

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

PRINTED: 07/30/2012  
FORM APPROVED  
OMB NO. 0938-0391

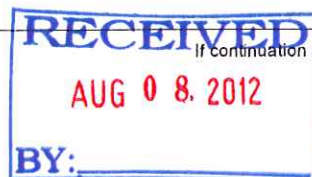
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/13/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-MONROE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 EAST SUNSET DR MONROE, NC 28112
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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 000  F 312 SS=E	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited as a result of the complaint investigation. Event ID# I6Y311.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to provide nail care for two (2) of four (4) sampled residents who were dependent on staff for their activities of daily living. (Residents #118 and #11)</p> <p>The findings are:</p> <p>1. The facility's policy "A.M. Care", dated 4/28/09, recorded in part, to provide nail care, if applicable and appropriate after breakfast.</p> <p>Resident #118 was re-admitted to the facility in June 2010. Diagnoses included diabetes mellitus II, dementia, degenerative joint disease of the hips/spine, osteoporosis, depression and a history of a cerebrovascular accident resulting in partial blindness.</p> <p>Review of the care plan dated 5/30/12 revealed Resident #118 had self care deficits and required total assistance with personal hygiene. He was at risk for decline in self care due to dementia and</p>	F 000  F 312	<p>Resident #11 and Resident #118 fingernails have been cleaned and trimmed. NA# 1 and NA #2 has been re-educated by the SDC regarding the centers policy and procedure for providing nail care daily and on an as needed basis.</p> <p>An audit of current resident fingernails was performed by the Unit Managers to identify residents that required their nails to be cleaned or trimmed. Residents identified through this audit received immediate cleaning or trimming as needed.</p> <p>The SDC re-educated the direct care-givers to the centers policy and procedure in providing proper nail care on a daily basis and as needed. This in-service will be included in the new employee orientation program for Licensed Nurses and Nursing Assistants.</p> <p>The Unit Managers or the SDC will observe ten residents fingernails 3 times weekly for four weeks then 2 times weekly for four weeks then weekly x4 to ensure ongoing compliance.</p> <p>Data results will be reviewed and analyzed at the facility's monthly Performance Committee Meeting (PI) monthly for three</p>	8/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Quentin D. Olson* TITLE *E.D.* (X6) DATE *8/6/12*

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 312	<p>Continued From page 1</p> <p>cognitive impairment. The care plan goal included that the Resident would receive assistance as needed with activities of daily living (ADL) with the intervention that staff would provide the amount of assistance/supervision with ADL that was needed. A quarterly minimum data set dated 5/28/12 assessed Resident #118 with moderate cognitive impairment and requiring total staff assistance with his personal hygiene.</p> <p>Resident #118 was observed in his room in bed on 7/10/12 at 12:12 PM and 7/12/12 at 9:38 AM and 11:08 AM. During each observation Resident #118 was observed with finger nails that extended approximately 1/8 to 1/4 of an inch beyond the nail bed and each finger nail on both hands was observed with dark matter underneath the nails. On 7/12/12 at 1:02 PM until 1:08 PM, Resident #118 was observed in his room feeding himself lunch and holding a slice of bread in his left hand; his nails were unchanged. He was observed again on 7/12/12 at 2:56 PM, after lunch, his nails were unchanged.</p> <p>An interview with nursing assistant #1 (NA #1) occurred on 7/12 at 3:10 PM. NA #1 stated that she provided a shower to Resident #118 that morning (7/12/12). During the shower, NA #1 stated that she checked the nails of Resident #118 and noted that his nails were dirty, but she did not offer him nail care at that time. She further stated "I should have cleaned his nails, but I didn't, there is no reason why I didn't." NA #1 observed the finger nails of Resident #118 at the time of the interview and confirmed that his finger nails looked the same as when she gave him a shower that morning. NA #1 was observed to ask</p>	F 312		



