

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2017
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704
---	--

(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	<p>INITIAL COMMENTS</p> <p>The survey team entered the facility on 09/29/17 to conduct a complaint survey and exited on 09/29/17. The survey team returned to the facility on 10/06/17 to obtain additional information. The survey team identified immediate jeopardy at past-non compliance and exited the facility on 10/8/17. The survey team obtained additional information on 10/09/17 via telephone. Therefore, the exit date was changed to 10/09/17.</p> <p>Past-noncompliance was identified at:</p> <p>CFR 483.10 at tag F157 at a scope and severity (J) CFR 483.25 at tag F309 at a scope and severity (J)</p>	F 000		
F 157 SS=J	<p>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14)</p> <p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or</p>	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/25/2017
--	-------	--------------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 1 clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, Medical Director interview, Physiatrist interview, and staff interview the facility failed to notify the physician in a timely manner of x-ray results for one (Resident #1) of three residents reviewed for notification of radiology results. The facility Physiatrist was not</p>	F 157	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 2</p> <p>notified of the abnormal x-ray results dated 8/3/17 and 8/29/17 until 9/13/17. The Medical Director was not notified of the abnormal x-ray results dated 8/29/17 until 9/13/17, when Resident #1 was discharged to the hospital for surgery. Findings included:</p> <p>Resident #1 was initially admitted to the facility on 8/17/15 for rehabilitation services with cumulative diagnoses which included arthritis, chronic pain syndrome, and multiple vertebral transverse process fractures.</p> <p>The most recent annual Minimum Data Set (MDS) dated 7/31/17 coded Resident #1 as cognitively intact, requiring limited assistance with transfers, and extensive assistance with dressing. The resident was coded as having no falls since admission or the previous assessment and had been receiving physical therapy since 11/17/2016.</p> <p>The care plan for Resident #1 had a focus area initiated on 8/17/15 and revised on 9/29/17 which revealed Resident #1 had acute and chronic pain due to a history of multiple spinal fractures rheumatoid arthritis, and a recent spinal hip fracture.</p> <p>Review of a 7/25/17 Physiatrist progress note revealed in the planning section of the note Resident #1 was, "Making excellent progress with gait," and "with recent progress, now goal is to return home."</p> <p>A nursing incident note, written by Nurse #2, dated 7/26/17 at 1:45 PM revealed a physical therapist and Resident #1 were in his room when the resident fell putting on his pants. The physical therapist called a nurse into the room. When</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 3</p> <p>asked about pain, the resident did not complain of pain. When asked if he hit his head, the resident stated no. Resident #1 was assisted back to bed with no problems. The resident was also educated to ask for assistance when needed.</p> <p>A Resident Event Report Worksheet filled out by PTA#1 provided the basic information of time, date, and location of the fall, resident name, and notifications. The worksheet documented the attending physician/medical director was notified of the fall on 7/26/17 at 1:00 PM. The worksheet documented the resident fell on his left hip.</p> <p>Review of the MAR for Resident #1 revealed on 7/26/17 the resident's pain level was coded as a 9 on a scale of 1 to 10. Resident #1 received the pain medication Acetaminophen as prescribed on 7/26/17.</p> <p>The medical chart contained documentation of a physician verbal order on 7/26/17 for Resident #1 requesting a left hip x-ray due to a fall. Radiology report results dated 7/26/17 revealed Resident #1 did not have a left hip fracture or dislocation but did have mild osteoarthritis of the left hip.</p> <p>The 7/26/17 X-ray result for Resident #1 was dated as reviewed by the attending physician on 7/27/17.</p> <p>An additional nursing incident note dated 7/27/17 at 3:55 AM revealed the x-ray results were negative for a fracture or dislocation but mild osteoarthritis of left hip was noted. The resident as well as the MD (medical doctor) were notified of the results.</p> <p>There were no further nursing progress notes</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 4</p> <p>after 7/27/17 documenting assessment of the resident's condition after the fall.</p> <p>The physician's order book contained documentation of an order dated 8/3/17 which requested a left hip x-ray because of a fall a week ago. The order stated it was a repeat x-ray due to continued pain.</p> <p>A second radiology report dated 8/3/17 revealed the results as, "No dislocation or destructive bony process. Acute left hip intertrochanteric fracture. Conclusion: Acute left hip intertrochanteric fracture, unchanged." The 8/3/17 x-ray result for Resident #1 was dated as reviewed by the attending physician on 8/7/17.</p> <p>On 8/4/17 a nursing progress note written by Nurse #3 at 9:13 AM revealed, "Radiology result viewed by MD (medical doctor) no new orders at this time."</p> <p>Review of an 8/15/17 Physiatrist progress note for Resident #1 revealed in the assessment, "Left hip pain s/p (status post) fall at facility at side of bed, hip x-rays reported as negative per nursing and patient." The plan in the 8/15/17 progress note stated, "Nursing monitoring skin closely, cardiac, respiratory, bowels/bladder, pain. No x-ray reports in the chart, asked nursing to find and place in chart."</p> <p>Verbal orders were documented on 8/29/17 for another left hip x-ray due to the fall and an orthopedic consult as soon as possible due to continued left hip pain.</p> <p>A third radiology report dated 8/29/17 concluded, "No acute osseous abnormality. Degenerative</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 5</p> <p>changes. Stable proximal femoral fracture." The 8/29/17 x-ray result for Resident #1 was dated as reviewed by the attending physician on 9/13/17.</p> <p>Review of an 8/29/17 Physiatrist progress note revealed the Physiatrist was only aware of the x-ray results that were negative for a fracture.</p> <p>A hospital record review revealed Resident #1 was admitted to the hospital on 9/13/17 from an orthopedic appointment during which a left hip fracture was identified with imaging results obtained from the mobile imaging company. Resident #1 underwent surgical repair of his left hip fracture on 9/14/17. He was discharged back to the facility on 9/22/17 with slightly limited mobility and weakness in both legs.</p> <p>On 9/25/17 the facility Medical Director, who was also the attending physician, documented a readmission history and physical when Resident #1 returned to the facility from the hospital after a repair to his left hip fracture. The subjective portion of the note stated that Resident #1 returned to the facility after a repair for his left hip fracture due to a fall in the facility. The note stated that initially the x-ray results were negative for a fracture but since he was in persistent pain a referral was made to an orthopedic doctor. The note also revealed two x-ray results became available and showed a left hip fracture. Resident #1 was sent from the orthopedic physician's office to the hospital for surgery.</p> <p>Resident #1 was interviewed on 9/29/17 at 1:00 PM. Resident #1 revealed he was putting on his pants, lost his balance and fell in his room. He revealed a physical therapist was the only other person present in the room. He stated he had</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 6</p> <p>significant pain in his left hip for over a month.</p> <p>An interview was conducted on 9/29/17 at 2:35 PM with the physical therapy assistant (PTA #1) present at the time of the 7/26/17 fall of Resident #1. She revealed she had gone to the resident's room for a therapy session and was in the room when the resident lost his balance and fell. She confirmed he fell on his left side and she went to get assistance from the nurse. She said he did not appear to be in extreme pain.</p> <p>The facility Director of Nursing (DON) was interviewed on 9/29/17 at 3:45 PM. The DON revealed the facility had new ownership as of 9/1/17. Prior to the transition to new ownership the mobile imaging company the facility used, would upload the radiology results directly into the facility software for medical records as well as fax the results of radiology reports. The DON stated the mobile imaging company delayed sending the radiology reports for Resident #1. She stated the facility noticed the mobile imaging company was no longer interfacing with facility software for medical records.