STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigattion (NC112798, NC107496 & NC107303).	F 000		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within the first fourteen (14) days of admission for one of three sampled residents (Resident #30). The findings included: Resident #30 was admitted to the facility on 12/4/15. A review of the medial record revealed an Admission MDS dated 12/11/15. The completion date for the Care Area Assessment (CAA) of the Admission MDS (VB 1) was 12/22/15. This was eighteen (18) days after admission to the facility. On 2/04/16 at 9:33AM, the MDS Coordinator stated the Admission MDS should have been completed by 12/18/15. She stated she was	F 273	1. Res #30 late assessment. Assessment was completed on 12/22/16 by MDS Coordinator. No adverse effect noted. 2. MDS Coordinator was educated by the DON (Director of Nursing) on timing requirements of all MDS submissions according to the RAI manual on 2/29/16. The Corporate MDS consultant did a review/ audit of all comprehensive MDS assessments in comparison to the facility census as of 2/5/16. 2/8/16, 2/15/16, 2/22/16, 2/29/16, any late assessments have been corrected and all care planning has been carried out. Corporate MDS consultant did an audit on all residents and as of 3/1/16. All residents have an opened and or MDS	3/8/16

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

Electronically Signed | 02/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 273	Continued From page 1 training a new person at that time and just got behind in her assessments. On 2/4/16 at 9:50AM, the Director of Nursing stated she expected the admission comprehensive assessment to be completed within the first 14 days of admission.	F 273	completed. All care planning is current and complete as of 3/2/16. 3. The MDS Coordinator will print the "In Progress MDS report"(an report of all open and in progress MDSs) and bring it to the Administrative Department Meeting for Review by the administrative team daily. Weekly audit of the "In Progress report" for late assessments of the MDS, will be conducted by the Corporate MDS consultant or Administrative Nurse and routed to the DON for review weekly for 4 weeks or until compliance is met and then every month for 3 months to ensure compliance, then Quarterly. 4. The Audits will be maintained by the DON and brought to QA Monthly for monitoring of trends and compliance.	
F 278 SS=D	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.	F 278		3/8/16

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F 278	Continued From page 2 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for medications for one of five residents (Resident #34) reviewed for unnecessary medications. The findings included: Resident #34 was admitted to the facility on 7/3/15 and readmitted on 9/8/15 with multiple diagnoses that included depression and diabetes mellitus type II. The quarterly MDS assessment dated 1/5/16 indicated Resident #34 had significant cognitive impairment. The Medications Section of the 1/5/16 MDS indicated Resident #34 received antianxiety medications on seven days during the seven day look back period. It also indicated that Resident #34 did not receive insulin injections or antidepressants during the seven day look back period.	F 278	1.Res #34 miscoding was corrected on 2/2/16 by the MDS Coordinator for the 7 day look back on the insulin, antidepressant, and anti anxiety medication removed. Education was provided by the DON to the MDS Coordinator on MDS regulations on Section N coding requirements, completed by 2/29/16. 2.The Administrative Nurse and or DON will complete an audit of all active charts, of sec N of the last MDS submitted, for coding errors. The Administrative Nurse or DON will check for medication use in the 7 day look back period for accurate coding on antidepressant, antianxiety and insulin use comparing to the Medication administration record of antidepressant, antianxiety, and insulin use by residents in	

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F 278	Continued From page 3 A review of the Medication Administration Record (MAR) for Resident #34 revealed she received an insulin injection on seven days, an antidepressant on seven days, and an antianxiety medication on zero days during the look back period of the 1/5/16 MDS. An interview was conducted on 2/2/16 at 5:05PM with the MDS nurse. She stated that she was responsible for completing the MDS. She stated that the Medications Section of the MDS was completed by reviewing the MAR for the seven day look back period. The MDS nurse reviewed the 1/5/16 quarterly MDS for Resident #34 as well as the MAR for the look period. She revealed that she made errors. She stated that she had mistakenly coded antianxiety medications instead of antidepressants. She also stated that she incorrectly coded insulin injections.	F 278	house. All errors found will be corrected by MDS coordinator or the Administrative Nurse before 3/8/16. 3. Ongoing monitoring audit will be completed by the Administrative Nurse for review of sec N of each MDS assessment completed, then reconciled to the Medication administration record for accuracy, regarding antianxiety, antidepressant and insulin used by patients during the 7 day look back period of the MDS. The results will be reviewed by DON every week for 4 weeks or until compliance met and then every month for 3 months to ensure compliance and then quarterly. This will be turned into the DON for audit and review every month. 4.Results of the Audits will be reviewed by the DON or Unit manager and maintained by the DON for review in QA meeting for trends and compliance.	
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	F 279		3/8/16

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F 279	Continued From page 4 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). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan for one of one sampled resident (Resident #97) whose Care Area Assessment (CAA) indicated that falls would be addressed in the care plan. The findings included: Resident #97 was admitted to the facility on 10/28/15 and last readmitted on 11/28/15. Cumulative diagnoses included left leg below the knee amputation (10/6/25), end stage renal disease on hemodialysis, peripheral vascular disease, right leg above the knee amputation, diabetes mellitus, anemia and history of venous thrombosis and embolism. An Admission MDS dated 11/4/15 indicated Resident #97 was cognitively intact. She required limited assistance with bed mobility, transfers, ambulation did not occur and limited assistance with locomotion on and off the unit. Her balance was noted as impaired and she was only able to stabilize with staff assistance for moving from seated to standing position, moving on and off the	F 279	1. Res #97 fall care plan was corrected on 2/2/16 by the MDS Coordinator. Education To MDS Coordinator was completed on 2/29/16 by DON regarding MDS CAAS decision and Care planning requirement, per state regulation. 2.100% of residents who have had a Comprehensive Assessment MDS completed since 2/5/16 were audited By Corporate MDS consultant on 2/5/16, 2/8/16, 2/15/16, 2/22/16, 2/29/16 and 3/1/16 a 100% audit by the Corporate MDS Consultant and the Administrative Nurse, Comparing those CAAS to care planning completed and all these care plans are current and in compliance as of 3/2/16. 3. Ongoing Monitoring: A review of all comprehensive assessment CAAS that are completed and their Care plans will be brought to the morning clinical meeting weekly by the MDS Coordinator. An audit	

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F 279	Continued From page 5 toilet and surface to surface transfers. No impairment was noted with upper extremity and impairment of range of motion was noted for both lower extremities. Resident #97 had not sustained any falls prior to admission to the facility and no falls since admission. The Care Area Assessment (CAA) for falls dated 11/5/15 indicated limitations included difficulty in maintaining standing balance and impaired balance during transitions. Falls would be addressed in the care plan. Resident #97's care plan was reviewed and there was not a care plan for falls. On 2/2/16 at 11:29 AM, the MDS Coordinator was interviewed and stated there should have been a care plan for falls and it must have been an oversight. On 2/4/16 at 9:50 AM, the Director of Nursing stated her expectation was to have a care plan in place for falls if that was indicated on the MDS.	F 279	by the Administrative nurse or the Unit manager will be conducted on all comprehensive MDS CAAS that are completed and this will be compared to the care plans completed weekly for 4 weeks or until compliance is met, then monthly for 3 Months to ensure compliance, then Quarterly. 4.Audits of this will be reviewed by DON and retained for monthly review in QA for trends and compliance.	
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 record review and staff interview, the facility failed to follow the care plan interventions for obtaining a psychiatric consultation (Resident	F 282	1. Resident #6 psych consult referral to Psych Services started on 2/3/16 obtained on 2/11/16. Behavior flow sheet ongoing	3/8/16

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F 282	Continued From page 6 #6) and monitoring behaviors for residents on psychotropic medications (Residents #6, #34) for two of five sampled residents reviewed for unnecessary medications. The findings included: 1a. Resident #6 was initially admitted to the facility on 8/14/13 and readmitted on 12/16/13 with multiple diagnoses including schizophrenia, bipolar disorder, and anxiety. The annual Minimum Data Set (MDS) assessment dated 12/17/15 indicated Resident #6 had moderate cognitive impairment. The Plan of Care with a review date of 12/22/15 indicated Resident #6 received psychotropic drugs and had a diagnosis of severe anxiety. The interventions included obtaining a psych consult as needed. A physician's progress note from 1/7/16 was reviewed for Resident #6. The progress note specified that a psychiatric visit for a medication review was needed for Resident #6. A review of the medical record revealed no documentation of a psychiatric consultation. An interview was conducted on 2/3/16 at 5:35 PM with the Social Worker (SW). She stated that Resident #6 had not received a psychiatric consultation. The 1/7/16 physician's progress note for Resident #6 was reviewed with the SW. She revealed she had not viewed this progress note previously and was not aware the physician wanted a psychiatric consultation for Resident #6. The SW reviewed the normal procedure for coordinating a psychiatric consultation. She stated that when the physician's progress notes were received at the facility they were reviewed	F 282	with behaviors monitored. Resident #34 Behavior flow sheet in place and used. 2. Licensed nurses will be educated by the Staff Development Coordinator and or DON and or Supervisor on behavior charting by 3/8/16 any staff unavailable for in-servicing by 3/8/16 will be educated prior to working their next scheduled shift by the Shift supervisor and or SDC(Staff Development Coordinator) and or DON(Director of Nursing). 100% audit of all patients receiving psychotropic medications will be completed for recommendations pending in the active chart, by Unit Manager and or DON, and or Administrative nurse by 3/5/16. All recommendations found will be addressed for needed completion by the Unit manager by 3/8/16 and any order needed will be obtained from Physician and this order will be given to MSW for psych services as needed, MSW will contact Psych Services regarding consult needed. 3. All Progress notes and consult recommendations arriving at facility will be reviewed by the assigned Unit Manager and brought to the clinical meeting daily for review for possible referrals and recommendations. If any recommendations are needed, these will be tracked for completion on a log and maintained by the DON and or the Unit	

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F 282	Continued From page 7 by nursing staff. She stated nursing staff then obtained a physician's order for the psychiatric consult. She indicated that nursing staff informed her when the order was received and then she scheduled the psychiatric consultation. The SW revealed this process was not followed for Resident #6 and she was unsure where the breakdown in the process occurred. She stated she was going to contact the attending physician for Resident #6 and obtain an order for a psychiatric consultation and then schedule the consultation. 1b. Resident #6 was initially admitted to the facility on 8/14/13 and readmitted on 12/16/13 with multiple diagnoses including schizophrenia, bipolar disorder, and anxiety. The annual Minimum Data Set (MDS) assessment dated 12/17/15 indicated Resident #6 had moderate cognitive impairment and received antipsychotic and antidepressant medications. The Plan of Care with a review date of 12/22/15 indicated Resident #6 received psychotropic drugs and had a diagnosis of severe anxiety. The interventions included: monitor and record any displayed behavior or mood problems, monitor the effectiveness of psychotropic medications, and monitor for involuntary movements and repetitive behaviors. An interview was conducted on 2/3/16 at 10:00 AM with Nurse #4. She stated that in December (2015) Resident #6 exhibited inappropriate behaviors. Nurse #4 stated Resident #6 packed her clothing in bags and stated she wanted to go home. Nurse #4 indicated that Resident #6 repeated this behavior several times. Nurse #4 revealed that she did not document these	F 282	manager. Ongoing monitoring:will be conducted by the Unit Manager or the Administrative Nurse by auditing all residents receiving psychotropic medications with a psychiatric diagnosis and associated behaviors, as obtained from, by comparing the Behavioral Flow sheet documentation to the staff interview of recent witnessed behaviors. Every week for 4 weeks then every month for 3 months the Quarterly then Review Audits in the monthly QA for trends and compliance. This Audit will be discussed in weekly PAR (Patients at Risk) meeting for behavior management and for needed referral to Psych services to ensure these patients are being followed for Medication review and or behavior management. This will be done weekly for 4 weeks or until compliance met, then monthly for 3 months 4. All Audits with any issues noted,will be forwarded to the DON by the Unit Manager for Review and retention for Monthly QA looking for trends and compliance.	

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F 282	Continued From page 8	F 282		

behaviors. She also stated she had not seen any other behavior documentation for Resident #6 in the medical record.

An interview was conducted on 2/3/16 at 10:20 AM with the Staff Development Coordinator (SDC). He stated that behaviors were documented on the psychotropic monthly flow sheet and/or on the nursing progress notes in the hard copy medical record.

The Antipsychotic Monthly Flow Sheets for December 2015 and January 2016 were reviewed for Resident #6. There were no behaviors documented.

The nursing progress notes for December 2015 and January 2016 were reviewed for Resident #6. There were no behaviors documented.

An interview was conducted on 2/3/16 at 3:00 PM with the Social Worker (SW). She revealed that Resident #6 had behaviors. She stated Resident #6 frequently became fixated on returning to her home. She indicated Resident #6 would remove all of her clothing from her closet and pack them so she was ready to move back to her home. She stated Resident #6 had repetitive pacing when she was anxious and had trouble sleeping at times. She stated Resident #6 made frequent phone calls to her family and to her physician requesting to return home. The SW revealed that nursing staff informed her verbally of resident behaviors. She stated she did not review the nursing documentation. She indicated she thought nursing staff documented behaviors in the hard copy medical record.

An interview was conducted on 2/3/16 at 3:30 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 9	F 282		

with the Director of Nursing (DON). The DON stated that she expected nursing staff to document any observed behaviors for all residents on psychotropic medications.

