including but not limited to ADL needs and requests. 5. Nursing staff, licensed and unlicensed, in-serviced by the DON and SDC on the resident's right for dignity. Addressed honoring residents dignity needs such as requests to be toileted, ensuring call lights are in place for resident to call for help if needed, for an alternate meal if requested, to sleep late, and any request that is not detrimental to the resident's health and well being. 90% of Nursing staff training completed as of 11/27/13. This training will be included in all future orientations for new staff. Completion date 11/28/13. Any staff that have not received in-service will not be allowed to work until training has been done. 6. DON and SDC facilitated a Nursing Supervisors meeting held on 11/8/13. Meeting addressed	DON SDC 11/28/13 DON SDC 11/8/13

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F 241	Continued From page 2 A copy of the Visitor ' s Log from 10/26/13 was viewed. It revealed that Resident #1 had a family visitor from 6:35 pm to 9:15 pm. On 11/1/13 at 11:43 am, a phone interview was conducted with Nurse Aide #1. She stated that she worked 10/27/13 from 7 am to 7 pm and was doing rounds that morning, before breakfast, when she entered the room of Resident #1. She remembered asking her if she was okay and was told that she was soaking wet. Resident #1 reported to her that she was told by staff during the night that " I can ' t get to you, just wet and I' ll get to you shortly. " Nurse Aide #1 did not convey that Resident #1 remained on a bed pan, but recalled that Resident #1 was wet from head to toe, stating that it was awful and that she apologized to her for the conditions that she found her in. Administrative Nurse #3 was interviewed by phone on 11/1/13 at 11:55 am. She confirmed that Nurse #2 discussed her concerns with her after she found Resident #1 very soiled. The nurse on duty, (Nurse #3,) on 10/26/13 told her that she had put Resident #1 on a bed pan. Several phone calls were made to Nurse #3, but unsuccessful. She recalled seeing Nurse #3 put Resident #1 on the bedpan around 8:30 pm while her family was present. Then she saw Nurse Aide #2 come out of Resident #1 ' s room once that night, but was told he had assisted her roommate. She briefly saw Resident #1 at 10:30 pm, when she went in the room, to answer a call light, Resident #1 placed on for her roommate, and at that time, she	F 241	duties of the Charge nurse and the Nursing Supervisor including making rounds, speaking with residents and family members regarding any issues or concerns/grievances pertaining to all aspects of the resident's care including but not limited to providing for the residents dignity. 7. Nursing Supervisors and Unit Managers will make rounds on their respective shifts to speak to random residents and note any resident's concerns regarding resident dignity. Any voiced concerns or issues will be turned into the DON for follow up during the week. If the concern requires immediate action the Supervisor will notify the DON by phone for immediate action to be taken. Weekend Supervisors will notify the DON by phone of any concerns noted and DON will direct Supervisor in how to address it at that time. Unit Manager will bring Nursing Supervisors report sheet to daily stand-up meeting daily x30 days. Concerns will be discussed with Administrative Nurses, Social Services, and Administrator during daily stand	DON 11/08/13

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F 241	Continued From page 3 expressed no concerns for herself. The Administrative Nurse was interviewed on 11/1/13 at 12:10 pm. She stated that she became aware of the concerns of Nurse Aide #1 and Nurse #2 regarding the lack of care that Resident #1 received on 10/26/13, during the night shift. She expressed that she was concerned the way that the Unit Nurse (Nurse #3) handled the matter.	F 241	up meeting x30 days with results discussed by DON in QA meeting monthly x3 months then quarterly. Completion date 11/28/13	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide incontinent care, when needed, for 1 of 3 residents (Resident #1) needing extensive assistance with toileting. The findings included: Resident #1 was admitted to the facility on 10/17/13 after a weeklong stay in the hospital for pneumonia, lung cancer and cardiomyopathy. The admission Minimum Data Set was not completed due to the resident ' s length of stay in the facility. However, on the FL-2, a form used by professionals to determine a patient ' s level of care needs for a skilled nursing environment,	F 312	F312 1. Resident #1 cleaned and dried by 7am-7pm NA on 10/27/13. 2. DON spoke with Nursing Supervisor for 7a-7p shift on 10/27/13. Asked if there were any other residents found to be wet or with any care issues noted from the 7p-7a shift 10/26/13. No other resident's noted to have any care issues. 3. NA assigned to resident #1 on 7pm-7am shift 10/26/13 disciplined by the DON on 11/8/13 for not providing toileting and incontinence care to resident #1. NA re-educated on providing timely care to residents including toileting needs, incontinence care, and any other needs. 4. Nursing Supervisor (Nurse #3)	NA 10/27/13 DON 10/27/13 NA 10/26/13 DON 11/18/13

