STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING ______ B. WING ______	C 07/24/2019

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 000	INITIAL COMMENTS A complaint investigation survey was conducted on 7/24/19. 1 of the 1 complaint allegation was substantiated resulting in deficiencies (F684 and F842).	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to provide treatments as ordered for 1 of 1 resident reviewed with a surgical wound (Resident #1). The findings included: Resident #1 was admitted to the facility on 6/19/19 and discharged on 6/23/19. His diagnoses included amputation of the second and third toes on the right foot, diabetes, osteomyelitis (inflammation of the bone or bone marrow due to an infection) of the right ankle and foot, and peripheral artery disease (PAD). Review of Resident #1's 6/19/19 hospital discharge orders for the right foot surgical wound read as follows: Silver Sulfadiazine 1% cream, apply topically daily. Last time was given 6/18/19	F 684	F684 – Quality of Care 1. The facility failed to provide treatments as ordered for 1 of 1 resident reviewed with a surgical wound. Resident #1 was discharged on 6/23/19. Resident #1 medical record reviewed by Director of Nursing (DON) and Unit Manager and no further discrepancies found. 2. Residents in the facility have the potential to be affected by the alleged deficient practice. On 8/1/2019, the DON and Minimum Data Set (MDS) Coordinator conducted an audit of the Treatment Administration Records for admissions and readmissions with effective dates 7/1/2019 – 7/31/2019. Treatments ordered were found to be	8/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/05/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 at 10:24am. During a review of the June 2019 Treatment Administration Record (TAR), revealed Resident #1's right foot surgical wound dressing change was not initialed as done on the following dates: 6/19/19 and 6/20/19. A review of the daily staffing assignment sheet dated 6/20/19 indicated the Treatment Nurse had called out for the day. There was no replacement indicated on the staffing sheet for a Treatment Nurse. Review of the baseline care plan revealed Resident #1 was marked with a care area for amputation. The interventions included to assess wound site and treatments as ordered. A review of the admission Minimum Data Set (MDS) dated 6/23/19 revealed Resident #1 to have moderately impaired cognition, displayed no behaviors and was coded with a surgical wound. An interview with the Treatment Nurse was conducted on 7/24/19 at 9:35am. The Treatment Nurse stated she could not recall assessing or changing the dressing for Resident #1's surgical wound when he was admitted on 6/19/19. The physician was interviewed on 7/24/19 at 10:19am and stated Resident #1 had suffered with a chronic ulcer to his right foot for some time and the amputation of his right second and third toes on 6/14/19, was done in an attempt to save his leg due to diagnoses of diabetes and PAD. The physician indicated Resident #1 suffered from lack of blood flow in the right leg which would slow down the healing process to the right	F 684	completed. 3. On 7/25/2019, the DON re-educated Nurse #1, #2, #3, and the Treatment Nurse on maintaining accurate documentation for wound assessments and completion of Treatment Administration Records. On 7/25/2019, the DON began re-education of all licensed nurses. This will be completed by 8/5/19. Any Licensed Nurse that has not received re-education by 8/5/19 will receive re-education prior to the next working shift. 4. Beginning 8/5/2019, the DON and/or unit manager will audit 5 treatment administration records weekly for 4 weeks then 3 treatment administration records weekly for 4 weeks then 2 treatment administration records weekly for 4 weeks to ensure all treatments have been completed as ordered. The DON and/or Unit Manager will present the audit results to the facility Quality Assurance Performance Improvement (QAPI) Meeting monthly x 3 months. Any issue or trends identified will be addressed by QAPI as they arise and the evaluation plan will be revised to ensure continued compliance. 5. The DON and the Unit Manager are responsible for implementing and maintaining the acceptable Plan of Correction. Corrective action completed by 8/5/19.	

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F 684	Continued From page 2	F 684		

foot surgical wound. His expectation would be for the facility staff to change the surgical wound dressing as ordered daily.

On 7/24/19 at 12:32pm a phone interview was completed with Nurse #1. She indicated she had completed the Admission Nursing Evaluation Data Collection form on 6/19/19, but she did not assess or change Resident #1's surgical wound to the right foot. She stated since he was admitted on the second shift, she felt like the Treatment Nurse would assess the surgical wound and change the dressing on the following day.

A phone interview occurred with Nurse #2 on 7/24/19 at 1:20pm. She explained she completed Resident #1's head to toe assessment and admission nursing note on 6/19/19 but did not assess or change the dressing to his right foot.

