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 06/27/2017

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 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff interviews and record review, the facility failed treat resident in a dignified manner by not responding to a call light for assistance with incontinent care for 1 of 3 sampled residents (Resident #28). The findings included: Resident #28 was admitted on 7/1/15. The diagnoses include congestive heart failure, diabetes mellitus, chronic kidney disease and atrial fibrillation. Review of the activities of daily living care area assessment, dated 4/18/17, indicated Resident #28 required extensive 1-2 person assistance with activities of daily living and incontinence. The quarterly Minimum Data Set (MDS) assessment, dated 5/4/17, revealed Resident #28 ' s cognition was intact, she required extensive to total assistance with activities of daily living and set up assistance only for meals. Review of Resident #28 ' s care plan, dated 6/20/17, identified the problem as activities of daily living self-care performance deficit and limited mobility. The goal included resident needed to be groomed, dressed and bathed. The	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. F241 Affected resident provided incontinent care and bed linens changed. Immediate individualized education and disciplinary action provided to Nurse #2 regarding call bell light expectations and provision of timely ADL care/meeting care needs. Education was provided to the staff on call light response expectation and provision of timely ADL care. An audit was completed of current resident in regards to answering of the call bell lights and services being provided timely. This audit will serve as measure of identifying noted improvement and/or ongoing re-education	7/21/17

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

Electronically Signed | 07/20/2017

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F 241	Continued From page 1 interventions included resident would use the call light for assistance, required two person assistance and was totally dependent upon staff for toileting, personal hygiene and repositioning assistance. During an observation on 6/24/17 at 8:15 AM, the meal tray was delivered and set up for Resident #28 in her room. Resident #28 was lying in a large wet spot in the bed. Resident #28 put the call light on at 8:20 AM. Nursing staff was present outside of Resident #28 ' s door when the light went on. Several staff were observed passing by the room. Nurse#2 was standing right outside of the door and did not enter the room to check to see what assistance Resident #28 needed. The call light was not answered until 8:38 AM. During an interview on 6/24/17 at 8:20 AM, Resident #28 stated "this happens all the time when the call light is put on, it takes staff forever to come and assist. They keep saying they are coming back and they do not. I get so upset waiting for staff to help and I am so tired of this stuff." Resident #28 was upset and tearful during conversation. During an interview on 6/24/17 at 8:45 AM, Nurse #2 stated he was focused on passing medication and did not see the light since there was no sound. Nurse stated the expectation was to check on the resident to see what assistance they need and provide it. During an interview on 6/24/17 at 9:00AM, the Administrator indicated the expectation was for staff to ensure that residents were not being left wet during meals. She further stated the nurse should have gone and asked the resident what	F 241	and disciplinary action as warranted with employees. The audit will continue to be part of the education process for staff current and newly hired upon orientation. Education was provided to current staff and reinforcement of the education had been completed regarding dignity and respect and provision of resident care timely when the call bell light is activated. The Interdisciplinary Team will perform audits - which includes feedback from residents regarding timely provision of ADL care and call light response. The audits will be completed 3 days per week for four weeks, then 2 days per week for four weeks: then audits will be completed weekly ongoing to ensure resident dignity maintained and call bell lights answered in a timely manner with care being provided in a timely manner. The ED/DNS will report the audit findings to the QA committee monthly for 12 months. The QA committee will review the audits and ensure compliance is on going and determine the need for further audits/re-education beyond the 12 month period.	

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F 241	Continued From page 2 assistance was needed when the call light was placed on by the resident.	F 241		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on resident, staff interviews and review of resident council meeting minutes, the facility failed to resolve group grievances that were reported in the resident council meetings for two consecutive months. The findings included: Review of the resident council meeting minutes, dated 3/30/17, revealed a concern: call bell not being answered. There was no follow-up documentation to the group regarding the action taken at the 4/27/17. The 4/27/17 meeting identified a concern regarding staff did not knock on doors and turning on lights without regard to	F 244	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. F244 Review of the Resident Council grievances were conducted to determine	7/21/17

