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

RECEIVED JUL 27 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 This survey was conducted from July 2-3, 2012 and July 5-6, 2012.	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 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on physician interview, resident interview, staff interview, and record review the facility failed to change a soiled dressing for 1 of 1 sampled residents (Resident #124) with a history of pressure ulcer infection. Findings include: Resident #124 was admitted to the facility on 04/20/12. The resident's documented diagnoses included left ischial and sacral pressure ulcers with a history of infection, history of cellulitis and abscess at the buttock, paraplegia, and chronic pain. Resident #124's 04/27/12 Admission Minimum Data Set (MDS) documented the resident's cognition was intact and the resident did not reject care. A 05/01/12 physician order began the resident on an antibiotic regimen for fourteen days due to signs and symptoms of wound infection. A 05/03/12 consult documented the plastic	F 224	1. Dressing for Resident #124 was changed on 7/3/2012 by the facility wound nurse. Upon completion of programmed therapy regimen, Resident #124 will be discharged to home on 7/30/2012. 2. All residents with pressure ulcers were identified and audited to assure timely dressing changes, and no other residents were affected. Nurse #4 was counseled on performing timely dressing changes. Licensed staff were inserviced during the period 7/16/2012 to 7/26/2012 on the importance of timely dressing changes to promote wound healing and reduction of infection risk. 3. The Director of Nursing Services (DNS), or her designee, will audit timely dressing changes for 5 pressure ulcers weekly for 4 weeks, bi-weekly for 1 month, then monthly for 1 month. Subsequent training will be conducted as needed.	F-224 7/30/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn A. Lancaster — TITLE: Executive Director — (X6) DATE: 7/26/12

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 224	Continued From page 1 surgeon recommended wound vac therapy for Resident #124's stage IV sacral and ischial pressure ulcers. Review of the resident's Treatment Administration Records (TARs) revealed prior to usage of the wound vac, all of Resident #124's pressure ulcer dressing changes were ordered regularly scheduled as well as on an as needed (PRN) basis due to leakage, dislodgement, or soilage. At 9:08 AM on 07/03/12 Resident #124 reported that he was having problems with diarrhea over the past three or four days which resulted in the temporary disconnection of his wound vac. The resident stated toward the end of second shift on 07/02/12 he had an episode of diarrhea, and the nursing assistant (NA)cleaned him up. However, he commented this NA informed him that his pressure ulcer dressing was soiled, and needed to be changed. The NA reported that she would inform his nurse who would change the dressing. According to the resident, a nurse never came to change his dressing on second shift. Resident #124 stated he had another episode of diarrhea as third shift began. He reported the NA on third shift discovered this as she did her initial rounds. The resident stated he shared with the third shift NA that he had a soiled dressing that required changing, and she commented she would tell a nurse about the problem. According to Resident #124, no nurse changed his soiled dressing on third shift. Instead, around 5:00 to 6:00 AM on 07/03/12 he reported a third shift supervisor came to him and apologized about not being able to change the dressing because of handling problems other residents were experiencing. The resident stated he was still waiting to get the	F 224	*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.* 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review.	

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F 224	Continued From page 2	F 224		

soiled wound dressing changed.

At 10:35 AM on 07/03/12 Nurse #3 (the facility's Treatment Nurse) provided new dressings on Resident #124's pressure ulcers. Gauze placed over a swab, and used to clean the sacral wound five times, was brown/tan when removed from the wound bed. The Treatment Nurse identified the brown/tan matter as liquid stool. She reported the resident's pressure ulcer dressings were having to be done now on an as needed basis due to diarrhea which caused wound vac treatment to be temporarily discontinued.

At 4:48 PM on 07/03/12 Nurse #1, who cared for Resident #124 until 9:00 PM on 07/02/12, stated no staff reported to her, after that the resident's wound dressing was changed between 10:00 and 11:00 AM on 07/02/12, that the resident's pressure ulcer dressing required changing due to soilage. She reported the resident's wound vac was discontinued about four days ago because of diarrhea. According to Nurse #1, it was even more important to keep pressure off the resident's ischium and sacrum and keep the wounds clean while the resident was without wound vac treatment. She stated Resident #124 was interviewable and reliable.

Multiple phone messages were left for NA #4, who cared for Resident #124 on 07/02/12 second shift, but the NA did not return any of the calls.

