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 _____	C 09/19/2013

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

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey as of 9/19/13. Event ID# VEP211.	F 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.*	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164	Corrective Action: Upon notification by a state surveyor regarding the violation of resident privacy/confidentiality of medical status the facility corrected the violation immediately through re-education and disciplinary action to the involved license nurse (Nurse 1). Exhibit #1. • All facility residents have the potential to be affected. • The DNS and or SDC will provide re-education to the facility nursing staff regarding resident's rights to privacy and confidentiality of medical status and clinical records. Exhibit #2 • The DNS and or SDC will provide education on the facility expectation regarding reporting between shifts as it relates to the maintenance of privacy and confidentiality of personal privacy and confidentiality of medical status and clinical records. Exhibit #3 • The SDC will include the resident's rights to privacy and confidentiality of the resident's personal and	10/04/13. 10/04/13 10/04/13 10/04/13

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

EXECUTIVE DIRECTOR 10-11-13

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
	345081	A. BUILDING _____ B. WING _____	C 09/19/2013

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

(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 164	Continued From page 1 Based on observations and staff interviews, the facility failed to ensure privacy of confidential medical information during report for residents on the Unit 2 Hall, rooms 5 through 11. Findings included: On 9/17/2013 at approximately 3:25 PM to 3:35 PM, Staff Nurse #1 was observed reporting to an oncoming nurse on the Unit 2 hallway. As the nurses moved from rooms 5 through 11 in the hallway, Staff Nurse #1 verbalized residents' names at each door and voiced medical information in the hallway which included medications, acuity information, pertinent findings and other medical information. The information was easily overheard in the hallway. Nonmedical staff as well as visitors were observed walking by the nurses during the reports. During the report, Staff Nurse #1 walked into room 9, and Staff Nurse #1 gave an oral report to the oncoming nurse on the resident in the A bed. Visitors were observed in the room for the resident in the C bed. The information was overheard outside the opened door in the hallway. In an interview with the Staff Nurse #1 on 9/17/2013 at 3:38 PM, the nurse stated "We do walking rounds when we give report to the oncoming nurse. We go from room to room and report to the oncoming nurse and point out anything that is going on with the residents in those rooms." In an interview with the Director of Nursing (DON) on 9/17/2013 at 3:45 PM, the DON reported the facility used walking rounds during shift change. The DON stated "During walking rounds, they go from room to room and speak briefly on any	F 164	*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.* clinical records and the facility's expectation for reporting between shifts as it relates to the maintenance of privacy and confidentiality to newly hired employees. • Walking rounds for the end shift reporting will be eliminated from the facility practice. Oncoming licensed nursing staff will receive shift report behind closed doors on individual nursing units. • The DNS and or ADNS will monitor 5x weekly for 90 days to assure compliance with the maintenance of resident's personal privacy and confidentiality of the resident's health status and clinical records. An audit tool will reflect monitoring of compliance. Exhibit #4 • All data collected will be submitted monthly x3 months and quarterly	10/04/13 10/04/13 10/04/13

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 _____	C 09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 164	Continued From page 2 acute episodes. I expect them not to speak so other people can hear what they are saying."	F 164	thereafter to the performance improvement committee for review and recommendations. The facility administrator is responsible for overall compliance.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure dignity during dining by failing to serve 1 of 4 residents close to the time other residents at table were served and by failing to ensure staff were seated while feeding 3 of 4 residents. Findings include: 1. Resident # 67 was admitted to the facility on 10/31/09 with a cumulative diagnoses that included dementia. A review of the annual Minimum Data Set (MDS) for 8/30/13 revealed Resident # 67 had severe cognitive / communication deficits and required all aspects of care by staff, including feeding. On 9/17/13 12:48 PM, the lunch meal was observed in the Special Care Unit (SCU) dining room. Twelve residents were seated with three staff members present to assist with feeding. Resident # 67 was observed sitting at a table with three other residents. Resident # 67's covered tray set before her while two of the residents at the table fed themselves, and the other resident was fed by staff.	F 241		

