STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345053	A. BUILDING _____ B. WING _____	C 06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-PETTIGREW	1615 W PETTIGREW ST DURHAM, NC 27705

(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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide recommended follow-up services for 1 of 3 sampled residents with behavior concerns(Resident #94). The findings included: Resident #94 was admitted to the facility on 9/12/12. The cumulative diagnoses included hypertension, dementia with behaviors, right temporal intracranial hemorrhage and delusions. The quarterly Minimum Data Set (MDS) dated 4/16/13, revealed Resident #94 had cognition and behavior problems and required extensive assistance with activities of daily living. Review of the care plan dated 3/4/13 identified the behavior problems as, physically abusive, socially inappropriate, verbally abusive(threatening) with physical attacks, pulling firm alarms, breaking furniture, cursing staff and wandering. The goals included Resident #94 would not harm self or others secondary to their behavior, would have fewer episodes of threatening, physical attacks, breaking furniture and cursing staff less than weekly. The	F 250	*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-250 Resident #94 was seen for a follow up visit on _6/25/13___ by Dr. Williams (Geriatric Neuropsychiatry). A chart audit was performed by the Director of Nurses, and Staff Development Coordinator on current resident population with behaviors to ensure follow-up of Geriatric Neuropsychiatry appointments' have been followed-up or scheduled as indicated. The Social Services Director have been re-educated by the Executive Director regarding the procedure for scheduling and follow up of Psychiatry visits for residents with behaviors. This protocol will be included in the new employee orientation program for social services staff. The Director of Nurses or Executive Director will audit five resident records with behaviors 2x weekly for 4 weeks then weekly x4 to ensure that follow-up Psychiatry appointments have occurred as ordered. Data results will be reviewed and analyzed at the centers monthly Performance	7/18/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 7-12-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-PETTIGREW	1515 W PETTIGREW ST DURHAM, NC 27705

(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 250	Continued From page 1 approaches included, report to physician in new or acute behavior status, provide non-confrontational environment for care, anticipate care needs and provide them before the resident becomes overly stressed, explain care to resident in advance, in terms resident understands, investigate/monitor need for psychological/psychiatric support. Provide services if desired and as ordered by physician, invite/encourage activity programs consistent with interest, monitor behavior episodes and attempt to determine under lying cause. Consider location, time of day person involved and behavior assessment, monitor the effect of the medication and report to the physician. 2. Psychotropic drugs use related to mood indicators/anxiety. The goal included that Resident #94 would be free from signs and symptoms of adverse consequences of psychotropic drug use through next review and would receive the least dosage prescribed to ensure maximum functional ability both mentally and physically. The approaches included consult psychiatric services as needed, document mood/behavior issues every shift (see monitoring behavior log), observe for behavioral symptoms directed toward others (threatening, screaming, cursing etc), observe for behavioral changes not directed toward others, and administer medication as ordered. Psychoactive medication quarterly evaluation dated 3/16/13, revealed that Resident #94 presented with verbal threats of abuse. The(named) medication was increased from 0.125mg bid (twice a day) to 0.25mg bid and the last dose reduction done on 12/11/12.	F 250	*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.* Improvement Committee Meeting for 3 months with a subsequent plan of correction as needed.	

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F 250	Continued From page 2	F 250		

Review of the Geriatric neuropsychiatry services dated 3/19/13, revealed the diagnosis as dementing illness with associated behavioral symptoms with targeted behaviors as elopement and delusions. The plan was for a follow-up in 8 weeks for Resident #94. There was no follow-up visit scheduled or documented in record.

Review of the Behavior/Intervention monthly flow record last documented behaviors on 3/29/13. There were no other records presented when requested for any current noted behaviors for April, May or June.

During an observation on 6/18/13 at 11:00 AM, Resident #94 was in another resident ' s room yelling/cursing telling resident she was going to kick someone ' s butt.

During an observation on 6/18/13 at 2:30 PM, Resident #94 was in hallway near dining room verbalizing profanity at another resident and using inappropriate language. .

During an interview attempt on 6/18/13 at 3:28 PM, Resident #94 began to use inappropriate language and cursing, verbalizing desire to kick someone ' s butt.

During an interview on 6/20/13 at 8:46AM, the physician indicated that when a resident had an on-going behavior/ psychiatric history he would be refer them to geriatric psychiatric services and he relied on the neuropsychiatry services to make the necessary medication changes or

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adjustments based on their assessment/condition of the resident. After review of the record and the last evaluation dated 3/19/13, plan for follow-up 8 weeks. The physician confirmed that Resident #94 should have been re-evaluated a month ago. In addition, he added that he was aware of Resident #94 inappropriate verbal, physical and social behaviors and acknowledged in the physician progress note 6/10/13, that Resident #94 behaviors had not been addressed. The physician also indicated that he was unaware of the process for who should follow-up with referrals needed for psychiatric services. The physician added that Resident #94 should have been reviewed to determine the need to continue or discontinue the medication.

