STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-GASTONIA	416 N HIGHLAND ST GASTONIA, NC 28052

(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 279 SS=D	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: Based on medical record review and staff interview the facility failed to develop a comprehensive care plan with measurable goals related to the use of a urinary catheter and vision and failed to update a care plan related to the use of protective arm sleeves for poor skin integrity for 1 of 16 sampled residents. (Resident #5) The findings are: Resident #5 was admitted to the facility in 2006. Diagnoses included, in part, Dementia,	F 279	*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 #5 Foley catheter, vision, and skin integrity care plans have been updated to reflect measurable goals. The care plan for skin integrity has been updated to include the intervention to wear protective arm sleeves. Current residents' care plans for vision, skin integrity, and Foley catheters were audited and updated by the Interdisciplinary Team to ensure that the goals are measurable. The DNS and or the District Director of Clinical Operations (DDCO) will re-educate the Interdisciplinary Team members to the centers policy and procedure for developing a comprehensive care plan with an emphasis on measurable care plan objectives. This information will be included in the orientation program for new IDT members. The ADNS or DNS will audit 5 care plans (through record review) 2X weekly for four weeks then weekly x4 then monthly x2 to ensure ongoing compliance.	6/7/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Brown — TITLE: Executive Director — (X6) DATE: 6/1/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 Parkinson's disease, Chronic Foley catheter use due to urinary obstruction, recurrent urinary tract infections, and legal blindness. Review of a significant change minimum data set (MDS) dated 3/30/12 assessed Resident #5 with the use of an indwelling Foley catheter, moderately impaired vision requiring corrective lenses, and a pressure reducing device for her bed. The Care Area Assessment for Resident #5 dated 4/4/12 documented the Resident used a Foley catheter, was legally blind, wore glasses, and received treatments for skin tears. The plan of care for Resident #5 dated 4/4/12 recorded that she would have no signs or symptoms related to a urinary tract infection and no complications associated with catheter usage; would be comfortable and safe in her environment and her skin would remain intact. The care plan was not measurable related to complications with the use of a catheter or a comfortable/safe environment. The care plan also did not include the intervention to wear protective arm sleeves. An interview on 5/10/12 at 3:45 PM with MDS nurse #1 revealed she was responsible for completing the care plan goals for Resident #5 and she was aware that the goals should be measurable. She stated that she used a care plan template, but that she could have adjusted the care plan to ensure the goals were measurable, but that she did not do so. She further stated that the goals for Resident #5 should have included how Resident #5 would remain free from injury in	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Data results will be reviewed and analyzed at the facilities monthly Performance Committee Meeting (PI) for three months with a subsequent plan of correction as needed.	

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F 279	Continued From page 2 her environment and signs/symptoms of infection. MDS nurse #1 also stated that she did not carry the protective arm sleeves forward from the previous care plan to current care plan.	F 279	*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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to follow standard nursing professional practice during medication administration of Lanoxin for one (1) of one (1) resident observed for the administration of Lanoxin. (Resident #158) The findings include: 1. An undated facility policy "Pharmacy Reminders" included to check apical/radial pulse prior to giving Digoxin. A review of the standard nursing manual revealed it included the following instructions: "The most important thing to measure when administering digoxin is heart rate. You want to count the apical pulse for a full minute." Resident #158 was admitted to the facility on 2/17/2012. The admitting diagnoses included Atrial Fibrillation, Cardiomyopathy, Hypertension and Dementia. A review of physician orders for Resident #158 dated 2/7/2012 included orders to administer	F 281	Resident #158 apical pulse was immediately checked by the Licensed Nurse and findings were within normal limits. The Licensed Nurse was re-educated on the centers policy and procedure for medication administration with an emphasis on checking an apical pulse for one full minute prior to administering the Digoxin. The ADNS and Unit Manager conducted an audit on current residents receiving Digoxin An order of clarification was written to check apical pulse prior to administering the medication. The Staff Development Coordinator (SDC) re-educated the Licensed Nurses to the centers policy and procedure for medication administration with an emphasis on checking an apical pulse for one full minute, prior to administering Digoxin. This information will be included in the orientation process for licensed nurses. The Assistant Director of Nurses and or the SDC will monitor 3 Nurses (administering Digoxin) 2x weekly for four weeks, then	6/7/2012