</p> <p>The facility Medical Director was interviewed on 9/29/17 at 4:20 PM. He stated, "We did not initially have the results from the x-rays for [Resident #1] but when he went to the orthopedic appointment he was able to take the x-rays with him. The facility was transitioning with a new owner and we were not able to see the x-rays on software. This was probably why it was not seen." The Medical Director stated that sometimes he saw the labs or x-rays before he was notified by nursing, sometimes nursing put documents to be signed in the physician's box, or sometimes he collaborated with the other physicians in the</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 7</p> <p>building regarding a patient's care and found out results.</p> <p>The facility Physiatrist was interviewed on 9/29/17 at 4:45 PM. She stated, "I never saw any of the x-rays that were ordered. I spent a significant amount of time after I found out he (Resident #1) had a fractured hip trying to figure out what happened. I called [the mobile x-ray company] and was unable to get an answer as why nobody called the facility with the abnormal result. The mobile x-ray company could not confirm the x-ray was faxed or that they communicated the results to the facility in any way. Luckily we were not pushing this guy to ambulate. He needed a significant amount of encouragement to participate in physical therapy prior to the fall and we knew he was in pain so we did not push him with physical therapy."</p> <p>Nurse #3, the unit manager, was interviewed on 10/6/17 at 11:45 AM. He stated, "On 8/4/17 [Medical Director] saw the x-ray for results that were negative for the fracture. He saw the results ordered on 7/27/17. He saw it, signed it, and I put it in the box to be filed. I saw the results for 7/27/17 but I was not aware of the physician's order for another x-ray on 8/3/17. I never notified the physician of the 8/3/17 results because I never saw them. Before the transition (to a new facility ownership on 9/1/17) [the mobile imaging company] would fax results but now they fax results and we can go to the website to view the results if we don't receive a fax."</p> <p>On 10/6/17 the facility Medical Director was interviewed at 12:35 PM. He stated, "I saw the x-ray results from 8/3/17 and I thought it was an</p>	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 8</p> <p>old fracture. The first x-ray was negative and when I saw the second x-ray it said "unchanged" so I thought it was an old fracture. I did not see the x-ray results from 8/29/17 until 9/13/17. I do not think a delay in receipt of the x-rays contributed to any harm to the resident. I think it is questionable whether or not he needed the surgery (on his left hip)."</p> <p>Nurse aide (NA #1), assigned to Resident #1 on the first shift on 7/26/17, and was interviewed at 7:18 PM on 10/6/17. NA #1 revealed Resident #1 never complained about pain before the fall but complained about hip pain daily after the fall.</p> <p>On 10/7/17 at 2:15 PM the facility Administrator provided the surveyor with fax confirmation sheets from the mobile imaging company confirming the x-ray results dated 7/26/17, 8/3/17, and 8/29/17 were all faxed to the facility on those days. The Administrator confirmed she did not know where the faxed results for Resident #1 went in the facility. She said she thought they were in medical records and she did not know why they did not get put in the chart.</p> <p>On 10/7/17 at 3:05 PM the facility Medical Director provided the surveyor with a case review note for Resident #1 dated 8/3/17. The note revealed another hip x-ray was taken due to continued complaints of pain from Resident #1. The note further revealed the physician thought the x-ray results from 8/3/17 were unchanged results of a chronic hip injury from a previous motor vehicle accident.</p> <p>The facility Medical Director was interviewed on 10/7/17 at 3:10 PM after receipt of the case review. He stated he signed a copy of the x-ray</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 9</p> <p>results on 8/3/17 and often signs multiple copies of the same x-ray result. He stated, "If I am here in the facility and nursing hands me a copy of x-ray results I will sign another copy of the same results. I looked at the x-ray results on 8/3/17 and I thought the fracture was an old fracture. It is faulty recollection on my part of his injuries. I thought it was a chronic fracture and that no surgical intervention would be necessary. I don't think his life would have been worse off without surgery. He is transferring better after the surgery. The x-ray I saw in the hospital was mildly displaced with some degree of calcification. It was slightly healed. I was surprised they (hospital physicians) recommended surgery." He stated he did not see the resident on 8/3/17 but did a case review on 8/3/17. He stated the date of service was not automatically populated when the note was written. He stated the date of service was information entered by the physician. The Medical Director confirmed the case review was in his personal computer and not in the facility record until 10/7/17.</p> <p>The Administrator was interviewed on 10/8/17 at 8:05 AM. She stated it was her expectation the physician be notified immediately by the nursing staff of any abnormal x-rays or labs based on the potential outcome of the results.</p> <p>The Radiologist who interpreted the results from the 8/3/17 x-ray was interviewed on 10/9/17 at 4:10 PM. He stated, "I said the results were unchanged because I was comparing the x-ray from 7/26/17 to the 8/3/17 x-ray. The 7/26/17 x-ray was not a good x-ray and was a very poor image. The 8/3/17 x-ray was a much better study so I could see the fracture much more clearly. I had the advantage of seeing the clearer image</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 10</p> <p>and could obviously see the fracture that was not seen on the 7/26/17 x-ray. I called it unchanged because the fracture was there on the 7/26/17 x-ray. The image was so poor I probably would have made the same mistake in saying there was no fracture on 7/26/17."</p> <p>On 10/6/17 at 9:38 AM the Director of Nursing was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 10/8/17. The credible allegation of compliance indicated:</p> <p>Credible Allegation of Compliance</p> <p>The following interventions have been effective - and will continue to be effective - to assure that, as of September 28, 2017, the Nursing Center has abated the immediate Jeopardy.</p> <p>What the problem is and why it happened:</p> <p>On 7/26/17 - Resident #1 had a witnessed fall while putting on his pants. Therapy was present in the room and was unable to single handedly stop the fall due to comparable size of resident to therapist. Resident #1 has a history of fractures and a diagnosis of osteoarthritis. Resident #1 was evaluated upon fall and assessed for pain. A post fall evaluation was completed by a nurse. Resident #1 was assisted back to bed from the floor after an assessment with no problems. X-ray results were obtained on date of fall which reflected negative for fracture. Because of ongoing complaints of pain, an additional x-ray was obtained 8/3/17. Per MD progress notes review on 8/3/17, MD stated this was a previous fracture. On 8/29/17 an additional x-ray was ordered due to continued pain after the fall on</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 11</p> <p>7/26/17. Resident #1 had a history of pain, prior to fall with medications per MD orders. Orthopedic appointment was arranged with earliest date available. An x-ray report for 8/29/17 x-ray was not available via the usual system of viewing or faxed to facility. Orthopedic consult was ordered after the fall and left hip pain and an appointment was made at the next available appointment time. Resident #1 was directed to the hospital after the orthopedic appointment. Resident #1 was admitted to hospital related to uncomplicated left hip fracture with uncomplicated open reduction and internal fixation left hip fracture.</p> <p>For the resident affected:</p> <p>All x-ray results for Resident #1 was verified and placed in chart 9/13/17. MD signature on the 8/3/17 x-ray was dated 8/7/17. MD signature of the 8/29/17 was dated 9/13/17.</p> <p>Based on a verbal statement from the attending Physician, Resident #1 quality of life was not compromised. The fracture is in process of healing.</p> <p>Plan to identify other residents who are at risk for the deficient practice:</p> <p>All x-ray reports have been reviewed on 9/14/17, including dates 9/4/17 and ongoing with no further fractures.</p> <p>Action taken to fix the problem:</p>	F 157			

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