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F 312	<p>Continued From page 2</p> <p>Resident #118 if he wanted nail care and the Resident responded "Yes Ma'am, that would be fine." NA #1 also stated that since Resident #118 was a diabetic, his nurse would have to trim his nails, but she had not informed his nurse that the Resident's nails should be trimmed.</p> <p>During an interview with licensed nurse #1 (NA #1) on 7/12/12 at 3:20 PM, she confirmed that Resident #118 was a diabetic and that nails for diabetic residents were trimmed by the nurses. LN #1 further stated that if a NA noted that the finger nails of a diabetic resident needed to be trimmed, the NA should inform the nurse because "direct care staff do not trim nails for residents who are diabetics." LN #1 stated she was not informed that Resident #118 need his nails cleaned and trimmed, nor had she noticed the condition of his nails that week.</p> <p>The director of nursing (DON) was interviewed on 7/12/12 at 3:23 PM and observed the finger nails of Resident #118 during the interview. The DON stated that nail care should be provided as needed, with AM (morning) care, showers or when noticed by staff. The DON further stated that if nail care could not be done with showers or AM care, the staff should notify the nurse that. The DON also stated that nail care for diabetic residents should be provided by the licensed nursing staff and the NA should inform the nurse if a diabetic resident needs nail care.</p> <p>2. The facility's policy "A.M. Care", dated 4/28/09, recorded in part, to provide nail care, if applicable and appropriate after breakfast.</p>	F 312			

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F 312	<p>Continued From page 3</p> <p>Resident #11 was admitted to the facility in February 2012. Diagnoses included chronic pain, general deconditioning, mental retardation, cervical arthritis, and depression. The quarterly minimum data set dated 6/21/12 assessed that Resident #11 was moderately cognitively impaired, required total assistance with activities of daily living (ADL), including personal hygiene, and had impaired range of motion of both sides. Review of the admission care area assessment and care plan dated 2/13/12 revealed an ADL care plan was not completed.</p> <p>Resident #11 was observed on 7/11/12 at 8:45 AM and 7/12/12 at 8:45 AM in his room in bed. During each observation, the first two finger nails of the left hand extended approximately 1/4 - 1/2 of an inch beyond the nail bed and the remaining three finger nails were jagged. The finger nails to his right hand were all observed to extend approximately 1/4 - 1/2 of an inch beyond the nail bed.</p> <p>On 7/12/12 at 9:36 AM, Resident #11 was observed in his room with nursing assistant #2 (NA #2). NA #2 stated she was providing Resident #11 with a bed bath.</p> <p>Resident #11 was observed again on 7/12/12 at 11:56 AM, after his bed bath, seated in his wheel chair in the hallway outside his room and on 7/13/12 at 8:45 AM in bed in his room. His fingernails remained unchanged. During the observation on 7/13/12 at 8:45 AM, Resident was asked if he wanted his finger nails trimmed, he replied "Yeah."</p>	F 312		

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F 312	<p>Continued From page 4</p> <p>On 7/13/12 at 12:45 PM, Resident #11 was observed seated in his wheel chair outside his room; his finger nails were trimmed, and all finger nails were jagged.</p> <p>An interview on 7/13/12 at 12:50 PM with nursing assistant #1 (NA #1) revealed that she provided AM (morning) care to Resident #11 that morning (7/13/12) and noticed that his finger nails were jagged and needed to be trimmed. She further stated that she did not provide nail care at that time because she did not have the necessary supplies with her while she provided AM care and she did not inform his nurse that nail care was needed.</p> <p>An interview with licensed nurse #2 (LN #2) (supervisor) on 7/13/12 at 12:55 PM revealed that she trimmed the finger nails of Resident #11 that morning because his finger nails were long and jagged. LN #2 stated she would expect the NA to try to file his nails during care, but that the Resident might pull away if the NA tried to cut his finger nails, so she cut them. LN #2 further stated she would expect the NA to inform the nurse to cut the Resident's finger nails if nail care was needed.</p> <p>LN #1 was interviewed on 7/13/12 at 12:57 PM and stated that NAs were responsible for providing finger nail care to Resident #11 and if the Resident was combative during care, the NA should inform her. LN #1 further stated she would instruct the NA to wait and reapproach the Resident later, if continued efforts to provide finger nail care was unsuccessful, NAs were instructed to try again the next day. LN #1 stated she did not remember being informed that</p>	F 312			



