STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 07/10/2014

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

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		8/7/14

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

Electronically Signed | 08/03/2014

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

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include the reason for Medicare non-coverage on the "Notice of Medicare Non-Coverage" forms for 3 of 3 residents (Resident #35, #96 and #98) reviewed for liability notices. The findings included: 1. Resident #35 was issued notice on 5/30/14 that Medicare coverage would end on 6/3/14. No reason was included in the notice. During an interview on 7/9/14 at 2:16 PM, MDS nurse #1 acknowledged that she issued the Medicare non-coverage notices. MDS nurse #1 stated she used a computer generated form that utilized prompts for the information she needed to input, and no prompt came up to enter the reason for non-coverage. MDS nurse #1 added she was not aware the reason needed to be included in the notice. 2. Resident #96 was issued notice on 4/9/14 that Medicare coverage would end on 4/14/14. No reason was included in the notice. During an interview on 7/9/14 at 2:16 PM, MDS nurse #1 acknowledged that she issued the Medicare non-coverage notices. MDS nurse #1 stated she used a computer generated form that utilized prompts for the information she needed to input, and no prompt came up to enter the reason for non-coverage. MDS nurse #1 added she was not aware the reason needed to be included in the notice.	F 156	1. MDS nurse #1 was provided one to one in-servicing by the DDCO (District Director of Clinical Operations) on the Medicare Services Policy which includes providing the reason for Medicare Non-coverage on the "Notice of Medicare Non-Coverage" forms with an emphasis on documenting a reason for noncoverage. 2. Residents requiring Notice of Medicare Non-Coverage forms have been identified as having the potential to be affected. 3. ED (Executive Director) will perform an audit on residents with current Medicare benefit to validate compliance with the Medicare Services Policy. A copy of the Notice of Medicare Non-Coverage forms will be provided to the ED by the MDS nurse weekly x 4, then monthly x 3 to ensure ongoing compliance with documenting a reason for noncoverage on the Medicare Non-Coverage forms. 4. Data results will be analyzed and reviewed at the centers monthly QAPI meething for 3 months with a subsequent plan of correction as needed.	

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F 156	Continued From page 3 3. Resident #98 was issued notice on 2/6/14 that Medicare coverage would end on 2/10/14. No reason was included in the notice. During an interview on 7/9/14 at 2:16 PM, MDS nurse #1 acknowledged that she issued the Medicare non-coverage notices. MDS nurse #1 stated she used a computer generated form that utilized prompts for the information she needed to input, and no prompt came up to enter the reason for non-coverage. MDS nurse #1 added she was not aware the reason needed to be included in the notice.	F 156		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to provide showers for 1 of 1 resident (Resident #32 who expressed a preference for showers. The findings included: Resident #32's active diagnosis included Cerebrovascular Accident. Resident #32's last	F 242	1. Resident #32 is receiving a shower weekly as requested. This resident's care card has been updated to reflect the shower preference and the level of assistance required. NA#5, NA#6, and NA#7 were re-educated to the facility's policy and procedures regarding Residents Rights with an emphais on honoring the resident choices (within	8/7/14