PRINTED: 11/21/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 12</p> <p>Upon notification from Orthopedic Physician that Resident #1 was being sent to hospital secondary to left hip fracture, Executive Director and Director of Nursing immediately initiated a performance improvement plan</p> <p>In-services were initiated 9/19/17 with licensed nurses and nursing assistants staff on documentation of incidents. In-services also include MD notification. Based on the effectiveness of the performance improvement plan as outlined below the Nursing Center is alleging compliance as of September 28, 2017.</p> <p>On 9/13/2017 a designated bin was placed next to the fax machine for all faxed x-ray reports to be placed and the Unit Managers check the bin hourly. The unit managers will notify physician of abnormal x-rays results or designate the charge nurse to call the MD. The x-rays with the no abnormality x-rays are put in the MD communication book for review by the MD. Unit Managers check documentation to ensure physician were notified and follow up is provided timely on 9/13/17 regarding process of review of radiology reports. The process is to bring MD communications books and MD order log and progress notes to clinical morning meeting to make sure that the x-rays results are received and the MD was notified of the results.</p> <p>X-ray reports will be obtained during the clinical morning meeting via the Mobilex website. Unit Managers will be responsible for getting x-rays</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 13 and appropriate follow up for MD signature. Mobilex will continue to fax results (will validate if duplicate). X-ray company directed to call facility for abnormalities. X-ray results called to facility and will be reported to assigned charge Nurse and MD. The assigned charge nurse will notify the MD of any abnormal results. X-ray results will be placed in MD communication for signature upon visit. If positive for fractures, X-ray reports will be called to facility.</p> <p>The daily x-ray monitoring tool to be reviewed during clinical rounds. The tool describes x-ray ordered, date of x-ray, finding, MD notification and if any initiation of treatment. The facility is directly obtaining x-ray results from Mobilex website. Nursing staff and Physicians have access for viewing of x-rays. Daily monitoring and direct access to Mobilex will ensure timely follow-up if x-ray result not obtained.</p> <p>Assessing a resident after fall for injuries to include documented Post Fall Evaluation. This includes ROM, pain monitoring, neuro-checks for unwitnessed fall or resident to have noted to hit head per protocol and a skin check. This will also involve MD and RP notification of fall.</p> <p>Licensed Nurses in-serviced by Director of Nursing focusing on Documentation expectations, process regarding follow up on X-ray orders was completed on 9/19/2017. The process for following up on orders is the following: Orders are reviewed daily during clinical meeting; nurses will notify MD of abnormal results; documentation is to include when an x-ray is obtained and when</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 14</p> <p>results are received; and notification of MD and RP with abnormal results.</p> <p>In-services were conducted on 9/19/17 by the Director of Nursing with Licensed Nurses, C.N.As. regarding accident/injury reporting to MD and required assessments, including pain. Post fall evaluations are reviewed daily during clinical rounds for ongoing education and compliance to expectations. Residents are assessed by means of ROM, resident questioning, pain assessment and skin checks. MD is notified of pain. Radiology and follow up per MD orders.</p> <p>The Executive Director held a meeting on 9/15/17 with the facility Physicians to discuss documentation expectations and process. All Physicians are to have progress notes to the facility within 48 hours of Physician visit. Physician log (List of residents seen) is reviewed daily during clinical rounds and supporting notes are audited. Immediate notification of MD to be made by Executive Director if supporting documentation was not signed and received within 48 hours. Documentation is faxed and emailed to the facility and once received, validated against the physician visit date log. Documentation once reviewed is provided to Medical records for filing. We were in compliance 9/28/17.</p> <p>Director of Nursing and Executive Director reviewed 9/13/2017 all Physician orders for x-rays, and compared orders to all x-ray results received for every resident within the last 30 days, there was no issues identified. MD</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 15</p> <p>signature to verify results reviewed. It is an ongoing working document.</p> <p>Subsequent review of all x-ray results from 1/2017 to present was conducted 9/13/17 with no positive results and no other residents had been affected.</p> <p>Director of Nursing uses Fast Log to capture all pending x-ray results, and monitoring resident conditions using Physician orders, which is updated during Clinical Morning meeting Monday thru Friday. Licensed Nurses review all pending Physician orders to assure results obtained daily and on the weekend x-ray results are obtained and reported to MD if positive results. All other x-ray reports are filed in MD communication book.</p> <p>The Executive Director and Director of Nursing held a meeting with Mobilex on 9/28/2017 to discuss x-ray result process to assure that all x-ray results are reported timely to the facility and entered in progress note in PCC Point Click Care) properly. MD and facility staff to have access for reports. The meeting including discussions on accessing x-ray reports via Mobilex website. Mobilex will notify the facility via phone of abnormal results. Once order is obtained for an x-ray from the physician, nursing will call Mobilex, place the order for x-ray, and obtain a claim number. Mobilex will arrive in the facility to obtain the image. Mobilex will fax results of x-rays to the facility. Nurses and MD will view x-rays via the Mobilex website. Mobilex notifies the facility of abnormal positive results. The facility notifies MD</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 157	<p>Continued From page 16 of the results and MD provides order for follow up.</p> <p>MD communication log to be audited daily Monday thru Friday by Unit Managers during clinical rounds. Review of weekend will occur on Monday. Documentation discussed and reviewed daily to identify MD notification of results, incidents, pain and evaluation of incidents. In-services ongoing and as needed with any future issues identified. Any negative findings will be reported monthly during PI meeting for review recommendations.</p> <p>Conclusion: Based on interview the MD was notified of accident, notified of x-ray results on 7/26 and 8/3/17 with no new orders. Systemic monitoring in place regarding x-ray notification and follow up. No other positive x-rays with fractures identified after audit. Process initiated with Mobilex prior to initial complaint survey on 9/29/17 for improvement of x-ray monitoring process. Meetings with Physicians initiated prior to complaint survey on 9/29/17.</p> <p>On 10/8/17 at 10:15 AM, the corrective action was validated. The validation included review of the MD communication log, the physician order log and fast log. Evidence of the in-servicing was also reviewed. Interviews with staff revealed the staff were aware of the facility corrective action plan and knew what they are supposed to do when there is an x-ray done to make sure the residents receive the services they need.</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309 F 309 SS=J	Continued From page 17 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309 F 309		10/25/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interviews with the medical director, psychiatrist, staff and resident interviews the facility failed to fully assess, obtain x-ray results, follow through with physician requests and coordinate care for a resident after a fall with a fracture for 1 (Resident #1) of 6 sampled residents reviewed for falls. Resident # 1 was hospitalized and underwent surgical repair of his left hip fracture on 9/14/17. Postoperatively, the resident suffered from anemia due to blood loss. Findings included:</p> <p>Resident #1 was initially admitted to the facility on 8/17/15 for rehabilitation services with cumulative diagnoses which included arthritis, chronic pain syndrome, and multiple vertebral transverse process fractures.</p> <p>The most recent annual minimum data set assessment dated 7/31/17 coded Resident #1 as cognitively intact, requiring limited assistance with transfers, and extensive assistance with dressing. The resident was coded as having no falls since admission or the previous assessment and had been receiving physical therapy since 11/17/2016.</p> <p>The care plan for Resident #1 had a focus area initiated on 8/17/15 and revised on 9/29/17 which stated, "[Resident #1] has acute/chronic pain r/t (relative to) chronic pain physical disabilities r/t (relative to) hx (history) of spinal multiple fractures, rheumatoid arthritis & recent LT (left) hip fracture." Interventions for this portion of the care plan included; "Administer medications as ordered. See medication record. Monitor for effectiveness and side effects; Administer narcotics as per orders, Give ½ hour before</p>	F 309	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 19</p> <p>treatments or care; apply assistive braces and splints as ordered & maintain as tolerated by resident; assist w/ (with) toileting & incontinence changes routinely & prn (as needed) per shift; encourage [Resident #1] to report early signs of pain; encourage resident to call for assistance when in pain, ask for medication, tell you how much pain is experienced and what increases or alleviates pain; keep bed linen clean, dry and wrinkle free per shift; keep room quiet & calm promoting rest and comfort; record pain utilizing the 1-10 Pain level before pain med (medication) admin (administration) & after. Goal is a pain level of 3 or < after pain admin."