

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

JUL 27 2012

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514	
(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 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior for 5 of 6 resident shower rooms.</p> <p>Findings include:</p> <p>On 06/29/2012 observations were made of the facility's resident shower rooms with the facility's maintenance manager. During the observations the following was noted:</p> <p>06/29/2012 between 7:35 a.m. in the resident shower room between rooms 204 and 205 - 3 electrical switch plate covers were found lose and had only 1 screw securing each of the covers. One of the switch plates was hanging by its 1 screw and was approximately 1" off the wall where electrical wiring could be seen behind the plate cover.</p> <p>06/29/2012 between 7:46 a.m. in the resident shower room between rooms 223 and 225 was observed to have a metal box paper towel dispenser not secure on wall (attached by 1 screw) The dispenser was hanging on the wall at a 45 degree angle and could swing freely when touched. The liquid soap dispenser in this same</p>	F 253	<ol style="list-style-type: none"> The corrective action taken for the issues identified through observations made with the Maintenance Director were corrected the day they were observed. Screws were replaced, damaged tile repaired and dispensers properly installed. The corrective action taken to prevent other residents from being affected by this was to do an audit of all resident rooms, bathrooms, common areas and hallways to identify and correct any concerns found during the audit. The systematic changes we have put into place are to begin using a Maintenance Request Log Book. The log books are located at each nursing station and in the front office. Staff members have been inserviced on the use of the books and the necessity of identifying and noting in the log book any items that need repair or replacement. The 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] Administrator 7/26/12

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.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 253	<p>Continued From page 1</p> <p>shower room had been taken off the wall and was lying on the short wall ledge next to the shower stall.</p> <p>06/29/2012 between 7:58 a.m. in the resident shower room across from room 211 was observed to have a broken and jagged tile on shower wall edge at elbow height by any resident seated in a wheel chair or shower chair.</p> <p>06/29/2012 between 8:16 a.m. in the resident shower room between room 112 and 100 hall nurse's station was observed to have a toilet water pipe fixture bracket at a 45 degree angle off wall (not attached via screw holes - x2) and a light switch plate with only 1 screw holding the cover plate loosely to wall.</p> <p>06/29/2012 between 8:33 a.m. in the resident shower room between rooms 122 and 124 was observed to have a broken and jagged tile on shower wall edge at elbow height by any resident seated in a wheel chair or shower chair.</p> <p>On 06/29/2012 at 8:45 a.m., an interview was conducted with the facility 's maintenance manager concerning the maintenance process and his files for work orders. The maintenance manager stated, "There are work orders at each nurse's station and when an item is found to be in need of repair the person finding the problem will fill out a work order and place it in my box at that nurse's station. I make several rounds during the day and pick up the work orders and get the things repaired." The maintenance manager was asked if he had any work orders on any of the items found in need of repair. The maintenance manager looked through the 4 work orders he</p>	F 253	<p>Maintenance Director or his designee will also be doing rounds in the building once a week for the first month using the Room Audit Form noting and correcting any maintenance issues that need to be addressed. These audits will then be done twice a month for the next 60 days. After this the audits / rounds will continue to be at least quarterly on an on going basis.</p> <p>4. The results of the audits will be brought to our monthly Performance Improvement Meeting for review of how effective the use of the Maintenance Log Books and the audit tools have been. The Administrator will monitor for compliance through meetings on a monthly basis with the Maintenance Director to ensure he is performing the building audits and following up on any issues identified from the audits or issues listed for repair in the Maintenance Request Log Books.</p>	7/27/12	

