STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ELIZABETH CITY	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to control noise levels for residents' comfort for 5 of 6 alert and oriented residents interviewed (#5, #90, #134, #161 and #167). Findings included: 1. Record review of the Resident Council Minutes dated 6/15/2015 noted a complaint of a "resident yelling at night, not being able to sleep." 1a. Resident #90 had been admitted to the facility on 1/28/2015. Her most recent quarterly Minimum Data Set (MDS) assessment was dated 5/05/2015 and indicated she was cognitively intact and had no behaviors reported. On 6/23/2015 at 9:55 AM she reported hearing a resident yelling at night which woke her up. 1b. Resident #5 had been admitted to the facility on 5/11/2015. The admission Minimum Data Set (MDS) dated 5/18/2015 indicated she was cognitively intact and had no behaviors reported. On 6/23/2015 at 10:48 AM she reported Resident #164 "Yells night and day", making it difficult for her sleep. 1c. Resident #161 had been admitted to the facility on 6/03/2015. The admission/5 day MDS dated 6/10/2015 indicated she was cognitively intact and displayed no behaviors. On 6/23/2015 at 4:38 PM she indicated when hearing Resident #164 yell, the yelling was disturbing and made it	F 258	1. Resident #164 is no longer in the facility. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the Staff Development Coordinator will perform a one time audit with the current resident population to determine if noise levels are acceptable. Interventions will be put in place to decrease the noise levels for those identified residents with behaviors contributing to the noise level. Residents with behaviors will be discussed weekly in the Standards of Care meeting to ensure ongoing compliance. 3. The Staff Development Coordinator will re-educate the Licensed Nurses and Certified Nursing Assistants on interventions to aide in controlling the noise levels caused by residents with behaviors by 7/24/2015. This information will be included in the new employee orientation program for LNs and CNAs. 4. The DNS, ADNS, and/or the SDC will interview 5 interviewable residents on various shifts and halls to include weekends 5 times a week x 4 weeks, 2 x	7/24/15

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

Electronically Signed | 07/15/2015

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F 258	Continued From page 1 difficult to rest. 1d. Resident #167 had been admitted to the facility on 6/12/2015. The admission/5 day MDS dated 6/19/2015 indicated she was cognitively intact and displayed no behaviors. On 6/26/2015 at 3:50 PM she stated she had "a hard time sleeping and resting" because of Resident #164 yelling. 1e. Resident #134 had been admitted to the facility on 5/05/2015. His admission MDS dated 5/15/2015 and indicated he was cognitively intact and displayed no behaviors. On 6/26/2015 at 4:00 PM he stated Resident #164 "yells morning, noon and night. He has been yelling since he has been here." Resident #134 also indicated he had difficulty sleeping because of Resident #164 yelling. 1f. Resident #164 had been admitted to the facility on 6/04/2015. His diagnoses included Alzheimer's disease, ischemic cerebrovascular disease, anxiety, depression, generalized muscle weakness and difficulty walking. An MDS assessment is not available. The care plan dated 6/25/2015 indicated Resident #164 had a Disruptive behavior problem: yelling out, cursing, resistive to care. Goal included: Resident will have fewer episodes of yelling weekly by review date of 9/23/15. Interventions included: Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet needs. Intervene as necessary to protect the rights and safety of others. Approach/speak in a clam manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Praise any	F 258	weekly x 4, weekly x4, then monthly x 3 to ensure that noise levels are acceptable. 5. Data results will be presented by the DNS and/or the ADNS, reviewed and analyzed by the IDT at the centers monthly Quality Assessment and Performance Improvement meeting for three months with a subsequent plan of correction as needed.	

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F 258	Continued From page 2	F 258		

indication of resident's progress/improvement in behavior.

Medications for resident #164 included: Ativan 0.5 milligrams (mg) 2 tablets every 6 hours as needed, BuSpar 10 mg one tablet three times a day, Risperdal 1 mg one daily, Paxil 30 mg one daily, Namenda XR 28 mg daily, Exelon 13.3 mg one 24 hour patch daily.

An initial evaluation by Psychiatric services was dated 6/10/15. Diagnoses included dementia with behavior and other cerebral degeneration. Recommendations included: Start BuSpar 10mg by mouth three times a day for anxiety and agitation, monitor for mood, behavior and cognition. Follow up as needed.