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F 242	Continued From page 4 Minimum Data Set (MDS) was dated 05/04/2014 and indicated Resident #32 was cognitively intact, independent with bathing, needed set-up help only, was at risk for falls related to an unsteady gait and found it somewhat important to choose between a tub bath, shower, bed bath or sponge bath. A review of Resident #32's "Nursing Care Plan" facility forms dated 4/23/14 and 5/27/2014 both included an identified "Focus" area that read, "Resident has a self-care deficit related to decreased stamina/weakness." The nursing care plan goal (in part) read, "Resident will have no negative psychosocial impact related to bathing and/or showering. Resident will accept assistance during bathing and/or showering." Nursing Care Plan interventions (in part) included "Honor resident's choices and preferences whenever possible. Resident will like a shower every Friday after dinner. Staff is to offer to bathe resident on a daily basis." A record review of Resident #32's facility document titled, "C.N.A. Flow Record", revealed documentation that indicated Resident #32's performance of Activities of Daily Living required limited assistance with one person assistance. The C.N.A. Flow Record had a daily section for each shift to document shampoo and shower/bath. Review of the C.N.A. Flow Record for the months of May, June and July 2014 revealed documentation that indicated the month of May was documented as not applicable (N/A) for shampoo, shower/bath. Documentation for the month of June indicated that Resident #32 had a bed bath (BB) 7 of 30 days and a partial bath (P) 7 of 30 days. All other days were documented as not applicable (N/A). In the month	F 242	reasonable accommodations) for bathing and showers. 2.The DNS, ADNS, and/or the SDC will perform a one time audit with current resident population to determine bathing preferences. Bathing/Shower preferences will then be updated on the resident care card, shower schedules, and care plans. 3. The Staff Development Coordinator will re-educate the Nursing Assistants and the Licensed Nurses to the centers policy and procedures regarding Residents Rights with an emphasis on honoring the resident choices (within reasonable accommodations) for bathing and showers. This information will be included in the new employee orientation program for direct caregivers. 4. The DNS and or the ADNS will interview 5 interviewable residents and review the ADL documentation records for 5 uninterviewable residents on various shifts and halls to include weekends 5 times a week for 4 weeks, 2 x week x 4, weekly x 4, then monthly x 3 to ensure compliance with showers and bathing preferences. 5. Data results will be analyzed and reviewed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed.	

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of July, Resident #32 had a bed bath (BB) on July 1st, 2nd and 5th. All other days were documented as N/A.

A record review of Resident #32's Resident Care Card for June and July 2014 had documentation that indicated Resident #32 was independent for grooming and bathing. A comment note written under "Other" read "Please offer resident to have a bath on a daily basis." The Resident Care Card did not indicate a choice for shower or bed bath.

On 7/8/14 at 11:35 am, an interview with Resident #32 revealed that he bathed in his room every day. Resident #32 stated, "I take a bath in the bathroom every day, head to feet on my own." Resident #32 added, "I cannot take a shower here because the nurses say it is not safe for me to stand up in the shower. I have asked about showers. I even asked last week, and they (the NAs ((nursing assistants)) and nurses) say that they are going to help me get one and then they never show up. I do not get a choice to take a shower here, I would like a shower. I did not know they had shower chairs. I am going to ask them about a shower tomorrow, today is half gone already."

On 7/9/2014 at 10:45 am, an observation of Resident #32 revealed the resident was clean shaven, with hair clean and well-groomed. Resident #32 was fully dressed, resting in bed. Resident #32 indicated that he had bathed and groomed himself without assistance. An interview with Resident #32 revealed that Resident #32 had shaved, bathed and dressed himself. Resident #32 stated, "I talked with the LPN (Licensed Practical Nurse) yesterday and she said I could get a shower if I like, but that I would have to

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have one person to help me. I told her it was okay to have someone with me to help. I do not know when I will get the shower though. I do not remember what her name was."

On 7/10/14 at 9:25am, an interview with Nurse #5 assigned to Resident #32's hall revealed a "Shower Schedule" for the residents on her hall. The Shower Schedule had resident room numbers correlated with the days of the week. Residents were scheduled for two showers a week. Resident #32's room number was listed on the shower schedule.

On 7/10/14 at 9:25 am, an observation revealed that Resident #32 was in his wheelchair and self-propelling past the nurse station. Nurse #5 indicated that Resident #32 usually gives his own bath in his bathroom. Nurse #5 indicated that the NAs offer to bathe residents each day. Nurse #5 indicated that if a resident prefers a shower the resident can ask for a shower and the NA would help the resident with a shower. Nurse #5 stated, "If a resident wants a shower they can have one, we ask them what they prefer. If they are unable to tell us what they prefer we ask the family." Nurse #5 indicated that most of the residents do not go to the shower and most of the residents receive bed baths or assistance with their bathing.

On 7/10/14 at 9:55 am, an interview with Resident #32 revealed that he would like a shower at least once a week and it could be on Saturday after lunch. Resident #32 stated, "Where I grew up, you got a shower at least once a week. I have not had one in a long time."

On 7/10/14 at 10:30a.m., an interview with NA#5

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F 242	Continued From page 7	F 242		

revealed that she had never given resident #32 a shower. NA #5 stated, "He is always up and out of the room by the time I get here at 7 am. But I always offer to give him a bath or help with his grooming and ADLs." NA #5 indicated that the NAs do not specifically offer showers but they do offer help with baths and ADLs. If a resident wanted a shower they could get one, but would probably have to ask for a shower.