2. Resident #34 was initially admitted to the facility on 7/3/15 and readmitted on 9/8/15 with multiple diagnoses that included depression and dementia with behaviors. The quarterly Minimum Data Set (MDS) assessment dated 1/5/16 indicated Resident #34 had significant cognitive impairment.

The Plan of Care dated 7/3/15 was reviewed for Resident #34. It indicated that Resident #34 received psychotropic drugs. The interventions included: monitor and record any displayed behavior or mood problems, monitor the effectiveness of psychotropic medications, and monitor for involuntary movements and repetitive behaviors. A problem area was added on 1/13/16 that indicated Resident #34 had anxiety and was combative and resistant to care. An intervention was added for antianxiety medication.

A Nurse Practitioner's (NP) note from 8/12/15 was reviewed for Resident #34. The note indicated that Resident #34 had behavioral issues that consisted of refusing care from the staff. This was resolved by leaving her alone when she got upset.

An NP note from 9/16/15 was reviewed for Resident #34. The note indicated that Resident #34 had behavioral issues that consisted of refusing care from the staff. This was resolved by leaving her alone when she got upset.

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F 282	Continued From page 10	F 282		

A nursing progress note from 1/13/16 was reviewed for Resident #34. The note indicated that Resident #34 received a new order for Ativan as needed for agitation.

The weekly nursing summary notes were reviewed from July 2015 through January 2016. The notes indicated that Resident #34 consistently exhibited inappropriate behaviors throughout this time frame. Specific behaviors and the time and date of the behaviors were not documented.

An interview was conducted on 2/3/16 at 10:00 AM with Nurse #4. Nurse #4 stated she had heard from other staff members that Resident #34 had behaviors that included being resistant to care. She stated she had not observed any of these behaviors herself and did not document these behaviors.

An interview was conducted on 2/3/16 at 10:20 AM with the Staff Development Coordinator (SDC). He stated that behaviors were documented on the psychotropic monthly flow sheet and/or on the nursing progress notes in the hard copy medical record. The hard copy medical record for Resident #34 was reviewed with the SDC. There were no psychotropic monthly flow sheets for Resident #34. There were no behaviors documented for Resident #34 in the nursing progress notes. The weekly nursing summary notes for Resident #34 were reviewed with the SDC. These notes indicated that Resident #34 consistently had inappropriate behaviors, but did not indicate specific behaviors or the time and date of the behaviors. The SDC was unable to locate any documentation of behavioral monitoring that included specific

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F 282	Continued From page 11 behaviors and the time and date of behavioral occurrences for Resident #34. An interview was conducted on 2/3/16 at 3:30 PM with the Director of Nursing (DON). The DON stated that she expected nursing staff to document any observed behaviors for all residents on psychotropic medications. She stated that weekly documentation on the nursing summary notes did not fulfill her expectation. She indicated the psychotropic flow sheet or nursing progress notes were to be used for behavior documentation and monitoring.	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, resident interview, and staff interview, the facility failed to provide psychological interventions for two of two sampled residents (Residents #6, #34) with behavioral issues. The findings included: 1. Resident #6 was initially admitted to the facility on 8/14/13 and readmitted on 12/16/13 with multiple diagnoses including schizophrenia, bipolar disorder, and anxiety. The annual Minimum Data Set (MDS) assessment dated 12/17/15 indicated Resident #6 had moderate	F 309	1.Res #6 Psychotropic behavior flow sheet was in place on 2/2/16. Referral to Psych services completed on 2/3/16, visit was on 2/11/16. Res #34 Psych services saw resident on 2/9/16 for follow up on continued behaviors. Recommendations completed on 2/9/16. 2. All residents, who have prescribed psychotropic medication classification given for psychiatric conditions that have	3/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 309	Continued From page 12 cognitive impairment and received antipsychotic and antidepressant medications. The Plan of Care with a review date of 12/22/15 indicated Resident #6 received psychotropic drugs and had a diagnosis of severe anxiety. The interventions included: monitor and record any displayed behavior or mood problems, monitor the effectiveness of psychotropic medications, monitor for involuntary movements and repetitive behaviors, and psych consult as needed. The physician's orders were reviewed for Resident #6. The orders included Zyprexa (antipsychotic) 2.5 milligrams (mg) every other day, Depakote (mood stabilizer) 250 mg twice daily, Remeron (antidepressant) 22.5 mg once daily, and Celexa (antidepressant) 10 mg once daily. A physician's note from 12/31/15 was reviewed for Resident #6. The note indicated Resident #6 phoned the physician's office and left a message that stated she wanted to go home. Resident #6 requested the message be given to the physician that same day. A physician's progress note from 1/7/16 was reviewed for Resident #6. The progress note revealed that Resident #6 had made multiple calls to his office reporting that she wanted to leave the facility to return home. The physician indicated it was not a realistic plan for Resident #6 to return home and that a psychiatric visit for a medication review was needed. An interview was conducted on 2/1/16 at 11:15 AM with Resident #6. She stated she did not	F 309	behaviors associated with them will be reviewed and audited by using census tool for appropriate professional intervention and or referral to primary physician for follow up. To be completed by MSW (Medical Social Worker) and or Unit Manager by 3/8/16. Licensed Nursing staff will be in-serviced on appropriate documentation required on behaviors, review of process and appropriate charting of behaviors. This will be completed by the Staff Development Coordinator, Unit manager, Supervisor, and or DON. Any staff unable to attend in-serving by 3/8/16 will be educated prior to their next scheduled shift by the Supervisor and or SDC and or DON. All patients using a psychotropic medication for a psychiatric diagnosis with associated behaviors will be tracked on a behavior flow sheet for amount and type of behavior resident is exhibiting found in the MAR or in the Nurses note. The staff nurse assigned to unit will complete this process each shift. All Patients with psychotropic medications with behaviors were audited for ongoing behaviors by the SDC and Supervisor on 3/2/16. Any ongoing behaviors found in Audit will be referred to physician, for follow up by Unit Manager for physician order for Psych Services, if agreed on by patient and or family and or responsible party. The Unit Manager will contact MSW for Psych Service consult by 3/8/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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

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F 309	Continued From page 13 have many personal belongings in her room because she was going home soon. There were no behaviors noted. An interview was conducted on 2/3/16 at 10:00 AM with Nurse #4. She stated in December (2015) Resident #6 exhibited inappropriate behaviors. Nurse #4 indicated Resident #6 packed her clothing in bags and stated she wanted to go home. Nurse #4 revealed Resident #6 repeated this behavior several times. An interview was conducted on 2/3/16 at 3:00 PM with the Social Worker. She revealed that Resident #6 had behaviors. She stated Resident #6 frequently became fixated on returning to her home. She indicated Resident #6 would remove all of her clothing from her closet and pack to return home. She stated Resident #6 had repetitive pacing when she was anxious and had trouble sleeping at times. She stated Resident #6 also made frequent phone calls to her family and to her physician requesting to return home. A follow up interview was conducted on 2/3/16 at 5:35 PM with the Social Worker (SW). She stated that Resident #6 had not received a psychiatric consultation. The 1/7/16 physician's progress note for Resident #6 was reviewed with the SW. She revealed she had not viewed this progress note previously and was not aware the attending physician wanted a psychiatric consultation for Resident #6. The SW reviewed the normal procedure for coordinating a psychiatric consultation. She stated that when the physician's progress notes were received at the facility they were reviewed by nursing staff. She stated nursing staff then obtained a physician's order for the psychiatric consult. She	F 309	3. All Residents with new psychiatric medications for behaviors will be reviewed in daily clinical meeting by the team consisting of DON or designee, Staff Development Coordinator, MDS Coordinator, Administrative nurse and Unit Managers. Any patients with new medications for behaviors, the team will review for placement in the PAR program (Patients at Risk)until behaviors are stable. All New residents will be reviewed in PAR for Psychiatric need and follow up. (PAR consists of a comprehensive Assessment of risk factors associated with Falls, Skin, Pain, Weights, Psych with associated elopement or behaviors. This program consists of DON, Administrative Nurse, Unit Supervisors, Wound Nurse, MDS Coordinator, Dietary Manager and MSW. Meeting to assess risk and need, for these areas of risk on a rotating and acute need schedule, held weekly. The MSW will assess through the PAR meeting using the format, the need for Psych services for all patients who are taking psychotropic medications,that are given for Psychiatric conditions and who have associated behaviors. Ongoing monitoring: an audit will be conducted by the Unit Manager or the Administrative nurse, to monitor the psych behavior flow sheets and interview staff on their witnessed behaviors. This audit will take place and results discussed in Clinical meeting for follow up. To be completed by to the Unit Manager and or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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

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F 309	Continued From page 14 indicated that nursing staff informed her when the order was received and then she scheduled the psychiatric consultation. The SW revealed this process was not followed for Resident #6 and she was unsure where the breakdown in the process occurred. She stated she was going to contact the attending physician for Resident #6 and obtain an order for a psychiatric consultation and then schedule the consultation. 2. Resident #34 was initially admitted to the facility on 7/3/15 and readmitted on 9/8/15 with multiple diagnoses that included depression and dementia with behaviors. The quarterly Minimum Data Set (MDS) assessment dated 1/5/16 indicated Resident #34 had significant cognitive impairment. The Plan of Care dated 7/3/15 was reviewed for Resident #34. It indicated that Resident #34 received psychotropic drugs. The interventions included: monitor and record any displayed behavior or mood problems, monitor the effectiveness of psychotropic medications, monitor for involuntary movements and repetitive behaviors, and psych consult as needed. A problem area was added on 1/13/16 that indicated Resident #34 had anxiety and was combative and resistant to care. An intervention was added for antianxiety medication. The physician's orders were reviewed for Resident #34. The orders included Paxil (antidepressant) 20 milligrams (mg) once daily and Ativan (antianxiety) 0.5 mg as needed for agitation. A Nurse Practitioner's (NP) note from 8/12/15 was reviewed for Resident #34. The note	F 309	weekend supervisor daily for 7 days then every week for 4 weeks or until compliance met, then every month for 3 months to ensure compliance, then ongoing quarterly. 4. An audit will be conducted to monitor the psych behavior flow sheets and interview staff on their witnessed behaviors. This audit will take place by the Unit Manager and or weekend supervisor daily for 7 days then every week for 4 weeks or until compliance met, then every month for 3 months to ensure compliance, then quarterly and taken to QA by DON for review in QA for trends and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 309	Continued From page 15	F 309		

indicated that Resident #34 had behavioral issues that consisted of refusing care from the staff. This was resolved by leaving her alone when she got upset.

An NP note from 9/16/15 was reviewed for Resident #34. The note indicated that Resident #34 had behavioral issues that consisted of refusing care from the staff. This was resolved by leaving her alone when she got upset.

A nursing progress note from 1/13/16 was reviewed for Resident #34. The note indicated that Resident #34 received a new order for Ativan as needed for agitation.

The weekly nursing summary notes were reviewed from 7/3/15 through 1/31/16 for Resident #34. The notes indicated that Resident #34 consistently exhibited inappropriate behaviors throughout this time frame. Specific behaviors and the time and date of the behaviors were not documented.

An interview was conducted on 2/3/16 at 10:00 AM with Nurse #4. Nurse #4 stated she had heard from other staff members Resident #34 had behaviors that included being resistant to care. She stated she had not observed any of these behaviors herself.

