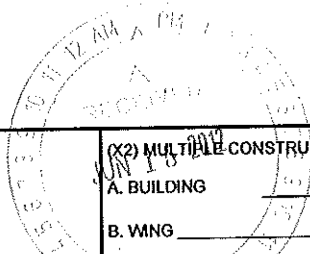
PRINTED: 06/05/2012
FORM APPROVED
OMB NO. 0938-0391

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



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to apply geri-sleeves as ordered by the physician for 1 of 1 sampled residents (Resident #131) who had physician orders for interventions to help prevent resident skin tears. Findings include: Resident #131 was admitted to the facility on 02/16/12, and readmitted on 03/08/12. The resident's documented diagnoses included history of falls, history of hip fracture, Parkinson's disease, and chronic obstructive pulmonary disease. A 03/08/12 Patient Nursing Evaluation documented Resident #131 was at medium risk for falls. A 03/17/12 11:35 AM Resident Progress Note and a subsequent Resident Event Report Worksheet/Post Fall Evaluation documented the resident experienced an unwitnessed fall from her bed, and was found on the floor in her room with two abrasions/skin tears.	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident #131 no longer resides at the facility. 2. Resident care cards were reviewed during the period 6/1-6/21 and updated as necessary to reflect residents' current plan of care. 3. The Director of Nursing Services (DNS) and/or the Staff Development Coordinator (SDC) will inservice licensed staff and nursing assistants on updating CNA assignment care cards to reflect residents' current plan of care during the period 6/1- 6/21. The DNS/ Supervisor/ADNS will review new telephone orders daily and care cards will be updated as needed. The DNS, or designee will audit care card interventions for 5 residents weekly for 1 month, then 5 residents every two weeks for 1 month, the 5 residents for one month. 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review.	F-309 6/21/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Exec. Dir. TITLE (X6) DATE 15 June 2012

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

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	345260	A. BUILDING ______ B. WING ______	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 1 A 03/20/12 physician's order initiated the use of geri-sleeves to Resident #131's bilateral arms. Resident #131's care plan identified, "Actual alteratin in skin integrity" as a problem on 03/26/12. The goal associated with this problem was, "Will be free of breaks in skin integrity." Approaches to the problem included, "Follow MD (physician) orders for skin care and treatments." A 04/17/12 9:25 AM Resident Progress Note and subsequent Resident Event Report Worksheet/Post Fall Evaluation documented the resident experienced an unwitnessed fall when attempting to reach for an object, and was found on the floor in her room. It was documented the resident experienced a skin tear to her right arm with a moderate amount of bleeding, and was sent to the emergency room for evaluation. A 04/20/12 Resident Event Report documented Resident #131 developed a skin tear with bleeding from the left lateral elbow. A Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 fell on 04/29/12 at 7:15 AM experienced an unwitnessed fall from her bed, and was found on the floor in her room. The resident sustained a small skin tear to her right elbow. A 05/20/12 7:30 AM Resident Progress Note and subsequent Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 experienced an unwitnessed fall in her room, and was found on a mat beside her bed. The resident sustained a laceration/skin tear to her right arm with bleeding.	F 309		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 2 During observations of Resident #131 on 05/21/12 at 12:19 PM and 4:08 PM the resident was not wearing geri-sleeves. The resident had on a short sleeve top. During observations of Resident #131 on 05/22/12 at 12:11 PM, 2:34 PM, 4:18 PM and 5:18 PM the resident was not wearing geri-sleeves. The resident had on a short sleeve top. During observations of Resident #131 on 05/23/12 at 8:13 AM, 11:26 AM, 12:57 PM and 4:05 PM the resident was not wearing geri-sleeves. The resident had on a short sleeve top. During an observation of Resident #131 on 05/24/12 at 8:12 AM the resident was not wearing geri-sleeves. The resident had on a short sleeve top. At 9:02 AM on 05/24/12 Nursing Assistant (NA) #3, who was assigned to care for Resident #131, stated the resident used to wear geri-sleeves, but she would not keep them on. She reported she continued to observe the geri-sleeves on the resident's night stand at times. At 9:28 AM on 05/24/12 the resident was not wearing geri-sleeves. The resident had on a short sleeve top. At 10:56 AM on 05/24/12 Nurse #1 stated Resident #131 was supposed to have geri-sleeves on at all times. She reported the resident liked the geri-sleeves because	F 309		

