

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

PRINTED: 11/08/2012  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/01/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 816 WADE AVENUE RALEIGH, NC 27605
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure staff oversight for 1 of 2 sample residents (Resident #2) that was identified per the care plan at risk for falls, who was found unsupervised outside of the facility in the smoking area, with a hematoma to the forehead, that was sustained from the fall.</p> <p>Findings included:</p> <p>Resident #2 was readmitted into the facility on 10/30/12. Diagnoses included Dementia, Memory Loss and Multiple Sclerosis. The significant change Minimum Data Set completed on 8/6/12 indicated Resident #2 mental status was severely impaired. Bed mobility was indicated as needed supervision with one person physical assist. Locomotion on and off the unit was indicated as needed supervision with set up. Balance was indicated as not steady but able to stabilize without human assistance. Moving on and off the toilet was indicated as not steady and required human assistance to stabilize self. Mobility devices included a walker. The care plan revised on 8/17/12 indicated Resident #2 was at risk for</p>	F 323	<p>Resident #2 has been referred to therapy and is receiving lower extremity strengthening, balance training and gait training.</p> <p>Resident #2 will continue to be supervised while smoking and monitored hourly while in the smoking area.</p> <p>Resident's with similar conditions will be evaluated for safety. (self ambulatory residents with assistive devices) Plan of care will be updated accordingly. Staff in-serviced on hourly monitoring of smoking area.</p> <p>The Director of Nursing will ensure auditing of resident's safety continues for four weeks and then monthly for three months</p> <p>The results of the audit will be taken to P.I. for three months and incorporated into the facilities Q.A. program.</p>	11/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator 11-12-12

deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 required to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED TRANSITIONAL CARE &amp; REHAB-RALEIGH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 WADE AVENUE</b> <b>RALEIGH, NC 27605</b>		
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F 323 SS=D	<p><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure staff oversight for 1 of 2 sample residents (Resident #2) that was identified per the care plan at risk for falls, who was found unsupervised outside of the facility in the smoking area, with a hematoma to the forehead, that was sustained from the fall.</p> <p>Findings included:</p> <p>Resident #2 was readmitted into the facility on 10/30/12. Diagnoses included Dementia, Memory Loss and Multiple Sclerosis. The significant change Minimum Data Set completed on 8/6/12 indicated Resident #2 mental status was severely impaired. Bed mobility was indicated as needed supervision with one person physical assist. Locomotion on and off the unit was indicated as needed supervision with set up. Balance was indicated as not steady but able to stabilize without human assistance. Moving on and off the toilet was indicated as not steady and required human assistance to stabilize self. Mobility devices included a walker. The care plan revised on 8/17/12 indicated Resident #2 was at risk for</p>	F 323			

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TITLE

(X6) DATE

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	<p>Continued From page 1</p> <p>falls related to weakness, impaired balance, impaired cognition, and unsteady gait. Goals included "Will be free of fall related injury through next review." Interventions included apply right lower leg brace as ordered, encourage and remind to use the roller walker when ambulating.</p> <p>A review of the physical therapy (PT) discharge summary dated 8/20/10 through 11/24/10 revealed Resident #2 was discharged from PT services on 11/24/10 due to maximal functional potential was met. Resident #2 was discharged at a low risk for falls.</p> <p>A review of the quarterly patient nursing evaluation for fall risk completed on 8/1/12 indicated Resident #2 was oriented to own ability and assessed with a weak gait.</p> <p>A review of the quarterly patient nursing evaluation for fall risk completed on 10/25/12 indicated Resident #2 was oriented to own ability, had a history of falls, and was assessed with a weak gait.</p> <p>A review of the nurse's note dated 10/28/12 at 9:15 pm read, "Patient was found on the floor at the smoking area by another patient (resident) but was not smoking. The writer and supervisor was paged at about 8:50 pm. Patient was assessed, had a hematoma on her forehead and not responding too well. 911 was called." The nurse's note included no documentation that supported at the time of the fall if the right leg brace was intact or the roller walker was present with Resident #2.</p> <p>A review of the medication record dated 10/28/12</p>	F 323		