An interview was conducted on 2/3/16 at 10:20 AM with the Staff Development Coordinator (SDC). He stated a care plan meeting was held on 1//13/16 and Resident #34's family was in attendance. He revealed Resident #34's family had requested an intervention to address Resident #34's ongoing behaviors. The SDC stated that the attending physician was contacted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 309	Continued From page 16 following this meeting and he ordered Ativan as needed for agitation. An interview was conducted on 2/3/16 at 2:42 PM with the Social Worker (SW). The SW stated she was aware Resident #34 had behaviors that included being resistant to care and combative when she was first admitted. She revealed she was not aware the behaviors were ongoing for Resident #34. She indicated that nursing staff updated her verbally on resident behavioral issues as it was not her normal procedure to review nursing documentation. She stated if she had been aware of the ongoing behaviors she would have discussed a psychiatric consultation referral with the attending physician for Resident #34. She indicated she was going to contact the attending physician for a psychiatric consultation referral for Resident #34. An interview was conducted on 2/3/16 at 3:30 PM with the Director of Nursing (DON). She revealed she expected a resident with ongoing behaviors to be assessed for a psychiatric consultation.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		3/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 17 Based on observation, record review, resident and staff interviews, the facility failed to properly secure one of one sampled resident reviewed for accidents (Resident #97) and the wheelchair in the transportation van according to manufacturer's instructions resulting in Resident #97 tipping over in the wheelchair and hitting her right stump on the floor of the van, failed to immediately notify administration about the accident and failed to complete a root cause analysis of the incident. Immediate jeopardy began on 1/8/16 and was removed on 2/4/16 at 6:20 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems have been put into place and are effective, the facility van has the appropriate securement system installed and all staff have been in-serviced. The findings included: Resident #97 was admitted to the facility on 10/28/15 and last readmitted on 11/28/15. Cumulative diagnoses included, in part, left leg below the knee amputation (10/6/25), end stage renal disease on hemodialysis, peripheral vascular disease, right leg above the knee amputation (11/2015) and history of venous thrombosis and embolism. An Admission Minimum Data Set (MDS) dated 11/4/15 indicated Resident #97 was cognitively intact. She required limited assistance with bed mobility and transfers. Ambulation did not occur. Balance was noted as impaired. Resident #97 was only able to stabilize with staff assistance for moving from seated to standing position, moving on and off the toilet and surface to surface	F 323	On 2/2/16 the facility transport van was taken out of service until the proper securement system could be verified by the manufacturer. On 2/5/16 the facility Administrator went to a manufacturer approved securement system installer in Raleigh, NC named Van Products, Inc. A qualified technician verified what type of securement system the facility van was equipped with and then contacted the manufacturer and sent photos of the securement system to the manufacturer to verify what type of securement tie down straps the van was equipped with. 1.Resident #97 was returned to the wound clinic immediately after the incident for evaluation by the physician. It was then determined patient #97 sustained no injuries and her dressing was changed. 2.An audit of the accident/incident reports was conducted by the Staff Development Coordinator dating back to 1/8/16 of all patient that were on transport between 1/8/16 to 2/2/16 and it was determined no other accidents/incidents had occurred. All staff was in-serviced on the facility accident/incident reporting policy with an emphasis on notification to Administrative staff concerning any accidents/incidents. All accident/incident reports will be reviewed during the monthly QA meetings. New securement straps were purchased during the visit to Van Products	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 18 transfer. No impairment was noted with upper extremity and impairment of range of motion was noted for both lower extremities. Resident #97 had not sustained any falls prior to admission to the facility and no falls since admission to the facility. The Care Area Assessment (CAA) for falls indicated limitation included difficulty in maintaining standing balance and impaired balance during transitions. On 02/01/2016 at 5:35PM, an interview was conducted with Resident #97. She stated she was riding in the facility van that was a new van and the driver hit the brakes. Resident #97 stated the wheelchair tipped over and she hit her right stump on the floor of the van causing her stump to begin bleeding. Resident #97 stated the van driver took her back to the wound doctor who checked her out and said it was ok because the doctor had tried to remove the scab from the stump and Resident #97 had scraped the scab off when her stump hit the floor of the van. On 2/3/16 at 11:45AM, Resident #97 was re-interviewed. She stated when she got on the van at the wound clinic, the maintenance man was the person who placed the back straps on her wheelchair and she felt he placed them too low and that was why they loosened and her wheelchair tipped up. She also again stated she hit her right stump on the floor of the van. A review of the medical record revealed a nursing note dated 1/12/16 at 12:00AM written by Nurse #2 for late entry for 1/9/16 stated Resident #97 said she was riding on the van and when the van came to a stop, resident and her wheelchair fell forward and she became wedged between the wall. Resident #97 stated an ambulance nearby came to assist the driver to get her up. Resident	F 323	Incorporated and installed onsite. A qualified technician did give instruction to the Administrator on the proper method of using the securement straps and how to secure a patient in a wheel chair while on the transport van. This is a three point securement system. 3.Education of the Activities Director, Transport Van Driver, and the Maintenance Assistant on the new securement system was completed by the Administrator on 3/1/16. The transport van remains out of service until the plan of correction is accepted by the state surveyors. When the plan of correction is accepted, the Administrator will audit each staff member on the transport van during resident transport for a minimum of one transport per day x3 days per week x2 weeks. A new instructional DVD was purchased for training purposes of any staff member that will drive the transport van and use the securement system. The Administrator will conduct the training sessions. Training will be completed before staff member drives the transport van. 4.A pre-trip daily inspection report sheet will be completed by the transport van driver each day of transport van usage. The completed inspection reports log book will be maintained by the transport	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 19 #97 was in a lot of pain and requested pain medication stating she was literally standing on her right stump which started to bleed and she said she was taken to the wound clinic and a large pressure dressing was placed on the stump which had several staples that were wedged into her skin and could not be removed. Her pressure dressing was not removed and Resident #97 was given PRN (as needed) medication for pain. On 2/2/16 at 9:21 AM, an interview was conducted with the transportation driver. She stated she had been the transportation driver since January of last year. The transportation driver said the facility had gotten the new van and they had been using that van since January 2016 as well as using an outside transportation company. The transportation driver stated she had not received training in using the new van or in using the securement system that was in the new van because she had been previously trained by former transportation staff in 2004 and both vans had the same securement system. The transportation driver stated she was the only staff member who transported residents in the facility van. She said she was the one transporting Resident#97 back from the wound center when incident happened. The transportation driver stated she thought the incident happened on 1/6/16 because it was a day when Resident didn't have dialysis and Resident #97 received dialysis on Tuesday, Thursday and Saturday. The transportation driver stated she picked up Resident #97 from the wound center around 10:40 AM. She stated she had called the maintenance director to come to the wound care center parking lot to help her because she had problems with the van lift. She said she had fixed the lift by the time the	F 323	van driver and reviewed during the quality assurance meeting each month. The accident/incident report audits will be reviewed during the monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 20	F 323		

maintenance director got to the wound care center and the maintenance director helped her strap down Resident #97's wheelchair in the van. She stated the maintenance director strapped down the back part of the wheelchair and she strapped down the front of the wheelchair. The maintenance director left and she started to leave the wound care center. When she got in the turn lane leaving the wound care center parking lot, the transportation driver said she heard Resident #97 say " Whoa " . She looked back and the wheelchair had tilted forward with Resident #97 still in the wheelchair. She stated the wheelchair was halfway flipped. The back securement strap was still on the chair but it was loose. The driver pulled over and there was an ambulance following the van. The ambulance stopped and ambulance personnel helped her lift the resident back into the chair. The transportation driver stated she saw a little bit of blood on the right stump dressing and felt that Resident #97 hit her right knee on the pole that was on the right side of Resident #97. She said they returned back to the wound clinic and the wound care staff checked Resident #97's stump and placed another bandage on the right stump. She indicated she informed the staff development coordinator (SDC), the Administrator and Nurse #1 about the incident when she returned to the facility. She told them they had an accident with the van, Resident #97 did not fall all the way out of the wheelchair and she had taken Resident #97 back to the wound center.
The maintenance director was unable to be interviewed as he no longer worked at the facility.
On 2/2/16 at 9:43 AM, Nurse #1 was interviewed and stated she had worked at the facility since August 2015. She stated she didn't remember anything about the incident except the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 21	F 323		

transportation driver told her Resident #97 had an accident in the van. She was not sure of the day of the incident. Nurse #1 stated she saw Resident #97 after the incident and her dressing on her right knee was fine since she had been at the wound clinic. The right stump was wrapped so she did not remove the dressing.

On 2/2/16 at 10:15 AM, a return demonstration of securing a resident in a wheelchair in the van was conducted with the transportation driver. The van was capable of holding two residents in wheelchairs. There was also seating available on the right side of the van. A pole was noted to be situated on the right side of the van near the right seat. Anyone in a wheelchair would not be located near the pole. The transportation driver placed the wheelchair in the center of the van, secured the front of the wheelchair by placing the securement straps around the crossbar that was located under the wheelchair seat at the center of the wheelchair and tightened up the straps using buttons on either side of the strap. She placed the back straps around the crossbar of the wheelchair and tightened up the straps in the same manner. The resident was then strapped in with a seatbelt that was placed across the waist. A shoulder strap was not visualized. The transportation driver stated that was how she secured the wheelchair in the van and the straps could be hooked anywhere on the wheelchair as long as it held the wheelchair in place. The transportation driver stated Resident #97 was in the front wheelchair position in the van at the time of the incident.

On 2/2/16 at 10:34 AM, an interview was conducted with Administrator and Director of Nursing. The Director of Nursing stated she was not aware of the incident until 2/2/16 but she would have to look at her notes. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 323	Continued From page 22	F 323		

Administrator stated he was not sure of the date and when he was made aware of the incident. Administrator stated he was notified that Resident #97 had slipped while she was in the van. He stated he does not have any documentation personally about the incident. The Administrator stated the transportation driver had been educated on how to properly strap down residents before the incident and he personally educated her. He stated, to his understanding, that the resident slipped and there was no injury. He was under the impression that Resident #97 started to slip off the edge of the seat and she did not fall. He said the people involved were in stand-up (morning meeting) and they were asked about the incident but no statements were done at that time. When asked if he had trained any other individuals in securement of the wheelchairs in the transportation van, he stated he had only trained the transportation driver.

On 2/2/16 at 1:15 PM, the Administrator stated he used educational material from the department of transportation web site for securement of a wheelchair in a transportation van. He in-serviced the transportation driver 9/2/15. He stated the current van was a 2009 E250 transportation van and it replaced an older van but the securement devices in the van were the same type. He was not sure if there was a manufacturer's manual for the van as they bought it secondhand. The Administrator checked in the van and stated there was not a manual for the care of the van or proper procedure for securement of the wheelchair.

On 2/2/16 at 1:35PM, a telephone interview was conducted with clinical manager for the wound clinic. She stated she remembered the phone call that Resident #97 had an accident after leaving the clinic in the van and she advised them

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 23	F 323		

to bring the resident back so her stump could be rechecked. She stated the incident occurred on 1/8/16. Resident #97 was taken back to the clinic and was seen by the physician again. There was a small amount of bleeding and Resident #97 was checked and the area was re-bandaged.
On 2/2/16 at 1:44 PM, the Administrator stated the incident happened on 1/8/16 after the stand-up meeting. On Monday, 1/11/16, during the stand-up meeting, the transportation driver informed all present at the meeting (which included the Administrator) that, during the transport of Resident #97 on 1/8/16, she looked back and saw that the back straps on the wheelchair of Resident #97 were loose. The transportation driver pulled over and tightened the straps. She stated there was no injury and the resident was fine. The Administrator stated that was all the information given at that time so he did not investigate any further. He stated he did not know until today (2/2/16) that EMS (Emergency Medical Services) assisted the transportation driver to put Resident #97 back to the chair. The Administrator stated his expectation was that the transportation driver should have notified him immediately of the incident so a full investigation could have been done at the time of the incident.
On 2/2/16 at 2:10 PM, the Administrator provided a copy of the in-service given to the transportation driver on 9/2/15. The material used for the in-service was titled " Ride Safe " from the (name of university) Health System dated 2005. Information included in the brochure stated, in part, " 1. It is best if you have wheelchair that has been designed and tested for use as a seat in motor vehicles, often referred to as a WC19 wheelchair or transit wheelchair (has four, crash tested securement points where tiedown straps

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 24	F 323		

and hooks can be easily attached. These points are clearly marked with a hook symbol). If a WC19 wheelchair is not available, the next best choice is a wheelchair with an accessible metal frame where tiedown straps and hooks can be attached at frame junctions. It is important to use a complete WTORS (Wheelchair Tiedown and Occupant Restraint System) to secure the wheelchair and provide the wheelchair occupant with a properly designed and tested seatbelt system ....The most common type of wheelchair tiedown uses four straps to secure the wheelchair to the vehicle. Although it requires someone other than the wheelchair rider to secure and release the wheelchair, this tiedown can secure a wide range of WC19 and non-WC19 wheelchairs. To protect the rider during a crash or sudden braking, and to minimize the likelihood of injury caused by contact with the vehicle, a seatbelt system with both pelvic and upper torso belts must be used .... "

On 2/3/16 at 7:42 AM, an interview was conducted with Nurse #2 who stated she went into Resident #97 ' s room Monday night (1/11/16) and Resident #97 stated she wanted to talk to her. Resident #97 started to tell her about the episode that happened on the van. Resident #97 said they were riding in the van, came to a sudden stop and she toppled over. She said there was an ambulance behind them and they helped them because the lady on the van was trying to get her upright. She said somehow they bumped her stump and said the scab came off and it bled a little bit. Resident #97 told her they went to the wound clinic and that is where they put on the dressing. Nurse #2 stated she had not heard about the incident during report change. She stated she checked the 24 hour reports from Saturday day shift and also checked the nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 25	F 323		

notes and did not see anything written/ recorded about the incident. Nurse #2 stated she called the staff development coordinator and asked him about the incident with Resident #97 in the van. Nurse #2 stated the staff development coordinator said he was aware of the incident.
On 2/3/16 at 3:00PM, the Administrator provided a copy of the investigation report that had been completed on 2/2/16 for Resident #97. The investigation report stated that an investigation was conducted on 2/2/16 concerning the incident involving Resident #97 on 1/8/16. The transportation driver did transport Resident #97 to the wound clinic for a follow up visit. After the follow up visit was completed, Resident #97 was paced back on the transport van by the transportation driver. The transportation driver did secure the safety straps. The transportation driver proceeded to leave the wound clinic and she started driving down the road. She noticed that the wheelchair tilted forward slightly but the seat belt prevented Resident #97 from sliding out of the wheelchair. The transportation driver immediately stopped safely to retighten the safety straps. An EMS (Emergency Medical Services) technician and the maintenance director had stopped behind the transport van. Resident #97 did lean forward and slightly slid downward but never touched the floor. The transportation driver, the EMS technician and the maintenance director did loosen the safety strap and help Resident #97 to the floor of the van. The EMS technician did assist the transportation driver with helping Resident #97 back safely in her wheelchair and safely retightened the straps. The transportation driver then proceeded to return back to the wound clinic to make sure there was no injury to Resident #97. Resident #97 did have some drainage due to some of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 26	F 323		