Observations included: on 6/25/2015 at 9:14 AM Resident #164 had been observed yelling loudly for over an hour. The nursing staff were observed entering the resident's room and asking him what he needed and what they could do to help him. The staff were observed offering him a beverage and repositioned him for comfort and the resident continued to yell loudly. On 6/25/2015 at 11:55 AM the Resident was observed to be asleep, lying on his left side in bed and positioned with pillows. On 6/25/2015 at 4:50 PM the Resident was observed lying in bed, yelling loudly. On 6/26/2015 at 7:56 AM the Resident had been observed yelling loudly while staff had been providing morning care. On 6/26/2015 at 9:44 AM the Resident had been observed yelling loudly, he was lying in bed. On 6/26/2015 at 10:17 AM the Resident was observed sitting up in a wheel chair, asleep with the television turned on.

An interview with the Social Worker (SW) on

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F 258	Continued From page 3 6/26/2015 at 8:29 AM was conducted. The SW indicated residents had complained about Resident #164 yelling and not being able to rest An interview with Nurse Aid (NA) #1 on 6/26/2015 at 9:23 AM was conducted. The NA indicated when Resident #164 is yelling other residents have difficulty resting or sleeping. An interview with NA #2 on 6/26/2015 at 10:19 AM was conducted. The NA indicated other residents are bothered by Resident #164 yelling. An interview with the Administrator on 06/26/2015 at 12:49 PM was conducted. The administrator indicated she had been involved with the most recent Resident Council Meeting. The Administrator stated the noise complaint which had been brought up in the Resident Council Meeting had been discussed with the Resident Council at that time. The Administrator indicated she had explained to the Resident Council that the noise making was a part of Resident #164 disease process, his yelling was not intentional and the physicians and staff are trying to manage his symptoms and the noise. The Administrator indicated Resident #164 behaviors are improving, and stated the resident used to also curse aloud with his yelling. An interview with NA #3 on 6/26/2015 at 3:50 PM was conducted. The NA reported several residents had complained about Resident #164 yelling. An Interview with NA #4 on 6/26/2015 at 3:55 PM was conducted. The NA indicated Resident #134 has complained about the yelling.	F 258		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		7/24/15

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F 279 SS=D	Continued From page 4 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 record review and staff interview the facility failed to put a care plan in place for urinary incontinence as decided in the Care Area Assessment (CAA) for one of two residents (Resident #86) who had been reviewed for urinary incontinence. Findings included: Resident #86 had been admitted on 1/26/2015. The resident's admitting diagnoses included: difficulty walking, generalized weakness, gastrointestinal hemorrhage, coronary artery disease, benign prostatic hypertrophy (BPH), anemia, chronic venous embolism lower	F 279	1. Resident #86 has been care planned for incontinence. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the Staff Development Coordinator will perform a one time audit with the current resident population to determine residents with incontinence, change in continent status, or risk factors that my lead to incontinence and the need for a toileting plan. Newly identified residents will have a care plan initiated. New admitted	

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F 279	Continued From page 5 extremity, hypertension and chronic pain. The Admission Minimum Data Set (MDS) assessment dated 2/2/2015 indicated the resident was cognitively intact and occasionally incontinent of urine. The most recent Quarterly MDS assessment dated 4/23/2015 indicated the resident was cognitively intact and frequently incontinent of urine. The CAA Urinary Incontinence Work Sheet dated 2/20/2015 indicated the resident had a diagnosis of BPH, had urinary urgency, needed assistance with toileting, and had received diuretic medication. Considerations for the care planning of the resident ' s incontinence included minimizing the risk of developing skin breakdown and urinary tract infection because of the resident's incontinence. The CAA work sheet indicated a care plan including these interventions would be developed. The most recent care plans for Resident #86 dated 5/12/2015 revealed no care plan related to urinary incontinence. An interview with the MDS nurse on 6/26/2015 at 11:22 AM was conducted. The nurse indicated a urinary incontinence care plan had not been initiated as the CAA work sheet had indicated. The nurse stated this had been an oversight. An interview with the Administrator on 6/26/2015 at 12:49 PM was conducted. The administrator stated she would expect the care plan to have been completed in a timely manner.	F 279	residents will be assessed for incontinence and will be care planned as appropriate. Residents identified with incontinence will be discussed in the weekly Standards of Care meeting to ensure ongoing compliance. 3. The Staff Development Coordinator will re-educate the Interdisciplinary Team, Licensed Nurses, and Certified Nursing Assistants regarding the facility policy and procedure to provide care and treatment to help the resident restore his/her highest level of normal bladder function as possible, implementation of a toileting plan, interventions to restore bladder function, and implementing resident care plans as it relates to incontinence by 7/24/2015. The above in-service will be included in the new employee orientation program for LNs, CNAs, and the IDT members. 4. The DNA and/or the ADNS will audit 5 resident care plans for the presence of incontinence and a toileting plan 2 x weekly x 4 weeks, then weekly x 4, and monthly x 3 to ensure resident care plans for incontinence are developed and implemented. 5. Data results will be presented by the DNS, reviewed and analyzed by the IDT at the centers monthly Quality Assessment and Performance Improvement meeting for three months with a subsequent plan of correction as needed.	

