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

PRINTED: 08/20/2012
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
	345081	A. BUILDING _____ B. WING _____	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROSE MANOR	4230 NORTH ROXBORO ROAD DURHAM, NC 27704

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure that a urinary catheter bag was kept off the floor for one of three residents (Resident #225). Findings included: Review of the medical record of Resident #225 revealed the resident was admitted to the facility on 7/26/2012 with cumulative diagnoses which included Acute Urinary Retention. No Minimum Data Set was available for review at the time of the survey. Review of nursing notes from 7/26/2012 through 8/9/2012 indicated the resident required extensive assistance for all activities of daily living. On 8/6/2012 at 2:28 PM, the resident was observed lying supine on the bed in his room.	F 315	Corrective action: Upon notification by the state surveyor regarding the indwelling catheter drainage bag of resident #225 touching the floor the Director of Nursing repositioned the drainage bag to assure clearance from the floor and in a manner to maintain the resident's dignity. • All residents who have indwelling catheters have the potential to be affected by this practice. An audit was conducted by the Administration Nursing staff to assure compliance with proper placement of indwelling catheter drainage bags. • The Staff Development Coordinator will provide re-education through in-servicing on the facility's policy and procedure related to the use of indwelling catheters with an emphasis on the proper placement of the catheter drainage bag. Exhibit #1. The Staff Development Coordinator will include education on the facility's policy and procedures r/t indwelling catheters to newly hired employees during the orientation process.	8-6-2012 8-6-2012 8-28-2012

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

EXECUTIVE DIRECTOR 8-28-12

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.

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F 315	Continued From page 1 The door to his room was completely open to the hallway. A urinary catheter bag was hung on right side of bed, facing the hallway. The bag was approximately half filled with urine. The bottom half of the urine bag lay on the floor. On 8/6/2012 at 3:24PM, a second observation was done and revealed the following: The resident was observed lying supine on the bed in his room. The door to his room was completely open to the hallway. A urinary catheter bag hung on right side of bed, facing the hallway. The bag was approximately half filled with urine. The bottom half of the urine bag lay on the floor. The resident was observed on 8/8/2012 at 3:40 PM on the A hallway. He was observed in his wheelchair wheeling himself. His urinary catheter bag dragged along the floor under his wheelchair as he moved. The bag was approximately one third filled with urine. In an interview with the Director of Nursing (DON) on 8/8/2012 at 3:43 PM, the DON reported the expectation was a urinary catheter bag should be hung properly as not to lie on the floor. The DON further indicated facility staff who cared for the resident were responsible for making sure the catheter bag was hung properly and that all staff should intervene if they saw a resident's urinary catheter bag lying on the floor.	F 315	• The DNS or her designee will audit the placement of indwelling catheter drainage bags during daily Infection Control/ Dignity rounds. The current daily Infection Control/Dignity audit tool was updated to include a means of documenting the findings r/t the positioning of indwelling drainage bags. Exhibit #2 • The director of Nursing will submit data and a summary of the findings to Performance Improvement Committee for review and recommendations monthly X 3 months and quarterly thereafter. The facility administrator is responsible for overall compliance.	Daily Process 8-28-2012
F 323 SS=G	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	F 323		

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F 323	Continued From page 2 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that 1 of 3 residents (# 11) was transferred safely with a mechanical lift. The findings include: Resident #11 was admitted to the facility on 11/21/11 with cumulative diagnosis that included H/O (history of) CVA (stroke), Hydrocephalus (increased fluid in the brain) requiring a shunt, Encephalopathy (any dysfunction of the brain), Hypertension, Coronary Artery disease and Chronic Kidney Disease. The resident was coded on the most recent MDS (minimum data set) dated 05/04/12 as being moderately impaired cognitively and as requiring extensive assistance with 2 person assist for transfers. A review of the CAA ' s (care area assessments) indicated that the resident required total care for all ADL ' s (activities of daily living). A review of the resident ' s Interim Care Plan (created at the time of admission) under the section " Mobility " was checked " Transfer, lift and 2 person. " Under the section " describe what is done by the staff " was written " total dependence with transfers." A review of the " Resident ' s Care Card " (information pertinent to a resident for the nurse aide) was written " Transfer " and the line for 2 assist was checked. Hoyer (name of mechanical lift) was written next to it and Sling size M (medium) was written above it. "	F 323	Past noncompliance: no plan of correction required.	