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
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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)	(X5) COMPLETION DATE
F 241	Continued From page 3 Observation of the Assisted Feeding dining room on the same hall on 9/17/13 12:58 PM revealed residents were seated in the dining room waiting for trays to be delivered. Five staff members were also seated in the dining room waiting for trays. Observation of the SCU dining room 9/17/13 at 1:02 pm revealed staff beginning to feed Resident # 67. Two of the other residents at the table had finished with the meal. On 9/18/13 12:59 PM, during observation of the noon meal in the SCU, the Director of Nursing (DON) entered the SCU dining room. The DON was informed some residents were waiting 15-20 minutes to be fed while others at the same table and around them were eating or being fed. At 1:01 PM, three additional staff were sent to the SCU dining room to assist with feeding. During an interview on 9/18/13 4:00 PM, the DON stated it was her expectation that all residents at one table be would be served and fed at the same time. 2. Resident # 26 was admitted to the facility on 11/22/13 with cumulative diagnoses that included dementia. The annual Minimum Data Set (MDS) dated 8/27/13 revealed Resident # 26 had severe cognitive / communicative deficits and required all aspects of care by staff, including feeding. On 9/16/13 12:32 PM, the Special Care Unit (SCU) was observed during the noon meal. Twelve residents were seated with three staff to assist with feeding. At 12:55 PM, Nursing Assistant (NA) # 1 entered the dining room and began setting up Resident # 26 to be fed. No	F 241	*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.* Corrective action: Upon observation by the DNS and notification by the state surveyor the facility re-organized the SCU dining room where the affected residents were dining to assure adequate staffing to assist the residents in a timely manner and the provision of adequate seating as to allow staff members to sit while assisting residents. Re-education and disciplinary action was rendered to involved staff members. NA #1 and nurse #2. • All facility residents have the potential to be affected. • The ED and DNS will evaluate facility dining areas to determine staffing and seating needs to assure that the facility is promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality. • The DNS and or the SDC will provide re-education to facility staff on dignity and respect of individuality as it promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity	10/04/13 10/04/13 10/04/13

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-ROSE MANOR	4230 NORTH ROXBORO ROAD DURHAM, NC 27704

(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 241	Continued From page 4 chairs were available for NA # 1 in the dining room. At 12:59 PM, NA # 1 began feeding Resident # 26 while standing next to her. At 1:06 PM, another staff member finished feeding and gave NA # 1 her chair. During an interview on 9/18/13 at 2:24 PM, NA # 1 stated she knew that standing while feeding a resident was a dignity issue. NA # 1 stated she was afraid the food would get cold while she went to find a chair. NA # 1 stated she usually did not stand while feeding a resident. During an interview on 9/18/13 at 4:10 PM, the DON stated it was her expectation that staff be seated while feeding a resident. 3. Resident # 52 was admitted to the facility on 3/9/07 with a cumulative diagnoses that included dementia. A Significant Change Minimum Data Set (MDS) assessment dated 4/28/13 revealed Resident # 52 had severe cognitive / communication deficits and required all aspects of care by staff, including feeding. On 9/18/13 12:45 PM, the Special Care Unit (SCU) dining room was observed during the noon meal. Twelve residents were seated with five staff present to assist with feeding. There were four chairs available for staff in the dining room and all were occupied. At 12:53 PM, Nursing Assistant (NA) # 1 began feeding Resident # 52 while standing. There were no chairs available in the dining room for NA # 1. During the observation on 9/18/13 at 12:59 PM, the Director of Nursing (DON) entered the dining room and noted NA # 1 standing while feeding. At 1:01 pm, another chair was obtained and given	F 241	*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.* and respect in full recognition of his or her individuality. • The SDC will include education to newly hired employees on dignity and respect of individuality as to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity in full recognition of his or her individuality. • Assisted feeding groups in the facility will be organized to provide adequate staffing as to assure that the residents requiring assistance will be assisted in a timely manner and that the residents are being assisted simultaneously. • Facility will secure additional seating to accommodate staff to assure that employees are seated while assisting residents. • The DNS and or ADNS will monitor designated feeding assistance areas to assure compliance with dignity and respect of in full recognition of the resident's individuality. An audit	10/04/13 10/04/13 10/04/13 10/04/13