staples being removed a few days before 1/8/16. The transportation driver did mention this situation briefly in the standup meeting the following Monday which was on 1/11/16 but only stated that the wheelchair straps had slightly loosened when she left the wound clinic with Resident #97 and approximately two miles from the clinic, she stopped and retightened the safety straps. The Administrator questioned her about the incident on 1/8/16 but all this information was not disclosed at that time. During the investigation on 2/2/16, the transportation driver did state that she reported the incident to the RN supervisor (Nurse #1) on 1/8/16. Nurse #1 made a late entry to the nursing notes on 2/2/16.
A witness statement signed by the transportation driver was provided by the Administrator on 2/2/16 and had been attached to the investigation. The statement stated the transportation driver provided transportation for Resident #97 to and from the wound clinic on 1/8/16. As she was leaving the wound clinic and was moving over into the turn lane, the transportation driver looked back and Resident #97 was tilted slightly forward and her seat belt was holding her in the wheelchair. She came to a safe stop with the emergency flashers on and then tried to help Resident #97 back in her wheelchair where she had slid forward. An EMS technician had stopped behind the transportation van to ask if she needed any help. The maintenance director from the facility had also stopped to help. Resident #97 was helped completely back in her wheelchair and strapped back in safely (it was not mentioned who strapped Resident #97 back in her wheelchair). There was some yellow drainage that had soaked through to the outside of her dressing. The transportation driver took Resident #97 back to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 27	F 323		

the wound clinic to have the doctor check her out to make sure she had not hurt herself. The wound clinic staff rewrapped her wound and they returned back to the facility. The transportation driver stated she reported the incident to the nurse on the hall (no name mentioned).
On 2/4/16 around 10:30 AM, a demonstration of proper wheelchair and safety belt securement was conducted with the Administrator and transportation driver. The transportation driver secured the wheelchair using the floor tiedowns and attached them to the frame of the wheelchair with the tiedowns attached just above the wheels of the wheelchair. She then placed the safety belt under the arms of the surveyor and tightened the safety belt straps. The Administrator stated the manufacturer ' s instructions that he had found in the transportation van indicated the postural belt should be placed around the person under the arms and buckled up around the wheelchair. The Administrator stated there were two different securement systems that could have been on the transportation van and the new van that had been purchased only had the postural seat belt for the wheelchair residents but did have lap and shoulder belts for those who rode in the seats of the van.
On 2/4/16 around 10:30 AM, the Administrator provided a copy of the (name of the system) securement system manufacturer's directions last revised 11/14/08. The instructions for the use of the (name) securement system manufactured by (name) was reviewed and indicated the tiedown securement straps for the wheelchair should be attached on the frame of the wheelchair just above each wheel and not on the crossbars of the wheelchair. The instructions also included the use of the pap/ shoulder belt and stated the belt should be worn low across the front of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 28	F 323		

pelvis with the junction between the lap and shoulder belts located near the passenger's hip. Adjust the belts as firmly as possible consistent with use comfort. Place the postural belt around the person below the arms. Buckle up around the wheelchair. Make sure the padding is located at the chest height. Note: postural belts are not crash tested.

On 2/4/16 around 5:00PM, the Administrator stated he called the (name) manufacturer for the securement system in Florida and they referred him to the local manufacturer in Raleigh who told him that the seat belt system that was currently in the transportation van was to be used only for a child or small person (postural seat belt). The Administrator stated he would take the transportation van to Raleigh on 2/5/16 to have the proper securement system installed. He also indicated the first use of the transportation van was on 1/8/16 when Resident #97 was taken to the wound care center.

On 2/2/16 at 3:49 PM, the Administrator and Director of Nursing were informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 2/4/16 at 6:00PM. The allegation of compliance indicated:

Credible Allegation of Compliance:

On 2/2/16, a full investigation was conducted by the Administrator and Director of Nursing (DON) concerning the alleged accident involving Resident #97 during transport from the wound clinic on 1/8/16.

The result of the investigation was that Resident #97 claims when her wheel chair leaned forward, her stump touched the floor. The wheel chair leaned slightly forward because the rear safety tie down straps attached to the wheel chair had slightly loosened just after leaving the wound clinic approximately 2 miles from the clinic. At that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 29	F 323		

time the rear tie downs were securely tightened and Resident #97 was lifted back into her wheel chair. The transport driver then transported Resident #97 back to the wound clinic to ensure there was no injury to her. While the resident was at the doctor's office, the dressing on the right stump was changed. After ensuring there was no injury, the transport driver returned Resident #97 safely back to the facility. The transport driver received a written disciplinary action for poor work performance for failing to properly tighten the rear wheel chair tie down straps. The RN (Registered Nurse) supervisor received a written disciplinary action for failing to enter the incident on the facility's incident report. Also, the staff development coordinator received a written disciplinary action for failing to report the incident on the facility incident report.

The Kingswood Nursing Facility Transport Van was taken out of service on 2/2/16. This transport van will not be in service until an authorized wheel chair tie down system technician can correctly install the tie downs correctly with the correct shoulder harness and all relevant documentation will be provided to the state surveyors. The facility will continue to use an outside transport agency to transport all residents to and from appointments until the proper securement system is installed by an authorized agent.

An audit was completed on 2/3/16 by the Administrator during the emergency QA (Quality Assurance) meeting to discuss the possibility of any other patients being affected by any deficient practices. The finding was that no one else was affected by any other accident/incident on the transport van as evidenced by interviewing the transport driver and based on incident/accident reports reviewed by the SDC (Staff Development Coordinator).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 323	Continued From page 30 The facility's staff development coordinator has educated/in-serviced all staff members actively working in the facility on the facility ' s incident/accident policy which included completing an incident report, reporting incidents to the DON and administrator, as of 2/3/2016. Seventy nine employees have been in-serviced. PRN (as needed) staff will be educated on the incident/accident policy before working their next shift. All staff that is not currently working will be educated/in-serviced on incident/accident policy of the facility before their next shift. Incident/accident education will be added for all new hires from 2/4/16 moving forward. Previously, just the nursing staff was receiving this education. The credible allegation was verified 2/4/16 at 6:20 PM as evidenced by staff interviews on the policy and procedure for reporting incidents/accidents, what to do if any type of incident/accident occurred no matter how minor, whom to report to, when to write the incident report and whom to notify in case of an incident/accident. The Transportation driver verified that the van had been out of service since 2/2/16 and the facility was currently using an outside transportation company for all transports. A review of the in-service for the policy and procedure for incidents/ accidents revealed 94 staff members had been in-serviced as of 2/4/16 at 6:20 PM.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325		3/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 325	Continued From page 31 status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a nutritional supplement as ordered for 1 of 3 sampled residents reviewed for nutrition (Resident #36). Findings included: Resident #36 was admitted to the facility on 3/12/15 with multiple diagnoses including convulsions and Chronic Obstructive Pulmonary Disease (COPD). The quarterly Minimum Data Set (MDS) assessment dated 1/22/16 indicated that Resident #36 had moderate cognitive impairment and weighed 90 pounds (lbs.) The assessment further indicated that Resident #36 needed limited assistance with eating. Review of Resident #36's medical record revealed the following weights: 11/29/15: 97 pounds 12/20/15: 93 pounds 01/24/16: 90 pounds 01/31/16: 89 pounds The resident's care plan dated 1/26/16 was reviewed. One of the care plan problems was weight loss. The goal was for the resident to consume at last 75 percent of meals/fluids and to have no further weight loss over the next 90 days. The approaches included to serve regular diet as ordered by the doctor, supplements as ordered and to monitor resident for meal intake daily. The resident's dietary notes were reviewed. The	F 325	1.Res #36 supplement was corrected to reflect the appropriate amount of supplement on 2/3/16 and medication error incident and accident process initiated. 2. Audit will be completed by Unit Manager or assigned staff nurse, checking residents receiving dietary supplements and comparing to MD order and MARs (Medication Administration Record) for accuracy by 3/5/16 Residents with found discrepancies will be corrected by Unit Manager and or Administrative nurse by 3/8/16. Licensed Nursing staff will be in serviced on proper transcription process with new tracking and direction form. Form will be used to ensure accurately and accountability of process. Assigned to Staff Development Coordinator and or Unit supervisor and or weekend supervisor, by 3/8/16.Any nurse unable to be in-serviced by 3/8/16 will be in-serviced prior to their next scheduled shift by the Supervisor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 325	Continued From page 32 dietary note dated 1/29/16 indicated that Resident #36 was on no added salt (NAS) diet with 60 milliliter (ml) house supplement three times a day for nutritional support. Her intake was usually 75 to 100 % and she accepted her bedtime snacks. Her intake was adequate to meet estimated energy needs and to promote healing. She has a stage 1 and a stage 11 to her coccyx/sacrum. She was on multivitamin with minerals to help promote wound healing. Her weight was 92 lbs. in January. The resident was at risk for dehydration due to the use of diuretics. Recommend to increase the house supplement to 90 ml. three times a day for nutritional support. On 1/29/16, a doctor's order was written to increase the resident's house supplement from 60 ml. three times a day to 90 ml. three times a day. Resident #36's Medication Administration Records (MARs) for February, 2016 were reviewed. The house supplement was transcribed to be administered at 60 ml. three times a day instead of 90 ml. three times a day as ordered. On 2/3/16 at 12:10 PM, Nurse #4 was interviewed. Nurse #4 was the nurse assigned to Resident #36. She indicated that she administered the medications and house supplements as what they were written on the MAR. She stated that the house supplement was transcribed at 60 ml on the MAR and she had administered 60 ml. of house supplement to the resident. On 2/4/16 at 9:00 AM, the Director of Nursing was interviewed. She stated that 2 nurses always	F 325	3. Implementation of new transcription process with a new tracking and direction form. An audit will be conducted by Administrative nurses and staff nurses monthly. This will be used to check for accurate transcription of MD orders from prior Physician Order Forms (POF) against telephone orders and against new Monthly POF forms. This was implemented with March change over of Monthly Physician Orders completed on 3/1/16. Any errors found during this process will be corrected by the Staff nurse, Unit Manager, and or Shift supervisor at the time of discovery. Ongoing monitoring: Any residents with weight issues, reviewed in PAR, that have supplements implemented by orders, will be checked against the MD orders and in MAR for correct transcription of order. This will take place in PAR meeting weekly. Any transcription errors found will be corrected and tracked through the incident and accident process. This tracking of incident and accident reports will be retained and forwarded to QA by Staff Development Coordinator or DON for trends and compliance review Monthly. All new orders, including supplement orders, will be reviewed in daily AM Clinical meeting by Unit Supervisor or staff nurse. She/ He will check that orders have all been transcribed out correctly on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 325	Continued From page 33 check resident's MARs at the end of the month to ensure physician orders were implemented correctly. She indicated that the checking might have happened too early and therefore they did not catch the order to increase the resident's house supplement. The DON confirmed Resident #36 was not receiving 90 ml of house supplement three times a day as ordered by the physician.	F 325	the Medication Record and Treatment Record. Medication or treatment orders reviewed and found in error will be corrected and recorded through the incident and accident tracking process by the Unit Manager. 4.The incident and accident tracking of medication errors and (or MD order errors found) will be maintained by the Staff Development Coordinator and any transcription errors involving supplements will be a focus of review by the DON and brought to the QA meeting Monthly by the Staff Development Coordinator for review of trends and compliance issues.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		3/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 329	Continued From page 34 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and resident interview, the facility failed to administer antipsychotic medications as ordered by a physician for one of five residents (Resident #6), failed to monitor behaviors for residents receiving psychotropic medications for two of five residents (Residents #6, #34), and failed to discontinue a medication as ordered for one of five residents (Resident #109) reviewed for unnecessary medications. The findings included: 1a. Resident #6 was initially admitted to the facility on 8/14/13 and readmitted on 12/16/13 with multiple diagnoses including schizophrenia and bipolar disorder. The annual Minimum Data Set (MDS) assessment dated 12/17/15 indicated Resident #6 had moderate cognitive impairment and received antipsychotic medications. A review of Resident #6's physician's orders revealed an order dated 9/16/15 for Zyprexa (antipsychotic) 2.5 milligrams (mg) every other day. On 2/2/16 a review of the December 2015 Medication Administration Record (MAR) for Resident #6 was conducted. The MAR included the order for Zyprexa 2.5 mg every other day. Further review of the MAR revealed Resident #6 was administered Zyprexa on December 1, 3, 5,	F 329	1.Res #6 medication error was reported to the Physician and managed through incident and accident med error process on 2/4/2016. Behavior monitoring sheet currently in use for tracking residents behaviors. Psych services were contacted for consult and seen on 2/11/2016. Res #34 medication error was reported to the Physician and managed though the incident and accident process med error for transcription error, corrected on 2/4/2016. Behavior documentation flow sheet started and in use for behavior documentation. Res #109 Medication Error reported to the Physician and managed through the incident and accident process for medication error and updated MD and corrected on 2/4/16. 2. All residents Medication records and Treatment records will be audited by Unit Supervisor, Administrative Nurse, Unit manager, and or assigned staff nurse for errors in transcription, by comparing the POF (Physician Order Form), to telephone orders, to actual transcriptions completed in the Medical Records and	