At 10:33 AM on 07/05/12, during a telephone interview, NA #2, who cared for Resident #124 on 07/02/12 third shift, stated as she began her initial rounds shortly after 11:00 PM on 07/02/12 the resident reported his wound dressing was still

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F 224	Continued From page 3 soiled from second shift, and he had a new bowel movement. According to the NA, she offered to clean the resident up, and told him she would notify a nurse about the dressing change. She commented the resident refused incontinent care, saying that he preferred to have to be cleaned and have his wound dressing changed at the same time. The NA stated she warned the resident it might take awhile for the nurse to get to him, and once again offered to provide incontinent care until then, but the resident refused. The NA stated she immediately told the RN (registered nurse) Supervisor about Resident #124's need for a dressing change, and informed her about the resident refusing incontinent care. According to NA #2, she was going to check back with the resident after she completed her initial rounds, but the resident was asleep at that time. The NA commented Resident #124 was interviewable, and the resident was "up and down" a lot at night due to pain in his legs and wanting to smoke. She reported on 07/02/12 third shift five NAs (usually six, but one had to leave during the shift to go to the hospital) and one LPN (licensed practical nurse), one medication aide, and one RN Supervisor were working (usually there was another nurse). At 07/05/12 at 6:28 PM Resident #124's primary physician stated soiled wound dressing should be changed as soon as possible, especially when the resident had a history of wound infections. At 7:57 AM on 07/06/12 Nurse #2 (LPN) who worked third shift on 07/02/12, stated during this time period she, a medication aide, and a RN Supervisor were working. She commented, to her knowledge, a medication aide could not	F 224		

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F 224	Continued From page 4 change wound dressings. Nurse #2 stated no staff came to her on 07/02/12 third shift to tell her about Resident #124's dressing needing to be changed. However, the nurse remarked she overheard something about a soiled dressing during a conversation between Resident #124 and the RN Supervisor sometime around 6:00 AM on 07/03/12. She stated she was unaware of any emergencies or residents being in distress on 07/02/12 third shift. At 9:03 AM on 07/16/12 Nurse #3 (the facility's Treatment Nurse) stated Resident #124 was admitted with stage IV pressure ulcers and a history of antibiotic therapy due to infection of those ulcers. She reported the resident was taken off his wound vac on the evening of 06/29/12 because of diarrhea. The Treatment Nurse stated without the wound vac it would be very important to limit pressure on the resident's sacrum/ischium and to change wet to dry dressings timely. She explained, if at all possible, a resident should not go more than a couple of hours without having a soiled dressing removed. At 11:12 AM on 07/06/12 the Director of Nursing (DON) stated it was important to change soiled dressings over wounds on a timely basis, hopefully within a couple of hours of being informed about the problem. According to the DON, timely change of a soiled dressing was particularly important for a resident with a history of wound infection. At 12:14 PM on 07/06/12, during a telephone interview, Nurse #4, the RN Supervisor who was on duty 07/02/12 third shift, stated NA #2 told her Resident #124's dressing was soiled and needed	F 224		

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F 224	Continued From page 5 to be changed. However, the nurse supervisor reported she did not get a chance to change the dressing because she was dealing with a resident who was yelling out and family of a dying resident on another hall. She commented she did not ask any other nurses working with her to change the dressing. According to Nurse #4, she asked NA #2 to try and persuade the resident to be cleaned up, and she left the soiled dressing for the Treatment Nurse to change when she began work on 07/03/12. She stated they were working short on 07/02/12 third shift because one nurse did not realize she was scheduled. She explained normally on third shift three nurses and a medication aide were on the schedule. At 12:22 PM on 07/06/12 the DON stated Resident #124 having to wait from second shift on 07/02/12 until first shift on 07/03/12 to get a soiled dressing changed was unacceptable because there was another nurse working on 07/02/12 third shift that the RN Supervisor could have asked to complete the dressing change.	F 224		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on physician interview, pharmacist	F 309		