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F 244	Continued From page 3 residents. There was no documented follow-up with the group at the 5/25/17 meeting. During an interview on 6/26/17 at 10:03 AM, Resident#178 was identified as alert and oriented. Resident #178 stated there were times when "I put the call light on, staff would come, turn them off and don ' t come back. So I turn the light right back on until someone helps me. This happened on different shifts, so I try and get in bed myself because they don ' t come when I need them to come." During an interview on 6/26/17 at 10:39 AM, Resident #23 was identified as alert and oriented. Resident #23 stated he had attended the resident council meetings on a regular basis and "I stop going because when you tell staff about the concerns nothing happened. We have talked about the call lights not being answered in a couple of meetings, nothing happened and it was still a problem. Staff come to room don ' t knock, turn the light off and then don ' t come back. They don ' t come back to the group and tell us what happened." During an interview 6/26/17 at 12:05 PM, the Director of Nursing (DON) reported the response to group concerns was done verbally among the department heads. The DON stated the expectation was the Activity Director would report the response to the group. The DON indicated communication was generally verbal and she did not know how each department handled responding back to the resident council group. If there was a nursing concern, it was a verbal response to the Activity Director, who would then tell the residents what was being done.	F 244	affected residents with unresolved grievances. The grievances without resolution reviewed; action for follow up discussed in resident council with plans for correction and follow up. The grievances without resolutions were completed. Education of the Activities Coordinator provided on ensuring proper documentation of grievances on the correct form, as well as the process for submitting to the ED for dissemination to the appropriate department for accurate completion and follow up for resident satisfaction. Staff education on provided on Grievance process with timely follow up and documentation. Staff education on call bell light expectation and providing necessary care prior to light being turned off. Resident council meeting conducted with residents to discuss grievance policy and facility actions for appropriate follow up and resolution. The resident council will meet at least monthly to review grievances and ensure timely follow up of grievances submitted. A Resident Council newsletter to be distributed to residents for follow up to ensure compliance. Individual grievances will be followed up with individuals: group grievances will be outlined in newsletter with details regarding follow up and facility action. Feedback to be obtained from residents regarding noted improvement in concerns and/or additional ongoing education and monitoring. Follow up regarding old	

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F 244	Continued From page 4 During an interview on 6/26/17 at 2:00 PM, the Administrator indicated the expectation was for each department head to address the concerns in the identified area and report the information to the Activity Director. The activity staff would discuss and document the action that took place at the next resident council meeting. The Administrator stated the Activity Director was responsible for addressing old and new business at each meeting and document the resolution. The department heads should complete a response form and give to the Activity Director for discussion at next meeting or with an individual within a few days of the reported concern. During an interview on 6/27/17 at 9:22 AM, Resident #62 was identified as alert and oriented. Resident #62 reported he was unaware of what happened with the information that was discussed in the group. Resident #62 added that call light response was a concern of the group for a few months, but he was unaware of how the concern was handled or resolved. During an interview on 6/27/17 at 9:34 AM, the Activity Director (AD) stated the expectation was to discuss the resident council concerns in morning meetings and give the department heads the concerns for follow-up. The AD added the residents had concerns with staff responding to call lights on different shifts. The AD reported that each month there was a verbal discussion with the group about the concerns, but she did not document on the resident council form the action taken to resolve the issue for the group. The Activity Director reported being unaware of the response and documentation process for resident council until she was informed by the Administrator during survey process.	F 244	business will be discussed and documented during resident council meetings monthly x 12 months. Adequacy of follow up will be expected monthly after each resident council meeting. Newsletters to be distributed monthly to all residents monthly as means of follow up to those not in attendance to resident council meetings. Resident council will invite appropriate departments to meeting to discuss specific concerns as needed. Resident Council results will be discussed during morning IDT meeting following resident council meeting. The Activities Director will report the Resident Council Grievance follow up to the QA committee monthly x 12 months. The QA committee will review the grievances and ensure compliance is ongoing and determine the need for further follow up beyond the 12 months period.	

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F 244	Continued From page 5 During an interview on 6/27/17 at 10:55 AM, Resident #33 was identified as alert and oriented. Resident #33 stated that when concerns were discussed in the group "we don ' t know what they do about it. There were concerns brought up about staff coming in turning off lights and don ' t come back, 3rd shift was the worst. I have put my light on different times of the day and staff would ask me what I need, turn light off, then I have to wait a long time for them to come back, then I have to keep turning it on to get help." "Even if someone else mentions it the next month nothing was done." During an interview on 6 /27/17 at 11:40 AM, Resident #117 was identified as alert and oriented. Resident #117 stated when things were brought up in resident council meetings, the staff activity director would write things down, but she was unaware of what happens with the information. The next month the concerns were the same but no change. Resident #117 reported that when she pushed the call light to get assistance, staff would come in ask what she needed, turn the call light off, and say they were going to help, and then don ' t return. She stated that you have to wait for a long time till they come back.	F 244		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		7/21/17

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F 278	Continued From page 6 participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the behavior (Resident # 84) and hospice care (Resident #179) for 2 of 22 sampled residents reviewed for MDS assessment. Findings Included: 1. Resident# 179 was admitted to the facility on	F 278	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	