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F 309	Continued From page 3 apparently they made the resident feel warm, comfortable, and protected. At 11:21 AM on 05/24/12, after surveyor intervention, Resident #131 was wearing bilateral geri-sleeves. At 11:42 AM on 05/24/12 NA #4 stated Resident #131 was supposed to wear geri-sleeves all the time because she had very fragile skin. She commented she had never noticed there being any compliance problems with the resident wearing the protective sleeves. At 1:56 PM on 05/24/12 the Director of Nursing (DON) stated Resident #131 was supposed to still be wearing geri-sleeves at all times. She reported she could not explain why the resident did not have the geri-sleeves on during the survey. Review of Resident #131's Resident Care Card revealed documentation under Special Skin Instructions that geri-sleeves were to be worn on the resident's bilateral upper extremities. At 3:21 PM on 05/24/12 NA # 5 stated Resident #131 did not wear anything on her arms for protection.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	Continued From page 4 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to implement a toileting schedule which had been developed as a fall intervention for 1 of 3 sampled residents (Resident #131) who experienced falls in the facility. Based on pharmacist interview, staff interview, and record review the facility also failed to obtain an order for a urinalysis per facility expectations and failed to administer an antibiotic as ordered to treat a urinary tract infection (UTI) for 1 of 1 sampled residents (Resident #131) who experienced a UTI. Findings include: a. Resident #131 was admitted to the facility on 02/16/12, and readmitted on 03/08/12. The resident's documented diagnoses included history of falls, history of hip fracture, Parkinson's disease, and chronic obstructive pulmonary disease. The Bladder Status and Bowel Status Screening sections of Resident #131's 03/08/12 Patient Nursing Evaluation documented the resident had no apparent bathroom pattern, was admitted with an indwelling catheter, and was physically reliant on a caregiver to go to the bathroom, but was continent of bowel on most occasions. Resident #131's 03/15/12 Admission MDS documented her cognition was intact, she was	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident #131 no longer resides at the facility. 2. The licensed staff completed bladder status evaluations during the period 6/1-6/21 on current incontinent residents, with follow up of toileting schedules as appropriate. DNS/ADNS/Supervisors reviewed resident care cards and updated them as necessary to reflect residents' current plan of care. The DNS/SDC, in-serviced licensed staff during the period 6/1-6/21/12 on proper notification to the attending physician during non-business hours. The DNS/SDC will in-service certified nursing staff during the period 6/1-6/21/12 on resident care cards and notification of new interventions. The nursing administration team to monitor, track and trend antibiotic use. The telephone orders to be monitored daily for transcription and timeliness for new antibiotic orders. SDC to monitor residents on antibiotics from month to month to ensure accurate transcription.	F-315 6/21/2012

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F 315	Continued From page 5 admitted with an indwelling catheter, and was always incontinent of bowel. A 03/28/12 physician order discontinued the use of an indwelling catheter for Resident #131. A 04/09/12 30-day Medicare assessment documented Resident #131's cognition was intact, she was not on a bowel and bladder training program, and she was frequently incontinent of bladder and always incontinent of bowel. A 05/06/12 60-day Medicare assessment documented Resident #131's cognition was moderately impaired, she was not on a bowel and bladder training program, and she was frequently incontinent of bowel and bladder. A 05/18/12 2:20 PM Resident Progress Note and subsequent Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 experienced an unwitnessed fall in her room, and was found sitting on the floor next to the bathroom. The Post Fall Evaluation documented bladder monitoring and a toileting schedule were the new fall interventions. A 05/20/12 7:30 AM Resident Progress Note and subsequent Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 experienced an unwitnessed fall in her room, and was found on a mat beside her bed. The Post Fall Evaluation documented bladder monitoring and a toileting schedule were the new fall interventions. At 3:40 PM on 05/23/12 the DON stated after	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3. The DNS/ADNS/Supervisor, will audit 10 residents with toileting schedules weekly for 1 month, then 10 residents every two weeks for 1 month, then 10 residents per month for 1 month. 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review.	

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F 315	Continued From page 6 Resident #131 fell on 05/18/12 there was not time to conduct voiding trials and establish voiding patterns so the staff was informed to toilet the resident after all meals and at night. Record review revealed a pink sheet in the Activities of Daily Living (ADL) Flowsheet notebook which documented, "Please toilet _____ (name of Resident #131) after meals and at night." During interviews with Nursing Assistant (NA) #1 and #2 at 4:30 PM on 05/23/12, NA #3 at 9:02 AM on 05/24/12, Nurse #1 at 10:56 AM on 05/24/12, NA #4 at 11:42 AM on 05/24/12, NA #5 at 3:21 PM on 05/24/12, and NA #6 at 3:50 PM on 05/24/12 they stated they had not been informed that Resident #131 was to be toileted at any particular times. They reported the resident was alert and oriented but confused at times, only used the call bell occasionally, could sometimes tell staff when she needed to go to the bathroom, was supposed to ask the staff for assistance to the bathroom, wore incontinent briefs for protection, and had a bedside commode in her room. They stated they took the resident to the bathroom when she reported she needed to go, and checked on the resident every couple of hours to make sure she was not wet or soiled. At 11:18 AM on 05/24/12 the Therapy Manager stated Resident #131 received physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services after her 03/08/12 readmission, and there was a general emphasis on safety education. However, she reported the resident was not evaluated specifically for bed and chair positioning in relation to fall prevention	F 315		