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 _____	C 09/19/2013

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

(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 241	Continued From page 5 to NA # 1. During an interview on 9/18/13 at 2:24 PM, NA # 1 stated she knew that standing while feeding a resident was a dignity issue. NA # 1 stated she was afraid the food would get cold while she went to find a chair. NA # 1 stated she usually did not stand while feeding a resident. During an interview on 9/18/13 at 4:10 PM, the DON stated it was her expectation that staff be seated while feeding a resident. 4. Resident # 67 was admitted to the facility on 10/31/09 with a cumulative diagnoses that included dementia. A review of the annual Minimum Data Set (MDS) for 8/30/13 revealed Resident # 67 had severe cognitive / communication deficits and required all aspects of care by staff, including feeding. On 9/18/13 12:45 PM, the Special Care Unit (SCU) was observed during the noon meal. Twelve residents were seated with five staff present to assist with feeding. Resident # 67 was noted to be leaning slightly to the left side of the wheelchair. Nurse # 2 was seated on Resident # 67's right side between Resident # 67 and Resident # 21. Nurse # 2 was observed standing intermittently to reach to feed Resident # 67. When standing, Nurse # 2 also fed Resident # 21 before sitting down again. During the observation on 9/18/13 at 12:59 PM, the Director of Nursing (DON) entered the dining room and noted Nurse # 2 standing while feeding Resident # 67 and Resident # 21. The DON immediately approached Nurse # 2 and advised her to remain seated while feeding.	F 241	*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.* tool will be created to monitor compliance with adequate staffing and a sufficient number of chairs to assure that the residents are assisted in a manner in which they are being assisted simultaneously with others in their environment and to assure that staff is seated when assisting residents. The DNS and or ADNS will monitor the assisted dining areas for compliance 5x weekly for four weeks and then 3x weekly for eight weeks. • All data collected will be submitted monthly x3 months and quarterly thereafter to the performance improvement committee for review and recommendations. The facility administrator is responsible for the overall compliance.	10/04/13

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 _____	C 09/19/2013

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

(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 241	Continued From page 6 During an interview on 9/18/13 at 2:30 PM, Nurse # 2 stated she was afraid Resident # 67 would begin to lean further as she ate so she stood from time to time to feed her, and then Resident # 21. Nurse # 2 stated she knew she should remain seated while feeding residents. During an interview on 9/18/13 at 4:10 PM, the DON stated it was her expectation that staff be seated while feeding a resident. 5. Resident # 21 was admitted to the facility on 1/16/02 with a cumulative diagnoses that included dementia. A review of the annual Minimum Data Set (MDS) for 12/4/12 revealed Resident # 21 had severe cognitive / communication deficits and required all aspects of care by staff, including feeding. On 9/18/13 12:45 PM, the Special Care Unit (SCU) was observed during the noon meal. Twelve residents were seated with five staff present to assist with feeding. Nurse # 2 was seated between Resident # 21 and Resident # 67. Nurse # 2 was observed standing intermittently to reach to feed Resident # 67. When standing, Nurse # 2 also fed Resident # 21 before sitting down again. During the observation on 9/18/13 at 12:59 PM, the Director of Nursing (DON) entered the dining room and noted Nurse # 2 standing while feeding Resident # 21 and Resident # 67. The DON immediately approached Nurse # 2 and advised her to remain seated while feeding. During an interview on 9/18/13 at 2:30 PM, Nurse # 2 stated she was afraid Resident # 67 would	F 241		

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 _____	C 09/19/2013

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 241	Continued From page 7 begin to lean further as she ate so she stood from time to time to feed her, and then Resident # 21. Nurse # 2 stated she knew she should remain seated while feeding residents. During an interview on 9/18/13 at 4:10 PM, the DON stated it was her expectation that staff be seated while feeding a resident.	F 241		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345081	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/19/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
F279

Based on observation, record review and interviews with staff, the facility failed to initiate an antipsychotic medication plan of care for 1 of 5 residents (Resident # 95) reviewed in Stage 2 for unnecessary medication use. Findings include:

Resident # 95 was admitted to the facility on 7/8/2012 with multiple diagnoses including:
traumatic subarachnoid hemorrhage, presumed tuberculosis meningitis, encephalocele, ventriculoperitoneal shunt 2010, cerebrovascular accident, hypertension, coronary artery disease, chronic kidney disease.

The Minimum Data Set (MDS) dated 7/9/2013 indicated that the resident was cognitively intact. The Care Area Assessment Summary (CAA) for antidepressant medications dated 10/20/2012 was reviewed. The summary indicated that the resident used antidepressant and antianxiety medications and will develop a care plan to avoid complications and maintain current level of functioning.

The care plan dated 11/2/2012 was reviewed. There was no care plan developed for the antidepressant medication.