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F 278	Continued From page 7 3/1/17 with diagnosis that included but not limited to Cancer (Malignant neoplasm of esophagus), Malnutrition, and Human immunodeficiency virus (HIV) and Adult Failure to Thrive. Review of admission note from the Facility Physician on 3/2/17 revealed Resident #179 was admitted to the facility on hospice. Review of the Duke Hospice contract dated 3/2/17 revealed Resident #179 was in hospice program starting 3/2/17. A review of the most comprehensive Minimum Data Set (MDS) assessment dated 3/10/17 marked as an admission assessment, revealed the assessment was coded as the resident ' s being cognitively intact with clear speech, adequate hearing and can make self-understood. The resident was not coded hospice services. Review of Hospice notes dated 3/6/17 read in part: Chaplin visit to room. Patient reports no pain or discomfort, non-demonstrative in emotion or talk, reports no local spiritual support, spiritual concern not important. Refuses further Chaplin visit. Review of Hospice notes dated 4/1/4/17 read in part: Goal to make patient comfortable, encourage patient to ask for pain medication as needed. Patient had an order for pain medications. Patient on Tube Feeding, tolerating Tube Feeding well. Review of Hospice notes dated 5/12/17 read in part: Patient indicated that pain level has improved and ranges from 2-7/10. Kadian 150 mg stated on 3/29/17. Rating throat pain 4/10,	F 278	it is required by the provisions of federal and state law. MDS Assessments for residents #84 and Resident #179 were accurately reassessed/updated/modified and resubmitted. The MDS team performed an audit of all potential residents with assessments completed and those upcoming which exhibited behaviors. MDS assessments modified as needed and resubmitted. MDS also performed an audit of all residents currently with Hospice services to validate accuracy of coding - no other Hospice residents affects: MDS assessments were accurate. MDS team members were re-in-serviced and re-educated at both facility level and corporate level regarding MDS Assessment completion expectations for accuracy. Daily discussions of assessments due are discussed during morning meetings - IDT members all present. Discussion to ensure all clinical services are addressed on MDS: specific discussions regarding clinical changes, Hospice, Behaviors, etc. RAI manual has been re-distributed to MDS team as reference tool. Weekly random audits of MDS assessments for accuracy will be completed weekly x 12 weeks: then randomly x 12 months. These audits will be completed in IDT team, which includes MDS team members, ED/DNS.	

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F 278	Continued From page 8 requesting as needed Morphine. Patient on Tube Feeding, facility nursing reports tolerating Tube Feeding well. Facility knows to call hospice before 911. Review of the Care plan revised on 5/30/17 revealed Resident# 179 was care planned for End of Life Care related to esophageal cancer, HIV, adult Failure to Thrive. Resident# 179 admitted on hospice and to be free from pain. Interventions include educated resident/family/responsible party about end of life process and follow hospice regime for comfort care measure. A review of the most resent Minimum Data Set (MDS) assessment dated 6/5/17 marked as a Quarterly assessment, revealed the assessment was coded as the resident being cognitively intact with clear speech, adequate hearing and can make self-understood. The resident was not coded hospice services. Review of Hospice notes dated on 6/9/17 read in part: Patient with minimum input during the visit, does not initiate any conversation. Patient refuses any further Chaplin visit. Gastrointestinal (GI) has Percutaneous endoscopic gastrostomy (PEG) tube in place, tolerating sips of fluids only, no solid intake by mouth. Hospice nurse on routine visit, resident with no issue. During an interview with Nurse # 4 on 6/25/17 at 8:45 AM, she indicated that Resident #179 was on hospice care and was followed by hospice service. She stated that Resident #179 change in condition and/or change in behavior was notified to the hospice nurse. She indicated that Hospice and facility Physician were responsible for	F 278	MDS Coordinators will report findings in QA meeting for the next 12 months. QA committee will review audits to ensure compliance is on-going and to determine the need for further audits and/or further re-education.	

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medication change.

During an interview with Nurse #12 on 6/26/17 at 2:45 PM, Nurse indicated that Resident #179 was followed by Duke Hospice services. She indicated that the resident ' s Activity of Daily Living and nursing care were provided by the facility and hospice nurse follows the resident every week. She stated that if there was a change in condition for the resident, then hospice and facility Physician were notified.

During an interview with the MDS Nurse on 06/27/17 at 1:30 PM, she indicated that all residents change in condition such as hospice, deterioration in medical condition, falls and other major details were discussed daily in the Facility ' s morning stand up meeting and MDS updated in 14 days to reflect these changes.

During an interview with MDS Nurse on 06/27/17 at 1:55 PM, she indicated that Resident #179 was admitted to the facility on Hospice and followed by Duke Hospice service since admission. She indicated that it was a mistake that both the annual and quarterly MDS assessment did not reflect Resident #179 hospice status.