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F 312	<p>Continued From page 5</p> <p>Resident #11 refused finger nail care.</p> <p>On 7/13/12 at 1:04 PM, an interview and observation of the finger nails for Resident #11 with the director of nursing (DON) revealed that finger nail care should be offered with showers, baths, and as needed. If a resident refused care or was combative, staff should reapproach later and inform the nurse. If during attempts to reapproach, the resident was still combative, the DON stated staff should stop the care and staff know to try the next day. The DON observed the finger nails of Resident #11 and confirmed his finger nails should have been filed.</p> <p>An interview with NA #2 on 7/13/12 at 1:27 PM revealed she gave Resident #11 a bed bath during the 7AM - 3 PM shift on 7/12/12, but did not offer nail care or notice that his nails were long or jagged. NA #2 stated that Resident #11 received a shower on 7/11/12 and nail care should have been provided with his shower. NA #2 stated if Resident #11 refuses care, staff come back to offer again and the Resident will usually cooperate when staff come back to offer care later.</p> <p>An interview on 7/13/12 at 2:59 PM with NA #3 who provided Resident #11 with a shower on 7/11/12, revealed that during the shower on 7/11/12 during the 7AM - 3PM shift, Resident #11 became combative, complained of pain and the NA informed his nurse. NA #3 stated she offered Resident #11 nail care again before the end of her shift, but he refused.</p>	F 312		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 6</p> <p>The facility must - (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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility records, the facility failed to store pre-cooked chicken tenders on the dinner tray line to maintain a minimum temperature of 135 degrees and failed to maintain one (2) of one (2) storage racks clean and free of dust.</p> <p>The findings are:</p> <p>The facility policy "Internal Food Temperature Matrix" dated 10/31/10, recorded in part, "Minimizing the amount of time that foods are at temperatures less than 140 (sign for degrees) decreases the risk of foodborne illness. Minimum holding temperatures on the tray line for potentially hazardous food is 140 (sign for degrees) or greater for hot foods."</p> <p>1. An observation of the dinner meal tray line occurred on 7/12/12 at 4:57 PM. The steam table was observed with pre-cooked chicken tenders stored uncovered in a shallow stainless steel pan with approximately four inches of space between the water in the steam table well and the pan of</p>	F 371	<p>F.371 Cooks will be in-serviced on food safety, food safety danger zones, holding time for foods on tray line prior to trayline start, internal temperatures for cooked and uncooked foods, thermometer calibration, proper pans for food storage on trayline.</p> <p>The R.D. will check food temperatures three times weekly for four weeks, then once weekly for four weeks.</p> <p>Food temperature logs will be monitored by the R.D.</p> <p>Thermometer calibrations will be done twice weekly and monitored by the R.D.</p> <p>Results will be reviewed and analyzed at the facility's PI meeting monthly for three months for ongoing compliance</p>	7/30/12	

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F 371	<p>Continued From page 7</p> <p>chicken tenders. There were no items stored in the space behind the chicken tenders and a half pan stored in front.</p> <p>On 7/12/12 at 5:10 PM and 5:17 PM chicken tenders were plated for two residents and placed on the cart for delivery.</p> <p>On 7/12/12 at 5:22 PM temperature monitoring of the chicken tenders was completed by the certified dietary manager (CDM) and revealed a temperature of 104 degrees Fahrenheit. The CDM was observed to place the chicken tenders in the oven to reheat and stated that the pan of chicken tenders should make contact with the water in the steam table well to keep them hot. She stated that hot foods should be served from the tray line at least 140 degrees Fahrenheit per facility policy.</p> <p>During an interview on 7/12/12 at 5:25 PM with dietary staff #1 she stated "I grabbed the wrong pan in a hurry, I should have put the chicken in a deeper pan to keep it hot."</p> <p>An interview with the consultant registered (RD) dietitian occurred on 7/13/12 at 9:05 AM. The RD stated that all staff would receive an in-service to maintain hot foods at an appropriate temperature on the tray line.</p> <p>2. Observations of the kitchen on 7/12/12 at 10:25 AM and 7/13/12 at 11:28 AM revealed two storage racks with items stored that were identified as ready for use use.</p> <p>One storage rack with five shelves contained 29 stainless steel pans, six metal muffin pans, one</p>	F 371	<p>The Dietary Manager will monitor the cleaning schedule daily to ensure staff is following and assigned duties are completed.</p> <p>Cleaning schedules will specify both pot rack and utensil rack to ensure both racks are being cleaned on a routine basis.</p> <p>Dietary Manager will complete kitchen audits one time weekly for four weeks, then monthly or prn as needed. The RD will complete kitchen audits once a month.</p> <p>Results will be reviewed and analyzed at the facility's monthly PI meeting for three months for ongoing compliance.</p>	7/30/12	