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F 309	Continued From page 6 interview, resident interview, staff interview, and record review the facility failed to provide scheduled pain medication which played an integral part in the pain management regimen for 1 of 2 sampled residents (Resident #124) with a documented diagnosis of chronic pain. Findings include: Resident #124 was admitted to the facility on 04/20/12. The resident's documented diagnoses included chronic pain, insomnia, history of cellulitis and abscess at the buttock, and paraplegia/spinal cord injury. The resident was admitted to the facility on Oxycontin CR (continued release) 60 milligrams every 12 hours, Oxycodone 5/325 two pills every 4 hours, and PRN (as needed) Oxycodone IR (immediate release) 15 mg every 4 hours. On 04/20/12 the resident's care plan identified "Pain (chronic and breakthrough) as evidenced by crying/moaning and complaints of pain related to stage IV decubiti" as a problem. Interventions to this problem included "Monitor & (and) report to nurse: worsening of pain, Report changes in pain location/type frequency/intensity to physician, and Administer and monitor for effectiveness and for possible side effects from routine pain medications and PRN pain medications." Resident #124's 04/27/12 Admission Minimum Data Set (MDS) documented the resident's cognition was intact, the resident had no behaviors, the resident did not reject care, the resident had pain/hurting in the past 5 days, pain made it difficult for the resident to sleep, pain limited the resident's activities, and the worst pain	F 309	*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.* 1. Pain medication for Resident #124 was received on 7/2/2012. On 7/3/2012, Resident #124 reported that he was not in pain during this time since he had been receiving his PRN pain medication while his routine medication was pending the MD's signature. On 7/6/2012, Resident #124 requested a decrease in his pain medication regimen to include staff not administering pain medication unless Resident #124 requested it. Pain regimen was adjusted on 7/11/2012. Pain noted on 7/4/2012 at a level of 3. Pain assessment completed on 7/24/12 reveals Oxycodone is the acceptable pain regimen of choice for resident #124. Upon completion of programmed therapy regimen, Resident #124 will be discharged to home on 7/30/2012. 2. Current residents were audited to ensure that all pain medication ordered was available. Licensed nursing staff were inserviced during the	F-309 7/30/2012

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F 309	Continued From page 7 the resident experienced in the past 5 days was at an intensity of 8 on a scale of 1 (mild) to 10 (severe). A 05/05/12 physician's order increased the resident's Oxycontin to 60 mg three times daily (TID). A 05/25/12 physician's order increased the resident's PRN Oxycodone IR to 20 mg every 4 hours. A 06/03/12 physician's order increased the resident's Oxycontin to 60 mg four times daily (QID) due to severe pain. A 06/27/12 electronic Progress Note documented Resident #124 received scheduled Oxycontin for pain control associated with stage IV sacral and ischial pressure ulcers. At 9:08 AM on 07/03/12 Resident #124 stated he had problems with chronic pain, and was not receiving his scheduled Oxycontin as ordered. He reported the Oxycodone did not provide the same type of pain relief as the Oxycontin which the facility did not have available to administer to him over the weekend. The resident commented the facility still did not have in his Oxycontin on Monday, 07/02/12. According to Resident #124, his pain had increased over the weekend because he was without the Oxycontin. He explained that if he did not receive the same medications about the same time daily his pain got out of control, and then it was very difficult to bring it back to a manageable level. Review of Resident #124's June 2012 and July	F 309	*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.* period 7/16/2012 to 7/26/2012 on the importance of ordering medications timely to ensure availability. When medications are not available due to lack of MD signature to notify DNS/ADNS to assist with MD response. Day shift nurses are instructed to audit narcotics on Wednesdays to ensure that there is an adequate supply of medications to last until the following Monday. 3. The Director of Nursing Services (DNS), or her designee, will audit medications on Friday for availability of medications weekly for 1 month, bi-weekly for 1 month, then monthly for 1 month. Subsequent training to be conducted for licensed staff as needed. 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review.	

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F 309	Continued From page 8 2012 Medication Administration Records (MARs) revealed the resident received 60 mg of Oxycontin at 12:00 noon on 06/30/12 which completed his punch card of 30 pills. The resident did not receive any Oxycontin as ordered at 6:00 PM or midnight on 06/30/12, and did not receive any Oxycontin as ordered at 6:00 AM, noon, 6:00 PM, and midnight on 07/01/12 and 07/02/12. The resident next received Oxycontin at 8:35 AM on 07/03/12. At 2:50 PM on 07/03/12 nursing assistant (NA) #1 stated Resident #124 consistently complained of pain associated with his legs and pressure ulcers. She reported the resident had a few more complaints about pain and the severity of the pain in the past 3 or 4 days. She commented the resident was interviewable and reliable. At 4:48 PM on 07/03/12 Nurse #1 stated she had to call the back-up pharmacy on 07/02/12 when she realized the resident was out of regularly scheduled Oxycontin. She reported apparently the resident was without the Oxycontin over the weekend and yesterday. The nurse commented this was the first time she was aware that Resident #124 ran out of any type of pain medication. According to Nurse #1, the weekend nurse should have called the back-up pharmacy before the resident actually ran out of his Oxycontin. She reported she thought the resident had complained more about pain in the last four days she had worked with him. She commented the resident was interviewable and reliable. At 10:33 AM on 07/05/12, during a telephone interview, NA #2 stated Resident #124 was up and down on third shift a lot on 07/02/12 because	F 309		