</p> <p>Review of the physician orders for July 2017 revealed Resident #1 was prescribed the following pain medications: Acetaminophen tablet 975 milligrams (mg) by mouth every 8 hours as needed (prn) for pain; Percocet Tablet 2.5-325 mg 1 tablet by mouth every 8 hours as needed for uncontrollable hand, wrist, and lower back pain; and Voltaren Gel 1 % 2 grams transdermally two times a day for arthritis pain to left hand and fingers then two times as needed for pain.</p> <p>Review of the Medication Administration Record (MAR) for Resident #1 from July 1 through 25, 2017 revealed the resident received Acetaminophen tablet 975 mg as ordered one time in July on 7/10/17. Resident #1 was documented on the MAR as receiving Percocet as prescribed from July 1 through 25, 2017 thirty five times. Resident #1 was not documented on the MAR as receiving Voltaren Gel 1% from July 1 through 25, 2017.</p> <p>A nursing incident note, written by Nurse #2, dated 7/26/17 at 1:45 PM revealed, "Called to</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 20</p> <p>room by PT (physical therapy) staff stating that resident was trying to pull up his pants when he slid to the floor. Resident noted on the floor in the seated position." The note indicated the resident was dry (did not need incontinence care) and he was returned back to the wheelchair with his legs sticking out at the wheelchair. When asked about pain, the resident did not complain of pain. When asked if he hit his head, the resident stated no. Resident #1 was assisted back to bed with no problems. The resident was also educated to ask for assistance when needed.</p> <p>Nurse #2 was interviewed on 9/29/17 at 6:01 PM. She stated she did not recall the fall of Resident #1 on 7/26/17. She stated, "I know me and if I documented it then that is the way it happened." Nurse #2 was interviewed again on 10/6/17 at 11:30 AM and did not recall any more details of what happened when Resident #1 fell. Nurse #2 did not recall if she assessed resident prior to moving him or not.</p> <p>Nurse aide (NA #1), who worked on the first shift and was assigned to care for Resident #1 on 7/26/17, was interviewed at 7:18 PM on 10/6/17. NA #1 stated, "He never complained about pain before the fall. I saw him every day. The only thing I had to do was make sure he had safe transfers. After he fell he complained about hip pain every day to me. I had to go and get the nurse to give him pain medication. It was pain in his left hip and the left hip was swollen. I worked at the facility and I had the same assignment until the end of August (2017)."</p> <p>The medical chart contained documentation of a physician verbal order on 7/26/17 for Resident #1 requesting a left hip x-ray due to a fall. A</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 21</p> <p>radiology report results dated 7/26/17 revealed Resident #1 did not have a left hip fracture or dislocation but did have mild osteoarthritis of the left hip.</p> <p>Review of the MAR for Resident #1 revealed on 7/26/17 the resident's pain level was coded as a 9 on a scale of 1 to 10. Resident #1 received the pain medication Acetaminophen as prescribed on 7/26/17.</p> <p>An additional nursing incident note dated 7/27/17 at 3:55 AM revealed, Resident #1 complained of left hip pain during this shift. Prn (as needed) oxycodone was given and effective. The x-ray results revealed no fracture or dislocation with mild osteoarthritis of left hip noted. The resident as well as the MD (medical doctor) were notified of the results. The resident was resting quietly in bed with eyes closed at that time. The resident voiced no concerns.</p> <p>On 7/27/17 a pain evaluation was completed for Resident #1. The pain assessment revealed the resident verbalized significant pain in his left hip in relation to a fall.</p> <p>There were no further nursing progress notes after 7/27/17 documenting assessment of the resident's condition after the fall.</p> <p>Resident #1 was interviewed on 9/29/17 at 1:00 PM. Resident #1 revealed, "It was one of those lazy days when I didn't feel like therapy. The therapist came to give me therapy. I was sitting on the side of the bed and was pulling my shorts up. I was ready to stand up and pull them up and I got off balance. I fell on my left side on my hip. I</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 22</p> <p>tried to get up but I needed help. My hip was hurting me so I couldn't do it by myself. The therapist tried to help me but she couldn't do it by herself so she got four or five more people to help me. They moved me from the floor to the wheel chair to the bed. I was in a lot of pain. It was pain like I never felt before. I couldn't lift my leg or do anything else. By the second or third day they got an x-ray. The x-ray was negative. I continued with rehab but I couldn't do anything. I couldn't transfer from the bed to the chair or stand and pivot anymore. I had a week of therapy and the pain was intense. The doctor said to get an x-ray again because swelling had gone down a little. That x-ray was negative too. It was three or four weeks and I was still in pain. I was still doing therapy and working through the pain. Gradually I was able to stand again but I couldn't put any weight on that left leg. The doctor said the hip should have gotten better by then. I got a third x-ray in the facility and it was negative again. After another week or two I got an appointment with an orthopedic doctor. After three sets of x-rays were done the orthopedic doctor said I had a broken hip. I was sent to the emergency room to have it fixed that day. Ever since the operation the pain has not been that bad. I was in pain for several weeks but the therapists were just doing their job."</p> <p>An interview was conducted on 9/29/17 at 2:35 PM with the physical therapy assistant (PTA #1) present at the time of the 7/26/17 fall of Resident #1. She revealed, "I went by the room of [Resident #1] because it was time for his therapy session. He was in the process of getting dressed. [Resident #1] was able to get dressed by himself so I went around the edge of the curtain to provide him with privacy. I heard him</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 23</p> <p>starting to fall so I rushed around the curtain and tried to lower him to the ground. He landed on his backside on his left side. It took three or four of us to get him up in a wheel chair and then to the bed. He did not appear in extreme pain."</p> <p>Review of the MAR for Resident #1 revealed he received prn Acetaminophen as prescribed on 7/27/17, 7/30/17, 7/31/17 and 8/1/17.</p> <p>On 7/27/17 a physician's order was written for Resident #1 for Voltaren Gel 1% 4 grams transdermally every 6 hours for pain to be applied to the left hip. In July 2017 Voltaren Gel 1% was administered as ordered to his left hip once on 7/27/17, twice on 7/28/17, three times on 7/29/17, once on 7/30/17, once on 7/31/17, twice on 8/1/17, twice on 8/2/17, and four times on 8/3/17.</p> <p>On 8/1/17 a verbal order was written for Percocet tablet 2.5- 325 mg 1 tablet by mouth one time only for pain for 1 day. This order was discontinued on 8/2/17. On 8/1/17 an additional verbal order was written for Percocet 5-325 mg 1 tablet by mouth every 6 hours as needed for left hip pain. This order was discontinued on 8/1/17. On 8/1/17 a verbal order was written for Percocet 5-325 mg 1 tablet by mouth every 6 hours for uncontrollable hand, wrist and lower back pain.</p> <p>The August 2017 MAR for Resident #1 revealed he received Percocet tablet 2.5-325 mg 1 tablet one time on 8/1/17. The MAR documented Resident #1 received Percocet tablet 5-325 mg 1 tablet by mouth every 6 hours as needed for uncontrollable hand, wrist, and lower back pain three times on 8/2/17 and three times on 8/3/17.</p> <p>The physician's order book contained</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 24</p> <p>documentation of an order dated 8/3/17 which stated, "1. [Left] hip x-ray 2 view - pain s/p (status post) fall 1 week [Left] pelvis - repeat from last week - continued pain." A second radiology report dated 8/3/17 revealed the results as, "No dislocation or destructive bony process. Acute left hip intertrochanteric fracture. Conclusion: Acute left hip intertrochanteric fracture, unchanged."</p> <p>On 8/4/17 a nursing progress note written by Nurse #3 at 9:13 AM revealed, "Radiology result viewed by MD (medical doctor) no new orders at this time."