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F 315	Continued From page 7 because the issue was not related to positioning but the resident's attempts to go to the bathroom without assistance. At 11:42 AM on 05/24/12 NA #4, who found Resident #131 on the floor after an unwitnessed fall on 05/20/12, stated the resident's door was closed when she began rounds at the start of her 7 AM- 3 PM shift on 05/20/12. At approximately 7:10 AM on 05/20/12 the NA reported she opened Resident #131's door, and found the resident on the floor, sitting on a mat with her back against the low bed and her legs out in front of her. The NA commented when she asked the resident what happened, the resident stated she was trying to go to the bathroom, and pointed to the bedside commode against the wall of the room. b. Resident #131 was admitted to the facility on 02/16/12, and readmitted on 03/08/12. The resident's documented diagnoses included history of falls, history of hip fracture, Parkinson's disease, and chronic obstructive pulmonary disease. The Bladder Status Screening section of Resident #131's 03/08/12 Patient Nursing Evaluation documented the resident was re-admitted with an indwelling catheter. A 03/09/12 physician's order documented Resident #131's catheter was in place secondary to hip fracture with intractable pain. A 03/22/12 10:45 PM Resident Progress Note documented, "Foley cath (catheter) intact, dark amber urine noted with (symbol used) some	F 315		

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F 315	Continued From page 8	F 315		

sediment noted in tubing - MD (physician) faxed for order to perform U/A C & S (urinalysis, culture and sensitivity) - awaiting reply."

A physician's order for a U/A C & S was not obtained until 03/25/12.

Lab results documented on 03/26/12 urine was collected, and on 03/28/12 the culture grew greater than 100,000 colony forming units of Proteus mirabilis.

A 03/28/12 physician order started Resident #131 on Keflex 500 milligrams (mg) four time daily (QID) x 7 days and discontinued the use of the resident's indwelling catheter.

Resident #131's March 2012 Medication Administration Record (MAR) documented she received four doses daily of Keflex for three days on 03/29/12 through 03/31/12.

Resident #131's April 2012 MAR documented she did not receive any Keflex again until 04/05/12 when two doses were administered. The resident received four doses daily of Keflex for three days on 04/06/12 through 04/08/12.

Record review revealed Resident #131 was sent out to the emergency room on 04/17/12 following a fall. While there 04/17/12 hospital urinalysis results documented the resident had 4+ bacteria in her urine. No C & S was performed.

A 04/17/12 physician's order started the resident on Augmentin 875 mg, one tablet twice a day (BID) x 10 days.

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F 315	Continued From page 9 At 3:40 PM on 05/23/12 the Director of Nursing (DON) stated there was a transcription error caused by the PM nurse not doing the second check for accuracy after midnight when transitioning between the March and April 2012 MARs. She reported this error is what caused the break in the administration of Resident #131's Keflex, being administered to treat the resident's urinary tract infection. At 4:12 PM on 05/23/12 the facility's Consultant Pharmacist stated when there was a break in antibiotic administration she would expect the staff to consult the physician who ordered the treatment to see if there was a need to extend the duration of administration once the antibiotic was resumed. She explained there was a chance with a break in antibiotic treatment that the antibiotic might not completely kill off all bacteria, and there could be the reoccurrence of a urinary tract infection. At 1:56 PM on 05/24/12 the DON stated her expectation was that the staff should have called the primary physician when there was a break in the administration of Resident #131's Keflex. She reported contact with the physician in such a case would be documented in a Resident Progress Note or on a fax sent to the physician, a copy of which should be found in the resident's medical record. After reviewing the resident's medical record, the DON commented she did not see any documentation that the physician was contacted about the break in antibiotic treatment. According to the DON, a med error report should have also been completed because the Keflex was not administered as ordered. However, the DON stated she had not received a copy of such	F 315		

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F 315	Continued From page 10 a report. She commented that the nurse who wrote the 03/22/12 Resident Progress Note documenting a request for Resident #131's UA C & S should have called the physician rather than faxing the physician at that time of night (10:45 PM). According to the DON, this same nurse should have passed on the information that she was waiting on an order for a urinalysis to the oncoming nurse and/or documented the need for the order on the 24-hour report. The DON stated the longest acceptable wait for an order should have been the next day on 03/23/12 which was a Friday. She reported labs were drawn in the afternoons so if an order for a urinalysis had been obtained on a timely basis the urine sample could have been collected on the afternoon of Friday 03/23/12 without the resident having to suffer from the signs and symptoms of a urinary tract infection over the weekend. However, record review revealed no documentation about Resident #131 experiencing signs and symptoms of a urinary tract infection over the weekend. A call was placed to Resident #13's primary physician on 05/24/12 regarding the issues with the interrupted antibiotic administration and delayed request for a UA and C & S. However, the physician did not return the call. Then the physician was supposed to call back on 05/25/12 to talk with the surveyor, and did not.	F 315		
F 323 SS=D	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.	F 323		