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	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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F 329	Continued From page 35 7, 9, 13, 17, 19, 21, 23, 25, 27, 29, 31. The Zyprexa was not administered to Resident #6 on December 11 or 15. On 2/2/16 a review of the January 2016 MAR for Resident #6 was conducted. The MAR included the order for Zyprexa 2.5 mg every other day. Further review of the MAR revealed Resident #6 was administered Zyprexa on January 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 24, 26, and 30. The Zyprexa was not administered to Resident #6 on January 22 or 28. On 2/2/16 a review of the February 2016 MAR for Resident #6 was conducted. The MAR included the order for Zyprexa 2.5 mg every other day. Further review of the MAR revealed Resident #6 was administered Zyprexa on consecutive days on February 1 and 2. An interview was conducted on 2/2/16 at 3:30 PM with Nurse #4. She reviewed the December 2015, January 2016, and February 2016 MARs for Resident #6. She revealed that she had not administered Zyprexa to Resident #6 on 12/11, 12/15, 1/22 or 1/28. She stated that she must have forgotten to administer it on those dates. She also revealed that she gave Resident #6 Zyprexa on consecutive days (2/1 and 2/2) by mistake. She stated that she should not have administered the Zyprexa to Resident #6 on 2/2. She stated that she had not identified these errors previously. An interview was on conducted on 2/3/16 at 3:30 PM with the Director of Nursing (DON). She stated that she expected medications to be administered as ordered by the physician. She stated that the facility was in the process of	F 329	Treatment records by 3/5/16. Licensed Nursing staff will be rein-serviced on appropriate documentation required on behaviors, review of process and appropriate places to chart behaviors and the ^ right of medication administration. Assigned to Staff Development Coordinator, DON, supervisor, and or Administrative nurse by 3/8/16. Any nurses unable to attend in-servicing by 3/8/16 will be in-serviced prior to next scheduled shift by Supervisor and or administrative nurse. 3. Ongoing monitoring: All patients using a psychotropic medication for a psychiatric diagnosis with associated behaviors will be tracked on a behavior flow sheet for amount and type of behavior resident is exhibiting. The staff nurse assigned to that shift will complete this documentation in the MAR and or Nurses notes each shift. For patients with psychiatric diagnosis that have associated behaviors, they will be monitored through the PAR (Patients at Risk) program until behaviors are stable. (PAR consists of a comprehensive assessment of risk factors associated with Falls, Skin, Pain, Weights, Psych with associated elopement or behaviors. This program consists of DON, Administrative Nurse, Unit Supervisors, Wound Nurse, MDS Coordinator, Dietary Manager and MSW. Meeting routinely to assess risk and need for these areas of	

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	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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F 329	Continued From page 36	F 329		

implementing a new system to monitor medication administration as the previous system was not working.

1b. Resident #6 was initially admitted to the facility on 8/14/13 and readmitted on 12/16/13 with multiple diagnoses including schizophrenia, bipolar disorder, and anxiety. The annual Minimum Data Set (MDS) assessment dated 12/17/15 indicated Resident #6 had moderate cognitive impairment and received antipsychotic and antidepressant medications.

The Plan of Care with a review date of 12/22/15 indicated Resident #6 was received psychotropic drugs and had a diagnosis of severe anxiety. The interventions included: monitor and record any displayed behavior or mood problems, monitor the effectiveness of psychotropic medications, monitor for involuntary movements and repetitive behaviors, and psych consult as needed.

The physician's orders were reviewed for Resident #6. The orders included Zyprexa (antipsychotic) 2.5 milligrams (mg) every other day, Depakote (mood stabilizer) 250 mg twice daily, Remeron (antidepressant) 22.5 mg once daily, and Celexa (antidepressant) 10 mg once daily.

A physician's note from 12/31/15 was reviewed for Resident #6. The note indicated that Resident #6 phoned the physician's office and left a message that stated she wanted to go home. Resident #6 requested the message be given to the physician that same day.

risk on a rotating and acute need schedule.)

All new residents will be reviewed in PAR for Psychiatric need and follow up by the PAR team.

New licensed nurses will have education on transcription process during hire orientation by SDC, DON, and or Unit Manager.

Implementation of new transcription process with a new tracking and direction form implemented for continuity of process. This is checking for accurate transcription of MD orders from prior Physician Order Forms (POF) against telephone orders and against new Monthly POF forms. This was implemented on March change over of Monthly Physician Orders completed on 3/1/16 by Administrative Nurse, SDC and Assigned staff nurses. This will continue monthly. Brought to Monthly QA to review issues found during process and to monitor for compliance.

All new licensed nurse employees will be in-serviced on the 6 rights of medication administration during their orientation process by SDC and or DON.

For on going monitoring of behavior documentation an audit will be conducted by the Unit Supervisor or The Administrative nurse or SDC to monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 37 A physician's progress note from 1/7/16 was reviewed for Resident #6. The progress note revealed that Resident #6 had made multiple calls to his office reporting that she wanted to leave the facility to return home. The physician indicated it was not a realistic plan for Resident #6 to return home and that a psychiatric visit for a medication review was needed. An interview was conducted on 2/1/16 at 11:15 AM with Resident #6. She stated that she did not have many personal belongings in her room because she was going home soon. There were no behaviors noted. An interview was conducted on 2/3/16 at 10:00 AM with Nurse #4. She stated that in December (2015) Resident #6 exhibited inappropriate behaviors. Nurse #4 indicated Resident #6 packed her clothing in bags and stated she wanted to go home. Nurse #4 revealed that Resident #6 repeated this behavior several times. Nurse #4 revealed that she did not document these behaviors. She stated that she had not seen any other behavior documentation for Resident #6 in the medical record. An interview was conducted on 2/3/16 at 10:20 AM with the Staff Development Coordinator (SDC). He stated that behaviors were documented on the psychotropic monthly flow sheet and/or on the nursing progress notes in the hard copy medical record. The Antipsychotic Monthly Flow Sheets for December 2015 and January 2016 were reviewed for Resident #6. There were no behaviors documented.	F 329	the psych behavior flow sheets and interview staff on their witnessed behaviors. This audit will take place by the Unit Supervisor and or weekend supervisor daily for 7 days then every week for 4 weeks or until compliance met, then every month for 3 months to ensure compliance, then quarterly and reviewed in QA. Nursing Supervisor will conduct a check of all Behavior monitoring flow sheets daily with an interview of the nurse as to any witnessed behaviors noted. This will be done for 7 day then weekly for 4 weeks until compliance is met then every month for 3 months to ensure compliance, then Quarterly. 4. An audit will be conducted by the Unit Supervisor or The Administrative nurse or SDC to monitor the psych behavior flow sheets and interview staff on their witnessed behaviors. This audit will take place by the Unit Supervisor and or weekend supervisor daily x 7 days then every week x 4 weeks or until compliance met, then every month x 3 months to ensure compliance, then quarterly and reviewed in QA. The transcription POF process results (audit of End of month Orders with any discrepancies) will be brought to the QA meeting By the DON and or SDC monthly for review of trends and compliance monitoring.	

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	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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F 329	Continued From page 38	F 329		

The nursing progress notes for December 2015 and January 2016 were reviewed for Resident #6. There were no behaviors documented.

An interview was conducted on 2/3/16 at 3:00 PM with the Social Worker. She stated that Resident #6 was a long term stay resident. She revealed that Resident #6 had behaviors. She stated Resident #6 frequently became fixated on returning to her home. She indicated Resident #6 would remove all of her clothing from her closet and pack them so she was ready to move back to her home. She stated Resident #6 had repetitive pacing when she was anxious and had trouble sleeping at times. She stated Resident #6 also made frequent phone calls to her family and to her physician requesting to return home. The SW revealed that nursing staff informed her of resident behaviors verbally. She stated that she did not review the nursing documentation. She indicated that she thought nursing staff documented behaviors in the hard copy medical record.

An interview was conducted on 2/3/16 at 3:30 PM with the Director of Nursing (DON). The DON stated that she expected nursing staff to document any observed behaviors for all residents on psychotropic medications.

2. Resident #34 was initially admitted to the facility on 7/3/15 and readmitted on 9/8/15 with multiple diagnoses that included depression and dementia with behaviors. The quarterly Minimum Data Set (MDS) assessment dated 1/5/16 indicated Resident #34 had significant cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 39	F 329		

The Plan of Care dated 7/3/15 was reviewed for Resident #34. It indicated that Resident #34 received psychotropic drugs. The interventions included: monitor and record any displayed behavior or mood problems, monitor the effectiveness of psychotropic medications, monitor for involuntary movements and repetitive behaviors, and psych consult as needed. A problem area was added on 1/13/16 that indicated Resident #34 had anxiety and was combative and resistant to care. The intervention for this problem area was antianxiety medication.

The physician's orders were reviewed for Resident #34. The orders included Paxil (antidepressant) 20 mg once daily and Ativan (antianxiety) .5 mg as needed for agitation.

Nurse Practitioner's (NP) notes from 8/12/15 and 9/16/15 were reviewed for Resident #34. The notes indicated that Resident #34 had behavioral issues that consisted of refusing care from the staff. This was resolved by leaving her alone when she got upset.

A nursing progress note from 1/13/16 was reviewed for Resident #34. The note indicated that Resident #34 received a new order for Ativan as needed for agitation.

The weekly nursing summary notes were reviewed from July 2015 through January 2016. The notes indicated that Resident #34 consistently exhibited inappropriate behaviors throughout this time frame. Specific behaviors and the time and date of the behaviors were not documented.

An interview was conducted on 2/3/16 at 10:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 329	Continued From page 40	F 329		

AM with Nurse #4. Nurse #4 stated that she heard from other staff members that Resident #34 had behaviors that included being resistant to care. She stated that she had not observed any of these behaviors and did not document these behaviors.

An interview was conducted on 2/3/16 at 10:20 AM with the Staff Development Coordinator (SDC). He stated that behaviors were documented on the psychotropic monthly flow sheet and/or on the nursing progress notes in the hard copy medical record. The hard copy medical record for Resident #34 was reviewed with the SDC. There were no psychotropic monthly flow sheets for Resident #34. There were no behaviors documented for Resident #34 in the nursing progress notes. The weekly nursing notes for Resident #34 were reviewed with the SDC. These notes indicated that Resident #34 consistently had inappropriate behaviors. The SDC was unable to locate any documentation of behavioral monitoring for Resident #34.

An interview was conducted on 2/3/16 at 3:30 PM with the Director of Nursing (DON). The DON stated that she expected nursing staff to document any observed behaviors for all residents on psychotropic medications. She stated that weekly documentation on the nursing summary notes did not fulfill her expectation. She stated that the psychotropic flow sheet or nursing progress notes were to be used for behavior documentation and monitoring.

3. Resident # 109 was admitted to the facility on 10/21/15 with multiple diagnoses including anemia. The quarterly Minimum Data Set (MDS) assessment dated 10/28/15 indicated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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F 329	Continued From page 41	F 329		

Resident #109 had moderate cognitive impairment.

Review of the doctor's orders revealed that on 11/4/15, there was an order for Ferrous Gluconate (iron supplement) 240 milligrams (mgs) by mouth daily for anemia.

On 12/15/15, there was a doctor's order to discontinue the Ferrous Gluconate and to start Ferrous Sulfate 325 mgs daily.

The Medication Administration Records (MARs) for December, 2015 were reviewed. The Ferrous Gluconate was discontinued on 12/15/15 and the Ferrous Sulfate was administered as ordered.

On 1/12/16, there was a doctor's order for Ferrous Sulfate 325 mgs by mouth twice a day for 5 days and then daily.

The MARs for January, 2016 were reviewed. The records indicated that Resident #109 had received Ferrous Gluconate 240 mgs daily from January 1 through January 31st, Ferrous Sulfate 325 mgs twice a day from January 13 through January 17th and Ferrous Sulfate 325 mgs once a day from January 18 through January 31st.

On 2/3/16 at 10:05 AM, Nurse #1 was interviewed. She stated that the Ferrous Gluconate was discontinued in December, 2015 and should not have been transcribed to the January, 2016 MARs. She indicated that she didn't know who transcribed the Ferrous Gluconate to the January, 2016 MARs.