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F 309	Continued From page 9 of pain in his legs and pressure ulcers. However, she stated the resident exhibited this same behavior on and off on a pretty regular basis. At 4:04 PM on 07/05/12 the Director of Nursing (DON) stated the resident refused his Oxycontin twice the day before, and asked the staff to stop bothering him all the time by bringing him all these medications. According to the DON, usually nurses were told to reorder medications five days before they ran out. However, in the case of Resident #124 she explained the facility was waiting on a hard script from the physician, and a weekend was involved. At 6:28 PM on 07/05/12 Resident #124's primary physician stated Resident #124 had chronic pain, and the management of that pain had been a challenge for a long time. According to the physician, in the management of pain it was important once a resident was on an effective medication regimen to supply the same amount of the medication at approximately the same time everyday. He reported it was not a good thing for a resident with chronic pain to go without a medication involved in pain management for 2 or 3 days. He commented the facility should know how utilize its reorder system and back-up pharmacy in order to prevent residents from running out of medications. The physician stated he assessed Resident #124 today, and thought he seemed a little oversedated so he would be working on reducing some of the resident's medications. At 9:03 AM on 07/06/12 Nurse #3 (the facility's Treatment Nurse) stated Resident #124's Oxycontin played an important role in keeping the	F 309		

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F 309	Continued From page 10 pain from the resident's stage III sacrum and stage IV ischium under control. At 9:35 AM on 07/06/12, during a telephone interview, the facility's Consultant Pharmacist stated once an effective pain management regimen was established for a resident it was important to make sure the resident received the medications at about the same times daily, not missing any doses. She explained Oxycontin was longer acting and usually prescribed on a scheduled basis for pain relief, and Oxycodone provided more immediate pain relief, but the relief did not last as long, and it was usually prescribed on a PRN basis. The pharmacist reported it was not good for a resident with chronic pain issues to be without a regularly scheduled pain medication for 2 1/2 days. She explained PRN pain meds would help with pain control, but the resident would not get the relief supplied by having consistent pain medication in the bloodstream throughout the day. According to the Consultant Pharmacist, for reimbursement purposes, sometimes medications could not be reordered until 72 hours before they were used up. She stated a written script would be required for Oxycontin, but the facility and MD should have worked together to make sure Resident #124 did not have to go without scheduled pain medication.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

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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 314	Continued From page 11 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on physician interview, resident interview, staff interview, and record review the facility failed to change a soiled dressing for 1 of 1 sampled residents (Resident #124) with a history of pressure ulcer infection. Findings include: Resident #124 was admitted to the facility on 04/20/12. The resident's documented diagnoses included left ischial and sacral pressure ulcers with a history of infection, history of cellulitis and abscess at the buttock, paraplegia, and chronic pain. On 04/20/12 the resident's care plan identified "Actual alteration in skin integrity (pressure ulcers to left ischium and sacrum) related to decreased mobility, urinary incontinence, fecal and or bowel incontinence, and paralysis-spinal cord injury" as a problem. Interventions to this problem included "Follow MD (physician) orders for skin care and treatments, Monitor for s/s (signs and symptoms) of infection & (and) report to MD, Protective skin care with incontinent care, and Toileting assistance on toileting schedule or routine." Resident #124's 04/27/12 Admission Minimum Data Set (MDS) documented the resident's cognition was intact, the resident had no behaviors, the resident did not reject care, the resident required limited assistance by a staff	F 314	*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.* 1. Dressing for Resident #124 was changed on 7/3/2012 by the facility wound nurse. Upon completion of programmed therapy regimen, Resident #124 will be discharged to home on 7/30/2012. 2. All residents with pressure ulcers were identified and audited to assure timely dressing changes, and no other residents were affected. Nurse #4 was counseled on performing timely dressing changes. Licensed staff were inserviced during the period 7/16/2012 to 7/26/2012 on the importance of timely dressing changes to promote wound healing and reduction of infection risk. 3. The Director of Nursing Services (DNS), or her designee, will audit timely dressing changes for 5 pressure ulcers weekly for 4 weeks, bi-weekly for 1 month, then monthly for 1 month. Subsequent training will be conducted as needed	F-314 7/30/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 12 member with toileting and extensive assistance by a staff member for personal hygiene, and the resident was occasionally incontinent of bowel. 05/01/12 physician orders changed the treatment to the resident's pressure ulcers, and due to signs and symptoms of wound infection, began the resident on a loading dose of 100 milligrams (mg) of antibiotic via picc (peripherally inserted central catheter) line followed by 50 mg of the antibiotic twice daily (BID) x 14 days. A 05/03/12 plastic surgery consult documented the surgeon recommended wound vac therapy for both of the resident's pressure ulcers. Review of the resident's Treatment Administration Records (TARs) revealed prior to usage of the wound vac, all of Resident #124's pressure ulcer dressing changes were ordered regularly scheduled as well as on an as needed (PRN) basis due to leakage, dislodgement, or soilage. At 9:08 AM on 07/03/12 Resident #124 reported that he was having problems with diarrhea over the past three or four days which resulted in the temporary disconnection of his wound vac. The resident stated toward the end of second shift on 07/02/12 he had an episode of diarrhea, and the nursing assistant (NA)cleaned him up. However, he commented this NA informed him that his pressure ulcer dressing was soiled, and needed to be changed. The NA reported that she would inform his nurse who would change the dressing. According to the resident, a nurse never came to change his dressing on second shift. Resident #124 stated he had another episode of diarrhea as third shift began. He reported the NA on third	F 314	*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.* 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review.	