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 253	Continued From page 2 had on hand and stated, "No, I have never been informed about the items that we found broken or needing repair today, I do not have any work orders for those items. "	F 253			
F 309 SS=D	<p>An observation of the nurse ' s stations was made on 06/29/2012 at 8:55 a.m. The nurse ' s areas had blank maintenance request forms. There were no filled out maintenance request forms for the maintenance manager to review or act on.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to administer the correct medications, administer ordered medications, and ensure residents were administered their medications as ordered for 3 of 13 residents (residents #8, #82, and #2) .</p> <p>Findings include:</p> <p>1. Resident # 8 was admitted to the facility on . 03/15/2012. A review of resident #8's medical record indicated resident #8 had diagnoses which included two pressure ulcers to the coccyx area.</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> 1. Resident #8's MAR was corrected for the missed transcription and the correct medication administered on 6/29/12. She did not experience any pain during the dressing change at that time and has continued to be pain free during dressing changes. 2. As all residents have the potential to be effected by incorrectly transcribed orders, the DNS audited all physician's orders written between 7/1/2012 and 7/24/2012 to ensure no other orders had been missed or incorrectly transcribed. Any discrepancies were immediately resolved. 		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 3</p> <p>The resident's Minimum Data Set (MDS) dated 03/22/2012 documented the resident to be cognitively intact and needing extensive assistance for bed mobility and transfers and total assistance for dressing, toilet use, personal hygiene, and bathing. The resident's medications included a physician's order for pain management dated 06/25/2012 - Oxycodone 2.5mg by mouth 1 hr before wound care dressing changes. The resident's Care Plan dated 05/22/2012 indicated the resident was at risk for and had Pressure Ulcers with interventions which included - Follow orders and treatments as ordered by the MD.</p> <p>An observation of resident #8's wound care was conducted on 06/29/2012 at 9:05 a.m. with the facility's wound care nurse, staff member #5. Staff member #5 was asked when the wound care pain pre-medication had been given to resident #8. Staff member #5 asked the medication nurse, staff member #3, what time the resident's wound care pain pre-medication was given. Staff member #3 stated, "1/2 hour ago - 8:30 a.m." Staff member #5 was asked if the correct waiting time for the pain premedication to take effect per the physician's orders had been met and the staff member #5 stated, "Yes it's been 1/2 hour since it was administered." During the wound care observation resident #8 was asked about receiving her wound care pain pre-medication. The resident indicated she had been given a pain pill by staff member #3 at 8:30 a.m. and had no pain.</p> <p>An interview was conducted with staff member #3 on 06/29/2012 at 9:45 a.m. Staff member #3 was asked what medication she used to pre-medicate resident #8 for pain. Staff member #3 stated, "I</p>	F 309	<p>3. To ensure ongoing compliance, nurses must transcribe new or changed orders onto the MAR at the time the order is written. Each new order or order change will be validated by nursing administration daily to verify both accurate and timely order implementation. Nurse initials on the order copy upper right corner will indicate the double check has been completed and that transcription has been validated. Further nurses were in-serviced on this procedural clarification and will continue to be in-serviced on hire during orientation.</p> <p>4. Nursing Administration will track transcription discrepancies noted during daily validation for a period of 90 days and report the information to the PI Committee monthly for their review. The Director of Nursing is responsible for this corrective action which will be fully implemented by 7/27/2012.</p> <p>1. Resident #82 medication regimen was verified to be carried out as ordered as of 6/29/2012 through 7/25/2012. She has verbalized she has had no further issues with her medication. Ordered medications are signed for appropriately.</p>	7/27/12	

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 4 gave resident #8 one Ultram 25mg (milligram) pill for pain premedication. I know the Ultram pre-medication order was discontinued and yellowed out - on 06/21/2012."</p> <p>A review of resident #8's Medication Administration Record (MAR) was conducted with staff members #3 and #5. The MAR indicated resident #8 had a discontinued order for Ultram 25mg by mouth daily 30 minutes prior to dressing change. The letter's D/C'd were written across the order line indicating the order was no longer valid and the order was noted to have been yellowed out via a yellow highlighter. Staff member #3 was asked why the order had been yellowed out and she responded, "It brings attention to the person seeing the order that it was discontinued." Staff member #3 was asked why she gave a discontinued medication to resident #8. Staff member #3 declined to answer the question. Staff member #3 was asked where she documented she pre-medicated resident #8 for pain before the dressing change with the discontinued Ultram medication. Staff member #3 stated, "I didn't, the order was discontinued and yellowed out."</p> <p>A review of resident #8's Medications was conducted with staff members #3 and #5 on 06/29/2012 at 9:48 a.m. Staff member #3 withdrew resident #8's discontinued Ultram 25mg medication card from the medication cart and stated, "This is the medication card I took the Ultram from and administered to resident #8 this morning. "The card was observed to be Ultram 25mg and had the resident's name on the</p>	F 309	<p>2. All residents have the potential to be effected by unavailable medication. All MARs were audited by the admin team to not contain any medications that have been circled for multiple days. All medications were established to be proceeding in compliance.</p> <p>3. To ensure ongoing compliance the Director of Nursing initiated a 24 hour tool for the nurses to write down any missing medications encountered during their med pass so nursing administration can resolve the issue as well as track the frequency of such occurrences with the results being brought to the Performance Improvement Committee meeting each month. Pharmacy contact information has been posted at each nurse's station as well as in the med rooms to assist nurses in resolving discrepancies between orders sent and medications received. In consultation with the pharmacy we have ensured that we utilizing the most effective procedure to receive meds timely. Furthermore, the nurses have been in-serviced on this procedure clarification and will continue to be as hired when in orientation.</p>		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 5</p> <p>prescription label. Staff member #3 was observed to take out an Oxycodone 2.5mg medication card with resident #8's name on the prescription label from the controlled medications box on the medication cart. There was only 1 pill removed from the card. Staff member #3 was asked if she had administered the missing pill from the Oxycodone 2.5mg medication card. Staff member #3 stated, "I didn't give the Oxycodone, I gave the resident a 25mg Ultram pill, the Oxycodone was given yesterday." A review of resident #8's MAR indicated the resident received 1 Oxycodone 2.5mg for as need pain on 06/28/2012</p> <p>At 12:30 p.m. prior to wound care dressing change. Staff member #3 indicated the physician's order for Oxycodone 2.5mg to pre-medicate resident #8 prior to wound care was not transcribed from the physician's verbal order sheet to resident #8's MAR.</p> <p>An interview was conducted with the facility's Director of Nursing (DON) on 06/29/2012 at 10:10 a.m. The DON was asked what her expectation was for the nursing staff to follow the physician's orders documented in resident's charts. The DON stated, "I expect the nurses to administer the medications and follow the physician's orders as were written or received from the physician."</p> <p>2. Resident #82 was admitted to the facility on 3/31/12 with multiple diagnoses including major depressive disorder and insomnia. Review of the resident's clinical record revealed physician orders dated 3/31/12 for Trazodone (antidepressant) 100mg (milligram) at bedtime, Cymbalta (antidepressant) 30mg in the morning and 60mg in the evening, and Ambien (sedative)</p>	F 309	<p>4. The Admin Team will audit the Nurse's Tool to Report Discrepancies daily for a period of 90 days. Any medications listed as unavailable will be discussed with the pharmacy by an Admin Team member directly to resolve the issue. The findings will be discussed at the monthly PI meetings. In the future the DNS is responsible for monitoring this corrective action to ensure it's implementation is achieved and sustained.</p> <p>1. Patient #2 Dialysis communication log was updated to include notification to the dialysis nurse that the resident is ordered to take medication at dialysis. The expectation has been made to the dialysis center that they will include on their daily dialysis report that he correctly took the medication as ordered. The to pharmacy was notified to individually package the medications to be taken with the patient to dialysis and it was validated by the DNS that</p>	7/27/12	