During an interview on 6/20/13 on 8:54AM, the director of nursing indicated that the social worker was responsible for ensuring that referrals and follow-up were done for specialized services. The DON indicated Resident #94 had a long history of behaviors, which included pulling fire alarms, verbal abuse, resist care, attempt to hit others. The expectation was the SW would follow-up on recommendations and make appointments to ensure residents receive proper services. The DON reviewed the record and confirmed that Resident #94 should have received a follow-up visit and a determination whether to continue the current medication should have been evaluated, since Resident #94 behaviors had decreased. The DON also reviewed behavior intervention monthly flow sheet from 4/2013 through 6/2013 and confirmed there were no behaviors documented.

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F 250	Continued From page 4	F 250		

During an interview on 6/20/13 at 9:12 AM, the social worker indicated that she was responsible for making appointments for residents that required follow-up services for specialized care. SW indicated that on 2/19/13-2/20/13 was the last time she documented that Resident #94 had behavior concerns. She added that unless there was an active or current concern the resident would be placed on a list for follow-up. Social worker reviewed the last evaluation dated 3/19/13, and confirmed the plan for follow-up due 8 weeks from the date noted and indicated a call should have been placed to the neuropsychiatric services and Resident #94 should have been seen per the last evaluation.

During an observation on 6/20/13 at 2:30 PM, Resident #94 was in the hall at nurses station #2 pointing finger at another resident using inappropriate language and telling other resident she was going to kick someone butt in the building.

During an interview on 6/20/13 at 2:59 PM, the administrator indication the expectation was for the SW to make the necessary referrals and follow-up appointments for all residents who utilizes specialize services. The social worker was responsible for monitoring and ensuring that follow-up appointments were done in accordance to recommendation using the facility protocol.

F 463 SS=E — 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH — F 463

The nurses' station must be equipped to receive resident calls through a communication system

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F 463 Continued From page 5

from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to provide a functioning call light for 12 of 82 residents.

The Findings included:

Observation on 6/17/13 at 12:34 pm revealed Bed 14B call bell was not functioning. When tested, the call bell could not be activated.

Observation on 6/17/13 at 3:30 pm revealed Bed 19B did not have a push button. When tested, the call bell could not be activated.

Observation on 6/17/13 at 3:23 pm revealed Bed 30B call bell did not function when tested.

Observation on 6/17/13 at 4:15 pm revealed 12 call lights were not operable, Resident rooms 30B, 34C, 35A, 48A, 49A, 37A, 44A, 28A, 22B, 20B, 19B, and 14B. A manual bell was observed for resident bed 44A to be at the bedside table. These rooms were observed to have residents residing in them.

The Administrator was made aware of the call bell concerns on 6/17/13 at 4:15 pm.

A review of Maintenance Request for the month of June 2013 revealed a total of 3 maintenance requests. Nurse Station 1 maintenance request binder revealed one maintenance request in

F 463

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 rooms 14B, 19B, 30B, 34C, 35A, 48A, 49A, 37A, (44A, will keep tap bell due to tying call bell around neck.) 28A, 22B, 20B, 19B, call bells are functioning properly. 7/18/2013

An audit was completed by the Staff Development Coordinator (SDC) and the Maintenance Director on all residents call bells to ensure proper functioning. Call bells that were identified through this process were replaced as needed.

The Maintenance Director and the SDC in serviced the licensed nurses and Certified Nursing Assistance to the centers protocol for checking call bell function daily and reporting call bell malfunction to the Licensed Nurse who will immediately change out the call bell cord and complete Maintenance request form. The SDC will include the above in-service in the orientation program for licensed nurses and certified nurses assistants.

The Maintenance Director, or the SDC will audit ten resident call bells 3x weekly for 4 weeks then ten call bells 2x weekly for 4 weeks then weekly x4 to ensure proper functioning and ongoing compliance

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KINDRED TRANSITIONAL CARE & REHAB-PETTIGREW	1515 W PETTIGREW ST DURHAM, NC 27705

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F 463	Continued From page 6 regards to call bell function on 6/8/13. Nurse Station 2's maintenance request binder had no maintenance request for the month of June 2013. Interview with the Maintenance Director on 6/20/13 at 8:47 am revealed, all call bells were physically checked by all staff on 6/17/13. The Maintenance Director indicated that a Preventative Maintenance Task Sheet is completed once monthly. The preventative Maintenance Task Sheets for Nurse Call System identify all components of the nurse call system are functioning. The Maintenance Director indicated that staff were to fill out maintenance request forms located at each nursing station in a binder. The Maintenance Director stated that on occasion staff will verbally notify the Maintenance Director of a maintenance concern and not write it on a maintenance request form. The Maintenance Director stated he had put additional call bells at the nursing station yesterday (6/19/13) at station 1. The Maintenance Director stated that extra call bells were always available and accessible to staff. The Maintenance director indicated the malfunction with the call light system could have been the call lights itself or the nursing call system at the nursing stations. The Maintenance Director revealed he was unaware of any call bells not functioning until 6/17/13 when it was communicated by Nurse #1. Interview with NA #1 on 6/20/13 at 9:10 am revealed she did not check the facility call lights for maintenance. NA #1 indicated that when residents were newly admitted to the facility she demonstrated how to use the call light. In the instance a call light was found not to be working, NA #1 would fill out a work order and	F 463	*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.* Data results will be reviewed and analyzed at the facility's monthly Performance Improvement (PI) Committee Meeting monthly for three months with a subsequent plan of correction as needed.	