On 7/10/14 at 10:50 am, an interview with NA #6 indicated that showers were offered on the 3 pm -11pm shift. NA #6 stated, "Residents get a bed bath in the mornings. They usually do not like a shower on 7 am - 3 pm shift, but if they want a shower they can have one. We have a few residents that are independent with showers and use the shower facility."

On 7/10/14 at 3:30 pm, an interview with NA #7 who primarily works on the 3 pm - 11 pm shift, revealed that the residents she was responsible for did not receive showers. NA #7 indicated that if a resident wanted a shower she would tell the nurse and then give the resident a shower. NA #7 indicated that all of the residents on the hall she was assigned to have a bed bath in the morning. NA #7 indicated she would give a partial bath to residents on her shift if they needed one. NA #7 revealed that she was not aware of a shower schedule and had not been asked to offer or give showers on the 3 pm - 11 pm shift.

On 7/10/14 at 4:00 pm an interview with the Director of Nursing (DON) indicated that residents had the choice of a shower, if they wanted a shower. The DON stated, "If a shower is indicated on the care plan, the resident should be offered a shower according to the plan. If a

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F 242	Continued From page 8 resident refuses a shower or bath, this should be recorded. The residents' choice of shower, self-bath or bed bath should be consistent with the Nursing Care Plan." The DON indicated that residents would be offered a shower usually twice a week and the residents' preference or refusal would be recorded on the C.N.A. Flow Record. The DON also indicated that the NA should communicate any concerns with ADLs to the nurse.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interviews, the facility failed to provide showers for 1 of 1 resident (Resident #32) whose care plan was not implemented according to the Interdisciplinary Care Plan The findings included: Resident #32's active diagnosis included Cerebrovascular Accident. Resident #32's last Minimum Data Set (MDS) was dated 05/04/2014 and indicated Resident #32 was cognitively intact, independent with bathing, needed set-up help only, was at risk for falls related to an unsteady gait and found it somewhat important to choose between a tub bath, shower, bed bath or sponge bath.	F 282	1. Resident #32 care plan and care card has been updated. He is receiving showers according to his preference and plan of care. 2. DNS, ADNS, or SDC will perform a one time audit on current resident care plans and care cards to validate shower preferences. Care plan/care card inconsistencies related to shower preferences will be clarified and updated as needed. 3. The SDC will re-educate the Interdisciplinary Team (IDT) and Licensed Nurses regarding updating the care plan/ care card as it relates to resident shower	8/7/14

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F 282	Continued From page 9 A review of resident #32's "Nursing Care Plan" facility forms dated 4/23/14 and 5/27/2014 both included an identified "Focus" area that read, "Resident has a self-care deficit related to decreased stamina/weakness." The nursing care plan goal (in part) read, "Resident will have no negative psychosocial impact related to bathing and/or showering. Resident will accept assistance during bathing and/or showering." Nursing Care Plan interventions (in part) included "Honor resident's choices and preferences whenever possible. Resident will like a shower every Friday after dinner. Staff is to offer to bathe resident on a daily basis." A record review of Resident #32's facility document titled, "C.N.A. Flow Record", revealed documentation that indicated Resident #32's performance of Activities of Daily Living required limited assistance with one person assistance. The C.N.A. Flow Record had a daily section for each shift to document shampoo, shower/bath. Review of the C.N.A. Flow Record for the months of May, June and July 2014 revealed documentation that indicated the month of May was documented as not applicable (N/A) for shampoo, shower/bath. Documentation for the month of June indicated that resident #32 had a bed bath (BB) 7 of 30 days and a partial bath (P) 7 of 30 days. All other days were documented as not applicable (N/A). In the month of July, Resident #32 had a bed bath (BB) on July 1st, 2nd and 5th. All other days were documented as N/A. A record review of Resident #32's Resident Care Card for June and July 2014 had documentation that indicated Resident #32 was independent for	F 282	preference. The SDC will re-educate the direct caregivers regarding adherence to the care plan/care cards with an emphasis on showers. The above in-service will be included in the new employee orientation program for direct caregivers. 4. The DNS and or the ADNS will audit 5 residents' care plans, care cards, and NA flow records for shower/bathing preferences 2 x weekly x 4 weeks then weekly x 4 and monthly x 3 to ensure that residents care plan for showers are implemented. 5. Data results will be reviewed and analyzed at the centers monthly QAPI meeting for three months with a subsequent plan of correction as needed.	