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 6</p> <p>5mg at bedtime as needed. Trazodone has unlabeled indications of augmenting therapy for other antidepressants and treatment of insomnia.</p> <p>Review of the resident's MDS (minimum data set) dated 6/13/12 revealed she was cognitively intact.</p> <p>Lexicomp's Drug Information Handbook, 14th edition, stated in part: "trazodone - therapy should not be abruptly discontinued."</p> <p>Review of the medication administration records (MARS) revealed trazodone was scheduled to be given at 8PM nightly. Review revealed trazodone was not given, as indicated by the nurses' initials being circled, on 5/12/12, 5/13/12, 5/17/12, 5/18/12, 5/21/12, 5/24/12, 5/25/12, 5/26/12, 5/27/12, 5/28/12, 5/29/12, 5/30/12, 6/1/12, and 6/2/12. Review of the back of the MARS revealed entries on 5/29/12 and 5/30/12 which read "trazodone reordered." There was no other documentation regarding trazodone not being given as ordered.</p> <p>In an interview on 6/29/12 at 12:55PM, resident #82 stated she didn't receive all of her medications that were ordered. Resident #82 stated her trazodone was unavailable and not given last month. She did not recall specific dates or staff. She was not sure why her medication was not given.</p> <p>In an interview on 6/29/12 at 5:47PM, the Director of Nursing (DON) stated the cutoff time for receiving medications from their pharmacy was 5PM. After 5PM, there was a pharmacist on call 24 hours per day, who called the local backup pharmacy. She stated the nursing staff should be</p>	F 309	<p>medications were received in the facility individually packaged and labeled appropriately with content. The resident's self-administration of meds ability was validated by the administration team. Furthermore the physician's order and subsequently the MAR was validated to reflect the proper anticipated disposition of the medication.</p> <ol style="list-style-type: none"> The admin team investigated if there were other residents who were ordered to take medications outside of the facility. No other residents were determined to be doing so. The other dialysis residents benefitted by enhanced communication between the facility nurses and the nurses at their dialysis centers. To ensure continued compliance any new admissions with a desire to self-medicate will be asked and identified. These residents will receive a self-medication assessment for appropriateness. This assessment will be performed quarterly and with any significant change in condition to determine ongoing appropriateness of the 		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 7</p> <p>sure medications were sent to the facility. If medications were not given, she expected the staff to circle their initials and document a reason on the back of the MAR and in the nursing notes. She expected the staff to follow up with the physician if medication was not available for some reason or if the resident continually refused medication. The DON reviewed resident #82's MAR and acknowledged the trazodone was not given as ordered.</p> <p>In a telephone interview on 7/2/12 at 4:07PM, the nurse (nurse #4) responsible for administering resident #82's bedtime medications, stated if a medication was not given, the nurses' initials were circled. Nurse#4 stated there had been problems with the resident's trazodone not being available. She had to get the medication from the facility's emergency supply or borrow it from another resident. The nurse stated she repeatedly asked the morning nurses to call the pharmacy regarding the trazodone not being available. She also spoke to the nurse practitioner about it several times.</p> <p>3. Resident #2 was re-admitted to the facility on 11/20/2011 after hospitalization for suicidal ideation, end stage renal failure, and being a new dialysis patient. The resident's Minimum Data Set (MDS) indicated the resident was cognitively intact and independent for all activities of daily living. The resident's diagnoses included: Schizoaffective disorder - depressive type and End Stage Renal Disease with urinary retention. Resident #2's medications included Klonopin 1mg (milligram) by mouth (PO) - give this extra dose every Tuesday, Thursday, and Saturday prior to</p>	F 309	<p>resident to have their scheduled medications in their possession. The medications that they receive that they have the expectation of dispensing independently will reflect on their order. The nurses were in-serviced on the expectation to validate that the resident took the scheduled medications as ordered on the return of the resident to the facility. The inservice will continue for new hired nurses during orientation.</p> <p>4. The Nurse Admin Team will track any patient who leaves the facility with medication on an ongoing basis x 90 days. The results will be discussed during the monthly PI meeting. The Director of Nursing is responsible for ensuring compliance.</p>	7/27/12	