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F 312	Continued From page 4 dated 10/16/13, it determined that Resident #1 had constant mental orientation to person, place and time. She was continent of bowel and bladder but required extensive assistance for ambulation, transfers and toileting. Resident #1 was not yet care planned for activities of daily living skills. On a nurse's note, 10/25/13 at 10:00 pm, Nurse #1 recorded that Resident #1 " must be assisted to ambulate due to increased weakness." A written statement from Nurse #2, dated 10/27/13 (7am to 7 pm shift) revealed that Resident #1 reported to a nurse aide (unknown) at the beginning of the shift that she had not been changed all night. The nurse went into the room to talk with Resident #1 and she stated, " look at my gown and bed." She wrote that the gown and bed was soaking wet with a brown ring under the resident. The Resident also stated to her that she was told by a female staff to go ahead and wet the bed and we will try to get back to you. Nurse #2 found the Resident's entire gown and bed was very cold. A phone interview was conducted with Nurse #2 on 11/1/13 at 11:15 am. She stated that last Sunday, she was called to the room of Resident #1 and found her soiled in urine and was told that she had been wet, all night long. She did not convey if Resident #1 remained on the bed pan. The Resident told her that she hadn't been touched all night long and her gown and sheets were wet. She stated that the Resident was cognitively intact. She continued by stating that the night shift staff	F 312	disciplined by DON on 11/6/13 for not ensuring that resident's needs were met and rounds made timely. 5. SDC in-serviced nursing staff on 11/8/13 on ADL care and making rounds timely with a focus on incontinence care and assisting residents with toileting needs as they are voiced by the resident. In-servicing of all nursing staff will be completed by 11/28/13. Any staff member who has not received this in-service will not be allowed to work until they have had this training. Training will also be addressed with all future hires in the initial orientation. 6. DON and SDC facilitated a Nursing Supervisors meeting held on 11/8/13. Areas covered included making rounds, checking to make sure residents ADL care is done timely and properly, and disciplining staff if care is not done. 7. Nursing Supervisors and Unit Managers will make rounds on their respective shifts to monitor for timely rounds and	SDC 11/8/13 DON SDC 11/28/13 DON 11/28/13

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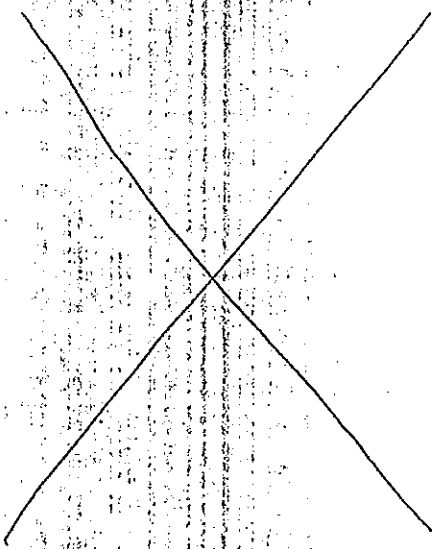
F 312	Continued From page 5 had already left, but she brought her concerns to the attention of Administrative Nurse #3. She also mentioned that when she entered the room, she noticed that Resident #1's call bell cord was hanging down next to her bed, but she was uncertain if she had used her call bell during the night. The nurse said that Nurse Aide #1 was one of the aides working that morning who came to the room to clean Resident #1 up. Nurse #2 then went to speak to Nurse #3, who worked on the hall last night. The nurse told her that she was unaware that Resident #1 was soiled all night long. She assured the nurse that she had put Resident #1 on a bed pan, the night before, while her family was present. A copy of the Visitor's Log from 10/26/13 was viewed. It revealed that Resident #1 had a family visitor from 6:35 pm to 9:15 pm. On 11/1/13 at 11:43 am, a phone interview was conducted with Nurse Aide #1. She stated that she worked 10/27/13 from 7 am to 7 pm and was doing rounds that morning, before breakfast, when she entered the room of Resident #1. She remembered asking her if she was okay and was told that she was soaking wet. Resident #1 reported to her that she was told by staff during the night that "I can't get to you, just wet and I'll get to you shortly." Nurse Aide #1 recalled that Resident #1 was wet from head to toe, stating that it was awful and that she apologized to her for the conditions that she found her in. Nurse Aide #1 stated that she went immediately to her Nurse #2, to report her findings.	F 312	Incontinence care, and all other care needs. Unit Managers and Nursing Supervisors will note any issues found on the daily Nursing Supervisors report sheet along with corrective action taken such as staff education and disciplines. Unit Managers will bring Supervisors report sheet to daily stand up meeting x30 days. DON will discuss results of these rounds in QA meeting monthly x3 months then quarterly. Completion date 11/28/13. 	DON 11/28/13