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F 314	Continued From page 13 shift discovered this as she did her initial rounds. The resident stated he shared with the third shift NA that he had a soiled dressing that required changing, and she commented she would tell a nurse about the problem. According to Resident #124, no nurse changed his soiled dressing on third shift. Instead, around 5:00 to 6:00 AM on 07/03/12 he reported a third shift supervisor came to him and apologized about not being able to change the dressing because of handling problems other residents were experiencing. The resident stated he was still waiting to get the soiled wound dressing changed. At 10:35 AM on 07/03/12 Nurse #3 (the facility's Treatment Nurse) provided new dressings on Resident #124's pressure ulcers. The wound beds of both pressure ulcers were 5% gray/yellow slough and 95% pink tissue, and presented with tunneling. There were no signs and symptoms of infection in the ulcers. However, gauze placed over a swab, and used to clean the sacral wound five times, was brown/tan when removed from the wound bed. The Treatment Nurse identified the brown/tan matter as liquid stool. She reported the resident's pressure ulcer dressings were having to be done now on an as needed basis due to diarrhea which caused wound vac treatment to be temporarily discontinued. At 4:48 PM on 07/03/12 Nurse #1, who cared for Resident #124 until 9:00 PM on 07/02/12, stated no staff reported to her, after that the resident's wound dressing was changed between 10:00 and 11:00 AM on 07/02/12, that the resident's pressure ulcer dressing required changing due to soilage. She reported the resident's wound vac was discontinued about four days ago because of	F 314		

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F 314	Continued From page 14 diarrhea. According to Nurse #1, it was even more important to keep pressure off the resident's ischium and sacrum and keep the wounds clean while the resident was without wound vac treatment. She stated Resident #124 was interviewable and reliable. Multiple phone messages were left for NA #4, who cared for Resident #124 on 07/02/12 second shift, but the NA did not return any of the calls. At 10:33 AM on 07/05/12, during a telephone interview, NA #2, who cared for Resident #124 on 07/02/12 third shift, stated as she began her initial rounds shortly after 11:00 PM on 07/02/12 the resident reported his wound dressing was still soiled from second shift, and he had a new bowel movement. According to the NA, she offered to clean the resident up, and told him she would notify a nurse about the dressing change. She commented the resident refused incontinent care, saying that he preferred to have to be cleaned and have his wound dressing changed at the same time. The NA stated she warned the resident it might take awhile for the nurse to get to him, and once again offered to provide incontinent care until then, but the resident refused. The NA stated she immediately told the RN (registered nurse) Supervisor about Resident #124's need for a dressing change, and informed her about the resident refusing incontinent care. According to NA #2, she was going to check back with the resident after she completed her initial rounds, but the resident was asleep at that time. The NA commented Resident #124 was interviewable, and the resident was "up and down" a lot at night due to pain in his legs and wanting to smoke. She reported on 07/02/12	F 314		