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A review of the medical record for resident #11 revealed a nurse note dated 07/16/12 timed 1600 (4:00PM) that read " resident sent to ER (emergency room) for CT (computerized tomography) scan of head. MD in to evaluate resident. " The nurse note did not indicate the reason why the resident was having a CT scan. According to the nurse notes, the resident was returned from the hospital on 07/18/12 at 4:00PM.

A review of the discharge summary from the hospital indicated under the section " History of Present Illness " She was being transferred from her bed when she fell from the Hoyer lifter and hit her head. She was brought to the emergency department. She was at her neurological baseline per the skilled nursing facility staff. She was not complaining of any headaches in the emergency department or of any neck pain. She was brought to the emergency room in a hard collar and CT scan was significant for Traumatic Subarachnoid Hemorrhage on the right temporal lobe. " According to the hospital records, the resident had a second CT scan 6 hours after the initial scan that showed " that the traumatic subarachnoid hemorrhage was stable. " The medical record indicated that the resident was observed in the hospital and that her " neurological exam remained stable ". The resident was returned to the facility with orders to continue her medications. The medication list did not include any anticoagulants (blood thinners).

During an interview with the resident on 08/08/12 at 11:30 AM it was revealed " I remember that I fell out of the lift. I ' m not sure when it happened. I hit my head but I was ok. I am fine. I still use

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the lift. "

During an interview on 08/09/12 at 3:30 PM with the Nurse #2, was revealed " I was called into the resident ' s room. When I went into the room she was already on the floor. She was in a sitting position. ST (Speech Therapy) was in the room with Nurse Aide #1 (NA #1). NA #1 stated resident slipped out of lift. I assessed the resident. She was sitting on her butt and she said she hit her head. There was no bump or bruising to her head. There was no bleeding. The doctor was in the building and we called him to see the resident and he advised us to send her out to the hospital. Two people are supposed to be with a resident that uses the lifter. One is supposed to work the lift and the other one is supposed to be near the patient. A ST should not have been the second person; they are not trained to use the lift. It should always be a nursing staff member. "

During an interview with the ST on 08/10/12 at 10:35 AM it was revealed " I did not participate in anyway with the lift. I am not trained to do that, and I made that clear to (name of NA #1). She asked me to just watch. I was in the room because the resident was going to have a Speech treatment. She said she wanted to go to bed, and (name of NA#1) said she would put her into bed. She attached the resident ' s pad to the lift and began to lift her up. She just fell out of it, she landed on her butt and I did see her hit her head. I immediately left the room to get the nurse. When the nurse came into the room she began to assess the resident. " The ST stated that in the future she would stop the nurse aide from performing the lift if she was the only other

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staff member in the room and would go and get help from a nursing staff member.

During an interview with NA#1 on 08/16/12 at 8:00AM it was revealed " I used the sling and crossed the bottom straps. She just fell out of it. I tried to grab her. I don ' t know what happened. Maybe the sling was not the right size. I used the same lift sling when I got her out of bed that morning. I did that transfer fine. " (NA #1 is no longer employed in the facility.)

During an interview with the Director of Nursing on 08/09/12 at 11:27 AM it was revealed " as soon as this happened, we began an investigation. I began by getting statements from the staff members involved. Based on interviews and a return demonstration by (name of NA #1) it was determined that the facility lift policy was not followed as evidenced by the nurse aide not obtaining assistance with the transfer. In addition, during the return demonstration, (name of NA #1) failed to cross the straps to properly secure the right leg of the person she was demonstrating on. The DON further stated that they had checked the size of the sling for resident # 11 and it was the correct size for the resident. The DON indicated that the facility had put together a plan of correction. The plan for the specific resident included : review and update care plan and care card specific to resident, employee involved suspended pending results of investigation, statements obtained from NA and others detailing event, statement from Nurse who assessed the patient and root cause-analysis of incident to be developed. " The target dates for these interventions were 07/16/12.