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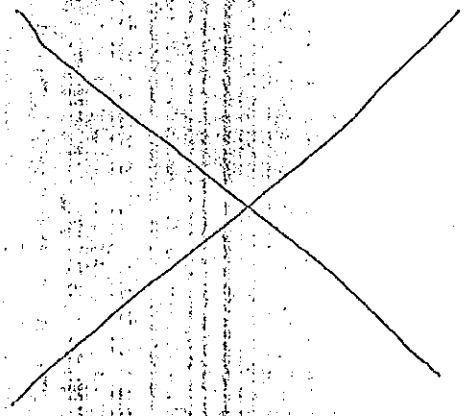
F 312	Continued From page 6 Administrative Nurse #3 was interviewed by phone on 11/1/13 at 11:55 am. She confirmed that Nurse #2 discussed her concerns with her after she found Resident #1 very soiled. The nurse on duty, (Nurse #3,) on 10/26/13 told her that she had put Resident #1 on a bed pan. Several phone calls were made to Nurse #3, but unsuccessful. Resident #1 was not interviewed, since she was admitted to the hospital on 10/27/13 and then later discharged to Hospice.	F 312		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	F353 1. Nurse #3 disciplined by DON on 11/8/13 regarding not notifying the on-call nurse or the Director of Nursing regarding staffing situation. Discipline included education of expectations of Nursing Supervisor to call Administrative Nurse on call in regards to staffing issues and to notify the DON if issue is not resolved and relief staff found. 2. DON and SDC facilitated a Nursing Supervisors meeting on 11/8/13. Covered expectations of Supervisors including notifying not only the Administrative nurse on-call of staffing situations but also notifying Director of Nursing when	DON 11/8/13 DON SDC 11/8/13

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F 353	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide sufficient nursing staff, on 10/26/13, without compromising the needs of 1 of 3 residents, (Resident #1) needing extensive assistance with activities of daily living. The findings include: Resident #1 was admitted to the facility on 10/17/13 after a weeklong stay in the hospital for, pneumonia, lung cancer and cardiomyopathy. On the FL-2, a form used by professionals to determine a patient ' s level of care needs for a skilled nursing environment, dated 10/16/13, it determined that Resident #1 had constant mental orientation to person, place and time. She was continent of bowel and bladder but required extensive assistance for ambulation, transfers and toileting. It noted that she should receive continuous oxygen at 4 liters a minute due to her medical diagnoses. The facility ' s Weekday Nursing Assignment sheet was reviewed for 10/26/13, 7pm to 7 am. The main unit, which consisted of halls Tanglewood, Greenbriar and Somerset, was slotted for 2 nurses to work a split shift on Tanglewood and 1 nurse to work on Greenbriar. Two nurse aides were scheduled to work on Tanglewood and the two aides scheduled to work on Greenbriar called off at 10:30 am and12:00 pm. One aide was scheduled to work on Somerset from 3 pm to 11 pm. The time sheets for 10/26/13 provided by the Human Resource department indicated that	F 353	staffing issues arise that have not been resolved. 3. Weekend NA on-call list initiated by DON with NA's signing up to take call on the weekend shifts. This will be done monthly by the DON. Each shift on the weekend will have an NA who is on call to cover any call ins on that shift. NA's will sign up each month to ensure there is back-up coverage for any staffing issues for each weekend. Call-in's during the week and on holidays will be covered by prn and weekend staff. Completed 10/31/13 4. Nursing Supervisors are to complete the daily staffing/census sheet for their shift. Any noted staffing shortages are to be reported to the Administrative Nurse on-call and replacement staff called in from on-call list. Completion date 11/28/13. 5. Administrative Nurse on call will contact the facility at the beginning of each shift on the weekends and speak to the Nursing Supervisor to ensure that all staff scheduled for that shift	DON 10/31/13 Nursing Supervisors 11/28/13 DON 11/28/13