</p> <p>Nurse #3, the unit manager, was interviewed on 10/6/17 at 11:45 AM. He stated, "On 8/4/17 [Medical Director] saw the x-ray for results that were negative for the fracture. He saw the results ordered on 7/27/17. He saw it, signed it, and I put it in the box to be filed. I saw the results for 7/27/17 but I was not aware of the physician's order for another x-ray on 8/3/17. I never notified the physician of the 8/3/17 results because I never saw them. Before the transition [the mobile imaging company] would fax results but now they fax results and we can go to the website to view the results if we don't receive a fax."</p> <p>Verbal orders were documented on 8/29/17 for another left hip x-ray due to the fall and an orthopedic consult as soon as possible due to continued left hip pain. A third radiology report dated 8/29/17 concluded, "No acute osseous abnormality. Degenerative changes. Stable proximal femoral fracture." The x-ray report received from the facility during the survey on 9/29/17 at 3:45 PM was not signed by a physician.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 25</p> <p>Review of the resident's MAR from August 4, 2017 to September 13, 2017 revealed Resident #1 received Percocet tablet 5-325 mg every 6 hours as needed twenty two times from 8/4/17 to 8/15/17. Resident #1 received Percocet tablet 5-325 mg every 8 hours as needed 33 times from 8/16/17 to 9/12/17. Voltaren Gel 1% was administered as ordered to his left hip four times of 8/4/17, four times on 8/5/17, three times on 8/6/17, four times on 8/7/17, three times on 8/8/17, three times on 8/9/17, three times on 8/10/17, four times on 8/11/17, four times on 8/12/17, four times on 8/13/17, four times on 8/14/17, two times on 8/15/17, four times on 8/16/17, one time on 8/17/17, two times on 8/18/17, four times on 8/19/17, four times on 8/20/17, three times on 8/21/17, five times on 8/22/17, and two times on 8/23/17.</p> <p>The facility's Physiatrist documented progress notes for Resident #1 on 7/25/17, 8/15/17, and 8/29/17.</p> <p>On 7/25/17 Physiatrist documented in the planning section of the note Resident #1 was, "Making excellent progress with gait," and "with recent progress, now goal is to return home."</p> <p>On 8/15/17 the Physiatrist progress note for Resident #1 stated in the assessment, "Left hip pain s/p (status post) fall at facility at side of bed, hip x-rays reported as negative per nursing and patient." The plan in the 8/15/17 progress note stated, "Nursing monitoring skin closely, cardiac, respiratory, bowels/bladder, pain. No x-ray reports in the chart, asked nursing to find and place in chart."</p> <p>The plan in the 8/29/17 Physiatrist progress note</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 26</p> <p>stated, "In light of reported negative x-rays, have encouraged him oob (out of bed) as much as possible. He voices understanding and is in agreement. He is anxious to get back to walking."</p> <p>Nurse #1 who was working on 8/15/17 for the day shift when the physiatrist was working was interviewed on 9/29/17 at 5:30 PM. She did not recall getting the directive from the physiatrist to find the x-ray reports that were ordered on 7/26/17 and 8/3/17.</p> <p>Review of Physical therapy treatment notes revealed Resident #1 began to receive physical therapy on 11/17/16 and continued with physical therapy five times weekly after his fall on 7/26/17.</p> <p>Physical therapy (PT) notes documented Resident #1 was in pain and had decreased functional ability after his fall on 7/26/17.</p> <p>PT daily treatment notes dated 7/27/17 revealed, "Attempted to roll (turn) patient into R (right) side lying in preparation for pain relief techniques however pt (patient) reporting increased pain and unable to roll (turn) at this time."</p> <p>PT notes dated 7/31/17 revealed, "Patient in bed complaining of high pain level in left hip since fall last week."</p> <p>PT notes dated 8/10/17 revealed, "Pt (patient) received in bed, continues to report increased pain and swelling in L hip and thigh and reports pain with any movements of LLE (left lower extremities)."</p> <p>On 8/14/17 PT notes documented, "Patient in bed in supine and admitting to decreased pain in left</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 27</p> <p>hip/thigh region yesterday and last night allowing him to sleep all night for the first time since the fall. Patient stated that rolling for hygiene today was painful however."</p> <p>On 8/31/17 PT notes revealed, "PTA (physical therapy assistant) and patient conferred with [Physician Name] regarding patient presentation and [Physician Name] states he will write order for an orthopedic consult."</p> <p>On 9/1/17 the PT notes revealed, "Pt stood [approximately] 2' (minutes) each trial and req (requested) rest breaks to relieve fatigue and hip pain."</p> <p>A hospital record review revealed Resident #1 was admitted to the hospital on 9/13/17 from an orthopedic appointment during which a left hip fracture was identified with imaging results obtained from the mobile imaging company. Resident #1 underwent surgical repair of his left hip fracture on 9/14/17. Post operatively he suffered from anemia due to blood loss. He was discharged back to the facility on 9/22/17 with slightly limited mobility and weakness in both legs.</p> <p>On 9/25/17 the facility medical director documented a readmission history and physical when Resident #1 returned to the facility from the hospital after a repair to his left hip fracture. The subjective portion of the note stated in part, "[Resident #1] returns to the facility [after a stay] at [hospital] 9/13-9/22/17 for ORIF (open reduction and internal fixation) L (left) hip fx (fracture) [secondary] to fall. He had initial neg (negative) hip x-ray after the fall but because of persistent pain he was ordered repeat x-ray and</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 28</p> <p>referred to ortho (orthopedic). While waiting his ortho appointment two x-ray reports showing well positioned subacute L introchanteric fx became available. From his ortho appointment he was sent for surgery. His post-op course was characterized by blood loss anemia requiring 1 unit PRBC (packed red blood cells) and hyperkalemia. He remains dependent for transfer, hygiene care and toileting [secondary] to spinal cord injury with impaired mobility and is being re-admitted for skilled nursing, PT/OT (physical therapy and occupational therapy) and wound care."</p> <p>The facility Administrator and Director of Nursing were interviewed on 9/29/17 at 3:45 PM. The Director of Nursing stated that mobile imaging company they used was found to be delaying in sending the radiology reports. She said previously, before the transition in ownership of the facility on 9/1/17, the mobile imaging company would upload the radiology results directly into the computerized medical record system, Point Click Care. Once the x-rays were in Point Click Care both nursing and the physician's would have had access to the radiology reports. She stated the facility noticed the mobile imaging company was no longer interfacing with Point Click Care. She further stated that now the facility can run a list of the imaging reports that have been ordered, discuss the reports in stand up meeting each morning, and make sure the results are available to be addressed as needed.</p> <p>The facility Medical Director was interviewed on 9/29/17 at 4:20 PM. He stated, "We did not initially have the results from the x-rays for [Resident #1] but when he went to the orthopedic appointment he was able to take the x-rays with</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 29</p> <p>him. The facility was transitioning with a new owner and we were not able to see the x-rays on Point Click Care. This was probably why it was not seen." The Medical Director stated that sometimes he saw the labs or x-rays before he was notified by nursing, sometimes nursing put documents to be signed in the physician's box, or sometimes he collaborated with the other physicians in the building regarding a patient's care and found out results.</p> <p>The facility Physiatrist was interviewed on 9/29/17 at 4:45 PM. She stated, "I never saw any of the x-rays that were ordered. I spent a significant amount of time after I found out he (Resident #1) had a fractured hip trying to figure out what happened. I called [the mobile x-ray company] and was unable to get an answer as why nobody called the facility with the abnormal result. The mobile x-ray company could not confirm the x-ray was faxed or that they communicated the results to the facility in any way. Luckily we were not pushing this guy to ambulate. He needed a significant amount of encouragement to participate in physical therapy prior to the fall and we knew he was in pain so we did not push him with physical therapy."</p> <p>The Director of Nursing (DON) was interviewed on 9/29/17 at 5:35 PM. She stated her expectation was for the staff to assess for pain and check for injury after a fall for at least 72 hours. The DON acknowledged she could not find the nursing assessment and monitoring in the notes for Resident #1 after the fall for the full 72 hours. She stated they may have done it but did not document it.