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
	345359	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

(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 observations, record reviews and staff interviews the facility failed to develop a comprehensive care plan to address combative behaviors in 1 of 1 residents (Resident # 90) and also failed to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction. 1) Resident # 90 was admitted to the facility on 7/16/12 with cumulative diagnoses which included Dementia, Psychosis, Hypertension, Diabetes,	F 279	F 279 1. Resident # 90 had her comprehensive care plan updated to include a Behavior Care Plan. Resident # 70 had her comprehensive care plan updated to include an At Risk for Constipation Care Plan. 2. Residents residing in center had a medical record review to audit resident comprehensive care plans. Behavior and At Risk for Constipation care plans were added as needed. 3. Interdisciplinary Care Team in-serviced to include comprehensive review of resident and update comprehensive care plan as needed per RAI (resident Assessment Instrument) manual. DNS or ADNS will audit three resident's comprehensive care plans weekly to validate comprehensive care plan is updated. Weekly audits will continue for a minimum of three months or until ongoing compliance is determined by the center's monthly Performance Improvement Committee. 4. Results of weekly audits will be reviewed by center's monthly Performance Improvement Committee for a minimum of three months or until ongoing compliance is sustained. Performance Improvement Committee will review audits and make recommendations as needed to sustain ongoing compliance.	12/28/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Fred V. Collins	Administrator	12-20-12

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 and Respiratory Failure. A review of the 90 day MDS (Minimum Data Set) assessment tool dated 10/22/12 indicated Resident # 90 was able to make her needs known and usually understood others. The MDS indicated Resident # 90 was cognitively impaired. The MDS also revealed Resident # 90 was dependent on staff for bathing, dressing, and personal hygiene. The MDS also revealed Resident # 90 had behaviors which included kicking, hitting, and refusing care for 1-3 days during the assessment period. A review of the care plan dated 9/17/12 for Resident # 90 revealed the resident was identified for Psychotropic Drug Use for a diagnosis of Psychosis. The goals of the care plan were Resident # 90 would be free of negative out comes or signs/ symptoms of drug related issues and Resident # 90 would receive the least dosage of the prescribed drug to ensure maximum functional ability. A review of the medical record revealed no care plan addressing Resident # 90 combative and care resisting behaviors. A review of the Nurses Aide Flow sheets completed for Resident #90 for September (9/9, 9/25, 9/28) and October (10/3, 10/5, 10/9, 10/10, 10/16,10/21) 2012 indicated Resident # 90 had multiple episodes of agitation, hitting/ combativeness, and refusing care. A review of the Nurses Progress Notes for August, September, October, and November 2012 indicated Resident # 90 had multiple	F 279		

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F 279	Continued From page 2 episodes of combativeness which included hitting, scratching, and punching staff. In addition, the Nurses Progress notes also revealed multiple episodes of Resident #90 refusal of care. Interview with NA # 2 who was familiar with resident # 90 on 11/29/12 at 11:20 AM revealed Resident # 90 had times when she was resistant to care and NA #2 indicated she would try to re-approach Resident # 90 at a later time. NA #2 revealed at times Resident # 90 absolutely refused care and she would let the nurse know when that occurred. Interview with Nurse #2 on 11/29/12 at 11:35 AM revealed Resident # 90 usually took her medication without difficulties or resistance. Interview with the on Director of Nursing (DON) 11/29/12 at 4:20 PM revealed a care plan should have been developed for Resident # 90 to address the combative behaviors and resistance of care. An interview with the Assistant Director of Nursing (ADON) on 12/7/12 at 8:40 AM revealed she was involved in the MDS process and was training a new MDS coordinator. The ADON indicated the SW would complete the behavior care plans for the residents as appropriate. The ADON also indicated a behavior care plan should have been completed for Resident #90 due to the usage of psychotropic medications and diagnoses and indicated she was not sure why it wasn't completed. 2) Resident # 70 was admitted to the facility on 10/1/12 for diagnoses which included Dementia,	F 279		

