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 _____	C 09/25/2012

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 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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that staff followed turning and positioning guidelines on the Resident Care Card which resulted in 1 of 3 sampled residents (Resident #1), who experienced falls, sustaining a left femur fracture. Findings include: Resident #1 was admitted to the facility on 01/13/12 and was readmitted to the facility on 06/05/12 and 08/10/12. The resident's documented diagnoses included osteoporosis, osteopenia, bilateral femur fractures, and uncontrolled diabetes. Review of Resident #1's undated Care Card revealed it documented the resident was total assist for bathing, required a lift for transfers, required two staff members for mobility, required an assist of two staff members for positioning every two to three hours, and was confused. Under "Other" the card documented, "Assist of 2 for T & P (turning and positioning)." The resident's 07/20/12 Quarterly Minimum Data Set (MDS) documented she was severely	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 I 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.* I. The CNA that was working with Resident #1 was suspended pending the outcome of an investigation into the alleged deficient practice. The CNA was terminated for failure to follow known facility policy and procedure. II. Resident Care Cards were reviewed and remain updated to reflect residents' current plan of care as well as the number of caregivers required for positioning. Residents requiring 2 person assist for positioning were noted and a log is maintained on each MAR.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/15/12

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 323	Continued From page 1 cognitively impaired, was totally dependent on one staff member for bed mobility/hygiene/bathing, and was totally dependent of two staff members for transfers. Review of the facility's Falls Detail Reports revealed Resident #1 had not experienced a fall in the facility since her admission. A 08/10/12 hospital Discharge Summary documented Resident #1 was admitted to the hospital on 07/30/12 for uncontrolled diabetes, altered mental status, and failure to thrive. The report documented x-rays obtained in the hospital revealed the resident had osteoporosis, flexure contractures, and a new right femur fracture with placement of a rod in the right femur. A 08/10/12 nursing readmission assessment documented in a fall risk scale that Resident #1 had no history of falling, had no secondary diagnoses to place the resident at risk for falling, and did not use an ambulatory aide, but she had impaired gait and over-estimated or forgot her limitations. A 09/07/12 11:13 AM electronic Resident Progress Note documented, "This nurse called to room at approximately (10:00 AM). Noted resident on floor between air conditioner and bed. Resident lying on left side with head resting on floor. Additional staff paged to room for assistance. Resident assisted back to bed with 3 person transfer. Nursing assistant stated that resident rolled off backside of bed while she was attempting to bathe and (provide incontinent care)..... EMS (emergency medical services) arrived at (10:30 AM) to transport resident to ER	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 I 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.* III. The Staff Development Coordinator has in-serviced licensed staff and nursing assistants on Resident Care Cards. This was completed on 10/2/12. As well, in-services on resident bed mobility with return demonstration have been given. This was completed on 10/7/12. Physician orders will be reviewed regularly and Resident Care Cards will be reviewed and updated as needed. DNS/ADNS to audit resident bed positioning / mobility per the Resident Care Cards for 5 residents weekly for the next 2 months, then bi-weekly for 2 months, then monthly for 2 months. IV. The results of the DNS's monitoring will be presented and discussed at the monthly performance improvement committee meeting. Any additional training needs identified in our monitoring process will be provided as needed.	10-7-12

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

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F 323	Continued From page 2 (emergency room)...." A 09/07/12 11:13 PM electronic Resident Progress Note documented, "Resident returned to facility approx (approximately) (6:00 PM). According to report Head CT (computed tomography) scan was negative, no other injuries noted..." Resident #1's care plan was updated immediately after the fall (without date provided), according to an interview with the Director of Nursing (DON) on 09/25/12 at 8:57 AM. The problem of "___ (name of resident) had an actual fall with no injury, r/t (in regard to) poor balance, poor communication/comprehension, functional problem, disease process/condition: dementia" was identified as a problem. Interventions for this problem included "assist 2 for all turning and positioning." Review of electronic Resident Progress Notes from 09/08/12 through mid-day 09/10/12 revealed Resident #1 did not exhibit any signs of pain or discomfort. A 09/10/12 3:33 PM electronic Resident Progress Note documented that Resident #1's facial expressions were indicative of pain when her left leg was moved. The resident's primary physician was notified, and x-rays of the resident's upper and lower legs were ordered. 09/10/12 mobile x-rays of Resident #1's bilateral hips revealed osteoporosis was present, and there were old fractures of both hips. X-rays of the resident's right femur revealed osteoporosis and an old fracture. X-rays of the resident's left	F 323		

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F 323	Continued From page 3 femur revealed osteoporosis and an "acute" fracture. A 09/11/12 physician's order documented Resident #1 was to be sent to the hospital for evaluation of her left femur fracture. The 09/11/12 hospital x-rays of Resident #1's right femur documented the presence of a rod with more displacement of the fracture fragments within the right femur when compared with x-rays from 08/04/12. The 09/11/12 hospital x-rays of the resident's left femur documented the presence of osteopenic bones and a fracture. At 2:13 PM on 09/24/12 Nurse #1, who cared for Resident #1 on first shift stated Resident #1 was dependent on the staff for her activities of daily living (ADLs), was very cognitively impaired, and had no history of falls prior to her fall on 09/07/12. Thus, she reported no fall interventions were in place for the resident prior to 09/07/12. However, Nurse #1 commented even prior to the resident's fracture of the right femur (08/10/12), two staff members were supposed to provide care and transfers for the resident because of her osteoporosis diagnosis. According to Nurse #1, the two fractures did not seem to change the resident's level of cognitive and physical functioning, other than the resident exhibiting more signs of pain. At 2:23 PM on 09/24/12 NA #1, who reported caring for Resident #1 before the fracture to her right femur (08/10/12) and several times about two weeks after that fracture, stated no one had ever told her that two staff members needed to be present when bathing and providing	F 323		

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incontinent care to Resident #1. She reported she knew the resident well, and felt comfortable providing baths and caring for the resident by herself. According to NA #1, the resident was total care and was very confused. She reported the resident was transferred by two staff members using a lift. After the resident was discharged from the hospital on 08/10/12 with a right femur fracture, the NA commented the only time she asked another staff member to help her bathe or provide care for the resident was when the resident exhibited signs of pain. NA #1 stated if she was unsure of how to care for residents she asked the hall nurse or referred to the Resident Care Card.