</p> <p>On 10/6/17 at 11:00 AM the DON provided the</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 30</p> <p>surveyor with the signed and dated copies of the x-ray results the facility Medical Director had reviewed. The 7/26/17 X-ray result for Resident #1 was dated as reviewed by the physician on 7/27/17. The 8/3/17 x-ray result for Resident #1 was dated as reviewed by the physician on 8/7/17. The 8/29/17 x-ray result for Resident #1 was dated as reviewed by the physician on 9/13/17.</p> <p>On 10/6/17 the facility Medical Director was interviewed at 12:35 PM. He stated, "I saw the x-ray results from 8/3/17 and I thought it was an old fracture. The first x-ray was negative and when I saw the second x-ray it said "unchanged" so I thought it was an old fracture. I did not see the x-ray results from 8/29/17 until 9/13/17. I do not think a delay in receipt of the x-rays contributed to any harm to the resident. I think it is questionable whether or not he needed the surgery (on his left hip)."</p> <p>On 10/7/17 at 2:15 PM the facility Administrator provided the surveyor with fax confirmation sheets from the mobile imaging company confirming the x-ray results dated 7/26/17, 8/3/17, and 8/29/17 were all faxed to the facility on those days. The Administrator confirmed she did not know where the faxed results for Resident #1 went in the facility. She said she thought they were in medical records and she did not know why they did not get put in the chart.</p> <p>On 10/7/17 at 2:19 PM a representative, from the mobile imaging company contracted with the facility, was interviewed. He stated the mobile x-ray company confirmed the results of all three x-rays of the left hip of Resident #1 dated 7/26/17, 8/3/17, and 8/29/17 were faxed to the</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 31 facility on the same day the results were finalized.</p> <p>On 10/7/17 at 3:05 PM the facility Medical Director provided the surveyor with a case review note for Resident #1 dated 8/3/17. The note stated, " F/U (follow up) abnormal hip x-ray 62 - YO (year old) M (male) resident had rept (repeat) hip Xray done today due to contd (continued) L (left) hip pain. Report read as unchanged L (left) hip Fx (fracture) compared to 7/26/17. Will cont (continue) current analgesic regimen with PT/OT pain mgmt. modalities as this is likely chronic from previous motor vehicle injuries."</p> <p>The Medical Director was interviewed on 10/7/17 at 3:10 PM, after receipt of the case review. He stated he signed a copy of the x-ray results on 8/3/17 and often signs multiple copies of the same x-ray result. He stated, "If I am here in the facility and nursing hands me a copy of x-ray results I will sign another copy of the same results. I looked at the x-ray results on 8/3/17 and I thought the fracture was an old fracture. It is faulty recollection on my part of his injuries. I thought it was a chronic fracture and that no surgical intervention would be necessary. I don't think his life would have been worse off without surgery. He is transferring better after the surgery. The x-ray I saw in the hospital was mildly displaced with some degree of calcification. It was slightly healed. I was surprised they (hospital physicians) recommended surgery." The Medical Director stated the case review was printed on 10/7/17. He stated he did not see the resident on 8/3/17 but did a case review on 8/3/17. He stated the date of service was not automatically populated when the note was written. He stated the date of service was information entered by the physician.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	Continued From page 32 The radiologist who interpreted the results from the 8/3/17 x-ray was interviewed on 10/9/17 at 4:10 PM. He stated, "I said the results were unchanged because I was comparing the x-ray from 7/26/17 to the 8/3/17 x-ray. The 7/26/17 x-ray was not a good x-ray and was a very poor image. The 8/3/17 x-ray was a much better study so I could see the fracture much more clearly. I had the advantage of seeing the clearer image and could obviously see the fracture that was not seen on the 7/26/17 x-ray. I called it unchanged because the fracture was there on the 7/26/17 x-ray. The image was so poor I probably would have made the same mistake in saying there was no fracture on 7/26/17." The facility Administrator provided a facility performance action plan dated as initiated on 9/13/17. The actions/interventions taken were: radiology reports to continue to be obtained per physician order, physician to review upon receipt; daily discussion of radiology reports due during clinical rounds; interdisciplinary team discussion to ensure we capture all clinical changes; discuss additional options for ability to review radiology reports/obtain full access; review radiology reports daily during clinical rounds/full discussion to obtain additional updates/diagnosis as needed; and results of radiology to be discussed during monthly quality assurance/quality management meeting; Ad hoc meetings as needed if issues are ongoing. The corrective action plan read as follows: What the problem was and why it happened: On 7/26/17 - Resident #1 had a witnessed fall while putting on his pants. Therapy was present in the room and was unable to single handedly	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 33</p> <p>stop the fall due to comparable size of resident to therapist. Resident #1 has a history of fractures and a diagnosis of osteoarthritis. Resident #1 was evaluated upon fall and assessed for pain. A post fall evaluation was completed by a nurse.</p> <p>Resident #1 was assisted back to bed from the floor after an assessment with no problems. X-ray results were obtained on date of fall which reflected negative for fracture. Because of ongoing complaints of pain, an additional x-ray was obtained 8/3/17. Per MD progress notes review on 8/3/17, MD stated this was a previous fracture. On 8/29/17 an additional x-ray was ordered due to continued pain after the fall on 7/26/17. Resident #1 had a history of pain, prior to fall with medications per MD orders.</p> <p>Orthopedic appointment was arranged with earliest date available. An x-ray report for 8/29/17 x-ray was not available via the usual system of viewing or faxed to facility. Orthopedic consult was ordered after the fall and left hip pain and an appointment was made at the next available appointment time. Resident #1 was directed to the hospital after the orthopedic appointment. Resident #1 was admitted to hospital related to uncomplicated left hip fracture with uncomplicated open reduction and internal fixation left hip fracture.</p> <p>For the resident affected:</p> <p>All x-ray results for Resident #1 was verified and placed in chart 9/13/17. MD signature on the 8/3/17 x-ray was dated 8/7/17. MD signature of the 8/29/17 was dated 9/13/17.</p> <p>Based on a verbal statement from the attending</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 34</p> <p>Physician, Resident #1 quality of life was not compromised. The fracture is in process of healing.</p> <p>Plan to identify other residents who are at risk for the deficient practice:</p> <p>All x-ray reports have been reviewed on 9/14/17, including dates 9/4/17 and ongoing with no further fractures.</p> <p>Action taken to fix the problem:</p> <p>Upon notification from Orthopedic Physician that Resident #1 was being sent to hospital secondary to left hip fracture, Executive Director and Director of Nursing immediately initiated a performance improvement plan</p> <p>In-services were initiated 9/19/17 with licensed nurses and nursing assistants staff on documentation of incidents. In-services also include MD notification. Based on the effectiveness of the performance improvement plan as outlined below the Nursing Center is alleging compliance as of September 28, 2017.</p> <p>On 9/13/2017 a designated bin was placed next to the fax machine for all faxed x-ray reports to be placed and the Unit Managers check the bin hourly. The unit managers will notify physician of abnormal x-rays results or designate the charge nurse to call the MD. The x-rays with the no abnormality x-rays are put in the MD</p>	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 35</p> <p>communication book for review by the MD. Unit Managers check documentation to ensure physician were notified and follow up is provided timely on 9/13/17 regarding process of review of radiology reports. The process is to bring MD communications books and MD order log and progress notes to clinical morning meeting to make sure that the x-rays results are received and the MD was notified of the results.</p> <p>X-ray reports will be obtained during the clinical morning meeting via the (The company that did the x-rays) website. Unit Managers will be responsible for getting x-rays and appropriate follow up for MD signature. (The company that did the x-rays) will continue to fax results (will validate if duplicate). X-ray company directed to call facility for abnormalities. X-ray results called to facility and will be reported to assigned charge Nurse and MD. The assigned charge nurse will notify the MD of any abnormal results. X-ray results will be placed in MD communication for signature upon visit. If positive for fractures, X-ray reports will be called to facility.