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F 279	Continued From page 3 Schizophrenia, Urinary Tract Infection, Cerebral Vascular Disease, and Hypertension. A record review revealed the 5 day Admission Assessment Minimum Data Set (MDS) completed for Resident #70 revealed she was able to make her needs known and had short term and long term memory deficits. The MDS indicated Resident #70 required extensive assistance of one staff member for toileting and Resident #70 was frequently incontinent of bladder and bowel. A record review of nursing progress notes dated 10/9/12 revealed Resident #70 had complained of abdominal pain and was vomiting. The note also revealed Resident #70 was sent to the Emergency Room and diagnosed with a fecal impaction. A record review of the hospital records revealed on 10/11/12 Resident #70 had a surgical procedure which included a small bowel resection with anastomosis of her bowel. The note also indicated during the surgery Resident #70 was found to have a necrotic segment of bowel. A record review revealed Resident #70 was discharged and readmitted to the facility on 10/16/12. Diagnoses for Resident #70 included Acute Renal Failure, Small Bowel Obstruction, Nausea and Vomiting, and a Fecal Impaction of the Colon. A record review revealed the Admission Assessment Minimum Data Set (MDS) dated 10/26/12 revealed Resident #70 was able to make her needs known and required extensive	F 279		

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F 279	Continued From page 4 assistance of one staff member for toileting. The MDS also indicated Resident #70 was dependent on staff for personal hygiene and bathing. A record review revealed there was no care plan for Resident #70 to address the bowel elimination process and monitoring related to her history and diagnosis on 10/9/12 of a fecal impaction. On 11/29/12 at 2:45 PM an interview with Nurse #3 revealed monitoring for bowel movements was done by the NAs. Nurse #3 revealed the NAs document and record Resident #70 ' s bowel movements. Nurse #3 also revealed the majority of the residents are incontinent on that unit (locked dementia unit) and the NAs would report if a resident had a loose stool. In addition, Nurse #3 revealed there was a resident bathroom close to the nurses ' station and staff could often tell by the smell if a resident had a bowel movement. On 11/29/12 at 3:00 PM an interview with NA #3 revealed Resident #70 wears incontinent briefs and Resident #70 was incontinent at times of bowel and bladder. NA#3 indicated she would check Resident #70 at the start of the shift and would ask Resident # 70 through out the shift if she would need to use the restroom. NA #3 indicated if Resident #70 had a bowel movement she would document on the elimination records. On 11/30/12 at 9:30 AM an interview with the DON and Regional Nurse Consultant revealed there should have been a care plan for Resident #70 to address bowel elimination due to her past diagnosis of a fecal impaction. On 12/7/12 at 8:45 AM an interview with the	F 279		

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F 279	Continued From page 5 ADON revealed was involved in the MDS process and was assisting training a new MDS coordinator. The ADON indicated a care plan should have been in place for bowel elimination for Resident # 70.	F 279		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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.	F 441	F 441 1. Bath basins, bed pans and urinals for the following rooms 117, 207, 208, 221, 22, 224, 313, 314, 317, 319 and 320 were discarded are replaced with new ones which were properly labeled and stored in bags. South Hall shower chair was discarded and replaced with a new chair in good repair. Licensed Nurse #1 is currently washing her hands before and after administering medication. 2. Staff has been in-serviced on proper labeling and storage of bath basins, bed pans, urinals, monitoring of equipment to ensure it is in good repair and does not present an infection control risk and hand washing before and after medication administration. During their orientation period, newly hired nursing staff will be in-serviced on proper labeling and storage of bath basins, bed pans, urinals and monitoring of equipment to ensure that it is in good repair and does not present as an infection control risk. During their orientation period, newly hired Licensed Nurses will be in-serviced on hand washing before and after medication administration. 3. Nurse #1 has been observed weekly on medication administration pass to validate appropriate hand washing before and after	12/28/2012