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 8</p> <p>dialysis. The resident's care plan dated 12/02/2011 indicated the resident had a potential for complications related to hemodialysis and chronic renal failure with an intervention of dialysis 3 times a week.</p> <p>A review of resident #2's medical record revealed a clinic note written by Established Freeform Clinic - Psych services dated 05/15/2012 which indicated resident #2 as taking Klonopin at lunch time at dialysis. Further record review revealed a dialysis note from Carolina Dialysis dated June 2012 documenting - resident is compliant with dialysis, no complaints, continues to take medications, little anxiety. Resident #2's medical record had no physician 's order in the chart or that the facility staff could find allowing the resident to take the controlled medication Klonopin out of the facility or changing the physician's order - to give Klonopin 1 mg every Tuesday, Thursday, and Saturday prior to dialysis.</p> <p>An interview was conducted with the staff member #8 (floor nurse) on 06/27/2012 at 4:15 p.m. regarding resident #2 taking Klonopin with him to dialysis instead of the medication being administered by facility staff as ordered prior to dialysis. Staff member #8 stated, "We give the resident his medication to take with him to dialysis."</p> <p>A second review of the resident's medical record indicated nursing staff had signed off the resident's Klonopin administration as being given prior to the resident going to dialysis for the months of April, May, and June 2012. There was no record to show the resident was taking the</p>	F 309			

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 9 medication to dialysis and self administering the medication.</p> <p>An interview was conducted with resident #2 on 06/27/2012 at 4:35 p.m. concerning taking Klonopin with him to dialysis. Resident #2 stated, "I go to Carolina Dialysis three times a week. I ride the transport van and I'm usually there all day and get back about 4:30-5:00 p.m. I take several medications with me to dialysis. The nurses put them in a very small plastic bag and I take them to dialysis and take them with my lunch." The resident was asked how long he had been taking the medications out of the facility to dialysis and the resident responded, "Since January this year."</p> <p>An interview was conducted with the DON on 06/27/2012 at 5:05 p.m. concerning her expectations for nursing staff to follow physician's orders (administering resident #2's Klonopin prior to dialysis). The DON stated, "My expectations are that the nurses follow the physician's orders as written, and in regards to the Klonopin, the nurses should follow the physician's order - give the Klonopin prior to dialysis.</p> <p>An interview was conducted with the resident #2's physician on 06/28/2012 at 3:00 p.m. The physician stated the resident had been recently diagnosed with end stage renal failure and now was on dialysis. The physician also stated he was aware of the psych medication (Klonopin) the resident was on and resident #2 was being followed by psych services. The physician indicated he had not written an order for the resident to take the Klonopin with him to dialysis and indicated his written order was the</p>	F 309			