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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to implement new fall interventions for 1 of 3 sampled residents (Resident #131) who experienced falls in the facility in order to help prevent the occurrence of subsequent falls. Findings include: Resident #131 was admitted to the facility on 02/16/12, and readmitted on 03/08/12. The resident's documented diagnoses included history of falls, history of hip fracture, Parkinson's disease, and chronic obstructive pulmonary disease. A 03/08/12 Patient Nursing Evaluation documented Resident #131 was at medium risk for falls. Review of Resident Progress Notes documented a low bed with mats on either side of the bed was put in place when the resident was readmitted on 03/08/12. On 03/08/12 the resident's care plan identified, "At risk for fall related injury as evidenced by: fracture r/t (due to) fall in last 6 mos (months)" as a problem. Approaches to this problem included low/platform bed, call light within reach, area free of clutter, lock brakes on bed/chair before transferring, educate/remind resident to request assistance prior to ambulation, and appropriate footwear. The resident's 03/15/12 Admission Minimum	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident #131 no longer resides at the facility. 2. Resident care cards were reviewed during the period 6/1-6/21/12 and updated as necessary to reflect residents' current plan of care. Residents at risk for falls were reviewed and interventions were initiated accordingly. 3. The DNS/SDC in-serviced licensed staff and nursing assistants on updating CNA assignment care cards to reflect residents' current plan of care during the period 6/1-6/22/12. Physician orders will be reviewed daily and care cards will be reviewed and updated as needed. The RN Supervisor to review new admissions for residents at risk for falls and interventions to be initiated accordingly. Residents to be reviewed 3 times weekly utilizing the angel care assignment rounds to ensure appropriate utilization of current safety interventions. The DNS, or her designee, will audit safety interventions for 5	F-323 6/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ____ B. WING ____	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 12 Data Set (MDS) documented her cognition was intact, she required limited assistance from a staff member with bed mobility, she required extensive assistance by a staff member with transfers, she did not walk in the room or corridor during the assessment period, she was dependent on a staff member for locomotion on and off the unit, and she was dependent on a staff member for toilet use and personal hygiene. A 03/17/12 11:35 AM Resident Progress Note and a subsequent Resident Event Report Worksheet/Post Fall Evaluation documented the resident experienced an unwitnessed fall from her bed, and was found on the floor in her room with two abrasions/skin tears. Resident #131's care plan was updated on 03/19/12, and documented a personal alarm while in the bed/chair and non-skid socks were added as approaches to the problem of being at risk for fall related injury. A 03/27/12 1:10 AM Resident Progress Note and a subsequent Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 experienced an unwitnessed fall from her bed, and was found on the floor in her room. A pain assessment was completed when the resident complained of back pain after the fall. The 03/27/12 Post Fall Evaluation documented the new approach put in place to help prevent injury from future falls was a speech therapy (ST) consult regarding visual cues to help remind the resident to ask for assistance before attempting to transfer. A 03/27/12 update to the care plan	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* residents weekly for 1 month, then 5 residents every two weeks for 1 month, then 5 residents per month for 1 month. 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 13 documented this same new intervention was put in place. A 03/27/12 Interdisciplinary Patient Referral form documented ST found visual cueing inappropriate for the resident due to the Health Insurance Portability and Accountability Act (HIPPA). At 3:40 PM on 05/23/12 the Director of Nursing (DON) stated there was some confusion about the use of visual cueing for Resident #131. She reported apparently ST did not realize the use of signs to remind the resident to ask for staff assistance before transferring was acceptable as long as permission to use them was obtained from the responsible party. At 11:30 AM on 05/24/12 Speech Therapist (ST) #1 stated she worked with Resident #131 from 05/07/12 through 05/14/12, and developed pink signage and intertwined pink paper in the resident's call bell to remind her of the need to call for assistance before transferring. She reported, after reviewing ST documentation, there was no documented use of signage or other visual cues for the resident prior to 05/07/12. Resident Event Report Worksheets/Post Fall Evaluations documented the resident fell on 04/01/12 at at 11:50 PM and on 04/02/12 at 12:15 AM. The forms documented on 04/01/12 the resident experienced an unwitnessed fall while transferring, and was found on the floor in her room. The forms documented on 04/02/12 the resident experienced an unwitnessed fall, and was found on her knees beside her bed. The new intervention for these falls was a psychiatric	F 323		

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F 323	Continued From page 14 evaluation. Record review revealed the timing of Resident #131's medication administration was adjusted during a psychiatric consult on 04/04/12. A 04/17/12 9:25 AM Resident Progress Note and subsequent Resident Event Report Worksheet/Post Fall Evaluation documented the resident experienced an unwitnessed fall when attempting to reach for an object, and was found on the floor in her room. It was documented the resident experienced a skin tear to her right arm with a moderate amount of bleeding, and was sent to the emergency room for evaluation. The Post Fall evaluation documented the new intervention for fall prevention was a rehab referral for wheelchair positioning. A 04/06/12 physician order requested an evaluation on Resident #131 by physical therapy (PT)/occupational therapy (OT) for safe seating when out of bed and best positioning while in bed. At 10:45 AM on 05/24/12 Physical Therapy Assistant (PTA) #1 stated in an undated Rehab Addendum Note she documented, "Pt (patient) has been in w/c (wheelchair) this past week vs (versus) gerichair to increase (symbol used) mobility & (and) access to facility in hopes to decrease (symbol used) fall risk." She reported she thought this addendum note was an extension of her 03/30/12 progress note. At 11:18 AM on 05/24/12 the Therapy Manager stated Resident #131 received PT, OT, and ST services after her 03/08/12 readmission, and there was a general emphasis on safety	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 15 education. However, she reported the resident was not evaluated specifically for bed and chair positioning in relation to fall prevention because the issue was not related to positioning but the resident's attempts to go to the bathroom without assistance. A Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 fell on 04/19/12 at 11:50 AM. The resident was observed getting out of her wheelchair unassisted near the nurse's station. The Post Fall Evaluation documented the new intervention for fall prevention was the use of hipsters. The resident's care plan was also updated on 04/20/12 to reflect this new approach to falls. Observations during the survey revealed the resident did not have hipsters in place. At 1:56 PM on 05/24/12 the DON stated hipsters were not ordered for Resident #131 until 05/24/12. A Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 fell on 04/29/12 at 7:15 AM experienced an unwitnessed fall from her bed, and was found on the floor in her room. The resident sustained a small skin tear to her right elbow. On 04/30/12 the resident's care plan was updated. Sensor (pad) alarms for the bed and chair were documented as new fall interventions. A 05/10/12 9:35 AM Resident Progress Note and subsequent Resident Event Report Worksheet/Post Fall Evaluation documented	F 323		