On 2/4/16 at 10:15 AM, the Director of Nursing was interviewed. She indicated that she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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F 329	Continued From page 42 reviewed the orders and the MARs and acknowledged that the Ferrous Gluconate should not be on the January, 2016 MARs because it was discontinued in December, 2015. The Director of Nursing further indicated that there were two nurses who checked the MARs at the end of the month and might have missed it.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate at 5% or below by not following the doctor's orders. There were three errors (Residents #89 & #34) of 25 opportunities for error resulting in a 12 % error rate. Findings included: 1a. Resident #89 was admitted to the facility on 12/30/14. Review of the doctor's orders revealed that Resident #89 had an order dated 11/14/15 for Potassium Chloride 10 millie equivalent (meq) by mouth twice a day with meals due to low potassium. On 1/27/16, there was a doctor's order to change Potassium Chloride to 20 meq daily. On 2/3/16 at 8:21 AM, Resident #89 was observed during the medication pass. Nurse #4 was observed to prepare and to administer the medications for Resident #89 including Potassium Chloride 20 meq. 1 tablet. Resident	F 332	1.Res #89 Medication error incident was completed on 2/3/16. physician was notified, no adverse findings associated. Res #34 Medication error incident was completed on 2/3/16 and physician notified. No adverse findings noted. 2.All Nursing staff will be reeducated by staff development coordinator under guidance of DON,on the 6 rights of medication pass by 3/8/16 and all nurses unable to attend education by 3/8/16 will be in-serviced prior to their assigned shift by their Shift supervisor, Administrative nurse, and or SDC. The nurse #4 was re-educated on 6 rights of Medication pass on 2/5/16. She had a med pass audit completed and Weekly checks on medication pass by Staff Development Coordinator and updates on	3/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 332	Continued From page 43 #89 had not eaten breakfast yet. On 2/3/16 at 8:30 AM, Nurse #4 was interviewed. She stated that normally, she administered the medications for Resident #89 with breakfast but today she did not. Nurse #4 did not give an explanation as to why she administered the medication before meals. On 2/3/16 at 8:40 AM, the breakfast cart was observed and had not been delivered to the floor yet. On 2/4/16 at 9:00 AM, the director of nursing was interviewed. She stated that she expected the nurses to follow the doctor's orders in administering the medications. 1b. Resident #89 was admitted to the facility on 12/30/14. Review of the doctor's orders revealed that Resident #89 had an order dated 12/30/15 for Vitamin B12 500 microgram (mcg) 1 tablet by mouth daily for vitamin B deficiency. On 2/3/16 at 8:21 AM, Resident #89 was observed during the medication pass. Nurse #4 was observed to prepare and to administer the medications for Resident #89 including Vitamin B12 1000 mcg. 1 tablet. On 2/3/16 at 8:30 AM, Nurse #4 was interviewed. She acknowledged that she had administered the wrong dose of Vitamin B12 to Resident #89. On 2/4/16 at 9:00 AM, the director of nursing was interviewed. She stated that she expected the nurses to follow the doctor's orders in administering the medications. 2. Resident # 34 was admitted to the facility on 9/8/15. Review of the doctor's orders for Resident #34 revealed an order dated 10/21/15 for Humalog 5 units subcutaneous (SQ) three times a day with meals for diabetes mellitus. There was also an order dated 10/21/15 for finger	F 332	her progress and compliance given to DON weekly for review. Nurse is no longer employed. Licensed nurses will have a medication pass audit completed by SDC and or DON and or Supervisor and or Administrative nurse, by 3/8/16. Any nurse that is unavailable for the medication audit will have one prior to their next scheduled shift by their supervisor and or administrative nurse and or DON. 3. All new physicians orders are brought to clinical meeting daily for review by DON/Unit Manager for accuracy and then post meeting, the unit manager will ensure orders are transcribed properly to MAR. (Medication administration record.) All incidents involving medication errors will be reviewed in morning department meeting as well as reviewed in clinical meeting for root cause analysis and be tracked according to the incident and accident tracking process. On a daily basis as they occur. Then this will be monitored for issues trends and compliance through the QA process that meets monthly for review. Ongoing monitoring: All licensed nurses will have a medication audit completed upon hire and yearly for competency evaluation by The staff Development Coordinator and or the administrative nurse and or The unit Manager. 4.All medication errors will be tracked by	

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F 332	Continued From page 44 stick blood sugar (FSBS) four times a day (6:30 AM, 11:30 AM, 4:30 P and 8:00 PM) and to give Humalog per sliding scale. The sliding scale indicated to administer 4 units of Humalog for blood sugar of 200-249. On 2/3/16 at 11:30 AM, Nurse #4 was observed to check the FSBS for Resident #34. The blood sugar was 219. On 2/3/16 at 12:05 PM, Nurse #4 was observed to prepare and to administer Humalog 9 (scheduled 5 units and sliding scale 4 units) units to Resident #34. Resident #34 had not had lunch yet. On 2/3/16 at 12:10 PM, Nurse #4 was interviewed. She stated that she administered the Humalog before meals because the order for the sliding scale was 11:30 AM and she didn't want to stick the resident twice. On 2/3/16 at 12:30 PM, the lunch cart was observed to arrive on the floor. On 2/4/16 at 9:00 AM, the director of nursing was interviewed. She stated that she expected the nurses to follow the doctor's orders in administering the medications.	F 332	staff Development Coordinator regarding type of error, trends and root cause analysis ongoing monthly and copy given to DON. This will be brought to QA Monthly for review.	
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).	F 356		3/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 - 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post daily staffing information that was accurate for one of four days of the recertification survey. The findings included: On 2/1/16 at 7:45AM, an initial tour of the facility was conducted. The staff posting located on the wall at the central nursing station was dated 1/31/16. The information for the 7:00PM-7:00AM shift was blank for RN (registered nurse), LPN (licensed practical nurse), CNA (certified nursing assistants), med aide and census. On 2/4/16 at 10:54AM, the Director of Nursing stated each supervisor was supposed to complete their section for their shift and the night supervisor posted the daily staffing sheet for the next day. The Director of Nursing stated she	F 356	1.Sign was correctly finished and accurately placed in public view per regulation on 2/1/16. 2. All Supervising staff will be in-serviced on process and requirements of the nursing staffing sheet by Staff Development Coordinator and or Administrative Nurse and or DON and or Supervisor, by 3/8/16. Any Licensed nurses unavailable will have education prior to their next scheduled shift. 3. Night Supervisor will fill out staffing sheet for following day and post in wall receptacle for display. Charge nurse for each shift will review staffing sheets and make appropriate changes each shift if necessary.	

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F 356	Continued From page 46 expected the daily staff posting information to be completed for each shift. The night supervisor was not interviewed during the recertification survey.	F 356	The Ward Clerk will collect staffing sheets daily, checking for completion. The Clerk will notify DON or her designee: Administrative Nurse and or Unit supervisor, and track any incomplete findings for Review. Ongoing monitoring: Unit Manager/Weekend Supervisor will check daily for accuracy and compliance by tracking any incomplete sheets x 7 days and then weekly x 4 weeks or until compliance met then monthly x 3 months to ensure compliance, then Quarterly 4.The staffing sheet audit tool will be reviewed by DON and retained for compliance review monthly in QA meeting.	
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 discard expired condiments and food by the use by date. The findings included:	F 371	1. All expired condiments/foods was disposed of properly on 2/1/16.	3/8/16

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F 371	Continued From page 47 On 2/1/16 at 8:00 AM the initial tour of the kitchen was completed with the Dietary Manager (DM). The following observations were made: 1. Three (one gallon each) containers of expired prepared yellow mustard located in the dry storage area. The use by dates indicated on the containers were 6/18/15, 10/18/15, and 1/30/16. All of the containers were unopened. At the time of the observation the DM stated that she audits the dry storage are twice per month. She revealed that she must have just overlooked the three containers of mustard. She removed the containers of mustard and disposed of them. 2. One (four quart) storage container filled halfway with macaroni and cheese and labeled with a remove by date of 1/29/16 located in the walk in refrigerator. At the time of the observation the DM stated that she checks the refrigerator every morning Monday through Friday. She revealed that she had not gone through the refrigerator prior to the initial tour. She stated that staff know not to utilize any food items that have exceeded their use by date. She removed the container of macaroni cheese and disposed of the contents. An interview was conducted on 2/3/16 at 11:30 AM with the District Manager of Health Care Services. He stated that he was responsible for the oversight of the Dietary Department. He indicated that his expectation was for all items that were not opened to be used or discarded by the manufacturer's use by date. He additionally indicated that all opened products were to be	F 371	2. An audit was carried out by the dietary manager to look at all food items in the refrigerator and pantry areas where food is stored to ensure there was no expired food products remaining on the premises on 2/1/16 . 3.An audit will be conducted seven times per week for three weeks by the Certified Dietary Manager or Cook. The audit results will be brought before our monthly Quality Assurance meeting by the certified dietary manager to be reviewed/ discussed to ensure no expired food is on the premises. This will ensure the safety of all residents concerning expired foods. All in-servicing and audits will be completed by 3/8/16 On 2/3/16, an in-service educating 100% of the dietary staff was completed by the dietary manager that addressed the fact that all food products in the kitchen must be labelled and has a used-by date on the food products. After the food products are opened or prepared, a used-by date must be placed on the food container that is seven days from the opening/preparing date. The food items must be discarded by the seventh day of the initial preparation date. 2.	

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F 371	Continued From page 48 labeled with the date opened/prepared and a use by date of seven days from the opened/prepared date. All opened items were to be discarded on the seventh day.	F 371		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to contain refuse in the one of two outside dumpsters (Dumpster #2) and failed to close the side sliding door on one of two dumpsters (Dumpster #2) in the outside dumpster area. The findings included: Observation on 2/1/16 at 8:15 AM with the Dietary Manager (DM) of the outside dumpster area revealed five white garbage bags filled with refuse on the ground behind Dumpster #2. Additionally, the sliding door located on the left side of Dumpster #2 was approximately halfway open and a white garbage bag was partially hanging out of the opening. At the time of the observation an interview was conducted with the DM. She stated that refuse should not be on the ground. She stated she did not know how long the five garbage bags had been on the ground outside of Dumpster #2. The DM explained that Dumpster #1 was utilized for cardboard boxes and Dumpster #2 was utilized for all other refuse. She indicated the refuse removal company retrieved the contents of	F 372	1. On 2/1/16 refuse/garbage was removed from behind the dumpster and placed in the dumpster by the house keeper. The sliding door of dumpster number two was closed by the house keeper. 2. On 2/3/16, an in-service educating 100% of the dietary staff was completed by the dietary manager that included proper disposal of all garbage and refuse from the kitchen area. An audit will be carried out seven days per week for three weeks by the dietary manager or cook to inspect the facility garbage dumpster to ensure no garbage or refuse is being dumped on the ground. The dietary manager or cook will also ensure the sliding door and top lids will remain closed at all times. 3. On 2/13/16 an extra garbage dumpster pickup was added by the Administrator each week moving forward to ensure there is no garbage overflow from the	3/8/16

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F 372	Continued From page 49 Dumpster #2 on Mondays, Wednesdays, and Fridays at approximately 12:00 PM. She revealed there had been multiple times in the past when Dumpster #2 became full prior to the scheduled time for refuse removal. She stated the time period over the weekend was particularly a problem time as there was an additional day without refuse removal. She indicated she was not aware of any official procedure for when a dumpster was full. She indicated the dietary department's procedure for when the dumpster was full was to keep their trash inside until the refuse removal company retrieved the contents of the dumpster. An observation on 2/1/16 at 2:30 PM of the outside dumpster area revealed no concerns. An interview was conducted on 2/3/16 at 7:55 AM with the District Manager of Health Care Services. He stated he was responsible for the oversight of the Dietary Department. He indicated the maintenance and monitoring of the dumpster area was a team effort with the housekeeping department. He stated his expectation was for the dumpster area to be free of garbage on the exterior of the dumpsters and for all dumpster lids and doors to be fully closed. He indicated he was unaware of any facility procedure for when the dumpsters were full. He stated the dietary department's procedure for when the dumpster was full was to keep their trash inside until the refuse removal company retrieved the contents of the dumpster. He stated he was unsure what the housekeeping staff's procedure was for when the dumpsters were full, but that it did not matter what department had placed the garbage outside of the dumpsters as both departments were responsible for the	F 372	facility in the future. Garbage is now being collected four times per week increased from three times per week to ensure no resident will be affected by garbage lying on the ground outside the dumpster. All education and in-servicing will be completed by 3/8/16.	

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F 372	Continued From page 50 maintenance and monitoring of the area. An interview was conducted on 2/3/16 at 7:58 AM with Housekeeping Staff #1. He stated the maintenance and monitoring of the dumpster area was the responsibility of the housekeeping and dietary staff. He indicated it was a joint effort. He revealed he was unaware of what procedure was followed when a dumpster was full. An interview was conducted on 2/3/16 at 12:04 PM with the Administrator. He stated his expectation for the dumpster area was for the area to remain clean at all times with all lids and doors closed fully. He stated no garbage was to be located on the ground outside of the dumpsters. He indicated the maintenance and cleanliness of the dumpster area was a shared responsibility with the dietary department, the housekeeping department, and the maintenance department. He revealed he was not aware of any issues with dumpsters being full prior to the refuse removal company's scheduled retrieval. He stated his expectation was for staff to inform him when a dumpster was full so an additional retrieval time could be scheduled with the refuse removal company.	F 372		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and	F 412		3/8/16

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F 412	Continued From page 51 must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and record review the facility failed to provide preventative dental services to a resident on Medicaid for 1 of 1 resident's (Resident # 90). The findings included: Resident #90 was admitted 11/20/14 with diagnoses including cardio vascular disease, hypertension and diabetes. The Annual Minimum Data Set (MDS) assessment dated 12/4/15 revealed Resident #90 was cognitively impaired and had no swallowing or dental problems. Observation of Resident #90 on 2/1/16 at 10:30 AM revealed that he was missing two upper teeth: his left front tooth (incisor) and the tooth next to his right front tooth (canine). Review of the medical record from 11/20/14 through 2/3/15 revealed that there were no orders for dental services and no dental consults in the medical record. Interview with the Social Worker on 2/3/16 at 4:17 PM revealed that she maintains the list of resident's to be seen by the dentist, who comes to the facility every 6 months. She stated that the dentist would be coming next on 2/18/16 but she did not have Resident #90 on the list to be seen by the dentist for preventative dental services. She also said that all residents were to be	F 412	1.Resident # 90 has been referred to dentist for consult and treatment on 2/18/16. 2. An audit by MSW, of all long term residents will be done on residents who have not had dental services during the year. The list of residents who have not had any dental services will have services scheduled by MSW. Any refusals will be documented in the medical record by MSW by 3/8/16. Results of audit and any needs identified will be reviewed with Unit Supervisor for follow up. 3. Standing orders will be initiated by facility physicians for consulting Dental services for all long term care residents for routine/PRN dental needs. MSW will address routine dental consultation with Family and or Resident on admit and at annual review. This will be documented in the chart by MSW. MSW and or her Admissions Assistant: will track on a dental services log tool. The will include a year to date listing of patients who received Dental consults, comparing with the current long term care patients, reconciling need for consult and facilitating consult option with patient and	