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 10 medication was to be administered prior to resident #2 going to dialysis.	F 309			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents were free from medication used for excessive duration for 1 of 13 residents whose medications were reviewed (resident #82), and failed to document pulse	F 329	Issue #1: Incorrect Transcription of Orders 1. Resident #82's MAR was reviewed and all medications that are on the MAR have accompanying physician orders for nurses to dispense to the resident. 2. All facility residents are potentially at risk for receiving medications for an excessive duration beyond physician expectation. The Director of Nursing performed an audit to verify that all residents admitted since 6/29/2012 have orders that correctly coincide with the hospital discharge summary then correctly updated to reflect any physician's orders that have occurred since the resident's admission. All MARs are now correct.		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 329	<p>Continued From page 11</p> <p>readings prior to digoxin administration for 1 of 1 sampled resident receiving digoxin therapy (resident #82). Findings include:</p> <p>1a. Resident #82 was admitted to the facility on 3/31/12 with multiple diagnoses including insomnia. Review of the resident's clinical record revealed admission orders dated 3/31/12 for Benadryl 25mg (milligram) at bedtime as needed. Benadryl (diphenhydramine) is an antihistamine used for treatment of allergic symptoms and treatment of insomnia.</p> <p>Lexicomp's Drug Information Handbook, 14th edition, stated in part: "diphenhydramine has high sedative and anticholinergic effects."</p> <p>Review of the admission orders revealed a hand-written entry next to the Benadryl order which read "d/c (discontinue)."</p> <p>Review of the resident's April medication administration record (MAR) revealed Benadryl was given on 4/5/12, 4/6/12, 4/8/12, 4/12/12, 4/13/12, 4/14/12, 4/15/12, 4/17/12, 4/23/12, 4/25/12, 4/26/12, and 4/29/12. Review revealed no physician's order for the Benadryl.</p> <p>In an interview on 06/29/12 at 5:47PM, the Director of Nursing (DON) stated for new admissions or readmissions, the initial orders were handwritten by the admitting nurse. The admission form was in duplicate, which provided a MAR for the current month. The orders were then entered into data entry and were printed on the MARS the following month. The changeover team checked for any changes to be sure that everything was correct on the MAR. The DON</p>	F 329	<p>3. To ensure future compliance orders written by the admitting nurse will be validated by a second nurse ensuring that orders taken from the hospital's discharge summary are correctly transcribed to the resident's facility MAR. Both nurses will sign the admission orders. The next business day following the admission, two members of the Nursing Administration team will validate the original orders have been correctly transcribed and that any new orders since admission have been correctly transcribed and implemented. The facility's process for review of the newly printed MARs for the first upcoming month after an admission has been revised to include a two nurse system of checks with one nurse reading the last month's MAR and the other reviewing the newly created MAR. All nurses have been in-serviced on this procedure and will continue to be as they are hired and oriented.</p>		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 329	Continued From page 12 reviewed the April MAR and acknowledged the Benadryl had not been discontinued. Her expectation was for the order to have been discontinued. 1b. Resident #82 was admitted to the facility on 3/31/12 with multiple diagnoses including atrial fibrillation. Review of the resident's clinical record revealed admission orders dated 3/31/12 for Lanoxin (digoxin) 0.125 mg daily, check pulse. Lanoxin is an antiarrhythmic agent. Lexicomp's Drug Information Handbook, 14th edition, stated in part: "monitoring parameters - heart rate and rhythm should be monitored to assess both desired effects and signs of toxicity." Review of the resident's MARS revealed no pulse monitoring prior to digoxin administration for 10 days in April, 12 days in May, and 4 days in June 2012. Review of the June MAR revealed pulse readings 49 on 6/2/12, 58 on 6/8/12, and 53 on 6/12/12 with no documentation that the digoxin was held or the physician notified. In an interview on 06/29/12 at 5:47PM, the Director of Nursing (DON) stated the staff was supposed to check the pulse rate prior to administering digoxin to any resident. She stated it was her expectation and a nursing standard for the staff to check the pulse before giving digoxin. The DON expected the staff to hold the medication and notify the physician if the pulse rate was below 60.	F 329	4. The Nursing Administrative team will monitor compliance with this process for 90 days. The findings will be reviewed by the PI team for improvement potential. The Director of Nursing is responsible for ongoing compliance with this corrective action which will be fully implemented by 7/27/2012. Issue #2: Assessment prior to Administration	7/27/12	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425	1. Resident #82's orders were reviewed and vital signs that are required prior to administration of medications are clearly marked on the MAR. Specific parameters for when to hold (not administer) the Lanoxin were added to state: "Do not administer if apical HR <60; if heart rate is greater than 100, give dose. For < 60 or > 100, notify physician". Review of the July MAR validates that the medication was given properly all month with the proper recording of the resident HR prior to administration. 2. All facility residents have the potential to be affected by non-implemented pulse parameters. The Director of Nursing completed an		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514
---	--

(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 329	<p>Continued From page 12</p> <p>reviewed the April MAR and acknowledged the Benadryl had not been discontinued. Her expectation was for the order to have been discontinued.</p> <p>1b. Resident #82 was admitted to the facility on 3/31/12 with multiple diagnoses including atrial fibrillation. Review of the resident's clinical record revealed admission orders dated 3/31/12 for Lanoxin (digoxin) 0.125 mg daily, check pulse. Lanoxin is an antiarrhythmic agent.</p> <p>Lexicomp's Drug Information Handbook, 14th edition, stated in part: "monitoring parameters - heart rate and rhythm should be monitored to assess both desired effects and signs of toxicity."</p> <p>Review of the resident's MARS revealed no pulse monitoring prior to digoxin administration for 10 days in April, 12 days in May, and 4 days in June 2012. Review of the June MAR revealed pulse readings 49 on 6/2/12, 58 on 6/8/12, and 53 on 6/12/12 with no documentation that the digoxin was held or the physician notified.</p> <p>In an interview on 06/29/12 at 5:47PM, the Director of Nursing (DON) stated the staff was supposed to check the pulse rate prior to administering digoxin to any resident. She stated it was her expectation and a nursing standard for the staff to check the pulse before giving digoxin. The DON expected the staff to hold the medication and notify the physician if the pulse rate was below 60.</p>	F 329	<p>audit and determined there are no other residents in the building currently taking Lanoxin. The data entry clerk was notified of need to verify the addition of the specific parameter to any Lanoxin orders in the future.</p> <p>3. The Nursing Administration team has identified other medications and reviewed specific parameters with the medical director. These specific parameters have been added to the appropriate MARs. Nurses have been provided with additional training on the importance of following these instructions and on when to notify the physician. Instructions regarding the requirement of adding these parameters to the MARs have been provided to the data entry clerk.</p> <p>4. The Director of Nursing will systematically audit 10 MARs each week at random to assure instructions are being followed and vital signs taken and recorded. Additionally, the DNS will validate all new admissions for the presence of Lanoxin or other medications that require specific parameters, for 90 days. The results of these audits will be reported to the PI Committee for 90 days. The Director of Nursing is responsible for ongoing compliance with this corrective action which will</p>	
F 425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency</p>	F 425		7/27/12