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

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F 323	Continued From page 16 Resident #131 experienced an unwitnessed fall in her room when she reached for an object while in her wheelchair. The resident sustained a laceration to the head above the left eye, and was sent to the emergency room for an evaluation. The Post Fall Evaluation documented a sensor alarm to the wheelchair was the new fall intervention. A 05/18/12 2:20 PM Resident Progress Note and subsequent Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 experienced an unwitnessed fall in her room, and was found sitting on the floor next to the bathroom. The Post Fall Evaluation documented bladder monitoring and a toileting schedule were the new fall interventions. A 05/20/12 7:30 AM Resident Progress Note and subsequent Resident Event Report Worksheet/Post Fall Evaluation documented Resident #131 experienced an unwitnessed fall in her room, and was found on a mat beside her bed. The resident sustained lacerations/skin tears to her right arm and back with bleeding and a hematoma to her forehead above her right eye. The resident was sent to the emergency room for an evaluation. The Post Fall Evaluation documented bladder monitoring and a toileting schedule were the new fall interventions. The 05/20/12 Emergency Room Clinical Summary documented Resident #131 was discharged back to the facility with a large hematoma to the right frontal scalp and a skin tear to the right forearm. Resident #131's 03/15/12 Admission MDS	F 323		

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

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F 323	Continued From page 17 documented her cognition was intact, she was admitted with an indwelling catheter, and was always incontinent of bowel. A 03/28/12 physician order discontinued the use of an indwelling catheter for Resident #131. A 04/09/12 30-day Medicare assessment documented Resident #131's cognition was intact, she was not on a bowel and bladder training program, and she was frequently incontinent of bladder and always incontinent of bowel. A 05/06/12 60-day Medicare assessment documented Resident #131's cognition was moderately impaired, she was not on a bowel and bladder training program, and she was frequently incontinent of bowel and bladder. Record review during the survey revealed a pink sheet in the Activities of Daily Living (ADL) Flowsheet notebook which documented, "Please toilet _____ (name of Resident #131) after meals and at night." At 3:40 PM on 05/23/12 the DON stated after Resident #131 fell on 05/18/12 there was not time to conduct voiding trials and establish voiding patterns so the staff was informed to toilet the resident after all meals and at night. However, during interviews with Nursing Assistant (NA) #1 and #2 at 4:30 PM on 05/23/12, NA #3 at 9:02 AM on 05/24/12, Nurse #1 at 10:56 AM on 05/24/12, NA #4 at 11:42 AM on 05/24/12, NA #5 at 3:21 PM on 05/24/12, and NA #6 at 3:50 PM on 05/24/12 they stated they had not been	F 323		

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

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F 323	Continued From page 18 informed that Resident #131 was to be toileted at any particular times. They reported the resident was alert and oriented but confused at times, only used the call bell occasionally, could sometimes tell staff when she needed to go to the bathroom, was supposed to ask the staff for assistance to the bathroom, wore briefs or diapers for protection, and had a bedside commode in her room. They stated they took the resident to the bathroom when she reported she needed to go, and checked on the resident every couple of hours to make sure she was not wet or soiled. They commented that after falls in April 2012, Resident #131 was supposed to have a sensor (pad) alarm in place when in bed or in a chair. They explained the resident would remove the clip alarm, commenting that it was too noisy. At 9:28 AM on 05/24/12 the DON tested the sensor (pad) alarm, which was observed on the resident during multiple days of the survey when in bed and in a chair. The pad alarm sounded when pressure was removed from the pad in Resident #131's wheelchair. At 11:42 AM on 05/24/12 NA #4, who found Resident #131 on the floor after an unwitnessed fall on 05/20/12, stated the resident's door was closed when she began rounds at the start of her 7 AM- 3 PM shift on 05/20/12. At approximately 7:10 AM on 05/20/12 the NA reported she opened Resident #131's door, and found the resident on the floor, sitting on a mat with her back against the low bed and her legs out in front of her. The NA commented when she asked the resident what happened, the resident stated she was trying to go to the bathroom, and pointed to the bedside commode against the wall of the	F 323		