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F 441	Continued From page 6 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to assure resident bath basins, bedpans, and a urinal were stored in a sanitary manner for 11 bathrooms (Rooms 117, 207, 208, 221, 222, 224, 313, 314, 317, 319, and 320) of 11 bathrooms observed; the facility failed to maintain a vinyl padded shower chair in good condition for 1 (South Hall) of 1 vinyl padded shower chairs; and the facility failed to ensure 1 (Nurse #1) of 4 nurses failed to wash her hands before and after administering medications to 3 (Residents #87, #147, and #148) and of 11 residents that were observed during the medication pass. Findings include: 1) Observations were made of resident bathrooms throughout the facility that revealed: 11/29/12 at 10:02 AM, in the bathroom of Room 117, the shelf had a bath basin stacked inside another basin with a resident ' s name partially worn off. The basins had no protective covering. The room was a semi-private room and was not shared with another room. 11/29/12 at 10:44 AM, a bathroom shared between private rooms, Room 222 and Room 224, revealed 1 bath basin in a clear plastic bag with no visible resident name was stored on the	F 441	medication administration. Nurse #1 will be observed weekly on medication administration pass for four weeks to validate appropriate hand washing before and after medication administration. There after, Nurse #1 will be observed monthly on medication administration pass for two additional months to validate appropriate hand washing before and after medication administration. DNS, ADNS or SDC will conduct five resident room and shower room rounds three times weekly to validate proper labeling and storage of bath basins, bed pans, urinals, monitoring of equipment to validate it is in good repair and does not present an infection control risk and hand washing before and after medication administration. Weekly audits will continue for a minimum of three months or until ongoing compliance is determined by the center's monthly Performance Improvement Committee. 4. Results of weekly audits will be reviewed by center's monthly Performance Improvement Committee for a minimum of three months or until ongoing compliance is sustained. Performance Improvement Committee will review audits and make recommendations as needed to sustain ongoing compliance.	

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F 441	Continued From page 7 shelf. 11/29/12 at 10:59 AM, an observation of Room 207, a private room, revealed the bathroom shelf had a bath basin labeled with a resident name with no protective covering, and a bedpan with no resident name or a protective covering. The bathroom was shared with another private room, Room 208. 11/29/12 at 11:24 AM, Room 221, the bathroom shelf over the toilet had a urinal bottle with brownish golden residue on the bottom and was not labeled with a resident name. The urinal bottle had no plastic protective cover. 11/29/12 at 11:29 AM, Room 319, a semi-private room, a bathroom shelf over the toilet had a stack of 3 bath basins, unbagged, and labeled with a smeared resident name. This semi-private room was shared with Room 320, a semi-private room. 11/29/12 at 11:34 AM, Room 317, the bathroom shelf had 2 gold colored basins stacked inside one other, with no resident name and were unbagged; a teal colored basin was unbagged, labeled with a resident name; and a gold basin unbagged and had no resident name. The room was a semi private room. 11/29/12 at 11:40 AM, Room 314, the bathroom shelf had 4 gold colored bath basins, bagged, with no visible resident names; and 4 bed pans, bagged, with no visible resident names. The room was a semi-private room shared with Room 313, a semi-private. 2) An observation of the South hall shower room on 11/29/12 at 12:11 PM revealed the shower stall area had an ivory colored, vinyl, padded seat in an L-shape. Inside the L corner was cracked in 3 places that extended from the base of the seat	F 441		