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F 412	Continued From page 52 provided routine dental services. The Social Worker added that the exceptions were when a Resident's Responsible would to dental services, or when a resident had a history of refusing dental services when the dentist came to provide the service, To put a resident on the list to be seen by the dentist the SW said she needed an order and that it was the responsibility of Nursing to obtain that order from the doctor. She then said she would review her records further to see if she could find any record of Resident #90 having been on the list to be seen by the dentist since admission. Interview with the Social Worker on 2/3/16 at 5:30 PM revealed that Resident #90 had not been on the list to be seen by the dentist since his admission. On 2/4/16 at 9:15 AM interview with Resident #90 revealed that he had no problems eating and no concerns with his mouth or teeth at this time. On 2/4/16 at 4:30 PM interview with the Director of Nursing (DON) revealed that she expected residents to receive preventative dental services as required.	F 412	or family to review and offer. 4. The MSW and or her Admissions Assistant will track on a dental services log weekly and bring to QA monthly to ensure compliance.	
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 490		3/8/16

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F 490	Continued From page 53 by: Based on observation, record review and staff interviews, the facility implemented the use of a new van without ensuring the seat belting was for adults and that lap and shoulder belts were in place, failed to provide training for the transportation driver prior to use of the new van, failed to possess manufacturer's instructions and manual for proper securement devices and how to accurately apply the devices, failed to impose expectations that all incidents would be reported to administration immediately and failed to complete a root cause analysis after a serious incident. The findings included: Immediate jeopardy began on 1/8/16 when the facility started to use the new van to transport residents to and from appointments. The transportation driver had not received training prior to using the new van in how to accurately apply the securement devices for the wheelchair resulting in an accident. The incident was not immediately reported to administration and a root cause analysis was not completed following the accident. On 2/2/16 at 4:43 PM, the Administrator was informed of the Immediate Jeopardy for F 490. The Immediate Jeopardy was removed on 2/4/16 at 6:20 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems have been put into place and are effective, the facility van has the appropriate securement system installed and all staff have been in-serviced. This tag is cross-referred to F323. Based on observation, record review, resident and staff interviews, the facility failed to properly secure one of one sampled residents reviewed	F 490	1. On 2/2/16 the facility transport van was taken out of service until the proper securement system could be verified by the manufacturer. On 2/5/16 the facility Administrator went to a manufacturer approved securement system installer. A qualified technician verified what type of securement system the facility van was equipped with and then contacted the manufacturer and sent photos of the securement system to the manufacturer to verify what type of securement tie down straps the van was equipped with. New securement straps were purchased during the visit to a manufacturer certified installer and new securement equipment was installed onsite on 2/5/16. A qualified technician did give instruction to the Administrator on the proper method of using the securement system and how to secure a patient in a wheel chair while on the transport van. This is a three point securement system. A new instructional DVD was purchased for training purposes for any staff member that will drive or assist on the transport van and use the securement system. The Administrator conducted the training sessions beginning on 2/29/16 and completed on 3/1/16. This training was documented on an in-service sheet and conducted by the Administrator. The transport van is not currently being used on weekends.	

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F 490	Continued From page 54 for accidents (Resident #97) and the wheelchair in the transportation van according to manufacturer ' s instructions resulting in Resident #97 tipping over in the wheelchair and hitting her right stump on the floor of the van, failed to immediately notify administration about the accident and failed to complete a root cause analysis of the incident. On 2/2/16 at 4:43 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 2/4/16 at 6:00PM. The allegation of compliance indicated: Credible Allegation of Compliance: An emergency meeting was convened on 2/3/2016 with all Administrative Staff and members of the QA committee, excluding the Pharmacist, to review the current transport accident that happened on 1/8/2016 and was reported to the Administrator and Director of Nursing on 2/2/2016. Effective 2/3/2016 and every weekday (Monday-Friday) thereafter, morning meetings will be conducted with all department heads to discuss daily issues and to include incident/accident reporting. QA meetings will be held monthly instead of quarterly to be conducted with members of the QA Committee to discuss all issues occurring during the month with emphasis on resident safety, safe transportation, and all safety concerns. The Kingswood Nursing Facility Transport Van was taken out of service on 2/2/16. This transport van will not be in service until an authorized wheel chair tie down system technician can correctly install the tie downs correctly with the correct shoulder harness and all relevant documentation will be provided to the state surveyors. The facility will continue to use an outside transport agency to transport all residents to and from	F 490	The Administrator will watch the van driver secure patients in the van before transport, twice per week x2 weeks. An emergency meeting was convened on 2/3/2016 with all Administrative Staff and members of the QA committee, excluding the Pharmacist, to review the current transport accident that happened on 1/8/2016 and was reported to the Administrator and Director of Nursing on 2/2/2016. All actively working staff was in-serviced on 2/3/16 on the facilities accident and incident reporting policy. All remaining staff will be in-serviced on the facilities accident and incident reporting policy before returning to work. Accident and incident education will be added to orientation all new hires moving forward. This in-servicing will be completed by 3/8/16. Effective on 2/3/2016 and every weekday (Monday-Friday) thereafter, morning standup meetings will be conducted with all department heads to discuss daily issues and to include incident/accident reporting. This will be ongoing with no end date. Quality Assurance meetings will now be held monthly instead of quarterly to be conducted with members of the Quality Assurance Committee to discuss all issues occurring during the month with	

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F 490	Continued From page 55 appointments until the proper securement system is installed by an authorized agent. From 2/3/2016 moving forward, the Administration of the facility will use resources for prevention of accidents/ incidents, effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This will be mandated by everyone attending the QA meeting. The Administrator will adjudicate this process to ensure full compliance with all facility policies and processes followed by the facility and decide if any additional processes need to be modified. The QA committee will have an emphasis on safety, and incident reporting. The director of operations has been in touch with the facility Administrator each day but is not familiar with the van wheelchair tie down system as we just bought the transport van in January. The director of operations will continue to monitor the administration of the facility on a monthly basis with an onsite visit to ensure all issues at the facility are being addressed properly. The credible allegation was verified 2/4/16 at 6:20 PM when the transportation driver verified that the transportation van had been out of service since 2/2/16 and the facility was currently sing an outside transportation company for all transports.	F 490	emphasis on resident safety, safe transportation, and all safety concerns.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		3/8/16

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F 514	Continued From page 56 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain complete physician progress notes in the medical records for six (Residents #6, #34, #17, #83, #10, & #90) of six sampled residents, resulting in the failure to provide psychiatric services for one (Resident #6) of six sampled residents. Findings included: 1. Resident #6 was initially admitted to the facility on 8/14/13 and readmitted on 12/16/13. The annual Minimum Data Set (MDS) assessment indicated Resident #6 had moderate cognitive impairment. A review of Resident #6's medical record revealed the most recent physician's progress note was dated June 2015. There were no physician progress notes in the medical record dated after June 2015 for Resident #6. An interview was conducted on 2/3/16 at 11:30 AM with the Medical Records Manager. She indicated she had started working in the Medical Records Department recently. She stated that to her knowledge all physician progress notes received at the facility for Resident #6 were placed in the medical record. An interview was conducted on 2/3/16 at 3:30 PM	F 514	1.Res #6 missing Progress notes were obtained and in the chart on (2/3/16) Res #34 Missing progress notes were obtained and in the chart on 2/3/16 Res #17 Missing progress notes were obtained and in chart on 2/3/16 Res #83 Missing notes will be obtained and placed in the chart by 3/8/16. Res #10 Progress Notes will be obtained and placed in the chart by 3/8/16. Res #90 Progress Notes progress notes will be obtained and placed in the chart by 3/8/16. 2. 100% audit on all active charts for appropriate sequential progress notes per state and federal guidelines will be completed by Medical Records Director. Any notes not found in charts will be obtained through the MD office. Medical records manager will be assigned to obtain these and have them in the medical chart by 3/8/16. 3. Progress notes will be routed upon entry to facility, to the Unit Manager to be reviewed in daily clinical meeting prior to being placed in MD book for review and or being placed in the chart.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 514	Continued From page 57 with the Director of Nursing (DON). She stated that she expected all physician progress notes to be in the medical records. She revealed the facility was not monitoring the medical records for completeness and accuracy. She stated she would contact the attending physician for Resident #6 to obtain the physician progress notes that were not at the facility. A follow up interview was conducted on 2/3/16 at 5:25 PM with the DON. She stated the attending physician's office had faxed the facility the progress notes that were not located in the medical record for Resident #6. The newly obtained physician progress notes for Resident #6 were reviewed. The progress notes were current through January 2016. The DON indicated the attending physician for Resident #6 apologized for the long turn around with the progress notes. A newly acquired physician's progress note from 1/7/16 was reviewed for Resident #6. The progress note revealed that Resident #6 had made multiple calls to his office reporting that she wanted to leave the facility to return home. The physician indicated it was not a realistic plan for Resident #6 to return home and that a psychiatric visit for a medication review was needed. An interview was conducted on 2/3/16 at 5:35 PM with the Social Worker (SW). She stated that Resident #6 had not received a psychiatric consultation. The 1/7/16 physician's progress note for Resident #6 was reviewed with the SW. She revealed she had not viewed this progress note previously and was not aware the attending physician wanted a psychiatric consultation for Resident #6. The SW reviewed the normal	F 514	An audit tool will be implemented Medical Records Manager to track the physician progress notes. Medical records will audit 25 Charts per week for progress notes and regulatory compliance of MD visits and review. Any missing notes will be reported via audit tool by medical records to DON. Medical records will then contact MD by phone or fax for missing progress notes. to ensure regulatory compliance. 4. Medical records review will be conducted on 25 charts a week for progress notes and their compliance with regulation, weekly for 4 weeks or until compliance met then Monthly to ensure compliance. Monthly chart audit findings will be brought to QA by Medical Records to review for trends and compliance.	

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	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 514	Continued From page 58	F 514		

procedure for coordinating a psychiatric consultation. She stated that when the physician's progress notes were received at the facility they were reviewed by nursing staff. She stated nursing staff then obtained a physician's order for the psychiatric consult. She indicated that nursing staff informed her when the order was received and then she scheduled the psychiatric consultation. The SW revealed this process was not followed for Resident #6 and she was unsure where the breakdown in the process occurred. She stated she was going to contact the attending physician for Resident #6 and obtain an order for a psychiatric consultation and then schedule the consultation.

2. Resident # 34 was initially admitted to the facility on 7/3/15 and readmitted on 9/8/15. The quarterly Minimum Data Set (MDS) assessment dated 1/5/16 indicated Resident #34 had significant cognitive impairment.

A review of Resident #34's medical record revealed the most recent physician ' s progress note was dated September 2015. There were no physician progress notes in the medical record dated after September 2015 for Resident #34.

An interview was conducted on 2/3/16 at 11:30 AM with the Medical Records Manager. She indicated she had started working in the Medical Records Department recently. She stated that to her knowledge all physician progress notes received at the facility for Resident #34 were placed in the medical record.

An interview was conducted on 2/3/16 at 2:30 PM with the nursing staff of the attending physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 514	Continued From page 59	F 514		

for Resident #34. She stated that Resident #34 was most recently seen by the physician in January 2016 and in November 2015 by their Nurse Practitioner. She indicated there was generally a two week turn around for the records to be received at the facility. She revealed she was unsure if the breakdown in the process occurred on their end or on the facility end. She stated she was going to have the progress notes for Resident #34 faxed to the facility that afternoon.

An interview was conducted on 2/3/16 at 3:30 PM with the Director of Nursing (DON). She stated she expected all physician progress notes to be in the medical record. She revealed the facility was not monitoring the medical records for completeness and accuracy.

A follow up interview was conducted on 2/3/16 at 5:16 PM with the DON. She indicated the attending physician's office had faxed the facility the progress notes that were not located in the medical record for Resident #34. The newly obtained physician progress notes for Resident #34 were reviewed. The progress notes were current through January 2016.

3. Resident # 17 was admitted to the facility on 9/4/07 with multiple diagnoses including Convulsions and Diabetes Mellitus. The quarterly Minimum Data Set (MDS) assessment dated 12/16/15 indicated that Resident #17 had severe cognitive impairment.

The clinical records of Resident #17 were reviewed. There was only 1 doctor's progress note dated 2/26/15 noted in the record for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 514	Continued From page 60	F 514		

year 2015.

On 2/4/16 at 11:15 AM, the Social Worker was interviewed. The Social Worker stated that the attending doctor of Resident #17 regularly came to the facility weekly on Wednesdays but she did not know the list of residents the doctor was visiting weekly. The Social Worker had reviewed the resident's clinical records and indicated that she would call the doctor's office if they had additional progress notes for Resident #17.

On 2/4/16 at 11:50 AM, the Social Worker provided additional progress notes dated 7/25/15, 9/9/15, 11/11/15 and 1/6/16. She indicated that the doctor's office had sent these notes via fax.