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

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F 323	Continued From page 19 room. According to NA #1, an alarm was not sounding when she entered the room. However, she reported there was a clip alarm on the bed. She reported the base of the alarm was mounted on the bed, and the string and the clip were laid out across the bed. NA #1 stated it looked as if the resident had removed the clip alarm from her clothing once again. NA #1 reported the resident's right arm was bleeding, and there was a knot on her head when she found her on 05/20/12. At 1:56 PM on 05/24/12 the DON stated at the time of Resident #131's falls on 05/18/12 and 05/20/12 the resident should have had a sensor (pad) alarm in place when she was in bed on in the chair. At 3:50 PM on 05/24/12 NA #6, who cared for Resident #131 on 05/19/12 first shift stated a clip alarm was being used on the resident during her shift. At 5:40 PM on 05/24/12 NA #2 stated there was a clip alarm in Resident #131's room on 05/18/12 and 05/19/12. However, she reported the resident had a sensor (pad) alarm in place when staff worked with her on 05/19/11 and 05/20/11 on third shift.	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 status, such as body weight and protein levels, unless the resident's clinical condition	F 325		

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

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F 325	Continued From page 20 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 observation, staff interview, and record review the facility failed to provide 1 of 1 sampled residents (Resident #131) experiencing unintentional weight loss with a nutritional supplement ordered by the physician. Findings include: Resident #131 was admitted to the facility on 02/16/12, and readmitted on 03/08/12. The resident's documented diagnoses included dysphagia, hypertension, diabetes, Parkinson's disease, and chronic obstructive pulmonary disease (COPD). Resident #131's 03/8/12 Patient Nursing Evaluation documented the resident's admission weight was 85.5 pounds, and the resident was at risk for malnutrition. A 03/08/12 physician order initiated a mechanical soft diet with honey thick liquids for Resident #131. The resident's Weight History documented she weighed 87.5 pounds on 03/13/12. A 03/13/12 physician order initiated a puree diet with honey thick liquids for Resident #131.	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident #131 no longer resides at the facility 2. Registered Dietician (RD) evaluated, during the period 6/15-6/21/12 current residents who trigger for 1,3, & 6 month weight loss for appropriate dietary interventions. This evaluation included comparison of dietary supplements as well as physician orders for supplements to ensure accuracy. 3. The DNS/SDC, in-serviced licensed nurses on dietary supplements and communication tool for dietary communication during the period 6/15-6/21/12 The DNS in-serviced the RD on the RD's use of physician orders in fulfilling her role. The Nutritional Services Manager, or her designee, will audit meal trays to ensure that ordered supplements are on meal trays for 8 residents per week for 1 month, then 8 residents every ~~two weeks for 1 month, then 8~~ residents per month for 1	F-325 6/21/2012

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

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F 325	Continued From page 21 The resident's care plan identified, "Resident at risk for nutritional decline related to diagnosis of COPD and dementia, difficulty swallowing, variable intakes of food/beverages, restrictive or mechanically altered diet, history of unplanned weight changes, and significant psychosocial event" as a problem on 03/14/12. The resident's Weight History documented she weighed 83.2 pounds on 03/21/12. In a 03/28/12 Nutrition Progress Note the Registered Dietitian (RD) documented Resident #131 lost 4.3 pounds in one week. The RD reported she attempted to talk to the resident, but was unsuccessful, but spoke with nursing instead. The RD recommended honey thick shakes for the resident. A 03/28/12 physician's telephone order started the resident on "honey-thick 4 oz (ounce) house shakes TID (three times daily) with meals." The order was signed off on by the physician on 03/30/12. The resident's Weight History documented she weighed 83.4 pounds on 03/29/12 and 81.4 pounds on 04/02/12. In a 04/13/12 Nutrition Progress Note the RD documented she talked with the Resident #131's family who do not desire placement of a feeding tube. Nursing communicated that the resident liked ice cream so the RD recommended adding Nutritional Treat as a frozen supplement which would be compatible with the resident's order for honey thick liquids.	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law* month. The RD will compare tray card dietary supplements to physician orders for supplements using a sample size of 20 residents monthly for 3 months. The DNS, or her designee, will audit the medication pass for 10 weight loss residents monthly for 3 months to ensure MD orders for supplements are being followed. 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review.	

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F 325	Continued From page 22 A 04/13/12 physician's telephone order started the resident on "Nutritional Treat 4 oz po (by mouth) with (symbol used) lunch & (and) supper." The order was signed off on by the physician on 04/18/12. The resident's Weight History documented she weighed 71.2 pounds on 04/18/12 and 74.2 pounds on 04/26/12. In a 04/30/12 Nutrition Progress Note the RD documented to continue the honey thick shakes and Nutritional Treat because the resident was eating well, intake of her nutritional supplements was good, and the resident was beginning to gain some weight back. The resident's Weight History documented she weighed 75.2 pounds on 05/02/12, 75 pounds on 05/09/12, and 76 pounds on 05/17/12. At 12:11 PM on 05/22/12 Resident #131 was eating lunch in the main dining room. There was no Nutritional Treat on her tray, but a liquid supplement in a plastic cup was sitting on the table beside her plate. At 5:18 PM on 05/22/12 the resident was eating supper in her room. There was no shake or Nutritional Treat on the resident's meal tray. At 8:13 AM on 05/23/12 the resident was eating breakfast in her room. There was no shake on the resident's meal tray. At 12:57 PM on 05/23/12 the resident was eating lunch in her room. There was no Nutritional Treat on her tray, but a liquid supplement in a plastic	F 325		