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F 441	Continued From page 8 up an over the top of the seat 5 " 3 " and 2 " long. The front right corner of the seat ' s front was cracked 5 " wide between the top and the bottom of the seat. The outside left corner of the seat was cracked 5 " between the top and bottom of the seat. The cracked corner and the seam above it were filled with blackened matter. The shower wall at the bottom where it met the floor was filled with brownish residue on the side walls and back wall. There was a reddish pink bar of soap, not wrapped or contained, on the seat. On the sink top were a bottle of baby shampoo without a resident name, and a bottle of body bath concentrate without a resident name on it. A large, opaque drinking mug + with a blue lid was on the seat of the whirlpool tub. There was no name labeled on the mug. During an observation of the South Hall shower room with the Administrator on 11/30/12 at 11:30 AM, the baby shampoo and body bath concentrate remained on the sink; the opaque mug remained in the whirlpool tub; the padded, vinyl shower seat remained in the same condition with tears and blackened matter; and the base of the shower walls had darkened brown matter buildup. The Administrator stated the shower seat needed replaced due to the splits in the vinyl and blackened buildup; the personal items of baby shampoo and body bath concentrate needed discarded; and the mug needed discarded as it should not have been stored inside the whirlpool tub. During an interview with Nursing Assistant (NA) #3 on 11/30/12 at 3:05 PM, the NA stated staff were expected to label basins and bedpans with resident names and put them in a bag to be	F 441		

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F 441	Continued From page 9 stored when not in use. During an interview with the Director of Nursing (DON) on 11/30/12 at 3:35 PM, the DON stated the staff were expected to store basins and bed pans in clear plastic bags and label them with the resident ' s name. 3) The facility policy titled " Medication Administration " , dated 8/31/12, indicated hands should be washed prior to preparing the medication for administration to each resident. An observation on 11/29/12 at 8:35 AM revealed a container of hand sanitizer on the medication cart attended by Nurse #1. An observation on 11/29/12 at 8:45 AM revealed Nurse #1 did not wash her hands or use hand sanitizer and proceeded to prepare the medications to administer to resident # 87. The observation then revealed Nurse #1 administered the medications and returned to the medication cart and documented the administration of the medications to resident #87. The nurse pushed the medication cart to the room of Resident #148. An observation on 11/29/12 at 9:05 AM revealed Nurse #1 did not wash her hands or use hand sanitizer and proceeded to prepare resident # 148 ' s medications and administered them to resident #148. The observation then revealed Nurse #1 returned to the medication cart and documented the medication pass to resident #148. The nurse pushed the medication cart to the room of Resident #147. An observation on 11/29/12 at 9:20 AM revealed	F 441		

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F 441	Continued From page 10 Nurse #1 did not wash her hands or use hand sanitizer and proceeded to prepare medications to administer to resident #147. An interview on 11/29/12 at 9:24 AM with Nurse #1 revealed she forgot to wash her hands or use the hand sanitizer on her medication cart. During the interview with Nurse #1, she revealed she would usually wash her hands or use hand sanitizer before and after administering medications to each resident. An interview on 11/30/12 at 9:30 AM with the Director of Nursing (DON) revealed she expected nurses washed their hands before and after administering medications to a resident.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 3 of 3 gas clothes dryers in clean condition. Findings include: An observation was made of the facility's clothing dryers on 11/30/12 at 11:12 AM with the Housekeeping and Laundry Director. The first of 3 dryers, on the left of the set, revealed a tan colored solid matter built up on the drum of the	F 465	~~F 465~~ 1. Gas Clothes Dryer have been cleaned. 2. Laundry staff has been in-serviced to observe dryers prior to use to ensure dryers are clean. Laundry Staff in-serviced to use wire brush in drum as needed to remove lint and debris. Laundry Staff in-serviced to notify the Laundry Supervisor, Maintenance Director or ED if the dryers need additional cleaning. During orientation, newly hired Laundry staff will be in-serviced to observe dryers prior to use to ensure dryers are clean. During orientation, newly hired Laundry staff will be in-serviced to use wire brush in drum as needed to remove lint and debris. During orientation, newly hired Laundry staff will be in-serviced to notify the Laundry Supervisor , Maintenance Director or ED if the dryers need additional cleaning. 3. ED or Laundry Supervisor will visually inspect clothes dryers five times weekly to validate dryers are clean. Maintenance Director will be contacted as needed for additional cleaning. Weekly audits will continue for a minimum of three months or until ongoing compliance is determined by the center's monthly Performance Improvement Committee. 4. Results of visual inspection audits will be reviewed by center's monthly Performance	12/28/12