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grooming and bathing. A comment note written under 'Other' read "Please offer resident to have a bath on a daily basis." The Resident Care Card did not indicate a choice for shower or bed bath.

On 7/8/14 at 11:35 am, an interview with Resident #32 revealed that he bathed in his room every day. Resident #32 stated, "I take a bath in the bathroom every day, head to feet on my own." Resident #32 added, "I cannot take a shower here because the nurses say it is not safe for me to stand up in the shower. I have asked about showers. I even asked last week, and they (the NAs ((nursing assistants)) and nurses) say that they are going to help me get one and then they never show up. I do not get a choice to take a shower here, I would like a shower. I did not know they had shower chairs. I am going to ask them about a shower tomorrow, today is half gone already."

On 7/9/2014 at 10:45 am, an observation of Resident #32 revealed the resident was clean shaven, with hair clean and well-groomed. Resident #32 was fully dressed, resting in bed. Resident #32 indicated that he had bathed and groomed himself without assistance. An interview with Resident #32 revealed that Resident #32 had shaved, bathed and dressed himself. Resident #32 stated, "I talked with the LPN (Licensed Practical Nurse) yesterday and she said I could get a shower if I like, but that I would have to have one person to help me. I told her it was okay to have someone with me to help. I do not know when I will get the shower though. I do not remember what her name was."

On 7/10/14 at 9:25am, an interview with Nurse #5 assigned to Resident #32's hall revealed a

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"Shower Schedule" for the residents on her hall. The Shower Schedule had resident room numbers correlated with the days of the week. Residents were scheduled for two showers a week. Resident #32's room number was listed on the shower schedule.

On 7/10/14 at 9:25 am, an observation revealed that Resident #32 was in his wheelchair and self-propelling past the nurse station. Nurse #5 indicated that resident #32 usually gives his own bath in his bathroom. Nurse #5 indicated that the NAs offer to bathe residents each day. Nurse #5 indicated that if a resident prefers a shower the resident can ask for a shower and the NA would help the resident with a shower. Nurse #5 stated, "If a resident wants a shower they can have one, we ask them what they prefer. If they are unable to tell us what they prefer we ask the family." Nurse #5 indicated that most of the residents do not go to the shower and most of the residents receive bed baths or assistance with their bathing.

On 7/10/14 at 9:55 am, an interview with Resident #32 revealed that he would like a shower at least once a week and it could be on Saturday after lunch. Resident #32 stated, "Where I grew up, you got a shower at least once a week. I have not had one in a long time."

On 7/10/14 at 10:30a.m., an interview with NA#5 revealed that she had never given resident #32 a shower. NA #5 stated, "He is always up and out of the room by the time I get here at 7 am. But I always offer to give him a bath or help with his grooming and ADLs." NA #5 indicated that the NAs do not specifically offer showers but they do offer help with baths and ADLs. If a resident

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wanted a shower they could get one, but would probably have to ask for a shower.

On 7/10/14 at 10:50 am, an interview with NA #6 indicated that showers were offered on the 3 pm -11pm shift. NA #6 stated, "Residents get a bed bath in the mornings. They usually do not like a shower on 7 am - 3 pm shift, but if they want a shower they can have one. We have a few residents that are independent with showers and use the shower facility."

On 7/10/14 at 3:30 pm, an interview with NA #7 who primarily works on the 3 pm - 11 pm shift, revealed that the residents she was responsible for did not receive showers. NA #7 indicated that if a resident wanted a shower she would tell the nurse and then give the resident a shower. NA #7 indicated that all of the residents on the hall she was assigned to have a bed bath in the morning. NA #7 indicated she would give a partial bath to residents on her shift if they needed one. NA #7 revealed that she was not aware of a shower schedule and had not been asked to offer or give showers on the 3 pm - 11 pm shift.