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

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F 325	Continued From page 23 cup was sitting on the table beside her plate. Review of Resident #131's tray slips revealed it was not documented that the resident should receive shakes or Nutritional Treat with meals. At 1:12 PM on 05/23/12 Nurse #2 stated shakes and Nutritional Treat were supplements which would be provided to residents by the dietary department. She reported she had not provided Resident #131 with either, but she did give the resident some Ensure product if the resident did not eat well at meals. At 1:24 PM on 05/23/12 the facility's RD stated the way in which the orders for Resident #131 were written indicated that the resident should be receiving shakes and Nutritional Treat from dietary on her meal trays. The RD reported she usually wrote a telephone order for nutritional supplements, and hall nurses would get the physicians to sign off on the orders when they were in the building. At 1:30 PM on 05/23/12 the Dietary Manager (DM) stated the dietary department was made aware of nutritional supplements they were supposed to provide when the hall nurses, who obtained physician signatures on telephone orders, forwarded them white copies of the approved orders. The DM reported the hall nurses were simultaneously supposed to completed a Nutrition/Nursing Communication form which was also sent to the dietary department. After reviewing the Nutrition/Nursing Communication forms she had on file for Resident #131, the DM commented there were no forms informing the dietary	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 24 department the resident was supposed to receive shakes or Nutritional Treat on meal trays. At 4:30 PM on 05/23/12 Nursing Assistant (NA) #1 and #2 stated Resident #131 usually ate 50% or less of her supper meal. They reported they occasionally provided the resident with some shake if her supper intake was 25% or less. However, they commented they had never provided the resident with any Nutritional Treat. According to these NAs, they had never seen a shake or Nutritional Treat on the resident's supper trays. At 5:11 PM on 05/23/12, during a telephone conversation, Nurse #1, the primary care nurse for Resident #131 on 7AM to 7 PM shift, stated she provided the resident with shakes three times a day during the resident's medication passes. She commented the liquid supplement observed by the resident's lunch plate on 05/22/12 was shake which Resident #131 was finishing up after her most recent medication pass. According to Nurse #1, she had not provided the resident with any Nutritional Treat, but stated maybe the resident received this supplement as a snack between meals. A review of a print out of residents who received physician-ordered supplements between meals revealed Resident #131 did not receive Nutritional Treat from dietary between meals. At 9:02 AM on 05/24/12 NA #3 stated Resident #131 usually ate 50% or less of her meals, and reported she had not seen any shakes or Nutritional Treat on the resident's meal trays. She reported she had never given the resident	F 325		

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

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KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

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F 325	Continued From page 25 either nutritional supplement herself, but had seen the nurse give the resident some shakes. At 3:21 PM on 05/24/12 NA #5 stated Resident #131 ate about 25% of her meals. She also reported she had never observed any shakes or Nutritional Treat on the resident's meal trays and she had never provided the resident with either nutritional supplement.	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	1. Nurse was in-serviced on glucometer training on 5/28/12 2. Nurse was inserviced by DNS on proper glucometer cleaning technique, to include waiting 1 minute with the bleach solution on the machine, on 5/28/12 including a return demonstration. Licensed nursing staff were inserviced by DNS/ADNS/SDC/RN Supervisor on proper glucometer cleaning technique, to include waiting 1 minute with the bleach solution on the machine on 5/28-6/21/12. In-services included return demonstrations. For residents with C-Difficile a separate glucometer will be assigned to that particular resident and kept at the bedside for single patient use. 3. The DNS, or her designee, will audit 5 nurses weekly for one month, then 5 nurses every two weeks for one month, then 5 nurses for one month for glucometer cleaning per protocol.	F-441 6/21/2012

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	345260	A. BUILDING ______ B. WING ______	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 441	Continued From page 26 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure that staff (Nurse #1) were disinfecting a blood glucose machine (glucometer) after resident use while being observed during medication pass. Findings include: [brand name disinfectant wipes] is an EPA-registered agent used to kill Clostridium difficile spores in 5 minutes. According to manufacturer ' s germicidal efficacy, [brand name disinfectant wipes] kills Mycobacterium tuberculosis (TB) in 2 minutes and clostridium difficile in 5 minutes. All others were killed in 1 minute. Included in the provided multi-use convenience section of the information was that the wipes could be used to clean and disinfect glucometers. The facility ' s policy for Cleaning and Disinfecting Diagnostic Equipment In-between Patients, dated 10/31/10, documented that equipment such as glucometers was to be cleaned in-between each patient use to prevent the spread of infectious disease. The procedure included cleaning the	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. Monitoring results will be presented and discussed at the monthly PI Committee meeting for review.	