</p> <p>The daily x-ray monitoring tool to be reviewed during clinical rounds. The tool described x-ray ordered, date of x-ray, finding, MD notification and if any initiation of treatment. The facility is directly obtaining x-ray results from (The company that did the x-rays) website. Nursing staff and Physicians have access for viewing of x-rays. Daily monitoring and direct access to (The company that did the x-rays) will ensure timely follow-up if x-ray result not obtained.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 36</p> <p>Assessing a resident after fall for injuries to include documented Post Fall Evaluation. This includes ROM (range of motion), pain monitoring, neuro-checks for unwitnessed fall or resident to have noted to hit head per protocol and a skin check. This will also involve MD and RP notification of fall.</p> <p>Licensed Nurses in-serviced by Director of Nursing focusing on Documentation expectations, process regarding follow up on X-ray orders was completed on 9/19/2017. The process for following up on orders is the following: Orders are reviewed daily during clinical meeting; nurses will notify MD of abnormal results; documentation is to include when an x-ray is obtained and when results are received; and notification of MD and RP with abnormal results.</p> <p>In-services were conducted on 9/19/17 by the Director of Nursing with Licensed Nurses, C.N.As (nursing assistants) regarding accident/injury reporting to MD and required assessments, including pain. Post fall evaluations are reviewed daily during clinical rounds for ongoing education and compliance to expectations. Residents are assessed by means of ROM, resident questioning, pain assessment and skin checks. MD is notified of pain. Radiology and follow up per MD orders.</p> <p>The Executive Director held a meeting on 9/15/17 with the facility Physicians to discuss documentation expectations and process. All Physicians are to have progress notes to the facility within 48 hours of Physician visit.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	<p>Continued From page 37</p> <p>Physician log (List of residents seen) is reviewed daily during clinical rounds and supporting notes are audited. Immediate notification of MD to be made by Executive Director if supporting documentation was not signed and received within 48 hours. Documentation is faxed and emailed to the facility and once received, validated against the physician visit date log. Documentation once reviewed is provided to Medical records for filing. We were in compliance 9/28/17.</p> <p>Director of Nursing and Executive Director reviewed all Physician orders for x-rays on 9/13/17, and compared orders to all x-ray results received for every resident within the last 30 days, there was no issues identified. MD signature to verify results reviewed. It is an ongoing working document.</p> <p>Subsequent review of all x-ray results from 1/2017 to present was conducted on 9/13/17 with no positive results and no other residents had been affected.</p> <p>Director of Nursing uses Fast Log to capture all pending x-ray results, and monitoring resident conditions using Physician orders, which is updated during Clinical Morning meeting Monday thru Friday. Licensed Nurses review all pending Physician orders to assure results obtained daily and on the weekend x-ray results are obtained and reported to MD if positive results. All other x-ray reports are filed in MD communication book.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	Continued From page 38 The Executive Director and Director of Nursing held a meeting with a representative of (the company that did the x-rays) on 9/28/2017 to discuss x-ray result process to assure that all x-ray results are reported timely to the facility and entered in progress note in PCC Point Click Care) properly. MD and facility staff to have access for reports. The meeting including discussions on accessing x-ray reports via (the company that did the x-rays) website. (The company that did the x-rays) will notify the facility via phone of abnormal results. Once order is obtained for an x-ray from the physician, nursing will call (the company that did the x-rays), place the order for x-ray, and obtain a claim number. (The company that did the x-rays) will arrive in the facility to obtain the image. (The company that did the x-rays) will fax results of x-rays to the facility. Nurses and MD will view x-rays via the (the company that did the x-rays) website. (The company that did the x-rays) notifies the facility of abnormal positive results. The facility notifies MD of the results and MD provides order for follow up. MD communication log to be audited daily Monday thru Friday by Unit Managers during clinical rounds. Review of weekend will occur on Monday. Documentation discussed and reviewed daily to identify MD notification of results, incidents, pain and evaluation of incidents. In-services ongoing and as needed with any future issues identified. Any negative findings will be reported monthly during PI meeting for review recommendations.	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 309	Continued From page 39	F 309			
F 386 SS=E	<p>On 10/8/17 at 10:15 AM, the corrective action was validated. The validation included review of the MD communication log, the physician order log and fast log. Evidence of the in-servicing was also reviewed. Interviews with staff revealed the staff were aware of the facility corrective action plan and knew what they are supposed to do when there is an x-ray done to make sure the residents receive the services they need.</p> <p>PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS CFR(s): 483.30(b)(1)-(3)</p> <p>(b) Physician Visits The physician must--</p> <p>(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;</p> <p>(2) Write, sign, and date progress notes at each visit; and</p> <p>(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility physicians failed to sign progress notes on the date of service for 4 (Residents #1, #3, #4, #5) of 7 residents reviewed for physician progress notes with signatures. Findings included:</p> <p>1. Resident #1 was initially admitted to the facility on 8/17/15 for rehabilitation services with</p>	F 386		11/4/17	
			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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 386	<p>Continued From page 40</p> <p>cumulative diagnoses which included arthritis, chronic pain syndrome, and multiple vertebral transverse process fractures.</p> <p>Nursing progress notes revealed Resident #1 had a fall in his room on 7/26/17. Radiology reports dated 8/3/17 and 8/29/17 revealed Resident #1 had a fractured left hip as a result of the fall. Hospital records from 9/13/17 to 9/22/17 revealed the resident underwent surgery for repair of the fracture on 9/14/17.</p> <p>Physician's progress notes for Resident #1 were obtained from the facility on 9/29/17.</p> <p>The Physiatrist progress notes with dates of service on 7/25/17, 8/15/17, and 8/29/17 were all electronically signed by the physician on 9/29/17.</p> <p>A physician's readmission history and physical with a date of service of 9/25/17 was electronically signed by the physician on 9/29/17.</p> <p>2. Resident # 3 was admitted to the facility on 9/12/17.</p> <p>Chart review revealed physician progress note dated 9/14/17 was not signed by the physician.</p> <p>3. Resident # 4 was admitted to the facility on 10/13/16.</p> <p>Chart review revealed physician progress note dated 8/28/17 was not signed by the physician.</p> <p>4. Resident # 5 was admitted to the facility on 8/7/17.</p> <p>Chart review revealed physician progress note dated 8/17/17 was not signed by the physician.</p>	F 386	<p>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.