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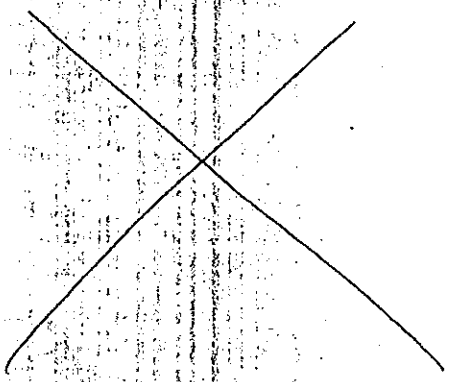
F 353	Continued From page 8 Nurse Aides #4 and #5 although scheduled to work, was not in attendance that day. It also reflected that both aides #2 and #3 were allowed lunch breaks at 11:45 pm to 12:15 am, with Nurse #3 taking her break from 12:00 am to 12:30 am. A written statement from Nurse #2, dated 10/27/13 (7am to 7 pm shift) revealed that Resident #1, reported to her that she had not been changed all night and was found soaked in urine and that she was having trouble catching her breath. A phone interview was conducted with Nurse #2 on 11/1/13 at 11:15 am. She stated that last Sunday, she was called to the room of Resident #1 and found her soiled in urine and was told that she had been wet, all night long. The Resident told her that she hadn ' t been touched all night long and her gown and sheets were wet. She stated that the Resident was cognitively intact. She also shared that Resident #1 had attempted to wear oxygen but there was no pressure coming through the canula. When she assisted Resident #1 she found her in respiratory distress with oxygen saturations of 77%. On 11/1/13 at 11:43 am, a phone interview was conducted with Nurse Aide #1. Nurse Aide #1 stated that the facility had been short staffed the night of 10/26/13. Normally, there are four aides on duty, for the three halls unit, but that night, they only had 2 aides on the unit. She stated that she worked 10/27/13 from 7 am to 7 pm and was doing rounds that morning, before breakfast, when she entered the room of Resident #1. She remembered asking her if she was okay and was told that she was soaking wet. Resident #1 reported to her that she was told by staff during.	F 353	are in attendance or that a replacement for any absentee staff has been made. Completion date 11/28/13. 6. Daily staffing/census sheets will be brought to the daily stand up meeting by the Unit Manager for review daily. Administrative Nurse on call will speak with the Nursing Supervisors on weekends and Holidays to review staffing for that time and will notify the DON of staffing situations and any issues and how they have been handled. Results will be discussed in QA meeting by the DON monthly x 3 months then quarterly. Completion date 11/28/13. 	DON 11/28/13

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F 353	Continued From page 9 the night that " I can ' t get to you, just wet and I' ll get to you shortly. " The Administrative Nurse was interviewed on 11/1/13 at 12:10 pm. She stated that she became aware of the concerns of Nurse Aide #1 and Nurse #2 regarding the lack of care that Resident #1 received on 10/26/13, during the night shift. She expressed that she was concerned the way that the Unit Nurse (Nurse #3) handled the matter. She mentioned that the nurse never informed the administrative staff that they remained short staffed throughout the shift Then explained that the facility ' s scheduler calls at the beginning of each shift to determine if there are any call offs. It was never relayed that Nurse #3 could not gather additional nursing help to the on call nurse, Administrative Nurse #1 or the Administrator.	F 353		