STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____ MAY 31 2012	05/10/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility posted nursing staff information records, the facility failed to post the actual number of	F 356	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Center posted the total number of and actual hours worked by licensed and unlicensed staff that is directly responsible for resident care per shift (RN, LPN, and C.N.A.) and the current resident census in a frame on top of the nursing station. 5/10/12 2. SDC will in-service nursing staff on the appropriate daily posting and location of the total number of and actual hours worked by licensed and unlicensed staff that is directly responsible for resident care per shift which includes the resident census. 5/10/12 3. DNS or designee will perform an audit on the total number of and actual hours worked by licensed and unlicensed staff that is directly responsible for resident care per shift posting daily for 2 weeks, weekly for 4 weeks and monthly for 3 months. 5/11/12 4. Results of the audits will be incorporated into center's Performance Improvement Committee for a minimum of months. 5/11/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anita Silleny — TITLE: Executive Director — (X6) DATE: 5-29-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	05/10/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 1 hours worked for licensed and unlicensed staff for all three shifts for 18 of the past 18 days leading up to and including the days of survey. Findings include: Observations on 5/7/12 at 9:00AM, 5/8/12 at 9:00AM, 5/9/12 at 9:00AM and 5/10/12 at 9:00AM revealed posted nursing staff information was not visible in any public area of the facility. The form was located in a clear sheet protector located under the counter of the nurses' station on 5/10/12 at 9:00AM. The form indicated the facility name, was dated 5/10/12 and the census was 113. Each sheet represented the shift to which it applied (7AM-3PM, 3PM-11PM and 11PM-7AM). The staffing data contained the number of unlicensed and licensed nursing staff but there was no documentation of the number of actual hours worked for each person. A review of the facility's nursing staff postings from 4/24/12 through 5/10/12 conducted on 5/10/12, revealed the facility's actual number of hours worked by licensed and unlicensed nursing staff was not posted as part of the data on the forms the facility posted for the following dates: 4/24/12, 4/25/12, 4/26/12, 4/27/12, 4/28/12, 4/29/12, 4/30/12, 5/1/12, 5/2/12, 5/3/12, 5/4/12, 5/5/12, 5/6/12, 5/7/12, 5/8/12, 5/9/12, and 5/10/12. During an interview with the Director of Nursing (DON) on 5/10/12 at 8:42AM, the DON stated she was unsure of where the nursing staff was posted. The DON reported the form was	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	05/10/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 2 completed by the staff scheduler and the scheduler placed it at the nurses station. On 5/10/12 at 8:48AM the staff scheduler was interviewed. She stated the nursing staff posting was completed daily and placed at the nurses' station desk. The scheduler indicated this was the only place it was kept. The posting was not visible to visitors, only staff, but if visitors asked, it was shown to them. When the scheduler was asked about the "actual number of hours" section not completed, she replied that she did not know why she didn't complete the section. The scheduler suggested a frame for the form so it could be hung on the wall where it would be visible. The DON was interviewed again at 9:00AM on 5/10/12. She stated the nursing posting form was expected to be visible to everyone.	F 356		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/01/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, and is utilizing delayed egress locking systems. The facility is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 6/1/2012 The sprinkler heads installed in the service hallway smoke compartment were a mix of a quick response Red and Green bulb heads witch deploy at two different temperatures. Actual NFPA Standard: NFPA 13,5-3.1.5.2 CFR#: 42 CFR 483.70 (a)	K 062	1. Identified sprinkler head on service hallway smoke compartment was removed and replaced with a sprinkler head that is the same type as the remaining ones on the service hallway smoke compartment. All sprinkler heads in this area are now the same type. 6/8/12 2. Maintenance Director or designee will make rounds in the center to ensure all sprinkler heads are consistent in designated smoke compartment areas. 6/8/12 3. Maintenance Director or designee will perform an audit weekly for 2 weeks to ensure sprinkler heads are consistent in designated smoke compartment areas. 6/8/12 4. Results of audits will be incorporated into center's Performance Improvement Committee for a minimum of 3 months. 6/8/12	

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

Executive Director — 6/13/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined tha
o[illegible] safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 da
fo[illegible]ng 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 1
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.