</p> <ol style="list-style-type: none"> Signed MD progress notes were completed and placed on chart for Residents: #1, #3, #4, #5 on 10/6/17 An audit was performed by the Executive Director and Medical Records on 100% of residents' charts to determine that all progress notes on charts had been signed by the Physician. Physician was provided a list of progress notes that were unavailable. All signed physician progress notes are to be provided to facility and will be placed on chart by 10/31/2017. Physician education was provided by the Executive Director regarding expectations regarding documentation/progress notes; Physician to provide Executive Director/designee the list of residents seen upon their visits, signed orders are to be provided to facility within 48 hours of visit. Medical records will audit for compliance; Medical records to ensure signed progress notes placed in Medical Record within 48 hours of receipt of signed progress notes. Weekly meetings will be conducted with Physician/Executive Director/Director of Nursing weekly x 4 weeks, then monthly x 2 months: then monthly thereafter to discuss and monitor continued compliance. Audit/Compliance tool will be utilized to validate Physician has signed all progress 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 386	Continued From page 41 During an interview with the Physician on 10/6/17 at 4:08 PM. Physician indicated that after his daily visit to residents, he writes their progress notes on his personal computer with the help of electronic software. He stated that an electronic signature was available on the software and he electronically signs the progress notes when notes were completed. He also stated that the completed progress notes were then emailed to the Director of Nursing (DON) or administrator to be placed in the resident's chart. He further indicated that sometimes he forgets to electronically sign the document and manually signs the document at a later time. He stated that he had forgotten to sign the notes for the residents reviewed. During an interview with the Director of Nursing (DON) on 10/6/17 at 2:00 PM, the DON stated that the Physician had his progress notes in his computer. She stated that the Physician sent the progress notes via email when completed and she printed them out for placement in the chart. She indicated that the Physician usually did sign the notes electronically. She was not aware that the Physician progress notes were sometimes not signed electronically. She further stated it was her expectation that the Physician notes were completed, signed and placed in the chart within 48 hours. During an interview with the administrator on 10/8/17 at 8:05 AM, she stated that it was her expectation that the physician provide the facility with complete documented records of progress notes signed and dated within 48 hours. She further stated that the medical records would ensure the signed progress notes were in the	F 386	notes per expectation. Weekly audits will be conducted during Medicare meetings to validate availability of signed progress; this will continue weekly x 4 weeks, then monthly x 2 months: then monthly thereafter. Physician will be notified immediately of any progress notes that are identified as unavailable. Audit results will be reviewed and discussed in the monthly Quality Assurance committee meeting which consist of ED/ Director of Nursing and all Department Managers x 3 months or until 100% compliance achieved.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 386	Continued From page 42 chart within 48 hours of receipt.	F 386			
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 514		11/4/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 514	<p>Continued From page 43</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to maintain three months of physician progress notes for 2 residents (Resident's #1 and #4) and include recent monthly orders for 5 (Resident's #3, #4, #5, #7, #8) of 7 residents reviewed for completeness of the medical record. Findings included:</p> <p>1. Resident #1 was originally admitted to the facility on 8/17/15 with cumulative diagnoses which included arthritis and multiple vertebral transverse process fractures.</p> <p>Nursing progress notes revealed Resident #1 had a fall in his room on 7/26/17. Radiology reports dated 8/3/17 and 8/29/17 revealed Resident #1 had a fractured left hip as a result of the fall. Hospital records from 9/13/17 to 9/22/17 revealed the resident underwent surgery for repair of the fracture on 9/14/17.</p> <p>Review of the medical record for Resident #1 revealed physician progress notes for July, August or September 2017 were not available in the chart until on 9/29/17 at 12:30 PM. At 3:45 PM on 9/29/17 the facility Administrator provided physician progress notes for Resident #1 retrieved from the fax machine. A physician's progress note dated 8/3/17 was requested on 9/29/17 but the facility was unable to locate a physician's progress note for that date or near that date.</p> <p>On 10/7/17 at 3:05 PM the facility Medical Director provided a case review note for Resident #1 dated 8/3/17. This case review was not in the medical chart in the facility until 10/7/17.</p>	F 514	<p>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.</p> <p>1. Physician signed September re-cap orders and signed progress notes has been placed in the charts for Residents: #1, #3, #4,#5,#7, #8: validated by Medical Records/Executive Director.</p> <p>2. A 100% medical record audit completed for all residents. A listing of all unavailable signed MD progress notes provided to MD. Signed progress notes to be completed by 10/31/17. A list of all unsigned physician re-cap orders provided to nursing and Physician for completion.</p> <p>3. Physician education provided by Executive Director regarding expectations of signed physician progress notes availability. Physician will provide list of residents seen upon their visit, signed orders are to be provided to facility within 48 hours of visit. Signed Physician re-cap orders to be completed monthly and placed on chart by the 2nd week of each</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 514	<p>Continued From page 44</p> <p>During an interview with the Administrator on 10/8/17 at 8:05 AM, she stated it was her expectation all physicians and consulting physicians provide completed signed documented progress notes within 48 hours of the date of service. She stated all provider notes are to be put in the resident's chart within 48 hours of receipt of the signed provider notes.</p> <p>2. Resident #4 was admitted to the facility on 10/13/16 with cumulative diagnoses including Parkinson's disease.</p> <p>Review of the medical record on 9/29/17 for Resident #4 revealed physician progress notes were not available in the chart. The medical record for Resident #4 also did not contain September 2017 physician orders.</p> <p>The facility Administrator was interviewed on 9/29/17 at 7:25 PM. She stated, after looking in the medical records office, the facility did not have physician progress notes for Resident #4 available but the facility would obtain them. The facility Administrator stated she knew the physician had been in the facility to see Resident #4 within the last three months. She stated her expectation was for the last three months of physician progress notes be in the medical charts.</p> <p>3. The medical record for Resident #3 was reviewed on 10/6/17. The medical record did not contain September 2017 physician orders in the medical record.</p> <p>4. The medical record for Resident #5 was reviewed on 10/6/17. The medical record did not</p>	F 514	<p>month. Medical Records will audit 100% of residents charts to validate. Physician signed progress notes and physician re-cap orders are monitored for compliance: audit will be completed by the 15th of each month.</p> <p>4. Audit results will be reviewed and discussed in the monthly Quality Assurance committee meeting which consists of Executive Director, Director of Nursing and Department Managers x 3 months or until 100% compliance achieved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 514	<p>Continued From page 45</p> <p>contain September physician orders in the medical record.</p> <p>5. The medical record for Resident #7 was reviewed on 10/6/17. The medical record did not contain September 2017 physician orders in the medical record.</p> <p>6. The medical record for Resident #8 was reviewed on 10/6/17. The medical record did not contain September 2017 physician orders in the medical record.</p> <p>The facility Medical Director, who was the attending physician for Resident's #1, #3, #4, #5, #6, and #7, was interviewed on 10/6/17 at 4:10 PM. He stated he either dictated his progress notes or would hand write a few lines in the chart to document his services. He said he has always and continues to e-mail his progress notes to the Director of Nursing who will then print them off for filing. He stated the physician's orders for the month are given to him in a stack at the beginning of the month for his signature. He stated he does sign the orders every month at the beginning of the month and the Director of Nursing gives the physician's orders to her staff for filing.</p> <p>The Director of Nursing was interviewed on 10/6/17 at 6:15 PM. She confirmed the Medical Director e-mails the progress notes for the residents to her. She then prints them off and they go in the chart. She also confirmed the physician's orders were printed at the beginning of the month, signed by the physician, and the filed in each chart. She did not know why the September 2017 orders for Residents #3, #4, #5, #6, #7, and #8 were not in the chart.</p>	F 514			

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

PRINTED: 11/21/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2017
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704		
(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 514	Continued From page 46 The Director of Nursing was interviewed again on 10/7/17 at 8:30 AM. She stated the signed physician's orders for September 2017 were in the staff development office because they were being checked to make sure there was accuracy with the transition to new ownership. The orders had not been put in the chart but were left in the stack in the staff development office until it was brought to their attention on 10/6/17 that the September orders were missing from the chart.	F 514		