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F 465	Continued From page 11 machine. The area measured 5" in diameter and was raised and hardened. The Director used a pen knife to pry the matter from the drum and stated it was probably a melted disposable glove. Additional debris on the drum included a rust colored matter and a scarred, blackened ring throughout the entire circumference of the drum. An observation of the center dryer revealed blackened scarring and rust colored debris build-up throughout the drum. A quarter was stuck to the drum and was removed using a pen knife to lift it from the surface by the Director. A penny was observed stuck to the drum in the midst of rust-colored debris that was built up at the rail of the drum. An observation of the third dryer, on the right of the 3, revealed a build up of blacked and rust colored matter through out the drum. An interview was conducted with the Laundry Director on 11/30/12 at 11:17 AM. The Director stated laundry staff alerted maintenance when the dryers needed cleaned since maintenance had to turn off the gas for the dryers, and maintenance cleaned the machines. During an interview with the Laundry worker on 11/30/12 at 11:25 PM, the laundry worker stated when the dryers showed build up of matter in them, she ran a brush over the drums to clean any debris from the inside the dryer. The laundry aide indicated it had been more than 2 weeks since she last used the brush in the dryers. A telephone interview was conducted with the Maintenance Director on 12/3/12 at 1:18 PM.	F 465	Improvement Committee for a minimum of three months or until ongoing compliance is sustained. Performance Improvement Committee will review audits and make recommendations as needed to sustain ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

(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 465	Continued From page 12 The Director stated the last time maintenance checked the inside of the dryers was 11/19/12 or 11/20/12; and the last time the dryer drums were scraped clean was 11/14/12 or 11/15/12. The Director stated no one had reported to him the dryers were in need of cleaning. During and interview and observation of the dryers with the Director of Nursing (DON) at 11:30 AM, the DON stated the inside of the dryers looked nasty and expected the dryers to have been clean. During an interview with the Administrator on 11/30/12 at 4:20 PM, the Administrator stated he expected the dryers to be maintained in a clean condition.	F 465		
F 499 SS=E	§483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to ensure 1 Medication Aide (Medication Aide #1) of 2 Medication Aides was properly certified to administer medications. Record review of nursing staff schedule for 11/16/12 through 12.13.12 revealed NA (Nursing	F 499	F 499 1. NA #3 is currently working as a Certified Nursing Assistant. Her certification has been verified on the NCNAR. (North Carolina Nurse Aide Registry) 2. Current SDC, ADNS, and DNS have been in-serviced on NC Medication Aide certification. The center employs one Medication Aide at this time; her certification has been verified on the NCNAR. She is currently listed with no substantiated findings on the NCNAR as a Nursing Aide I and NC Medication Aide. 3. DNS will verify individuals applying for Medication Aide positions are listed on the NCNAR as a Nurse Aide I and NC Medication Aide prior to making a job offer. 4. Verification Audits will be reviewed in monthly Performance Improvement Committee Meetings monthly for a minimum of three months or until ongoing compliance is sustained.	12/28/12

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
	345359	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