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F 280	Continued From page 6	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to update the care plan for 1 of 3 residents (Resident #43) reviewed for range of motion. The findings included: Resident #43 was readmitted to the facility on 5/26/14. Diagnoses included cognitive deficits due to cerebrovascular disease, aphasia and contracture of joint not specified. A physician order dated 5/3/15 included an order for Occupational Therapy (OT) to evaluate	F 280	1. Resident #43 care plan has been updated for contracture management. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the Staff Development Coordinator will perform a one time audit to identify residents with contractures to validate implementation of contracture management interventions on the care plan. Interventions will be initiated or revised on the residents' care plan as	7/24/15

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F 280	Continued From page 7 bilateral hand contractures. OT notes dated 5/4/15 revealed therapy had been initiated for treatment of the contractures. The annual Minimum Data Set (MDS) dated 5/28/15 indicated Resident #43 had functional limitation in her upper and lower extremities bilaterally. OT notes revealed OT services were completed on 6/3/15, and that Resident #43 was to continue with use of hand splints and a right elbow splint daily from 9:00 AM - 5:00 PM. Review of the comprehensive care plan revealed no plan of care for the Resident ' s contractures. An observation on 6/24/15 at 12:35 PM revealed Resident #43 wearing her splints. During an interview on 6/25/15 at 12:09 PM the MDS nurse indicated care plans should be updated during the morning meeting when new orders for therapy are received. The nurse stated that not adding contractures as a problem for Resident #43 was an oversight. During an interview on 6/25/15 at 12:18 PM the Director of Nursing said her expectation was for the contractures to be care planned.	F 280	needed. Residents with contractures will be reviewed weekly in the Standards of Care meeting to ensure ongoing compliance. 3. The SDC will re-educate the Interdisciplinary Team and Licensed Nurses regarding revision of the resident care plan as it relates to implementing contracture management by 7/24/2015. The above in-service will be included in the new employee orientation program for LN and new IDT members. 4. The DNS and/or the ADNS will audit 5 residents' care plans for the presence of contracture management interventions 5 x weekly x 4 weeks, then 2 x weekly x 4, then weekly x 4, and monthly x 3 to ensure that residents' care plans have been updated to reflect contracture management and interventions. 5. Data results will be presented by the DNS, reviewed and analyzed at the centers monthly Quality Assessment and Performance Improvement meeting by the IDT for three months with a subsequent plan of correction as needed.	
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	F 315		7/24/15

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F 315	Continued From page 8 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 interview the facility failed to put measures in place to restore as much normal bladder function as possible to 1 of 2 residents who was in need of an assessment for a toileting program. Resident #15 Findings included: Resident #15 was readmitted on 12/1/14 with diagnosis that included Diabetes, Dementia, Peripheral Vascular Disease, and Hypertension. The admission assessment dated 12/17/14 coded the resident was always continent of bowel and bladder and she could ambulate with a walker. The assessment indicated the resident was moderately cognitively impaired. The resident was hospitalized on 2/26/15 and was readmitted on 3/4/15 with diagnosis that included sepsis and Urinary tract infection and an ankle fracture. A significant change assessment was completed 3/11/15. The assessment indicated the resident was cognitively intact and she required extensive assistance of one person for activities of daily living (ADLs). She was assessed as occasionally incontinent of urine. A quarterly assessment was completed on 6/12/15 and she was moderately impaired in cognition. She required extensive assistance of one person for ADLs and always incontinent. The medical record indicated that she had not participated in a toileting program or trial,	F 315	1. Bladder status evaluation was completed on resident #15 on 7/23/2015 by the DNS. A bladder status evaluation is performed on residents identified as incontinent upon admission/readmission, annually if change in patient condition that affects continent status. The assessment identifies incontinence cause and type that may be reversible and not associated with acute infection. The evaluation may take up to seven (7) days to complete. At the completion of the bladder status evaluation, a voiding pattern was not established and resident #15 is most appropriate for incontinent care. Staff will continue to make routine checks on resident and provide incontinent care as needed. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the MDS nurse will perform a one time audit with the current resident population to determine residents in need of a bladder status evaluation by 7/17/2015. Newly identified residents will have a bladder status evaluation performed to identify a change in the residents' condition that affects continent status such as a decline in mental status and the patient no longer asks to be toileted and becoming	