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F 371	<p>Continued From page 8 metal pot, one sifter, and one plastic bowl.</p> <p>A second storage rack with three shelves contained two tongs, three wire whisks and two ladles.</p> <p>The back side and the shelves of each storage rack was observed with a build-up of a greasy residue and a thick layer of dust.</p> <p>An interview with the certified dietary manager (CDM) on 7/13/12 at 11:28 AM revealed that the storage racks contained items ready for use and should be cleaned weekly. The CDM confirmed the shelves contained a build-up of dust and debris and may require more routine cleaning. The CDM also stated that she thought the storage racks were cleaned last week, but she was not certain. The CDM stated that she monitored the kitchen daily to ensure the cleaning schedule was implemented, but she had not noticed the build-up on the storage racks. Review of the cleaning schedule during the interview revealed that one of the two storage racks was not included on the weekly schedule for routine cleaning. The CDM further stated that she expected staff to monitor the racks and clean them as needed.</p>	F 371		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program</p>	F 441		

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F 441	<p>Continued From page 9</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews the facility failed to clean the blood glucose meter in a manner to adequately disinfect after performing a finger stick blood glucose (FSBS) test on one (1) of four (4) sampled residents. (Resident #143)</p>	F 441	<p>Resident #143 blood glucose (meter) is being cleaned with 10% bleach before and after individual resident use. License Nurse #3 was removed from the medication cart and re-educated by the DNS to the centers policy and procedure for disinfecting equipment with a 10% bleach solution. License Nurse #3 was monitored by the SDC during two subsequent medication passes and successfully demonstrated proper procedure in cleaning the glucose meter with the 10% bleach solution between residents.</p> <p>The Staff Development Coordinator (SDC) will re-educate current licensed nurses to the centers policy and procedure for disinfecting equipment with an emphasis on (blood glucose meters) and wiping with 10% bleach between residents. This in-service will be included in the new employee orientation program for Licensed Nurses.</p> <p>The Unit Managers or the SDC will observe five nurses 2 times weekly for four weeks performing glucose checks to ensure proper cleaning with bleach wipes between residents.</p> <p>Data will be reviewed and analyzed at the facility's monthly Performance Committee Meeting (PI) monthly for three months for</p>	8/9/12	



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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
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F 441	<p>Continued From page 10</p> <p>The findings are:</p> <p>A review of the facility policy on 'Cleaning and Disinfecting Diagnostic Equipment In-between Patients' PRO 55004 pages 1 included: "Clean the outside of patient equipment with a 10% bleach solution moistened wipes in-between each patient and as needed. Allow contact with bleach solution for 1-minutes. Follow with a cloth dampened with water to remove residual bleach."</p> <p>And a review of the recommendations for cleaning and disinfection of Glucometers in North Carolina Statewide Program for Infection Control and Epidemiology (undated) specified to disinfect blood glucose meters (Glucometers) after each use using an EPA (Environmental Protective Agency) registered detergent/germicide with a Tuberculocidal or Hepatitis B Virus/Human Immune Virus label claim ....Alcohol is not an EPA registered detergent/disinfectant.</p> <p>Resident #143 was admitted to the facility with diagnoses including Diabetes Mellitus, among others. A review of Resident #143' s medical record revealed a physician order to check the resident ' s blood sugar four times daily and administer Insulin (Humalog) sliding scale coverage as needed.</p> <p>On 7/11/2012 at 4:24 PM Licensed Nurse (LN) #3 was observed to perform finger stick blood glucose check on Resident #143. LN #3 began by donning the gloves. She pricked the resident's finger with a disposable, one time use lance to get a drop of blood and inserted the glucose measurement strip into the glucometer and</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/13/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-MONROE			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 EAST SUNSET DR MONROE, NC 28112		
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F 441	<p>Continued From page 11</p> <p>checked blood sugar level. LN #3 disposed of the lancet and test strip and cleaned up the surface and the interior of the glucometer with alcohol swabs.</p> <p>An interview with LN #3 at that time revealed that she did not have bleach wipes on the medication cart and hence would use alcohol wipes to clean the glucometer. LN #3 stated that most of the time she used alcohol wipes to clean the glucometer as bleach wipes were not always available for cleaning. LN #3 had to be prompted related to cleaning the glucometer and she stated that she had been trained to use alcohol wipes to clean the glucometer after each use. She proceeded to use the finger stick glucometer for the next resident.</p> <p>An interview with the Director of Nursing (DON) and the Staff Development coordinator on 7/12/2012 at 9:12 AM revealed that all nurses had been in-serviced related to the use of bleach wipes after each time glucometer use. All nurses were expected to sanitize the glucometers after use.</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p>		