Page 13 A. 0622

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 425	<p>Continued From page 13</p> <p>drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interviews, the facility failed to remove outdated items from 3 of 4 medication carts and 1 of 2 medication refrigerators, and failed to provide services to ensure medication was available for 1 of 13 sampled residents whose medications were reviewed (resident #82). Findings include:</p> <p>1. The facility policy titled Storage of Medications, dated 2/23/11, read in part: "Medications and biologicals are stored under proper conditions of sanitation, light, ventilation, segregation, and security, following manufacturer's recommendations or those of the supplier as well as in compliance with applicable federal and state</p>	F 425	<p>Issue #1: Improper storage</p> <ol style="list-style-type: none"> 1. All refrigerators and med carts used for storage of medications and biologics have been inspected and any outdated items have been removed. 2. The potential exists for medications to continue to be in their storage area beyond their expiration date. Audits were initiated for the floor nurses to check their carts each shift to assure no expired medications remain in use. 3. To ensure ongoing compliance the each shift audits by the floor nurses will continue. Their monitoring is to include expired meds, meds to be dated when opened, meds to be stored only with meds of like route and appropriate barrier existing between medications as directed by the pharmacy and/or manufacturer. The results of the each shift audit will be reviewed by the nursing administrative team to ensure any deviation from the expectation is handled timely and correctly. The pharmacy provided a medication storage guideline which was placed in a plastic sleeve in each MAR notebook as a quick 		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514	
(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 425	<p>Continued From page 14 laws/regulations and accreditation standards."</p> <p>An inspection of the 100 front hall medication cart on 6/29/12 at 4:00PM revealed one opened 1000 ml (milliliter) bottle of 0.9% Sodium Chloride for Irrigation. Sodium Chloride for Irrigation 0.9% is used for wound cleansing, irrigation, and flushing. Inspection revealed approximately 300ml of the solution had been used. The label did not indicate when the solution had first been opened. The manufacturer's label read "one time use only, discard unused solution." Further inspection revealed one Advair 250/50 inhaler, opened but not dated. Advair is an oral inhaler used to treat asthma and chronic obstructive pulmonary disease. The manufacturer's storage requirements for Advair read in part "should be discarded 1 month after removal from foil pouch."</p> <p>An inspection of the 200 hall medication cart on 6/29/12 at 4:25PM revealed one Advair 250/50 inhaler, opened but not dated. The manufacturer's storage requirements read in part "should be discarded 1 month after removal from foil pouch."</p> <p>An inspection of the 200 Hall medication room refrigerator on 6/29/12 at 4:31PM revealed two multi-dose vials of Tuberculin Purified Protein Derivative (PPD), opened but not dated. PPD is a diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part: "A vial of PPD which has been entered and in use for 30 days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30</p>	F 425	<p>reference for the nurses to be reminded of the medication storage expectation. The administration team will continue weekly audits of the medication carts and refrigerators to ensure continued compliance. The pharmacist will perform a monthly review of the medication storage areas to help identify any areas of potential concern and to ensure ongoing compliance. A comprehensive quarterly review will be completed by a pharmacy consultant. The results of the pharmacy audits will be discussed with the Director of Nursing after each visit to provide alerts that further education or reorganization might be needed to sustain compliance. The nursing staff has been inserviced on the procedural clarification and will continue to be in-serviced as needed and when during orientation .for newly hired nurses.</p> <p>4. The nursing administration team will track any deviations from expectation by continued review of all audits performed x 90 days and will discuss the findings</p>	

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514	
(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 425	<p>Continued From page 15</p> <p>days resulting in reduced potency and possible inaccurate test results.</p> <p>An inspection of the 100 back hall medication cart on 6/29/12 at 4:40PM revealed two Advair 250/50 inhalers, opened but not dated. The manufacturer's storage requirements read in part "should be discarded 1 month after removal from foil pouch."</p> <p>In an interview on 6/29/12 at 4:15PM, the 100 front hall nurse (nurse #1) confirmed the Sodium Chloride Irrigation had been opened and used. She examined the Advair inhaler and confirmed it was not dated. Nurse #1 stated the nurse who opened the items should have dated them.</p> <p>In an interview on 6/29/12 at 4:31PM, the 200 hall nurse (nurse #2) examined the Advair inhaler and vials of PPD and confirmed they were not dated. Nurse #2 stated the items should have been dated when they were opened.</p> <p>In an interview on 6/29/12 at 4:52PM, the 100 back hall nurse (nurse #3) examined the Advair inhalers and confirmed they were not dated. She stated Advair was supposed to be dated when it was removed from the foil pouch.</p> <p>In an interview on 6/29/12 at 5:47PM, the Director of Nursing (DON) stated the nurses were supposed to date items when opened. She stated the pharmacy conducted audits of medication storage monthly. The night manager also checked one cart per week for outdated items. For those items that required dating, her expectation was for the staff to date them as soon as they were opened.</p>	F 425	<p>during the monthly P1 interdisciplinary team meeting. The Director of Nursing is responsible to ensure continued compliance with this corrective action which will be fully implemented by 7/27/2012.</p> <p>Issue #2: Failure to Provide ordered medications.</p> <ol style="list-style-type: none"> 1. Resident #82 orders have been reviewed and it was validated that all medication are present in the medication cart to be dispensed as ordered. The resident verbalizes that she has received her medications as expected. 2. The potential exists for other residents to be affected by unavailable medications. All MARs were audited by the admin team not to contain any medications that have been circled for multiple days. All medications were established to be proceeding in compliance. 3. To ensure ongoing compliance the DNS initiated a 24 hr tool for nurses to write down daily any missing medications encountered during their med pass. Nursing administration validates a quick and accurate resolution of any problems encountered. Pharmacy contact information has been displayed at each nurse's station as well as in the med rooms to 	7/27/12