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F 315	Continued From page 9 scheduled toileting prompted voiding or a bladder training program since the readmission from the hospital. The care plan for the area of ADLs was initiated on 6/20/13. The goal was Res #15 will maintain current level of function in toilet use through the review date. The care plan was reviewed quarterly but there wasn't a change written from when she was occasionally incontinent to being always incontinent. Also there wasn't a plan to restore as much normal bowel and bladder function as possible. On 6/24/15 at 12:50pm the resident was observed sitting up in her wheelchair feeding herself lunch. On 6/25/15 at 3:32pm the resident was observed in her bed and Nursing Assistant (NA) #2 was in her room preparing to take her blood pressure. NA #4 indicated that she had never known the resident to be on any toileting program. The NA indicated that she recalled when the resident used to take herself to the bathroom using the walker but now she stays in the bed or wheelchair all the time. On 6/26/15 at 9:07am, NA #3 was asked if there had ever been a toileting program for the resident. The NA indicated that the resident could tell you that she had messed on herself. After she broke her ankle she was put in a diaper and we would clean her up when needed and check on her every two hours. Nurse #4 for the hall was interviewed on 6/26/15 at 9:15am, and said the resident had been incontinent since she had been assigned on that hall in March. She was not aware of any toileting program that was developed for her. The MDS nurse was interviewed 6/26/15 at 9:30am regarding the assessments that was conducted on Resident #15. She confirmed that when the resident was assessed as cognitively	F 315	incontinent. A three day voiding trial will be completed to determine a pattern and if an individualized toileting program with appropriate interventions should be implemented to help restore the highest level of normal bladder function as possible. Results will be care planned as appropriate. Newly admitted residents identified as incontinent will have a bladder status evaluation completed to identify the cause of incontinence and three day voiding trial completed to determine a voiding pattern and if interventions can be initiated to help restore his/her highest level of normal bladder function as possible. This information will be reviewed weekly in the Standards of Care meeting to ensure ongoing compliance. 3. The Staff Development Coordinator will re-educate the Licensed Nurses and Certified Nursing Assistants on the centers policy and procedures regarding completing a bladder status evaluation and a three day voiding trial on residents identified as incontinent in an attempt determine a voiding pattern and implement interventions to restore normal bladder function by 7/24/2015. The interventions initiated will be placed on the residents' care plan and care card to communicate resident toileting needs to direct care staff. Based on the results of the bladder status evaluation and the three day voiding trial, an individualized toileting plan will be initiated whether it is prompted voiding, habit/scheduled toileting, incontinent care, or bladder	

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KINDRED TRANSITIONAL CARE & REHAB-ELIZABETH CITY	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

(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 315	Continued From page 10 intact there wasn ' t a bowel and bladder assessment to determine how to best restore as much normal functioning as possible. The routine toileting policy was reviewed with her to determine if this policy was used when the cognitive status of the resident changed from being cognitively intact to severely cognitively impaired. The policy contained guidelines for schedule toileting for a resident who is unable to communicate the need to void. The policy had not been implemented for the resident as far as she knew but the Director of Nurses (DON) should be asked. During an interview on 6/26/15 at 9:45am, the DON she confirmed that there wasn't a written toileting program for Resident #15. She indicated that the resident was provided normal care every two hours. There wasn't anything written on paper about restoring normal bladder functioning for the resident and the care plan didn't address the issue. She said the resident lacked motivation and didn ' t use the call bell. They have ordered an antidepressant for her and a psychological evaluation.	F 315	retraining. The toileting program for each resident will be based on the three day voiding trial and the bladder evaluation which could include offering toileting on a routine basis including when resident request, before or after meals, at bedtime, and once during the night if appropriate to help restore his/her highest level of normal bladder function as possible. The above information will be included in the new employee orientation program for LNs and CNAs. 4. The DNS, ADNS, and/or the MDS nurse will observe 5 residents on the toileting program 2 x weekly x 4 weeks, then weekly x 4 weeks, and monthly x 3 to monitor the care delivery as designated in the toileting plan, if the residents are being toileted, the effectiveness of individualized interventions and modify them, as appropriate to ensure compliance. 5. Data results will be presented by the DNS and/or the MDS nurse, reviewed and analyzed at the centers monthly Quality Assessment and Performance Improvement meeting by the Interdisciplinary Team for three months with a subsequent plan of correction as needed.	