At 2:40 PM on 09/24/12 NA #2, who reported she cared for Resident #1 before the fracture to the right femur (08/10/12) and assisted with care occasionally after that fracture, stated no one had ever told her that two staff members needed to be present when bathing and providing incontinent care to the resident. However, she commented she knew the resident's family was very particular so she felt more comfortable asking for another NA to assist her any time she was providing care to this resident. She reported after Resident #1's fractures the resident was more confused and experienced more pain. According to NA #2, Resident #1 was transferred using a lift. She stated the resident was unable to provide any assistance during turning and repositioning. NA #2 reported if she was unsure of how to care for residents she asked the hall nurse or referred to the Resident Care Card.

At 3:43 PM on 09/24/12 NA #3, who cared for Resident #1 after her right femur fracture

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(08/10/12), stated the resident never had a fall until 09/07/12. She reported after the right femur fracture (08/10/12) the DON reviewed with her that anytime care was provided to the resident, that involved turning and positioning, two staff members had to be present. According to NA #3, the DON also showed her notations on the Resident Care Card which documented this information. She explained that before the right femur fracture (08/10/12), it had not been necessary to always have two staff members present to bathe or provide incontinent care to Resident #1. The NA stated if she was unsure of how to care for residents she asked the hall nurse or referred to the Resident Care Card.

At 3:52 PM on 09/24/12 Nurse #2, who cared for Resident #1 on second shift, stated Resident #1 did not have any falls until 09/07/12. He reported even before the resident returning to the facility on 08/10/12 with a right femur fracture, the staff had been instructed to always have two people present during Resident #1's care. After the right femur fracture (08/10/12), the nurse commented the resident was temporarily more lethargic. He also reported Resident #1 did not exhibit any signs and symptoms of pain from her 09/07/12 fall until 09/10/12.

At 4:32 PM on 09/24/12 the facility's Staff Development Coordinator (SDC) reported after Resident #1's 09/07/12 fall in-servicing began on 09/08/12 about abuse and use of Resident Care Cards and turning and repositioning. She stated all staff were being in-serviced on abuse, but she still had between 15 and 20 staff, many of whom worked on the weekend, who had not yet received the abuse in-service. According to the

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F 323	Continued From page 6 SDC, only NAs were being in-serviced about Resident Care Cards/turning and positioning, but she still had 12 NAs, including two new hires, that still needed this in-servicing. At 5:17 PM on 09/24/12 the DON stated Resident #1 had required extensive assistance or had been totally dependent on the staff for her ADLs even prior to her femur fractures. However, she explained that she made it mandatory for two staff members to turn and reposition this resident after the fracture of her right femur (08/10/12). After Resident #1 returned from the hospital on 08/10/12, she reported the resident's Care Card was revised to reflect the new requirement. She explained the NA, who on 09/07/12 did not follow these instructions, was terminated. She explained bathing and incontinent care involved turning and positioning Resident #1, and the 09/07/12 NA attempted to provide these services alone. According to the DON, even though Resident #1 sustained bilateral femur fractures, there was no change in her mental or physical functioning after the fractures. At 8:57 AM on 09/25/12 the DON clarified that the facility did not provide in-servicing to all staff about Resident Care Cards or the need to turn and reposition Resident #1 after the resident returned to the facility on 08/10/12. However, she reported she went individually to those staff who would be caring for Resident #1, and reviewed the new requirement to have two staff present any time the resident was turned and repositioned. She also commented she showed these staff this revision of Resident #1's Care Card.	F 323		

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F 323	Continued From page 7 At 12:34 PM on 10/05/12 a telephone interview was conducted with NA #4 who was providing care to Resident #1 on 09/07/12 by herself when she reported the resident had to be lowered to the floor. She explained as she turned back toward Resident #1 after obtaining a wash cloth she saw the resident falling, attempted to catch her legs, but the resident was too heavy, and slid to the floor. The NA stated she was aware the Resident Care Cards contained information about how to care for residents. She reported she was pulled form another hall to provide baths on Resident #1's hall. She commented she had not worked with Resident #1 in a long time, but the last time she had worked with the resident only one staff member was needed to bathe her. According to NA #4, she was in a hurry so she did not refer to Resident Care Cards on 09/07/12, but no other staff members provided her with the Care Cards or told her that Resident #1 now required two staff for tasks involving turning and repositioning. At 12:47 PM on 10/05/12 a telephone interview was conducted with Physician #1 who reviewed the 09/11/12 x-ray of Resident #1's left femur. He reported no x-ray of Resident #1's left femur was taken during her 07/30/12 to 08/10/12 hospitalization, which could be compared to the 09/11/12 hospital x-ray of the left femur. After review of the 09/11/12 x-ray of the resident's left femur, Physician #1 stated he could not say with 100% assurance that the left femur fracture was not pathological. However, he reported the fracture occurred as the result of hitting or touching. According to Physician #1, he could not say for sure that the left femur fracture captured on the 09/11/12 x-ray was the result of Resident	F 323		

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F 323	Continued From page 8 #1's fall on 09/07/12.	F 323		