During an interview with Facility Administrator on 06/27/17 at 2:55 PM, administrator indicated that it was her expectation that when residents were admitted to the facility on hospice, the admission staff should make the Physician, MDS staff and other facility staff aware of the hospice care needed. She stated that it was her expectation that facility staff were aware of all residents receiving hospice services and that the residents was provided with appropriate care and services. Administrator indicated that she had made an

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error of not entering Resident #179 ' s name in the CMS form under hospice care.

2. Resident #84 was admitted to the facility on 2/7/17. His diagnoses included dementia, anxiety, depression, bilateral below knee amputation and diabetes mellitus.

Review of the admission MDS assessment, dated 2/15/17, revealed that Resident #84 was not coded for verbal and physical behavioral symptoms toward others in section E and it was not triggered in the care area assessment.

Record review of Resident 84 ' s multiple nurses ' notes, dated 2/8/17 - 2/15/17, revealed: on 2/8/17 the resident refused to sleep in bed, to take medication as ordered, became upset about the absents of trapeze in his bed; on 2/12/17 the resident resisted care, refused assessment of dialysis access site, refused the blood sugar test, stated "I was a nurse and could take care of myself, walk out of my room!"; on 2/15/17 the resident refused to get up in the morning, called 911 service several times, stated nobody could get him out of the bed. On the same day later the resident refused blood sugar test, refused to take his bed bath and was not cooperative with care.

On 6/25/17 at 2:10 PM, during an interview, Nurse #3 indicated that Resident #84 showed non-cooperative and manipulative behavior on the regular bases. He, often, refused care, treatment and medications, left the facility and missed medication administration and treatment procedures, refused assistance with preparation to his dialysis appointment, became verbally abusive toward staff. The nurse notified the physician and administration about resident ' s

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F 278	Continued From page 11 behavior. On 6/27/17 at 7:45 AM, during an interview, Nurse Aide #9 indicated that Resident #84 was not cooperative with care since admission, showed manipulative behavior, often requested assistance but refused it, did not follow the scheduled tasks and was verbally abusive with the staff. On 6/27/17 at 11:00 AM, during an interview, the MDS nurse indicated that different employees completed parts of MDS assessment. She was responsible for closing the assessment when it was completed, but not for accuracy of every section. She stated that behavior section was completed by the Social Worker. On 6/27/17 at 12:10 PM, during an interview, the Social Worker (SW) indicated that she was responsible for sections C, D, and E of the MDS. Seven days prior to the assessment due date, the SW was responsible for interview/observation of the resident, review the nurses notes and for completion of the appropriate assessment section. The SW confirmed that Resident 84 ' s MDS assessment, dated 2/15/17, had to reflect resident ' s non-cooperative and abusive behavior in section E (behavior) and care area assessment. On 6/27/17 at 1:40 PM, during an interview, the Director of Nursing indicated that her expectation was the MDS assessment to accurately reflect resident ' s behavior. The MDS nurse and Social worker were responsible for assessment accuracy.	F 278		
F 312	483.24(a)(2) ADL CARE PROVIDED FOR	F 312		7/21/17

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F 312 SS=D	Continued From page 12 DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff interviews and record review, the facility failed to provide incontinent care for 1 of 3 dependent resident, who requested assistance (Resident #28.) The findings included: Resident #28 was admitted on 7/1/15. The diagnoses include congestive heart failure, diabetes mellitus, chronic kidney disease and atrial fibrillation. Review of the activities of daily living care area assessment, dated 4/18/17, indicated Resident #28 required extensive 1-2 person assistance with activities of daily living and incontinence. The quarterly Minimum Data Set (MDS) assessment dated 5/4/17, revealed Resident #28 ' s cognition was intact and she required extensive to total assistance with activities of daily living and set up assistance only for meals. Review of Resident #28 ' s care plan, dated 6/20/17, identified the problem as activities of daily living self-care performance deficit and limited mobility. The goal included resident needed to be groomed, dressed and bathed. The intervention included resident would use the call light for assistance, required two person assistance and was totally dependent upon staff for toileting, personal hygiene and repositioning assistance.	F 312	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. Resident #28 had her request for water and incontinent care provided. Education was provided to the staff regarding call bell light expectations and timely provision of resident care when answering the resident call bell light. An audit was completed of current residents in regards to the answering of call bell lights and services being provided in a timely manner. This audit will continue to be part of the education process for staff current and newly hired upon orientation. Education was provided to current staff and reinforcement of the education had been completed regarding call light response and timely ADL care provision,	