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F 281	Continued From page 3 Digoxin (Lanoxin) 125 mcg (Microgram) by mouth daily at 8:00 AM. The medication administration record (MAR) also included space for recording the Resident's pulse daily at the time of medication administration. Resident #158 was observed for medication administration on 5/9/2012 at 8:12 AM. Licensed Nurse (LN) #1 was observed administering medications including Digoxin 125 mcg to Resident #158. LN #1 pulled all medications including Digoxin and stated that she had to check the pulse for Resident #158. LN #1checked the pulse using a finger tip Oximeter unit. She documented the pulse rate and stated that it was 80 and administered Digoxin. An interview with LN #1 on 5/9/2012 at 8:28 AM revealed that she always checked the pulse for residents using the finger tip Oximeter unit prior to Digoxin administration. LN #1 stated that she knew how to obtain apical pulse using her stethoscope. The interview revealed that she was never instructed or in-serviced to obtain an apical pulse rate for a resident while administering Digoxin tablets. An interview with Director of Nursing (DON) on 5/10/2012 at 8:31 AM revealed her expectation was that nursing staff would obtain an apical pulse rate prior to Digoxin administration and document the results on the MAR in the space provided. She further stated that all nurses were aware of this information.	F 281	*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.* weekly x4 weeks and monthly x2 to ensure ongoing compliance with checking apical pulse prior to administering Digoxin. Data results will be reviewed and analyzed at the facilities monthly Performance Committee Meeting (PI) for three months with a subsequent plan of correction as needed.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371	The outdated milk and buttermilk was discarded from the 2nd floor nourishment room.	6/7/2012

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F 371	Continued From page 4 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove twenty-one (21) cartons of outdated milk from one (1) of two (2) nourishment rooms. The findings are: During the initial tour of the facility on 5/7/2012 at 11:15 AM an observation of the nourishment room for the 200 unit revealed a refrigerator with the following dairy products stored beyond the manufacturer's date of expiration: a) twelve (12) cartons of buttermilk with an expiration date of 5/5/12 , b) one (1) carton of buttermilk with an expiration date of 5/6/2012 and c) three (3) cartons of whole milk with an expiration date of 5/6/12. On 5/8/2012 at 8:00 AM an observation of the refrigerator in the nourishment room on the 200 unit revealed five (5) cartons of skim milk with a manufacturer's expiration date of 5/7/2012. On 5/9/2012 at 10:45 AM an interview with the Director of Nurses (DON) revealed she expected all staff to check the nourishment refrigerators	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 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.* The Registered Dietician (RD) re-educated the dietary staff on the centers policy and procedure for food storage, with an emphasis on checking for expired milk products. This in-service will be included in the new employee orientation program for dietary staff. The evening shift dietary aide will be responsible for checking the nutrition room refrigerator daily for expired milk and food products. He or she will be required to dispose of the outdated items immediately. The dietary aide will be responsible for initialing the log daily indicating that check has been completed. The RD or Food Service Manager (FSM) will audit the hydration room refrigerators for expired milk products 3x weekly for 6 weeks then weekly x4 weeks then monthly x3 for ongoing compliance. Data results will be reviewed and analyzed at the facilities monthly Performance Committee Meeting (PI) for three months with a subsequent plan of correction as needed.	

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F 371	Continued From page 5 and discard any expired food items. The DON stated the housekeeping and laundry supervisor was responsible to assign her staff to clean the refrigerators and discard any expired food items they found. An interview on 5/9/2012 at 10:47 AM with the Registered Dietitian revealed the dietary staff member assigned to deliver the nourishment snacks at 10:00 AM, 3:00 PM and Hour of Sleep (HS) was responsible for removing any expired foods from refrigeration when snacks were delivered to the units, including on the weekends. On 5/9/2012 at 2:50 PM dietary staff #1 stated she delivered the snacks at 3:00 PM and HS. She further stated that she did not check for expired foods in the nourishment rooms, but rather left the snack tray on the counter at the nurse's station as requested by the nursing staff. An interview on 5/9/2012 at 2:55 PM with the Dietary Manager (DM) revealed her expectations were when dietary staff delivered the nourishment snacks three (3) times a day to the units, they would also go into the nourishment room and check the refrigerator for and discard any expired food items. The DM produced for review the assignment sheet posted in the kitchen. The assignment sheet stated the following: "3pm and HS snack-post menu/juice station." The DM confirmed the refrigerator in each nourishment room was the juice station and there was not a scheduled time for juice and milk to be delivered to the halls. Interview on 5/9/2012 at 3:10 PM with the Housekeeping and Laundry Supervisor revealed	F 371		