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The plan for residents with the potential to be affected included : " identify all residents requiring the use of a mechanical lift for transfers (07/16/12), ensure that facility has sufficient number of mechanical slings available in various sizes to accommodate mechanical lift transfers (07/20/12), re-educate the NA ' s to centers policy and procedure for mechanical lift transfers (with emphasis on two staff assistance) (07/20/12), assess the current resident population who use mechanical lift for transfers to assure appropriate sling size relative to the resident ' s weight and body composition (07/20/12), re-educate the nurses to the criteria for determining appropriate sling size for mechanical lift transfers (07/21/12), return demonstration performed with each nursing employee that utilizes the lift in their daily routine (07/20/12), update care cards to reflect correct sling size for all residents (07/19/12), initiation of a lift buddy system. The buddy system will be reflected on the daily assignment sheet (07/17/12).

The plan for systemic changes included : re-educate the laundry staff on sorting the mechanical lift slings and cleaning of the slings with an emphasis on air-drying and sorting of various sizes (07/20/12), re-educate facility staff to inspect the mechanical lift slings for damage or frayed areas (prior to use) give to Central Supply or Nursing Administration for replacement, mechanical lift to be utilized by 2 persons (07/19/12), in-service on mechanical lifts with an emphasis on: selection of appropriate sling size on admission will be in serviced quarterly, and with new employee orientation (07/19/12 and ongoing), return demonstration on the mechanical lift for ALL new nursing employees

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(07/21/12), have maintenance to validate the lifting equipment to assure proper functioning as a part of preventative measures (07/16/12), assess all new admissions that have been identified as a mechanical lift transfer for appropriate sling size (07/17/12 and ongoing), ADNS (Assistant Director of Nursing) will validate lift assessments and sling sizes on newly admitted residents during the 24 hour admission chart audit (07/17/12 and ongoing).

The plan for monitoring included: SDS (Staff Development Coordinator) to validate that nursing staff is utilizing the lift properly (check 3 employees each week x 3 months), SDS or Unit Manager will audit 5 resident slings weekly x 3 months to identify appropriate size (ongoing 3 months), DNS (Director of Nursing)/Nsg. Admin (nursing administration) to validate care cared to assure sling size has been determined (on going /3 months).

As part of the validation process, the entire plan was reviewed including reeducation of staff, resident mechanical lift sling compliance, nurse aide lift compliance and care card reviews. On 08/08/12 two residents (including # 11) were observed being transferred to bed using a mechanical lift. The 4 nurse aides involved provide a safe transfer for the residents. Interviews with the nurse aides after the transfers revealed that the nurse aides were aware of the 2 person / mechanical lift procedure and knew where to find the information needed regarding a residents transfer abilities. A review of the monitoring tools revealed that the facility had completed " Resident Mechanical Lift Sling Compliance " audits on 08/03/12, 08/07/12 and