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F 312	Continued From page 13 During an observation on 6/26/17 at 8:45 AM, Resident #28 turned on the call light for assistance. The nursing assistant (NA) #2 entered the room at 8:49 AM, and asked Resident #28 what she needed. Resident #28 stated she needed to be changed and wanted some water. NA#2 staff turned off light and told resident she would get her assigned aide. The resident pressed the call light again at 9:11 AM, and NA #8 entered the room and asked the resident what assistance was needed. Resident #28 stated she needed to be changed and wanted some water. NA#8 turned the light off and informs the resident she would go get assistance. Resident #28 pressed the call light again at 9:14 AM. Nurse #8 entered the room at 9:16 AM, and asked the resident what she needed. Resident #28 reported she needed to be changed and wanted some water. The light was turned off and Nurse #8 informed resident someone would be in to assist as soon as they could. During an interview on 6/26/17 at 9:20 AM, Resident #28 reported that she had told each of the staff she needed to be changed, wanted water and to be pulled up in bed. Resident #28 stated she was upset for not getting the assistance she needed. Observation on 6/26/17 at 9:30 AM revealed Resident #28 received incontinent care and requested water. During an interview on 6/26/17 at 9:30 AM, NA#2 stated when she entered the room Resident #28 asked for the assigned aide, so she went to get her. NA #2 did not respond as to why she did not assist the resident or get another staff from the	F 312	including dignity. The audits will be completed 3 days per week for four weeks, then 2 days per week for four weeks, then weekly to ensure resident dignity maintained, call bells lights answered timely and provision of timely ADL care. The Director of Nursing/ED will report the audit findings to the QA committee monthly for 12 months. The QA committee will review the audits and ensure compliance is ongoing and determine the need for further audits beyond the 12 month period.	

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hall to assist.

During an interview on 6/26/16 at 9:34 AM, NA#3 indicated she was the assigned person to Resident #28, but was assisting with dining until 9:20 AM. NA#3 reported that Resident #28 required two person assistance. NA#3 acknowledged that Resident #28 was wet when Nurse #8 asked her to assist the resident.

During an interview on 6/26/17 at 9:39 AM, NA#1 reported that when she went into Resident #28's room, the resident asked to be changed. She stated she left the room to get assistance because the resident needed two people to get resident up. She could not recall who she went to get assistance from. NA#1 did not respond when asked why she did not ask for assistance from the staff on the hall.

During an interview on 6/26/17 at 9:45 AM, Nurse #8 stated Resident #28 did ask to be changed when she went into the room. The assigned staff was working with another resident and would assist her as soon as she was done. When asked why there was no other person that could assist with the care, there was no response.

During an interview on 6/26/17 at 9:57 AM, the Director of Nursing (DON) indicated that any nurse or nursing assistant should answer the call light, find out what assistance the resident needed and provide the care. The DON added the lights should not be turned off until the task was completed.

During an interview on 6/26/17 at 11:09AM, the Administrator indicated the expectation was for staff to respond to call light by asking the

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F 312	Continued From page 15 residents what assistance was needed and to provide the assistance timely. The administrator indicated any staff could assist with ADL care.	F 312		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to label opened bread loaves, failed to store leftover supplements appropriately, discard left over juice and inappropriately store staff personal food in walk-in refrigerator. Facility failed to store food under	F 371	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	7/21/17

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F 371	Continued From page 16 sanitary conditions in the walk- in freezer, failed to provide a clean ice scoop, failed to maintain temperature of hot foods during operation of tray line, and failed to use clean plates and bowl on tray line. The facility also failed to maintain temperature, discard food appropriately and inappropriately store staff personal food in one of one the nourishment refrigerator. Finding Included: 1. Observation of the bread rack on 6/24/17 at 5:25 AM revealed three (3) opened bags containing loaves of bread and one (1) opened bag containing hamburger buns that were not labelled. During an interview with the dietary staff at 5:27 AM, she indicated that the bread was opened previous day and should have been labelled. 2a. Observation of the walk - in refrigerator on 6/25/17 at 5:30 AM revealed three (3) Styrofoam To Go containers with a label "6/23/17 - ROD". The containers contained fries, fried fish, steamed broccoli. During an interview with the dietary staff at 5:31 AM, she indicated that she was unsure what "ROD" on the label meant and indicated that the food should not be placed in the refrigerator. 2b. Observation of the walk-in refrigerator on 6/25/17 at 5:30 AM revealed a plastic tub placed on a cart in the center of the refrigerator floor containing four (4) cup labelled "Sysco - frozen nutrition treat" with brown liquid outside the cups. The dietary staff indicated that the cups were frozen nutrition supplements left over from last night dinner and should have been placed in the freezer.	F 371	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 371: The following immediate actions were made upon identification of problems: identified food were labeled appropriately, leftover supplements were discarded, personal food discarded in walk in refrigerator, ice scoops were cleaned and put in appropriate holders, temperatures were re-heated to appropriate temperature prior to being served and plates/bowls were cleaned prior to resident use. Ice built up was immediately removed from freezer and actions taken for external company to evaluate freezer. Nourishment refrigerator was locked to avoid personal use of food storage and staff educated on this procedure and expectation. The Culinary Manager provided immediate education to staff regarding identified dietary department concerns and education provided to Activity Director regarding monitoring of Nourishment refrigerator. Immediate monitoring put in effect regarding any other potential areas of concern. Current employees re-educated on food labeling, date monitoring/discard of food items/supplements, no personal food in refrigerators, expectations of cleanliness	