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F 314	Continued From page 15 third shift five NAs (usually six, but one had to leave during the shift to go to the hospital) and one LPN (licensed practical nurse), one medication aide, and one RN Supervisor were working (usually there was another nurse). At 07/05/12 at 6:28 PM Resident #124's primary physician stated soiled wound dressing should be changed as soon as possible, especially when the resident had a history of wound infections. At 7:57 AM on 07/06/12 Nurse #2 (LPN) who worked third shift on 07/02/12, stated during this time period she, a medication aide, and a RN Supervisor were working. She commented, to her knowledge, a medication aide could not change wound dressings. Nurse #2 stated no staff came to her on 07/02/12 third shift to tell her about Resident #124's dressing needing to be changed. However, the nurse remarked she overheard something about a soiled dressing during a conversation between Resident #124 and the RN Supervisor sometime around 6:00 AM on 07/03/12. She stated she was unaware of any emergencies or residents being in distress on 07/02/12 third shift. At 9:03 AM on 07/16/12 Nurse #3 (the facility's Treatment Nurse) stated Resident #124 was admitted with stage IV pressure ulcers, one on the ischium and one on the sacrum. She reported clinically the ulcer on the resident's sacrum now presented as a stage III wound, while the ischial ulcer still presented as a stage IV wound. She commented the resident was admitted to the facility with a history of wound infection requiring antibiotic therapy. In fact, she explained the resident's wounds began to exhibit	F 314		

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F 314	Continued From page 16 signs and symptoms of infection in the facility on 05/01/12, and antibiotic treatment was initiated. According to Nurse #3, Resident #124 had not exhibited any signs and symptoms of infection in the ulcers since completing this antibiotic regimen. She reported the resident was taken off his wound vac on the evening of 06/29/12 because of diarrhea. The Treatment Nurse stated without the wound vac it would be very important to limit pressure on the resident's sacrum/ischium and to change wet to dry dressings timely. She explained, if at all possible, a resident should not go more than a couple of hours without having a soiled dressing removed. At 11:12 AM on 07/06/12 the Director of Nursing (DON) stated it was important to change soiled dressings over wounds on a timely basis, hopefully within a couple of hours of being informed about the problem. According to the DON, timely change of a soiled dressing was particularly important for a resident with a history of wound infection. At 12:14 PM on 07/06/12, during a telephone interview, Nurse #4, the RN Supervisor who was on duty 07/02/12 third shift, stated NA #2 told her Resident #124's dressing was soiled and needed to be changed. However, the nurse supervisor reported she did not get a chance to change the dressing because she was dealing with a resident who was yelling out and family of a dying resident on another hall. She commented she did not ask any other nurses working with her to change the dressing. According to Nurse #4, she asked NA #2 to try and persuade the resident to be cleaned up, and she left the soiled dressing for the Treatment Nurse to change when she began	F 314		

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F 314	Continued From page 17 work on 07/03/12. She stated they were working short on 07/02/12 third shift because one nurse did not realize she was scheduled. She explained normally on third shift three nurses and a medication aide were on the schedule. At 12:22 PM on 07/06/12 the DON stated Resident #124 having to wait from second shift on 07/02/12 until first shift on 07/03/12 to get a soiled dressing changed was unacceptable because there was another nurse working on 07/02/12 third shift that the RN Supervisor could have asked to complete the dressing change.	F 314	*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.* 1. NA #1 and NA #2 were re-educated on incontinent care, with return demonstration, on 7/13/12. 2. All incontinent residents have the potential to be affected. All NA's were re-educated on incontinent care, with return demonstration, during the period 7/3/2012 to 7/26/2012. 3. The Director of Nursing Services (DNS), or her designee, will audit 5 NA's for correct incontinent care technique weekly for 4 weeks, then bi-weekly for 1 month, then monthly for 1 month. Subsequent training will be conducted as needed. 4. Monitoring results will be presented and discussed at the monthly Performance Improvement (PI) Committee meeting for review.	F-315 7/30/2012
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide incontinent care per facility policy for 2 of 2 sampled residents (Resident # 5 and Resident #9) whose care was observed. Findings include: 1. Resident #5 was admitted to the facility on 5/2/12 with cumulative diagnoses of dementia,	F 315		