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	345260	A. BUILDING ______ B. WING ______	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

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F 441	Continued From page 27 outside of the patient equipment with a 10% bleach solution moistened wipe in-between each patient and as needed. It also indicated to " Allow contact with bleach solution for 1-minutes. Follow with a cloth dampened with water to remove residual bleach. " An addendum to this policy, dated 10/31/10, indicated that the glucometers were to be cleaned at the beginning and end of each shift as well as between each patient. The addendum also included wiping the outside of the glucometer completely using a 10% bleach wipe allowing the solution to remain wet and in contact with the surface for at least " one full minute " . During medication pass observation of Nurse #1, beginning at 8:30 AM on 05/23/12, she prepared medications for Resident #228. She also prepared supplies to check a fingerstick blood glucose. She went into the room and performed a fingerstick. She obtained the blood sample onto the glucose strip. Resident #227 was eating breakfast. She administered the medications and went back to the medication cart. Before inserting the strip into the glucometer, she was questioned about disinfecting the glucometer. She stated she had cleaned it after the last resident. She completed the test and signed off the medications on the medication administration record (MAR). Nurse #1 donned gloves and used a bleach wipe to wash the exterior surface of the glucometer and removed the strip holder (eye) and wiped it with the wipe. She immediately wiped away the excess with a paper towel. Nurse #1 did not allow the solution to stay on the meter for one minute per the facility ' s policy for disinfecting. As she was wiping the excess from the meter she stated she would need to recheck	F 441		

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	345260	A. BUILDING ______ B. WING ______	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

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F 441	Continued From page 28 Resident #228 ' s blood glucose as it was low. She continued on her medication pass. After administration of medications to Resident #19, Nurse #1 performed a fingerstick glucose and inserted the strip into the glucometer. She signed off the medications on the MAR and rolled her medication cart to Resident #227 ' s room. At 9:20 AM, Nurse #1 was observed preparing medications for administration to Resident #227. After she had poured all of the medications, she prepared supplies to check Resident #227 ' s blood glucose. She performed the fingerstick and obtained the blood sample onto the glucose strip. She used a bleach wipe to disinfect the exterior surface of the meter and wiped away the excess with a paper towel. She did not allow the solution to remain on the meter for one minute per the facility ' s policy. She inserted the blood sample into the meter. Nurse #1 reported that she needed to clarify Resident #227 ' s blood pressure medication so she left the medication cart. She returned in approximately 5 minutes and administered medications to Resident #227. She signed the medications off on the MAR and rolled her cart back down to Resident #228 ' s room. She did not disinfect the glucometer. She prepared her supplies and performed a fingerstick to obtain the blood sample from Resident #228. When she approached the medication cart, she was asked to wait before she inserted the strip into the glucometer. When questioned about disinfecting the meter, she replied that she had forgotten to do it and stuck the strip into the meter. Nurse #1 reported that it was facility policy to disinfect the glucometers between every resident. She also stated she was not to take the glucometer into the resident ' s room. She donned gloves and washed the	F 441		

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	345260	A. BUILDING ____ B. WING ____	05/24/2012

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KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

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F 441	Continued From page 29 surface of the glucometer and the eye with the bleach wipes and wiped the excess away with a paper towel. During an interview with the Director of Nurses (DON), on 05/24/12 at 12:00 PM, she stated staff were instructed to use the bleach [brand name disinfectant] wipes that the facility provided for disinfecting glucometers. The DON stated the machine's external surface was to be wiped down completely with the [brand name disinfectant] wipes and the solution was to be left to air dry on the meter surface for 30 seconds to one full minute before wiping it with a clean cloth. The DON commented that in order for the bleach solution to disinfect the surface it needed to be left on the surface for at least one minute. She stated staff should never assume that the previous nurse had disinfected the glucometer. The DON stated all glucometers were to be disinfected in-between residents. She commented that the nurses should not be combining checking blood sugars with medication pass. The DON reported that she was in the process of training the Nurse Aide II to perform the fingerstick blood sugars.	F 441		

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

PRINTED: 07/02/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A BUILDING 01 - MAIN BUILDING 01 B WING ______	06/27/2012

NAME OF PROVIDER OR SUPPLIER: KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT

STREET ADDRESS, CITY, STATE ZIP CODE: 160 WINSTEAD AVE, ROCKY MOUNT, NC 27804

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7 1 19.2 1 This STANDARD is not met as evidenced by: A Based on observation on 06/27/2012 the delayed egress doors near the maintenance office failed to release when pressure was applied 42 CFR 483.70 (a)	K 038	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. All residents have the ability to be affected by this deficient practice. 2. The company District Facility Engineer repaired the delayed egress doors on 6/28/2012. Additionally, the delayed egress hardware will be replaced with new hardware by 7/27/2012. 3. The Maintenance Director, or his designee, will check the delayed egress function of all doors 5 times per week for 4 weeks. 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review and evaluation. The facility administrator retains overall responsibility.	K-038 7/27/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Lynn A. Lancaster
TITLE: Executive Director
(X6) DATE: 10 July 12

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.