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KINDRED TRANSITIONAL CARE & REHAB-PETTIGREW	1515 W PETTIGREW ST DURHAM, NC 27705

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F 463	Continued From page 9 storms had come through the area recently and could be a result of the call bells malfunctioning. The Administrator stated there wasn't any way that the facility could have been made aware of the call bell system being down until the next maintenance round during the checks of the call lights. The Administrator indicated that it was her expectation that call lights are operational for residents or resident are provided an alternative for calling for assistance. In the instance a resident has a broken call light it should be replaced.	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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communicate the issue with Maintenance. NA#1 did not report or noticed any malfunctioning call bells.

Interview with Nurse #1 on 6/20/13 at 1:46 pm revealed maintenance did preventative maintenance checks with the resident call system. Nurse #1 further revealed NAs are not provided direction to check the call bell for function but to ensure residents call lights were within reach of the resident. Nurse #1 was not aware of any non-functioning light until 6/17/13 when it was communicated to her by NA #3.

Interview with NA #2 on 6/20/13 at 9:18 pm revealed resident call lights were placed within reach of the resident or attached directly to the resident. NA #2 stated she did check the call bells for functioning prior to exiting the resident's room. NA #2 indicated that in the instance a call light was found not to be working, a work order would be completed and placed in a binder located at each nurse's station. NA#2 was not aware of any call lights not functioning.

An Interview with the Director of Nursing (DON) on 6/20/13 at 10:32 am revealed the facility becomes aware of malfunction call bells by NA's that communicating the call lights are not working. The DON included family and residents also make the facility aware when call bells were not operating. The DON indicated that the NA's were aware that extra call lights were located at the nursing station. The DON could not recall when the extra call bells were placed at the nurse's station. The DON stated that from a nursing standpoint there is no system for checking the function of the call lights. NA's

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responsibility is to ensure the call light is within reach of the resident. In the instance there is a call light found to not be working staff would take a working call light from an empty resident room and replace the used light for an operational call light. NA's do not necessarily check the call bell for function. The DON indicated that she did not locate any call bells not functioning on the 6/17/13. The Maintenance director held an inservice on 6/17/13 at 4:17 pm to notify the NA ' s to check all resident call lights. Nurse #1 approached the DON and communicated a call light was located without a red push button and immediately had staff check all the call lights. The DON stated that 8 call lights were identified as not working on 6/17/13. The Rooms identified were 14B, 19B, 20B, 22B on one hall, and 35A, 48A, and 49A, 37A on another. The DON stated that the call lights were identified as a pattern with B beds on one hall and A beds on another. The DON stated that an action plan was put into place immediately. The DON indicated that it was her expectation that a malfunctioning or broken call light be reported and replaced immediately.

Interview with the Administrator on 6/20/13 at 2:00 pm revealed Maintenance has a preventative maintenance book that he checks once a month that included resident call lights. The maintenance director orders and changes call lights routinely. The NA's check call lights for placement. The Administrator stated that NA# 1 would be able to communicate the time that the call light was identified as not working, and as a result an inservice was initiated. The Administrator also communicated that an outside agency also had come into the facility to check the system. The Administrator indicated that

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storms had come through the area recently and could be a result of the call bells malfunctioning. The Administrator stated there wasn't any way that the facility could have been made aware of the call bell system being down until the next maintenance round during the checks of the call lights. The Administrator indicated that it was her expectation that call lights are operational for residents or resident are provided an alternative for calling for assistance. In the instance a resident has a broken call light it should be replaced.

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	345053	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/19/2013

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CONSTRUCTION SECTION

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-PETTIGREW	1616 W PETTIGREW ST DURHAM, NC 27705

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	*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.*	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: At the time of survey, the facility was using the corridor as a return air plenum. Note: If a waiver is requested, the provider must certify that the following conditions are met: (1) Air handling units must be equipped with smoke detectors. (2) There must be a complete corridor smoke detection system. (3) Smoke detectors must be wired to the fire alarm system. (4) Fire alarm system must shut down all air handling units when activated.	K 067	K067 Waiver Request 1. All air- handling units are equipped with smoke detectors 2. All corridors are equipped with smoke detectors. 3. All smoke detectors are wired into the fire alarm system. 4. Fire alarm system shuts down all air handling units when activated.	July 19, 2013

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

ED — July 31, 2013

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.