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 425	<p>Continued From page 16</p> <p>2. Resident #82 was admitted to the facility on 3/31/12 with multiple diagnoses including major depressive disorder and insomnia. Review of the resident's clinical record revealed physician orders dated 3/31/12 for Trazodone (antidepressant) 100mg (milligram) at bedtime, Cymbalta (antidepressant) 30mg in the morning and 60mg in the evening, and Ambien (sedative) 5mg at bedtime as needed. Trazodone has unlabeled indications of augmenting therapy for other antidepressants and treatment of insomnia.</p> <p>Review of the resident's MDS (minimum data set) dated 6/13/12 revealed she was cognitively intact.</p> <p>Lexicomp's Drug Information Handbook, 14th edition, stated in part: "trazodone - therapy should not be abruptly discontinued."</p> <p>Review of the medication administration records (MARS) revealed trazodone was scheduled to be given at 8PM nightly. Review revealed trazodone was not given, as indicated by the nurses' initials being circled, on 5/12/12, 5/13/12, 5/17/12, 5/18/12, 5/21/12, 5/24/12, 5/25/12, 5/26/12, 5/27/12, 5/28/12, 5/29/12, 5/30/12, 6/1/12, and 6/2/12. Review of the back of the MARS revealed entries on 5/29/12 and 5/30/12 which read "trazodone reordered." There was no other documentation regarding trazodone not being given as ordered.</p> <p>In an interview on 6/29/12 at 12:55PM, resident #82 stated she didn't always receive all of her medications that were ordered. Resident #82 stated her trazodone was unavailable and not</p>	F 425	<p>ensure the nurses can resolve any discrepancies between medications ordered and medications received. DNS coordinated with the pharmacy to ensure that we are using the most effective procedure to receive ordered meds timely. Also, the nurse's have been inserviced on this procedural clarification and will continue to be when hired during orientation.</p> <p>4. The nurse admin team will audit the daily unavailable meds from the floor nurses for a period of 90 days. The findings will be reviewed during the monthly PI meeting. The Director of Nursing is responsible to ensure the full implementing of the process by 7/27/2012.</p>	7/27/12	

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 425	Continued From page 17 given last month. She did not recall specific dates or staff. She was not sure why her medication was not given. In an interview on 6/29/12 at 5:47PM, the Director of Nursing (DON) stated the cutoff time for receiving medications from their pharmacy was 5PM. After 5PM, there was a pharmacist on call 24 hours per day, who called the local backup pharmacy. She stated the nursing staff should be sure medications were sent to the facility. If medications were not given, she expected the staff to circle their initials and document a reason on the back of the MAR and in the nursing notes. She expected the staff to follow up with the physician if medication was not available for some reason or if the resident continually refused medication. The DON reviewed resident #82's MAR and acknowledged the trazodone was not given as ordered. In a telephone interview on 7/2/12 at 4:07PM, the nurse (nurse #4) responsible for administering resident #82's bedtime medications, stated if a medication was not given, the nurses' initials were circled. Nurse #4 stated there had been problems with the resident's trazodone not being available. She had to get the medication from the facility's emergency supply or borrow it from another resident. The nurse stated she repeatedly asked the morning nurses to call the pharmacy regarding the trazodone not being available. She also spoke to the nurse practitioner about it several times.	F 425			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431			