On 9/18/2013 at 11:25 am, the MDS coordinator looked through the care plan dated 11/2/2012 for a plan for antidepressants. Ay that time it was stated by the coordinator " there is not one " (care plan)

In an iterview with the Director of Nursing (DON) on 9/19/2013 at 9:30 am, she revealed that it was her expectation that care plans are to be done.

Kindred
Transitional Care
and Rehabilitation
Rose Manor

Dedicated to Hope, Healing and Recovery

Nov 6th, 2013

NOV 13 2013

Mr. Roger Fortman
Building System Engineer
Construction Section
NC Division of Health Service Regulation
2705 Mail Service Center
Raleigh, NC 27699

Dear Mr. Fortman,

Enclosed please find our plan of correction in response to our Life Safety Survey on October 23rd, 2013. Please be advised that all necessary corrective action will be completed by December 7th, 2013.

We are requesting herewith a waiver for K067 and submit the following:

1. All air handlers are equipped with smoke duct detectors.
2. There is a complete corridor smoke detector system tied into the fire alarm system.
3. Air handlers shut down upon activation of the fire alarm system.
4. Our fire alarm system will shut down all air handling units when activated.

Please feel free to contact me if you have any question regarding our plan of correction and the request for K067 waiver.

Sincerely,

Francis Emodi
Administrator

4230 North Roxboro Road • Durham, North Carolina 27704
919.477.9805 • 919.479.5261 fax • 800.735.8262 TDD/TTY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/23/2013

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

(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
K 000	INITIAL COMMENTS This Life safety Code(LSC) survey was conducted as per The Federal Register, using the Existing Health Care section of the LSC and its referenced publications. This building is type II (111) construction , one story with a complete automatic sprinkler system.	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 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 10/23/13 at approximately 8:30 AM onward the following deficiencies were noted; 1) The fire alarm control panel was not connected to dedicated electrical circuit. 42 CFR 482.41(a)	K 052	It is the practice of Kindred Transitional Care and Rehab-Rose Manor to assure that fire alarm systems are installed, tested and maintained in accordance with NFPA 70 and 72 to maintain compliance at all times to include: The fire alarm control panel connected to a dedicated electric circuit. A) The facility obtained the services of House electrical company B) House electric company connected our fire alarm control panel to a dedicated circuit. There are no other similar life safety issues having the potential to affect residents by the same deficient practice. Maintenance director will incorporate this into our monthly preventive program for 3 months to ensure compliance.	10/24/13
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the	K 056	System components will be reviewed at the center's monthly performance improvement meeting for consistency and compliance. Subsequent action will be implemented as necessary. The Administrator is responsible for the overall compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/23/2013

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

(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
K 056	Continued From page 1 building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Wednesday 10/23/13 at approximately 8:30 AM onward the following deficiencies were noted; 1) There are sprinkler heads in the facility rated for Intermediate Temperature Classification, Glass Bulb Color of Yellow temperature rating of (175°F) and High Temperature Classification Blue (225°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F) . The area were Ordinary Temperature Classification sprinkler heads need to changed are the following; a) The Kitchen has (225°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F) b) Outside canopy's have Intermediate Temperature Classification, Glass Bulb Color of Yellow temperature rating of (175°F) sprinkler heads in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F) . c) The boiler room has (225°F) sprinkler head in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F)	K 056	*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.* It is the practice of Kindred Transitional Care and Rehab-Rose Manor to assure that automatic sprinklers are installed and maintained in accordance with NFPA 13 and NFPA 25 to remain in compliance at all times to include: 1A) The facility obtained the services of Simplex Grinnell and the technician replaced the blue bulb sprinkler heads (225°F) in the kitchen with the appropriate temperature rating for the area (155°F). 1B) The facility obtained the services of Simplex Grinnell and they informed us that the yellow glass bulb sprinkler heads temperature rating of (175°F) is the appropriate sprinkler heads based on NFPA 13 (Table 6.2.5.1 Temperature ratings, classifications, and color coding). **Exhibit One** 1C) The facility obtained the services of Simplex Grinnell and the technician replaced the blue bulbs sprinkler heads in the boiler room with the appropriate temperature rating for the area. 2) The facility obtained the services of Simplex Grinnell and the Technician replaced the ¾ inch line with a 1 inch line. 3) The facility obtained the services of	12/07/13.