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F 315	Continued From page 18 muscle weakness, and urinary tract infection (UTI) over the last 30 days. Resident #5's admission Minimum Data Set (MDS) dated 5/18/12 indicated that Resident #5 was moderately impaired cognitively. Resident #5 was always incontinent of bowel and bladder and was totally dependent on 1 person for hygiene needs. A review of the Perineal Care for the Female Resident check list dated 4/28/07 showed that step #15 was, "a. Uses one gloved hand to stabilize and separate the labia and use the other hand to wash from front to back." A review of Resident #5's Care Plan updated on 5/16/12 showed a problem for potential complications associated with incontinence. Approaches included providing incontinence/perineal care after each incontinence episode. Perineal care for Resident #5 was observed on 7/3/12 at 2:45 PM. Privacy was provided for Resident #5 by Nursing Assistant (NA) #1 prior to care. Resident #5's adult brief was opened. NA #1 cleansed the groin folds of Resident #5. NA #1 then wiped down the middle of the vaginal area with one swipe using a front to back motion. She did not separate or cleanse the labia. Resident #5 was rolled onto the side and observed to have a moderate amount of stool. NA #1 cleansed the area using front to back motions and the soiled brief was removed. Resident #5 was rolled onto her back. NA #1 did not check for possible stool that could be in the labial area prior to replacing the adult brief.	F 315		

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F 315	Continued From page 19 In an interview on 7/3/12 at 3:17 PM NA #1 indicated that she had been in-serviced on incontinent care that morning. She stated that the process for incontinent care included informing the resident of what she was going to do, gathering supplies, and wiping front to back. NA #1 indicated that she should wipe the groin areas and then down the middle. She stated that the resident should then be turned over and wiped from front to back. NA #1 stated that she should make sure the resident was clean. She indicated that she should have spread the labia and cleansed it. She stated that by not cleansing the area the resident could get an infection. In an interview on 7/3/12 at 4:00 PM Nurse #5 indicated that prior to providing incontinent care the aides should gather their supplies, wash and glove their hand and let the resident know what they were going to do. The aide should wipe from front to back using a clean wipe each time. The aide should spread the labia on a female resident to clean it. If the labia was not cleansed it would not be effective perineal care and could lead to a urinary tract infection (UTI) especially if it was contaminated with stool. In an interview on 7/3/12 at 4:20 PM the Staff Development Coordinator (SDC) indicated that in-services on incontinent care had begun that morning. She stated that she watched the NA's perform care and filled out a skill demonstration check list. She indicated that she had to remind several aides to open and cleanse the resident's labias. She stated she spoke with the aides about preventing infections by spreading and cleansing the labias. She indicated that it was not	F 315		

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F 315	Continued From page 20 acceptable to not spread and cleanse the labia while performing perineal care. In an interview on 7/6/12 at 11:46 AM the Director of Nursing (DON) stated that it was her expectation that the NA's follow the facility policy while providing perineal care. She indicated the NA's should wipe from front to back and spread the labia to clean it. She indicated spreading and cleaning the labia was important to prevent infections. She stated that the aides needed to maintain the good urinary health of the residents. 2. Resident # 9 was re-admitted to the facility on 5/25/12 with cumulative diagnoses of Congestive Heart Failure (CHF), renal insufficiency, UTI over the last 30 days and muscle weakness. Resident #9's Admission/re-entry Minimum Data Set (MDS) dated 6/1/12 indicated that Resident #9 was cognitively aware. Resident #9 was incontinent of bowel and bladder and needed the extensive assistance of 1 person for hygiene. A review of the Perineal Care for the Female Resident check list dated 4/28/07 showed that step #15 was, "a. Uses one gloved hand to stabilize and separate the labia and use the other hand to wash from front to back." A review of Resident #9 's Care Plan updated 6/6/12 showed a problem with incontinence. Approaches included providing incontinence/perineal care after each incontinence episode. Perineal care for Resident #9 was observed on 7/3/12 at 3:12 PM. Privacy was provided for	F 315		