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F 371	Continued From page 17 2c. Observation of the walk-in refrigerator on 6/25/17 at 5:30 AM revealed a plastic jar, half filled with orange colored liquid which was not labelled. Dietary staff indicated that the jar contained leftover juice from last night dinner. 3a. Observation of the walk-in freezer on 6/25/17 at 5:38 AM revealed floor icy, ice on the boxes placed on a rack beneath the freezer compressor. The boxes were labeled "cinnamon rolls", "pies", "and sweet potatoes fries". Observation also revealed icicle formation from the freezer compressor. Dietary staff indicated that the ice may be due to defrost of the freezer. 3b. Observation of the walk-in freezer on 6/25/17 at 5: 38 AM revealed an opened three (3) gallon white cardboard container with a dent on the top of the container and lid not fitted properly. The container's label indicated "Strawberry ice-cream - 3 Gallons". No label indicating open or use by date was noted. 4. Observation of the ice- machine outside the kitchen on 6/25/17 at 5:45 AM revealed the ice scoop placed over the ice scoop holder. During an interview with dietary staff on 6/25/17 at 5:46 AM, staff indicated that the ice machine was used by nursing staff for resident's needs. She further stated that she was unsure why the scoop was not placed in the holder. During an interview with the Dietary Manager (DM) on 6/24/17 at 8:10 AM, DM stated that the freezer had been defrosted last night which caused the ice to form on the floor and on the boxes. She also stated that the three (3) Styrofoam To-Go container in the in walk-in - refrigerator belonged to a staff member and should not have been placed there. She also	F 371	of ice scoops/plates/bowls, etc, food temperature expectations and monitoring of freezer for ice built up and immediate removal. Newly hired staff will be educated upon hire and as needed if ongoing education required regarding expectations. An audit tool for dietary/nourishment monitoring will be utilized daily to monitoring food labeling, foods dated, leftover supplements stored correctly, no personal food in refrigerators, cleanliness of ice scoops/dishes/etc, completion of food temps and monitoring for freezer ice built up. This will be monitored daily by dietary department personnel. These daily audits will be ongoing monthly x 12 months. The Dietary Manager will also perform weekly dietary Rounds to assess Dietary compliance . The RD will perform monthly dietary Rounds for compliance. The ED will perform random dietary Rounds to validate on-going compliance. Dietary Manager will report findings in QA committee monthly meetings. The QA committee will review audits to ensure compliance is on-going and to determine the need for further audits/and or re-education.	

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indicated that the staff should appropriately store frozen food in the freezer.

5a . A Calibrated thermometer was used by DM, to check the temperatures of food on the tray line in the kitchen on 6/26/17 at 12:05 PM. Temperature for ground grilled ham was registered at 130 degrees Fahrenheit. The food was reheated so that internal temperature reached 165 degrees Fahrenheit. DM indicated she was unsure why the temperature of ground ham was low and that the temperatures recorded earlier for all foods was above 140 degrees.

5b . A Calibrated thermometer was used by DM, to check the temperatures of food on the steam well in the dining room on 6/26/17 at 12:20 PM. Temperature registered for Beef steak with gravy was 120 degrees Fahrenheit, Stewed tomatoes was 100 degrees Fahrenheit, Ground ham was 120 degrees Fahrenheit, Grilled Sliced ham was100 degrees Fahrenheit, Squash casserole was 120 degrees Fahrenheit. The lunch was not yet served in the dining room. All of the food from the serving line was sent the kitchen and reheated. A Calibrated thermometer was used by DM and temperatures were rechecked at 12:35 PM. Temperatures of all food recorded temperatures above 150 degrees Fahrenheit.

During an interview with the Dietary Manager (DM) on 6/26/17 at 12:40 PM, DM indicated that the staff must not have started the steam wells early enough for water to heat adequately and maintain food temperature.

6. On 6/26/17 at 12:05 PM, multiple bowls and plates used to plate food that were stacked near the tray line were observed to have stains and

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dried food particles on the them. All plates and bowls were removed from the pile and sent for rewash.

During an interview with the Dietary manager on 6/27/17 at 8:34 AM, DM indicated that she had purchased new thermometers for checking temperatures of food. She indicated that the thermometer may not been working accurately during yesterday lunch observation. She further stated that all food temperatures were taken before tray line began so that appropriate temperatures are maintained.