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	345081	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/23/2013

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K 056	Continued From page 2 2) In the laundry room there is a 3/4 inch line supplying water to two sprinkler heads. Facility will need to provide documentation that the sprinkler line is properly sized. 3) In the soiled linen room there appears to have two separate sets of sprinkler heads on two separate systems. Facility will need to verify that there only one separate system in the facility. 4) Upon review of the sprinkler inspection report it stated that the bushes and trees around the backflow preventor will need to cut back inorder to allow for access and inspection. 42 CFR 483.70(a)	K 056	*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.* Simplex Grinnell and the Technician verified that we have only one system in the facility. 4) The facility has cleared the bushes and trees around the backflow preventer to create access for inspections.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation on Wednesday 10/23/13 at approximately 8:30 AM onward the following deficiencies were noted; 1) Sprinkler heads installed in the laundry room and soiled linen room smoke compartment were a mixture of quick response heads and standard fused heads. NFPA 13, 1999 edition, Standard for the Installation of Sprinkler Systems 5-3.1.5 Thermal Sensitivity 5-3.1.5.1 Sprinklers in light hazard occupancies shall be of the quick-response type as defined in 1-4.5.2	K 062	There are no other similar life safety issues having the potential to affect residents by the same deficient practice. The maintenance director will incorporate this into our monthly preventive program for two months. System components will be reviewed at the center's monthly performance improvement meeting for consistency and compliance. Subsequent action will be implemented as necessary. The Administrator is responsible for the overall compliance.	

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K 062	Continued From page 3 Exception No. 1 Residential sprinklers shall be permitted in accordance with 5-4.5. Exception No. 2 For modifications or additions to existing system equipped with standard response sprinklers, standard response sprinklers shall be permitted to be used. Exception No. 3 When individual standard response sprinklers are replaced in existing systems, standard response sprinklers shall be permitted to be used. 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed. 42 CFR 482.41(a)	K 062	*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.* It is the practice of Kindred Transitional Care and Rehab-Rose Manor to assure that the sprinkler system is maintained and inspected to ensure compliance at all times to include: 1) The facility obtained the services of Simplex Grinnell and the Technician converted the sprinkler heads in the laundry and soiled linen room smoke compartment to quick response heads.	12/07/13
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: A. Based on observation on 10/23/13 the facility was using the corridor as a return air plenum. in order to obtain a waiver for this these requirements must be met. a. fire alarm must shut down the air handlers. b. there must be a complete corridor smoke detection system that is tied into the fire alarm system.	K 067	There are no other similar life safety issues having the potential to affect residents by the same deficient practice. The maintenance director will incorporate this into our monthly preventive program for three months. System components will be reviewed at the center's monthly performance improvement meeting for consistency and compliance. Subsequent action will be implemented as necessary. The Administrator is responsible for the overall compliance.	

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K 067	Continued From page 4 c. have duct detectors at the air handlers. 42 CFR 483.70(a)	K 067	*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 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 10/23/13 at approximately 8:30 AM onward the following deficiencies were noted; 1) By observation, oxygen cylinders was not properly chained or supported in a proper cylinder stand or cart in resident room #4 . [NFPA 99 4-3.5.2.1b(27)] 2) The oxygen storage was non-compliant, specific findings include; full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (oxygen storage room)	K 076	**We are requesting herewith a waiver for K067 and submit the following:** 1. All air handlers are equipped with smoke duct detectors. 2. There is a complete corridor smoke detector system tied into the fire alarm system. 3. Air handlers shut down upon activation of the fire alarm system. 4. Our fire alarm system will shut down all air handling units when activated.	12/07/13

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K 076	Continued From page 5 42 CFR 483.70(a)	K 076	*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.* It is the practice of Kindred Transitional Care and Rehab-Rose Manor to assure that all oxygen storage areas remain in compliance at all times to include: 1) Securing the oxygen cylinder in room #4 2) Securing and separating full and empty oxygen cylinders in our oxygen storage room. Facility staff were properly in-serviced There are no other similar life safety issues having the potential to affect residents by the same deficient practice. Maintenance director will incorporate this into our monthly preventive program for 3 months to ensure compliance. System components will be reviewed at the center's monthly performance improvement meeting for consistency and compliance. Subsequent action will be implemented as necessary. The Administrator is responsible for the overall compliance.	12/7/13.