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 431	<p>Continued From page 18</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on continuous observation and staff interviews the facility failed to ensure 1 of 1 facility wound care treatment cart was secure when not</p>	F 431	<ol style="list-style-type: none"> 1. The facility has 1 treatment cart. The consistently locked cart has been observed across both shifts as is expected when not in use and/or unattended. 2. Medications and biologics are stored in multiple places in the facility including the 2 med rooms, 4 medication carts as well as the treatment cart. The nurses have the potential to not properly secure the areas when not in use. The DNS has validated daily that the med rooms, and med carts continue to be properly locked when unattended as was seen in our 6/20/12 survey. 		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 431	<p>Continued From page 19 being used.</p> <p>Findings include:</p> <p>On 06/28/2012 from 7:30 a.m. to 8:05 a.m. a continuous observation was made of the facility 's wound care treatment cart located on the red hall next to room 221. The treatment cart was observed to be unattended in front of room and the cart's locking mechanism (button) was in the out position and had a red dot on the side of the mechanism indicating it was out and unlocked. During the observation residents, housekeeping staff, therapy staff, and nursing assistant staff were observed passing in close proximity to the unlocked wound care treatment cart. The hall 's medication nurse was observed administering residents their medications and going in and out of the resident's rooms in close proximity of the cart but was not utilizing the cart.</p> <p>On 06/28/2012 at 8:05 a.m. an interview was conducted with the facility's wound care nurse, staff member # 5 concerning the facility's wound care treatment cart. Staff member #5 indicated the cart was unlocked and unattended. Staff member #5 stated, " When the locking mechanism is in the out position and the red dot is showing the cart is unlocked. I just came on duty, the night nurses are required to do the wound care for the resident's after 7:00 p.m. after I go home until I return in the morning about now - they must have left it unlocked." Staff member #5 was asked if the cart was allowed to be left unlocked. Staff member #5 stated, "The wound care treatment cart is supposed to be locked at all times when it is not being used in a treatment. " When asked who may have left the cart</p>	F 431	<p>3. To ensure ongoing compliance, audits are continuing across both shifts to validate areas and carts remain locked when unattended throughout the day. A visual cue was secured to the top of the treatment cart to remind the nursing team that the cart is to be locked when they walk away from it. The Admin team will perform spot checks to validate that the carts and med rooms remain properly secure. The treatment nurse is to report daily to the DNS if she comes on shift and finds the treatment cart unlocked. The nurses have been inserviced on this expectation and will continue to be as hired during orientation.</p> <p>4. Nursing Administration will track any variance from expectation. The results will be discussed at the monthly PI meeting of the IDT team. The DNS is responsible to ensure full compliance of the process by 7/27/2012</p>	7/27/12	

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(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 431	<p>Continued From page 20</p> <p>unlocked the wound care nurse looked at the shift schedule and Treatment Administration Record (TAR) book then stated, "The night nurse from last night (staff member #6) did a dressing change sometime between midnight and 7:00 a.m. on a resident on the 200 hall. "</p> <p>An interview was conducted on 06/28/2012 at 8:10 a.m. with the 200 hall (red hall) medication nurse, staff member # 7. Staff member #7 was asked who used the facility ' s wound care treatment cart leaving it on her hall unlocked and unattended. Staff member #7 stated, " (staff member #6) was on duty last night. The night nurse does not report off the dressings they change to the morning shift nurse, we only have 2 residents that are receiving wound care twice a day on this hall. I don't know how long the cart was unlocked. I've been passing medications this morning since I came on duty and have been in and out of other resident's rooms." Staff member # 6 was unavailable for interview.</p> <p>On 06/28/2012 at 8:35 a.m. a review of the facility ' s night shift staffing schedule indicated the nurse working the hall was staff member #6. A review of the TAR book indicated a resident on the hall was signed off for having received wound care treatment and a dressing change of the coccyx area between midnight and 7:00 a.m. The initial on the TAR was a C. Staff member # 5 indicated the initial written on the resident's TAR was that of the night nurse, staff member # 6.</p> <p>An interview was conducted with the facility's Director of Nursing (DON) on 06/29/2012 at 10:10 a.m. The DON was asked what her expectation was for the nursing staff to secure the wound</p>	F 431			

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514	
(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 431	Continued From page 21 care treatment cart. The DON stated, "The wound care and medications carts are supposed to be locked/secured when not being used or unattended. "	F 431		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED AUG 13 2012 07/24/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS	K 000		
K 056 SS=D	<p>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system.</p> <p>The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation on Tuesday 7/24/12 at approximately 11:00 AM onward the following was noted; 1) The glass bulb for the sprinkler heads in resident room closets 201 and 203 were painted over and not maintained in good condition.</p>	K 056	<p>It is the practice of the facility to assure that all Life Safety systems are always in compliance and in working order at all times. It was noted on the Life safety inspection of a few sprinkler heads that had paint on the Heads.</p> <p>We had the Maintenance Supervisor look in all areas to see how many heads we had with this issue and the finds were noted.</p> <p>We hired an outside Company to replace the Heads noted on the inspection and any that we found and that work was completed on 8/2/12 and rechecked by Maintenance on 8/6/12. All completed on 8/6/12 and in Compliance.</p> <p>The Maintenance Supervisor will inspect Sprinkler Heads each week x 4 for 1 month and then Monthly after to assure this don't happen again.</p> <p>Findings will be discussed on the monthly PI and Safety Committee meetings.</p>	08/06/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Chonnette Ashburn* TITLE: *Executive Director* (X6) DATE: _____

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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345225	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CHAPEL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 E FRANKLIN ST CHAPEL HILL, NC 27514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 056	Continued From page 1 42 CFR 483.70(a)	K 056			