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F 371	Continued From page 6 her department was responsible for cleaning the refrigerators in the nourishment rooms and to check for expired foods. She confirmed that her staff checked the nourishment refrigerators daily between 8:00-8:30 and should document on the refrigerator log any discarded items.	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 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 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to document in the residents' medical record the immunization status for three (3) of six (6) sampled residents. (Resident #110, #127 and #159). The findings are: 1. The facility policy for Immunizations dated: Revised: 4/28/11; recorded in part, "The administration or the refusal of or medical contraindication to the vaccine (s) is documented	F 514	Resident #110, #127, and #159 immunization record has been updated to reflect the administration of the influenza and pneumonia vaccination. The SDC was re-educated by the Director of Nurses to the centers policy and procedure for Immunizations with an emphasis on recording the administration, refusal, or the medical contraindication in the residents' medical record. An audit was performed by the SDC, ADNS and Unit Manager on current resident populations' immunization record to ensure that influenza and pneumonia vaccination status (i.e., administered, refused, or contraindicated) is documented in the medical record. The DNS re-educated the Licensed Nurses to the centers policy and procedure for Immunizations with an emphasis on recording Pneumonia and influenza status in the medical record. This information will be included in the orientation process for Licensed Nurses.	6/7/2012

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F 514	Continued From page 7 in the patients' medical record." Resident #110 was admitted to the facility in February 2011 with diagnoses including Dementia and Anxiety. Review of the Immunization record in Resident # 110's chart revealed no documentation under the sections for Pneumonia or Influenza Vaccinations for 2011 or 2012. An interview on 5/10/2012 at 9:40 AM with the Infection Control Nurse revealed she documented the resident's immunization status along with any vaccines administered on a log she kept in her office. She confirmed the facility policy included that immunizations were to be documented in the resident's medical record however, she had not been doing that. An interview on 5/10/2012 at 9:55 AM with the Director of Nurses confirmed she expected her staff to follow the facility policy and document the immunization status and vaccines in the resident's medical record. 2. The facility policy for Immunizations dated: Revised: 4/28/11; recorded in part, "The administration or the refusal of or medical contraindication to the vaccine (s) is documented in the patients' medical record." Resident #127 was admitted to the facility in July 2011 with diagnoses including Seizures and Liver Disease. Review of the Immunization record in Resident # 127's medical record revealed no documentation under the sections for Pneumonia or Influenza Vaccinations for 2011 or 2012.	F 514	*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.* The ADNS and or the DNS will audit 5 resident records 2x weekly x4 weeks then weekly x4 weeks and monthly x2 months to ensure ongoing compliance. Data results will be reviewed and analyzed at the facilities monthly Performance Committee Meeting (PI) for three months with a subsequent plan of correction as needed.	

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F 514	Continued From page 8 An interview on 5/10/2012 at 9:40 AM with the Infection Control Nurse revealed she documented the resident's immunization status along with any vaccines administered on a log she kept in her office. She confirmed the facility policy included that immunizations were to be documented in the resident's medical record however, she had not been doing that. An interview on 5/10/2012 at 9:55 AM with the Director of Nurses confirmed she expected her staff to follow the facility policy and document the immunization status and vaccines in the resident's medical record. 3. The facility policy for Immunizations dated: Revised: 4/28/11; recorded in part, "The administration or the refusal of or medical contraindication to the vaccine (s) is documented in the patients' medical record." Resident #159 was admitted to the facility in February 2012 with diagnoses including Cerebrovascular Accident and Hemiplegia. Review of the Immunization record in Resident # 159's medical record revealed no documentation under the sections for Pneumonia or Influenza Vaccinations for 2012. An interview on 5/10/2012 at 9:40 AM with the Infection Control Nurse revealed she documented the resident's immunization status along with any vaccines administered on a log she kept in her office. She confirmed the facility policy included that immunizations were to be documented in the resident's medical record however, she had not been doing that.	F 514		

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F 514	Continued From page 9 An interview on 5/10/2012 at 9:55 AM with the Director of Nurses confirmed she expected her staff to follow the facility policy and document the immunization status and vaccines in the resident's medical record.	F 514		