7a. During observation of the nourishment refrigerator on 6/27/17 at 8:34 AM, DM manager indicated that the Activity Director was responsible for the nourishment refrigerator as the refrigerator was located in the activity room which was also the assisted dining room. Temperature log on the refrigerator indicated multiple days in the month of June when temperatures were recorded above 40 degree Fahrenheit. Temperature recorded by the thermometer placed inside the refrigerator indicated 42 degrees Fahrenheit.

7b. Observation of the nourishment refrigerator revealed two (2) lunch bags with no name, two (2) lunch boxes with staff names on it, one (1) lunch box with no label, a transparent fast food cup with a straw half filled with light brown milky liquid, one (1) opened carton of "Sysco Thickened cranberry juice, 46, Fl. Oz" with a date 5/31/17 written on it, one (1) opened carton of "Sysco Thickened orange juice , 46 Fl. Oz" with a date 5/3/17 written on it, one (1) opened carton of "Sysco Thickened water, - 46 Fl. Oz" with no date.

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7c. Observation of the nourishment freezer revealed one (1) 8 Oz opened aluminum soda can labeled Spirit, one (1) 8 Oz Styrofoam cup with frozen liquid with no label and two (2) bags labeled "frozen mixed vegetables" with ice on the bags. Activity Director (AD) indicated that she was unsure to whom the food belonged to.
During an interview with the Activity Director (AD) on 6/27/17 at 8:34 AM, AD indicated that the lunch bags, lunch boxes and To-Go cup containing coffee belonged to staff. She indicated that maintenance staff checks the temperatures for the refrigerator and if the temperature were higher than the safety zone of 40 degree Fahrenheit, Dietary was notified and the food was discarded.

During an interview with the Activity Director (AD) on 06/27/17 at 8:40 AM, AD indicated that the refrigerator was used for the resident and the staff should not store their lunch in the refrigerator. She also indicated that all food should be labelled and that any opened container should be discarded within 7 days from the day of opening. She further stated that she was unsure why the opened cartons of thickened liquids were not discarded.
Review of the facility food storage and labeling policy revealed, staff food , food brought by families or friend from home or other foods from other establishments should not be stored in the kitchen storage areas (i.e. refrigerators, dry storage rooms). Policy also indicates that any food container that was opened must be labeled with "open date" and "use- by day".

Review of the facility refrigerator/ freezer temperature monitoring policy revealed, that the

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F 371	Continued From page 21 internal temperature of the refrigerator should of 41 degrees Fahrenheit or below, nourishment room refrigerators temperatures should be checked and recorded once daily and all out of range temperatures be reported immediately to the designated supervisor. During an interview with Administrator on 6/27/17 at 2:55 PM she indicated that it was her expectation that the nourishment refrigerator not be used by staff for their personal use. She indicated that the refrigerator will be locked so that the refrigerator was solely used for residents only. She stated that the food temperatures and refrigerators containing residents food should be monitored and be within appropriate range.	F 371		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and	F 431		7/21/17

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F 431	Continued From page 22 disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews for 3 out 4 medications carts, the facility failed to; 1) refrigerate 1 of 4 unopened insulin bottles and 1 of 3 unopened insulin syringes in medication cart #1A, 2) failed to refrigerate unopened eye drops on 1 of 1 bottles on medication cart SCU (skilled	F 431	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	

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KINDRED TRANSITIONAL CARE & REHAB-ROSE MANOR	4230 NORTH ROXBORO ROAD DURHAM, NC 27704

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F 431	Continued From page 23 care unit), and 3) failed to properly store 1 of 1 insulin bottles in the appropriate residents ' prescription container on medication cart #2B. Findings included: 1a) Observation on 6/27/17 at 10:05 am of medication cart #1A with Nurse #6 revealed an unopened insulin bottle with a date received from the pharmacy on 6/26/17 for Resident #196 with a label that indicated "keep refrigerated until opened." There was no date written on the label of the bottle. 1b) Observation on 6/27/17 at 10:05 am of medication cart #1A with Nurse #6 revealed an unopened insulin syringe with a date received from the pharmacy on 6/25/17 for Resident #123 with a label that indicated "keep refrigerated until opened." There was no date written on the label of the bottle. An interview with Nurse #6 on 6/27/17 at 10:07 am was conducted. Nurse #6 reported she checked her cart at the start of her shift. Nurse #6 stated she checked her cart for loose pills, ensured medications were dated when opened such as insulin, checked for and disposed of any expired medications, and made sure the cart was clean. Nurse #6 reported she did not check the insulin when she started her shift and did not notice the unopened insulin vial and insulin syringe. The insulin was not refrigerated. 2) An observation on 6/27/17 at 10:22 am of medication cart #2B with Nurse #5 revealed Resident #48 ' s insulin vial was in Resident #97 ' s container.	F 431	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. F431 Resident affected had medications returned to the pharmacy and replaced by emergency kit medications. The medications were ordered and replaced stat for the residents next administration. The MD was notified and no new orders were obtained for the residents. Medications were put in appropriate prescription container. The Director of Nursing and Unit Managers performed an audit of each medication cart; there were no additional medications on the cart that were improperly stored; medications requiring refrigeration were in the refrigerator, as well as labeled dated. There were no other residents medications in inappropriate medication containers. Current licensed staff educated by Director of Nursing and SDC on the organization of medication cart, medication storage and facility perimeters of refrigeration of medication. Newly hired staff will be educated upon hire and as needed per education calendar. An audit tool for monitoring of medication carts for improperly stored medications, as well as properly labeled dated an in proper container will be monitored 5 days per	