(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 499	Continued From page 13 Assistant) #3, was scheduled as a " Med aide " for the 7 AM to 3 PM shift. A review of the nurses aide schedule revealed NA #3 had worked on the 7 AM to 3 PM shift on November 19, 20, 21, 22, 24, 25, 26, 27, and 29, 2102 as a Medication Aide. The schedule documented NA#3 was scheduled as a Medication Aide " M3 " for the remainder of the schedule period ending December 13, 2012. An interview with the Nursing Staff Scheduler (NSS) on 11/30/12 at 11:00 AM revealed the code " M3 " indicated Medication Aide to administer medications on Unit 3. The NSS also indicated NA #3 had given her proof of certification as a Medication Aide to the previous Staff Development Coordinator (SDC). The NSS was directed by the SDC to schedule NA#3 for orientation for the Medication Aide position. The NSS indicated NA#3 was scheduled to orient with a Registered Nurse who supervised NA#3 during her training to administer medications in the facility. An interview with the Director of Nursing (DON) on 11/30/12 at 11:45 PM revealed NA#3 had received orientation for the Medication Aide position based on the certificate provided to the former SDC. The DON indicated the facility had started a Medication Aide program and NA#3 was in the process of training to administer medications. The DON indicated she attempted to verify NA#3 ' s medication aide certificate on the Nurses Aide Registry and could not verify the certificate. The DON revealed she contacted the Nurses Aide Registry and learned NA#3 was not certified to administer medication in a long term care facility. NA #3 was taken off the schedule as	F 499	F 499 1. NA #3 is currently working as a Certified Nursing Assistant. Her certification has been verified on the NCNAR. (North Carolina Nurse Aide Registry) 2. Current SDC, ADNS, and DNS have been in-serviced on NC Medication Aide certification. The center employs one Medication Aide at this time; her certification has been verified on the NCNAR. She is currently listed with no substantiated findings on the NCNAR as a Nursing Aide I and NC Medication Aide. 3. DNS will verify individuals applying for Medication Aide positions are listed on the NCNAR as a Nurse Aide I and NC Medication Aide prior to making a job offer. 4. Verification Audits will be reviewed in monthly Performance Improvement Committee Meetings monthly for a minimum of three months or until ongoing compliance is sustained.	12-28-12

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
	345359	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

(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 499	Continued From page 14 a Medication Aide. An interview with NA#3 on 11/29/12 12:20 PM revealed NA#3 had taken a course to become a Certified Medication Aide. NA#3 indicated she had given her certificate of successful completion of the course to the former SDC. NA#3 revealed the SDC arranged for her to start orientation as a Medication Aide. NA#3 indicated she started training at the facility to administer medications under the supervision of a Registered Nurse. NA#3 indicated she administered medications and signed them off in the Medication Administration Record. NA#3 revealed she had worked 8 shifts as a Medication Aide. An interview with the DON on 11/30/12 at 12:30 PM revealed her expectation was for all medications administered in the facility be administered by qualified staff only.	F 499		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V 111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	RECEIVED JAN 14 2013 CONSTRUCTION SECTION	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/20/2012 there were unprotected PVC conduites penetrating the ceiling of the Nursing Supply Room across from the business office. 42 CFR 483.70 (3)	K 012	K012D LSC Unprotected PVC Conduits 1. The PVC Conduit penetrating the Nursing Supply Room across from the business office was sealed using LCC Firestop Collar. 2. Other conduit penetrations were checked and found to be in compliance with the Standard. 3. Any future conduit penetrations will be supervised by maintenance Supervisor and subsequently sealed with LCC Firestop. 4. The Maintenance staff will make visual observations monthly to check and monitor potential non-compliant conduit penetrations.	1/1/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029		

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

Ex. DIRECTOR 1/11/13 cD

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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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
	345359	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/20/2012 the door to the dry storage room in the kitchen failed to close and latch. 42 CFR 483.70 (a)	K 029	K029 D Self Closing Door 1. The door to the dry storage room failed to close and latch. A piece of metal had prevented the door was closing completely. Metal was removed and door closed as required. 2. Other doors within the facility Were checked and closed per the LSC standard. 3. Any future door installation or maintenance will be checked for proper closure. 4. Maintenance personnel will check and monitor doors per our monthly PM Checklists.	1/1/13

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	345359	A. BUILDING 02 - BUILDING 02 B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V 111 construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows Based on observation and staff interview there were no LSC deficiencies noted.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EX DIRECTOR — (X6) DATE: 1/11/13

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

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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
	345359	A. BUILDING 03 - BUILDING 03 B. WING _____	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V 111 construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows Based on observation and staff interview there were no LSC deficiencies noted.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EQ Director — (X6) DATE: 1/11/13

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

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	345359	A. BUILDING 05 - REPLACEMENT BUILDIN(B. WING _____	12/20/2012

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KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE	604 STOKES STREET EAST AHOSKIE, NC 27910

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

EX. DIRECTOR 1/11/13

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