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F 323	<p>Continued From page 2</p> <p>stated "Brace to be applied to right leg when resident is up walking to promote improvement in walking, balance, and nursing to check for placement every shift". The document was initialed for 3 pm - 11 pm shift as checked for placement at some point throughout the shift.</p> <p>A review of the hospital discharge record dated 10/30/12 indicated Resident #2 was admitted on 10/29/12 to the hospital and was treated for a fall with a mild subcutaneous hematoma.</p> <p>On 10/31/12 at 9:20 am, Resident #2 was observed with a resolving darken coloration to the left forehead and surrounding structures surrounding the eye. Resident #2 was observed propelling self throughout the unit in a wheelchair.</p> <p>In an interview on 11/1/12 at 10:10 am, Nursing Assistant (NA) #1 stated prior to the fall Resident #2 sometimes stumbled when walking, wherein, the right leg would get caught behind, thus making balance off at times. NA #1 indicated prior to the fall Resident #2 ambulated on the unit with the roller walker, and currently used a wheel chair to propel self throughout the facility.</p> <p>In an interview on 11/1/12 at 10:20 am, Nurse #1 indicated prior to the fall Resident #2 needed safety reminders to ensure the roller walker was used when walking throughout the unit. Nurse #1 added sometimes Resident #2 gait was good and at other times the resident stumbled with the right leg, due to missing a step. Nurse #1 concluded Resident #2 had a hard time balancing self still and would constantly move from side to side.</p> <p>In an interview on 11/1/12 at 10:35 am, NA #2</p>	F 323		

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F 323	<p>Continued From page 3</p> <p>indicated prior to the fall Resident #2 wobbled from side to side when walking throughout the unit with the roller walker.</p> <p>In a telephone interview on 11/1/12 at 11:30 am, Nurse #2 (nursing supervisor) stated upon her respond to the page on 10/28/12 she went to the smoking area (located outside of the building) and observed Resident #2 positioned on the ground on her back in front of the seating bench. Nurse #2 concluded prior to the fall Resident #2 used a roller walker and had a slow shuffled gait to the right foot when walking. Nurse #2 concluded Resident #2's walk was slow but steady.</p> <p>In an interview on 11/1/12 at 12:53 pm, Nurse #3 (unit manager) indicated Resident #2 was to be accompanied outside of the building by staff only during scheduled smoking hours (8:00 pm, 10:00 pm - smoking hours surrounding fall event) and brought back to the unit. Nurse #3 concluded Resident #2 was capable to ambulating with the roller walker off the unit independently, and was functionally safe without staff supervision or oversight prior to the fall.</p> <p>In an interview on 11/1/12 at 3:20 pm, NA #3 who was the primary NA for Resident #2 on the day of the fall, stated prior to the fall Resident #2 walked normal, used a roller walker and ambulated on and off the unit. NA #3 indicated she last saw Resident #2 on the night of the fall on the fourth floor after dinner time, but could not recall the exact time.</p> <p>On 11/1/12 at 3:25 pm accompanied by the Assistant Director of Nursing (ADON) and NA #3,</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>the location where Resident #2 was indicated as found per direction of NA #3 was observed to be outside of the facility in the smoking area, on a concrete surface in front of the bench seat.</p> <p>In an interview on 11/1/12 at 3:37 pm, the Administrator (accompanied by the ADON and nurse consultant) indicated Resident #2 knew the alarm code to the exit door that led outside of the building. He added he was not sure who gave the exit code to Resident #2. He added Resident #2 resided at the facility for years and the alarm code was made known to the alert and oriented residents, and their families.</p> <p>In an interview on 11/7/12 at 11:25 am, the Director of Nursing (DON) stated that Resident #2 was at risk for falls. She added her expectation was if there were any observed changes in Resident #2's ability to ambulate safely from baseline, to have been reported, and a referral to therapy services completed for an evaluation prior to the fall. The DON concluded the goal prior to the fall was to allow Resident #2 as much functional independence as possible, without limiting or restricting Resident #2 quality of life.</p>	F 323			