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F 315	Continued From page 21 Resident #9 by NA #5 prior to care. Resident #9' s adult brief was opened. NA #5 cleansed the groin folds of Resident #9. NA #5 then wiped down the middle of the vaginal area with one swipe using a front to back motion. She did not separate or cleanse the labia. Resident #9 was rolled to her side and her buttocks were cleansed using a front to back motion. A clean adult brief was placed on Resident #9. NA #5 did not check for possible stool that could have been in the labial area prior to replacing the adult brief. In an interview on 7/3/12 at 3:22 PM with NA #5, she indicated that she had been in-serviced that morning on incontinent care. She stated that after making sure supplies were in place the NA should wash and glove their hands. The resident should be told what the aide would be doing and wipe front to back. Clean the groin area and one wipe down the middle of the vagina front to back. Then roll the resident over and wipe front to back. NA #5 stated she did not spread the labia to cleanse it. She indicated that not cleansing the labia could cause an infection. In an interview on 7/3/12 at 4:00 PM Nurse #5 indicated that prior to providing incontinent care the aides should gather their supplies, wash and glove their hand and let the resident know what they were going to do. The aide should wipe from front to back using a clean wipe each time. The aide should spread the labia on a female resident to clean it. If the labia was not cleansed it would not be effective perineal care and could lead to a urinary tract infection (UTI) especially if it was contaminated with stool. In an interview on 7/3/12 at 4:20 PM the Staff	F 315		

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F 315	Continued From page 22 Development Coordinator (SDC) indicated that in-services on incontinent care had begun that morning. She stated that she watched the NA's perform care and filled out a skill demonstration check list. She indicated that she had to remind several aides to open and cleanse the resident's labias. She stated she spoke with the aides about preventing infections by spreading and cleansing the labias. She indicated that it was not acceptable to not spread and cleanse the labia while performing perineal care. In an Interview on 7/6/12 at 11:46 AM the Director of Nursing (DON) stated that it was her expectation that the NA's follow the facility policy while providing perineal care. She indicated the NA's should wipe from front to back and spread the labia to clean it. She indicated spreading and cleaning the labia was important to prevent infections. She stated that the aides needed to maintain the good urinary health of the residents.	F 315		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345260	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE: 7/6/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOU	STREET ADDRESS, CITY, STATE, ZIP CODE 160 WINSTEAD AVE ROCKY MOUNT, NC		

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to submit a 5 day report to the state agency for 1 of 1 sampled residents (Resident #17) whose family reported an injury of unknown origin to the facility.
Findings include:

Resident #17 was admitted to the facility on 5/31/12 with cumulative diagnoses of anoxic brain damage, traumatic brain injury, constant vegetative state and muscle weakness.

Resident #17's admission Minimum Data Set dated 6/7/12 indicated that Resident #17 had short and long term memory problems and was severely impaired in daily decision making. Resident #17 was totally dependent on one person for bed mobility, hygiene and bathing.

A review of the Progress Notes dated 6/10/12 at 5:00 PM showed Resident #17's family member reported swelling to Resident #17's forehead. Resident #17's physician was notified and an order to send Resident #17 to the Emergency Room (ER) was received.

A review of the Investigation and Follow-up Form dated 6/10/12 at 5:00 PM, showed that Resident #17 had a 3 centimeter (cm) elongated shaped raised area 1 cm in height on his forehead. There was no bruising noted.

A review of the 24-Hour Initial Report dated 6/11/12 showed an attached Transmission Verification Report

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345260	MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	DATE SURVEY COMPLETE: 7/6/2012
NAME OF PROVIDER OR SUPPLIER: KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOU	STREET ADDRESS, CITY, STATE, ZIP CODE: 160 WINSTEAD AVE ROCKY MOUNT, NC		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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with a fax date/time stamp of 6/11/12 5:42.

A review of the 5-Working Day Report dated 6/18/12 showed that an investigation was conducted for this incident involving Resident #17. The investigation did not include a Transmission Verification Report showing that the state regulatory agency had been notified of the result of the investigation.

On 7/3/12 at 3:40 PM a call was placed to the Healthcare Personnel Registry. The Registry reported that they had received the 24-Hour Initial Report from the facility for Resident #17 but had not received the 5-Working Day Report for Resident #17.

In an interview with the Administrator (Abuse Coordinator) on 7/5/12 at 3:30 PM, he indicated that the process for reporting an injury of unknown origin consisted of several steps. These steps included speaking with staff, residents and reviewing records. A 24 hour report would be faxed into the state regulatory agency. On completion of the investigation, a 5 day report detailing the investigation would be faxed to the state regulatory agency. When presented with the Healthcare Personnel Registry's report that they had not received the 5-Working Day Report he responded that he could not remember if he had faxed it to the state agency but thought that he had. He stated he would look for the fax verification sheet for the 5-Working Day Report. He was unable to produce the Transmission Verification Report for the 5-Working Day Report.

In an interview on 7/6/12 at 11:46 AM with the Director of Nursing (DON), she indicated that it was her expectation that both a 24 hour report and a 5 day report be faxed to the state regulatory office.