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F 431	Continued From page 24 An interview with Nurse #5 was conducted on 6/27/17 at 10:22 am. Nurse #5 reported she overlooked the insulin being in the wrong container this morning when she checked her cart. 3) An observation on 6/27/17 at 12:50 pm of the SCU (Skilled Care Unit) medication cart with Nurse #3 revealed an unrefrigerated and unopened bottle of eye drops received from the pharmacy on 6/26/17, which indicated "keep refrigerated until opened." There was no date written on the label of the bottle. An interview with Nurse #3 at 12:51 pm was conducted. Nurse #3 confirmed the eye drops should have been refrigerated until they were opened. An interview was conducted with the pharmacist on 6/27/17 at 2:30 pm. The pharmacist reported insulin was to be refrigerated until opened. The pharmacist indicated medications that were taken out of the refrigerator, but not opened, should be dated as the day it was put at room temperature. An interview was conducted with the Director of Nursing (DON) on 6/27/17 at 2:33 pm. The DON indicated her expectation was for the nurses to follow the facility parameters when storing insulin.	F 431	week for 4 weeks, then 3 times per week for 4 weeks and 2 times per week for 4 weeks and weekly for 2 weeks ,: then weekly as needed. The audits will be completed by Nurse Management. The current licensed nursing staff educated on the audit tool and any newly hired staff will be educated. The pharmacy will also complete monthly checks to ensure compliance. The audit tool consists of the following categories for monitoring: medications stored in correct containers, medications dated and stored correctly - refrigerated as needed, insulin on cart opened and dated: plus additional categories per facility need. Director of Nursing will report findings in Quality Assurance committee meeting for the next 12 months. QA committee will review audits to ensure compliance is on-going and to determine the need for further audits beyond 12 months.	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	F 520		7/21/17

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F 520	Continued From page 25 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and residents interviews the facilities Quality Assessment and Assurance Committee failed to maintain	F 520	This Plan of Correction is the center's credible allegation of compliance.	

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F 520	Continued From page 26 implemented procedures and monitor the interventions that the committee put into place in July of 2016. This was for recited deficiency, which was originally cited on 7/28/16 during the recertification survey and on the current recertification survey. The deficiency was in the area of pressure ulcer and active diagnoses. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross-referred to: F278: Accuracy of assessment: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the behavior (Resident # 84) and hospice care (Resident #179) for 2 of 22 sampled residents reviewed for MDS assessment. The facility was originally cited for F278 for failing to accurately code the MDS assessments on pressure ulcer and active diagnoses for 2 of 16 residents in July 2016. On 6/27/17 at 1:30 PM, during an interview, the Administrator indicated that the Quality Assessment and Assurance Committee meetings occurred monthly and based on the results of the several previous surveys the facility created and implemented the plan of correction. The Administrator confirmed that the facility constantly worked on quality improvement projects and conducted multiple audit in different areas of care.	F 520	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. Current resident have the potential to be affected. A modified MDS was completed for residents #84 and #179. An AD HOC QA meeting was conducted to ensure the committee has addressed the MDS Assessments for accuracy: to include residents with behavior, as well as with hospice care of residents. The committee also reviewed ongoing staff education reinforcement regarding facility follow up processes and expectations outlined. The QA committee procedures discussed : action plan development/follow up and ongoing monitoring for resolution. Monthly the QA committee meeting will be conducted to review and discuss the facilities adherence to monitoring the accuracy of the MDS; plus identified areas of concern. Designated Nurse Management will perform audits of the MDS process weekly for 12 weeks follow by random checks for a period of 12 months. The Executive Director will report the audit findings to the QA committee monthly for	

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F 520	Continued From page 27	F 520	12 months. The QA committee will review the audits and ensure compliance is ongoing and determine the need for further audits/re-education beyond the 12 month period.	