On 2/4/16 at 2:10 PM, the Director of Nursing was interviewed. She stated that she expected the attending doctor to see their residents every 60 days and their progress notes placed in the resident's records. The Director of Nursing further stated that she was not aware that some doctor's progress notes were not available in the resident's clinical records. She revealed that the medical record person was new to the facility and nobody had been monitoring the resident's clinical records for accuracy and completeness.

4. Resident # 83 was admitted to the facility on 5/20/14 with multiple diagnoses including Dementia with Lewy bodies, Major Depressive Disorder, Diabetes Mellitus and Anxiety. The quarterly Minimum Data Set (MDS) assessment dated 11/6/15 indicated that Resident #83 had memory and decision making problems.

The clinical records of Resident #83 were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 514	Continued From page 61	F 514		

reviewed. There were only 2 doctor's progress notes dated 1/8/15 and 6/3/15 noted in the resident's clinical records for the year 2015.

On 2/4/16 at 11:15 AM, the Social Worker was interviewed. The Social Worker stated that the attending doctor of Resident #83 regularly came to the facility weekly on Wednesdays but she did not know the list of residents the doctor was visiting weekly. The Social Worker had reviewed the resident's clinical records and indicated that she would call the doctor's office if they had additional progress notes for Resident #83.

On 2/4/16 at 11:50 AM, the Social Worker provided additional progress notes dated 7/23/15, 9/2/15, 11/11/15 and 1/8/16. She indicated that the doctor's office had sent these notes via fax.

On 2/4/16 at 2:10 PM, the Director of Nursing was interviewed. She stated that she expected the attending doctor to see their residents every 60 days and their progress notes placed in the resident's records. The Director of Nursing further stated that she was not aware that some doctor's progress notes were not available in the resident's clinical records. She revealed that the medical record person was new to the facility and nobody had been monitoring the resident's clinical records for accuracy and completeness.

5. Resident #90 was admitted to the facility on 11/20/14. The annual Minimum Data Set (MDS) assessment dated 12/4/15 indicated Resident #90 was severely cognitively impaired.

A review of Resident #90's medical record revealed the most recent physician's progress note was dated November 2015. There were no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 514	Continued From page 62	F 514		

physician progress notes in the medical record dated after November 2014 for Resident #90.

An interview was conducted on 2/3/16 at 11:30 AM with the Medical Records Manager. She indicated she had started working in the Medical Records Department recently. She stated that to her knowledge all physician progress notes received at the facility for Resident #90 were placed in the medical record.

An interview was conducted on 2/3/16 at 3:30 PM with the Director of Nursing (DON). She stated that she expected all physician progress notes to be in the medical records. She revealed the facility was not monitoring the medical records for completeness and accuracy. She stated she would contact the attending physician for Resident #6 to obtain the physician progress notes that were not at the facility.

A telephone interview was conducted with Resident #90's Attending Physician on 2/4/16 at 11:30 AM. The Physician said his progress notes were not in the facility and on the resident's medical record due to a problem in his office. He also said he was having the missing notes faxed to the facility but aware his progress notes should have been at the facility and in the medical record already. He added that he would be working to fix the problem.

6. Resident #10 was admitted to the facility on 6/16/10. The annual Minimum Data Set (MDS) assessment dated 12/7/15 indicated Resident #10 had moderate cognitive impairment.

A review of Resident #10's active medical chart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 514	Continued From page 63 revealed there were no physician's progress notes present. An interview was conducted on 2/3/16 at 3:30 PM with the Director of Nursing (DON). She stated that she expected all physician progress notes to be in the medical records. She revealed the facility was not monitoring the medical records for completeness and accuracy. An interview was conducted on 2/4/16 at 10:30 AM with the Medical Records Manager. She indicated that she was unable to locate any physician progress notes for the year 2015 in Resident #10 ' s active or thinned medical record. She added that any physician notes received by the facility should already have been filed in Resident #10's medical record. A telephone interview was conducted with Resident #10's Attending Physician on 2/4/16 at 11:30 AM. The Physician said his progress notes were not in the facility and on the resident's medical record due to a problem in his office. He also said he was having the missing notes faxed to the facility but aware his progress notes should have been at the facility and in the medical record already. He added that he would be working to fix the problem.	F 514		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520		3/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 520	Continued From page 64 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility's Quality Assessment and Assurance committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place in March of 2015. This was for five (5) recited deficiencies which were originally cited on 3/26/15 during the recertification survey and on the current recertification/complaint investigation survey (F278, F279, F323, F329 and F490). The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included:	F 520	Corrective action for the alleged deficiencies in the following areas: Assessment accuracy, comprehensive care plans, accidents, drug regimen free from unnecessary medications, and Administration/resident well being was accomplished by correcting each of the alleged deficient practices according to the proposed facility plan of correction. To ensure others are not affected by the same alleged deficient practices, all staff received educational in-services beginning on 2/2/16 and will be completed by 3/8/16. Each staff member was informed of all	

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	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 520	Continued From page 65 Immediate jeopardy began on 1/8/16 for F323 at scope/ severity (s/s) J, F490 s/s J and F520 s/s J and was removed on 2/4/16 at 6:20 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems have been put into place and are effective, the facility van has the appropriate securement system installed and all staff have been in-serviced. F278 is cited at s/s D, F279--s/s D and F329-s/s D. This tag is cross referred to: 1. F323: Accidents: Based on observation, record review, resident and staff interviews, the facility failed to properly secure one of one sampled residents reviewed for accidents (Resident #97) and the wheelchair in the transportation van according to manufacturer's instructions resulting in Resident #97 tipping over in the wheelchair and hitting her right stump on the floor of the van, failed to immediately notify administration about the accident and failed to complete a root cause analysis of the incident. During the recertification survey of 3/26/15, the facility was cited F323 for failure to maintain water temperatures at or less than 116 degrees Fahrenheit (F) in eight (8) of eleven (11) resident's rooms (room #102,#103,#114,#201,#202,#203,#215,#302) and two (2) of two (2) central bathrooms (100 and 400 hall). Immediate jeopardy began on 1/8/16 and was removed on 2/4/16 at 6:20 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no	F 520	findings and remedies. In addition, these alleged deficient practices and plan of correction will be discussed in orientation for all new hires. This will continue for twelve months of substantial compliance. To ensure that each of these areas: assessment accuracy , comprehensive care planes , accidents, drugs regimen free from un-necessary medications and administration/ resident wellbeing remain in compliance a substantial compliance tool for each tag will be completed monthly by DON, Administrator or SDC. The tool will be created by the QAPI process improvement team. To be completed monthly. Any negative findings found by tools will be discussed immediately with the administrator with immediate correction and plan of action required. To ensure that the system is effective a report of the findings will be discussed monthly during QA for twelve months after continued substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 520	Continued From page 66	F 520		

actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems have been put into place and are effective, the facility van has the appropriate securement system installed and all staff have been in-serviced.
On 2/4/16 at 3:48 PM, an interview was conducted with the Director of Nursing and the staff development coordinator. The staff development coordinator stated they were still monitoring for the hot water which was the F323 in 2015 but did not monitor for accidents in the transportation van because there had been no incidents prior to the accident on 1/8/16.
2. F490: Effective Administration: Based on observation, record review and staff interviews, the facility implemented the use of a new van without ensuring the seat belting was for adults and that lap and shoulder belts were in place, failed to provide training for the transportation driver prior to use of the new van, failed to possess manufacturer ' s instructions and manual for proper securement devices and how to accurately apply the devices, failed to impose expectations that all incidents would be reported to administration immediately and failed to complete a root cause analysis after a serious incident.
During the recertification survey of 3/26/15, the facility was cited F490 for failure to utilize the manufacturer ' s instructions to maintain and monitor the hot water system, failure to have a policy and procedure to address notification of administration when the hot water problem was not promptly resolved and failure to monitor and train the maintenance supervisor on the mixing valve. The administrator was not aware that the maintenance supervisor was not providing preventative maintenance on the mixing valve

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 520	Continued From page 67	F 520		

and was not aware that the maintenance supervisor was not monitoring the water temperatures in the shower rooms.
Immediate jeopardy began on 1/8/16 when the facility started to use the new van to transport residents to and from appointments. The transportation driver had not received training prior to using the new van in how to accurately apply the securement devices for the wheelchair resulting in an accident. The incident was not immediately reported to administration and a root cause analysis was not completed following the accident. On 2/2/16 at 4:43 PM, the Administrator was informed of the Immediate Jeopardy for F490. The Immediate Jeopardy was removed on 2/4/16 at 6:20 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems have been put into place and are effective, the facility van has the appropriate securement system installed and all staff have been in-serviced.
On 2/2/16 at 3:49 PM, the Administrator and Director of Nursing were informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 2/4/16 at 6:00PM. The allegation of compliance indicated:
Credible Allegation of Compliance:
An emergency meeting was convened on 2/3/2016 with all Administrative Staff and members of the QA committee, excluding the Pharmacist, to review the recent accident on the facility transport van and to review the facility policy on incident/accident reporting that was reported to the Administrator and Director of Nursing on 2/2/2016. Effective 2/3/2016 and every weekday (Monday-Friday) thereafter,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 520	Continued From page 68	F 520		

morning meetings will be conducted with all department heads to discuss daily issues and to include incident reporting. QA meetings will be held monthly instead of quarterly to be conducted with members of the QA Committee to discuss all issues occurring during the month with emphasis on resident safety, safe transportation, and all safety concerns.
Responsibilities contiguous to the F-520 tag for the areas of concern were delegated to designated individuals, i.e. delegation of Administrator to follow up with the transport driver to review the transport driver ' s pre-trip inspection reports weekly x4 weeks, DON, and SDC to lead mandatory in-services on notification of incidents and accident reporting. The incident/accident education will be added to the orientation process for ALL new hires from 2/4/2016, not just nursing staff.
The credible allegation was verified 2/4/16 at 6:20 PM as evidenced by staff interviews on the policy and procedure for reporting incidents/accidents, what to do if any type of incident/accident occurred no matter how minor, whom to report to, when to write the incident report and whom to notify in case of an incident/accident. The Transportation driver verified that the van had been out of service since 2/2/16 and the facility was currently using an outside transportation company for all transports.
A review of the in-service for the policy and procedure for incidents/ accidents revealed 94 staff members had been in-serviced as of 2/4/16 at 6:20 PM.
On 2/4/16 at 3:48 PM, an interview was conducted with the Director of Nursing and the staff development coordinator. The staff development coordinator stated there had been four (4) Director of Nursing personnel since the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 02/04/2016

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 520	Continued From page 69	F 520		

last survey on 3/26/15 and three (3) Administrators over the past year. He also stated the Administrator had been here five (5) months and the Director of Nursing just under three months. Turnover of administrative staff was a factor in the repeat deficiencies.
3. F278: Assessment accuracy: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for medications for one of five residents (Resident#34) reviewed for unnecessary medications.

During the recertification survey of 3/26/15, the facility was cited F278 for failure to accurately code Preadmission Screening Resident Review (PASRR) on the Minimum Data Set (MDS) for three of three residents admitted with a PASRR level 2 (Resident #37, #83 and #92). On the current recertification/ complaint investigation survey of 2/4/16, the facility failed to accurately code the MDS assessment for medications for one of five residents (Resident #34).

On 2/4/16 at 3:48 PM, an interview was conducted with the Director of Nursing and the staff development coordinator. The Director of Nursing stated the corporate nurse consultant made her aware of the previous survey and the deficiencies cited. The staff development coordinator stated there had been new staff hired for the MDS position to assist the current MDS nurse. As the MDS coordinator was training new staff, the new staff were inputting data in the computer. Therefore, errors might have occurred. The staff development coordinator also stated they had hired three people to help with the MDS process and all three were no longer employed at the facility. Turnover was also a

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F 520	Continued From page 70	F 520		

factor.

4. F279: Develop a comprehensive care plan: Based on record review and staff interviews, the facility failed to develop a care plan for one of one residents (Resident #97) whose Care Area Assessment (CAA) indicated that falls would be addressed in the care plan.

During the recertification survey of 3/26/15, the facility was cited F279 for failure to develop a care plan to address the limitation in range of motion for one (Resident#10) of one sampled residents with a left hand contracture. On the current recertification/complaint investigation survey of 2/4/16, the facility failed to develop a care plan for falls as noted on the CAA for falls for one of one residents (Resident #97).

On 2/4/16 at 3:48 PM, an interview was conducted with the Director of Nursing and the staff development coordinator. The staff development coordinator stated there had been a lot of turnover in the MDS department which could have contributed to the omission of the falls care plan.

5. F329: Drug regime free from unnecessary medications: Based on record review, staff interview, and resident interview, the facility failed to administer antipsychotic medications as ordered by a physician for one of five residents (Resident #6), failed to monitor behaviors for residents receiving psychotropic medications for two of five residents (Residents #6, #34), and failed to discontinue a medication as ordered for one of five residents (Resident #109) reviewed for unnecessary medications.
During the recertification survey of 3/26/15, the

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F 520	Continued From page 71 facility was cited F329 for failure to obtain laboratory tests as ordered by the physician for one (1) of five (5) sampled residents (Resident #91) reviewed for unnecessary medications. On 2/4/16 at 3:48 PM, an interview was conducted with the Director of Nursing and the staff development coordinator. Both stated the process of checking the physician ' s orders had been changed in January 2016. They stated the process of double checking the physician orders and the Medication Administration Record (MAR) might have been completed but the process was so recent that it was too early to catch.	F 520		