On 7/24/19 at 1:25pm the Director of Nursing (DON) stated if a resident was admitted on 2nd shift, the dressing changes were deferred until the next day unless otherwise ordered, with the thought that the hospital would have changed the dressing prior to transfer. She further stated the Treatment Nurse would assess any wounds on the day of admission or the next day if she had already left the facility. The DON explained the nursing staff are expected to complete their assigned resident's dressing changes if the Treatment Nurse was out and not replaced, however, Medication Aides were not allowed to change dressings. She indicated that neither she nor the Unit Manager changed the dressing for Resident #1 on 6/19/19 or 6/20/19. The DON indicated it was her expectation the dressing change to Resident #1's right foot should have

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F 684	Continued From page 3 been completed on 6/20/19. An interview was conducted with Nurse #3 on 7/24/19 at 1:40pm. Nurse #3 was noted to be on the staffing schedule for 1st shift on 6/20/19. She indicated she did not change the dressing to Resident #1's right foot on 6/20/19 as she was not assigned to his hallway. On 7/24/19 at 2:00pm an interview occurred with the Administrator who stated it was her expectation for wound care to be completed as ordered.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		8/12/19

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regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 5 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records for 1 of 1 resident reviewed for wound care (Resident #1). The findings included: Resident #1 was admitted to the facility on 6/19/19 and discharged on 6/23/19. His diagnoses included amputation of the second and third toe on the right foot, diabetes, osteomyelitis (inflammation of the bone or bone marrow due to an infection) of the right ankle and foot, and peripheral artery disease (PAD). A review of the Nursing Evaluation Data Collection form marked as an Admission for 6/19/19 revealed the form was not signed or dated. A review of the admission Minimum Data Set (MDS) dated 6/23/19 revealed Resident #1 to have moderately impaired cognition. On 7/24/19 at 12:32pm a phone interview was completed with Nurse #1. Nurse #1 was listed on the Daily Staffing Sheet as the 2nd shift Charge Nurse for 6/19/19. She indicated she had completed the Admission Nursing Evaluation Data Collection form for Resident #1's admission on 6/19/19 and it was an oversight not to have signed or dated the form at the time of the completion.	F 842	F842 – Resident Records – Identifiable Information 1. The facility failed to maintain an accurate medical record for resident #1 for wound care. Resident #1 was discharged on 6/23/19. Resident #1 medical record reviewed by the Director of Nursing (DON) and Unit Manager and there were or discrepancies found. 2. Residents in the facility have the potential to be affected by the alleged deficient practice. On 7/25/2019 an audit of admissions/readmissions with effective dates 7/1/2019 – 7/31/2019 was completed. No other residents were found to be affected by this deficient practice. Beginning 7/25/2019, the DON, Staff Development Coordinator (SDC), Unit Manager and Minimum Data Set (MDS) Coordinator will review admissions/readmissions during the daily clinical meeting. 3. On 7/25/2019, Licensed Nursing Staff was re-educated by the DON and Unit Manager regarding maintaining accurate medical records and completion of Nursing Evaluation Data Collection Form. This will be completed by 8/5/19. Any Licensed Nurse that has not received re-education by 8/5/19 will receive re-education prior to the next working shift.	

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F 842	Continued From page 6 A phone interview occurred with Nurse #2 on 7/24/19 at 1:20pm. Nurse #2 was listed on the Daily Staffing Sheet as the 2nd shift nurse for Resident #1's room on 6/19/19. She explained she completed Resident #1's head to toe assessment and admission nursing note on 6/19/19, but she did not complete the Admission Nursing Evaluation Data Collection Form. On 7/24/19 at 2:00pm an interview occurred with the Administrator and the Director of Nursing. They both stated it was their expectation for the Nursing Evaluation Data Collection form to be signed and dated by the nurse completing the form.	F 842	4. The DON and Unit Manager will complete an audit of new admissions and readmissions weekly x 3 months to ensure appropriate medical record documentation is completed. The DON and/or Unit Manager will present the audit results to the facility Quality Assurance Performance Improvement (QAPI) Meeting monthly x 3 months. Any issues or trends identified will be addressed by (QAPI) as they arise and the evaluation plan will be revised to ensure continued compliance. 5. The DON and the Unit Manager are responsible for implementing and maintaining the acceptable Plan of Correction. Corrective action completed by 8/5/19.	