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F 323	Continued From page 8 08/08/12, " C.N.A. Lift Usage Compliance " audits on 08/02/12, 08/03/12, 08/07/12 and 08/08/12 and " Sling Size Accuracy and Resident Care Card " audits on 07/30/12 and 08/07/12. During an interview with the Director of Nursing on 08/09/12 at 11:27 AM it was revealed " the results of the audit tools will be presented at the next Quality Assurance meeting.	F 323		
F 329 SS=D	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 contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to ensure 2 of 11 residents (Resident # 119 and Resident # 91) were free from unnecessary drugs by administering medications that had been discontinued or were not given at the prescribed dosage. Findings include: 1. Resident #119 was admitted to the facility on 12/11/09 with a cumulative diagnoses which included dementia with psychotic features with targeted behaviors of delusions and anxiety. A review of the Medication Administration Record (MAR) revealed Klonopin 0.125 mg twice daily at 9 am and 5 pm was ordered on 11/17/11 prn (as needed) for anxiety. On 3/22/12, Klonopin 0.125 mg every eight hours prn for anxiety was ordered. (Klonopin is a medication used for treatment of seizures and anxiety). A review of physician's orders for 6/11/12 revealed an order to "discontinue Klonopin prn." A review of the June 2012 MAR revealed a handwritten notation to "D/c (discontinue) 6/11/12" the Klonopin 0.125 mg every eight hours prn. A review of the physician's orders for 6/25/12 revealed that the Klonopin dosage was changed to 0.125 mg every am, 0.25 mg at bedtime, and 0.125 mg every day prn. The order was signed off by (Nurse # 4). A review of the June 2012 MAR revealed that the Klonopin dosage was not changed on the MAR and Resident # 119 continued to receive 0.125 mg at 9 am and 5 pm	F 329	• All residents have the potential to be affected by this practice. The Director of Nursing and the Administrative Nursing staff will audit the medical records and the medication administration records of current facility residents to assure that orders written over the past 60 days were transcribed correctly to assure that residents receive the medication and the correct dosage of the medication as ordered by the MD. This audit will include written MD orders and telephone orders received by the nursing staff. Any errors will be reported to the Medical Director. To be completed 8/15/2012. Exhibit #3. • The Director of Nursing and/or the Staff Development Coordinator will provide re-education through in servicing for the current facility licensed nursing staff and data entry personnel on the facility policy and procedure r/t transcription of medication orders and the entering of orders into the computer system to assure that the facility residents are administered the medications and the correct dosages of medications as ordered by the MD. Exhibit # 4 . Newly hired licensed nursing staff and Data Entry personnel will be provided education on the facility policy and procedure for MD order transcription and submission of data entry into the facility system. This education will be incorporated into the facility orientation process.	8-15-2012 8-28-2012 8-28-2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROSE MANOR	4230 NORTH ROXBORO ROAD DURHAM, NC 27704

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F 329	Continued From page 10 daily. The prn order for 0.125 mg every day prn was not written on the June 2012 MAR. A review of the July 2012 MAR and August 2012 MAR revealed the Klonopin dosage orders of 6/11/12 and 6/25/12 were not printed on the MARs. The July and August MARs continued to have Klonopin 0.125 mg bid (twice daily) 9 am and 5 pm and was documented as having been given daily. The MARs also continued to have Klonopin 0.125 mg every eight hours prn, but was not given. During an interview on 8/8/12 at 3:21 PM, Nurse # 3, the Unit Manager, stated, "(Nurse # 4) took off the orders. When you take off an order and sign it, it means you made sure the order was transcribed correctly and completely. Whoever transcribes a medication order is supposed to make sure the data entry person gets the green copy of the order so the change can be made on the MAR in the computer. The facility has an in-house computer system for printing out the monthly MARs. It looks like there was a breakdown where the order was signed off as being transcribed, but it wasn't. A nurse manager checks the new MARs against the old MARs to be sure they are correct each month. They review the new ones against the old ones for any orders written since the new MARs were printed and make sure the changes are made on the new MARs." During an interview on 8/9/12 at 4:30 pm, the Director of Nursing (DON) stated (Nurse # 4) had transcribed the medication orders on 6/25/12. The DON stated Nurse # 4 had also been responsible for checking the new monthly MARs	F 329	• A two step system for validation of MD orders to assure correct transcription will be initiated. Orders received throughout a 24 hour period will be validated by the 11-7 Supervisor and/or Charge Nurses. Orders received on the 11-7 shift will be validated by the 7-3 supervisor and/or other administrative nursing personnel. Exhibit #5 • The DNS and/ or her designee will run a daily manifest of all new orders that have been entered into the computer system for the previous 24 hours. The DNS will audit 10 medical records and 10 medication administration records of facility residents with new orders to assure compliance with the facility policy and procedure for transcription of MD orders to assure residents receive the correct medication and the correct dosages of medication. This audit will be done weekly for 90 days. Exhibit # 6 • End of month chart checks will be removed from the responsibility of facility charge nurses and will be completed by Nursing Administrative personnel. To start with the review of September 2012 MD orders and September 2012 Medication Administration Records. • All data and findings will be presented to the monthly X 3 months and quarterly thereafter to the Performance Improvement Committee for review and recommendations. The facility administrator is responsible for overall compliance	8-28-2012 8-28-2912 8-28-2012