On 7/10/14 at 4:00 pm an interview with the Director of Nursing (DON) indicated that residents had the choice of a shower, if they wanted a shower. The DON stated, "If a shower is indicated on the care plan, the resident should be offered a shower according to the plan. If a resident refuses a shower or bath, this should be recorded. The residents' choice of shower, self-bath or bed bath should be consistent with the Nursing Care Plan." The DON indicated that residents would be offered a shower usually twice a week and the residents' preference or refusal would be recorded on the C.N.A. Flow Record.

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F 282	Continued From page 13 The DON also indicated that the NA should communicate any concerns with ADLs to the nurse.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor the frequency of bowel movements for 2 of 3 residents whose bowel movement records were reviewed (Resident #169 and #131). The findings included. 1. The physician's undated standing orders titled (Name of physician's) Standing Orders read: "8. Milk of Magnesia 30 ml (milliliters) po (by mouth) PRN (as needed) daily (constipation). 9. Dulcolax tablet 5 mg (milligrams) po daily PRN (constipation). 10. Colace 100mg po BID (twice a day) (recurrent constipation)." Resident #169 was admitted to the facility on 6/28/14 and had diagnoses of Aftercare for Traumatic Fracture of Hip and Dementia. An admission progress note dated 6/28/14 revealed Resident #169 was alert and oriented to self only.	F 309	1. Resident #169 and #131 bowel frequency is being monitored and reviewed by the LN. This information will be documented on the MAR. 2. DNS, ADNS, or SDC will perform a one time bowel assessment audit on current resident population to ensure that each resident has had a bowel movement within 3 days. Residents identified as to not having a bowel movement in 3 days will be administered a stool softener or a laxative per physicians' standing order. 3. The SDC will re-educate the Licensed Nurses to the facility's bowel assessment protocol. The Bowel Protocol has been added to the resident's Medication Administration Record. Licensed nurses will document every shift on the Medication Administration Record, the	8/7/14

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F 309	Continued From page 14 The initial Care Plan dated 6/28/14 revealed the resident required assistance with activities of daily living and did not include information regarding constipation. There were no nurse's notes related the resident's bowel movement status from 7/3/14 to 7/8/14. A nursing progress note dated 7/8/14 at 10:32 AM revealed the resident was incontinent of bowel and bladder but occasionally would request the bedpan to have a BM. Review of the resident's June 2014 monthly physician's orders revealed an order for Percocet 5/325 mg (milligrams) 1 tablet every 4 hours as needed for pain. The July 2014 monthly orders were not on the chart. Review of the written physician's orders revealed there were no changes in the resident's pain medication for June or July 2014. Review of the resident's Medication Administration Record (MAR) for July 2014 revealed the resident had received the prescribed dose of Percocet twice on 7/1/14, once on 7/2/14, once on 7/3/14, once on 7/4/14, twice on 7/5/14, once on 7/6/14, twice on 7/7/14, twice on 7/8/14 and once on 7/9/14. Percocet is a narcotic medication used for moderate to severe pain. The package insert listed one of the most common side effects of Percocet as being constipation. There was an entry on the July 2014 MAR for Milk of Magnesia 30 ml PO daily PRN constipation. The MAR revealed the resident had not received the Milk of Magnesia or other medications for constipation in July 2014. Review of the C.N.A. (Certified Nursing Assistant) Flow Record for July 2014 for Resident #169	F 309	presence or absence of a bowel movement. If no BM in 3 days, initiate bowel protocol. This in-service will be included in the new employee orientation for Licensed Nurses. 4. The DNS, ADNS, and/or the SDC will audit 5 residents' bowel records 3 x weekly x 4, then weekly x 4, and monthly x 3 to ensure ongoing compliance with monitoring resident bowel elimination. 5. Data results will be reviewed and analyzed at the centers monthly QAPI meeting for three months with a subsequent plan of correction as needed.	

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revealed documentation that showed no bowel movement (BM) for July 3-8 (6 days).

NA #1 stated in an interview on 7/10/14 at 9:00 AM the NAs document in the flow record when the resident had a BM. The NA stated the charge nurse looked to see when a resident had a BM and gave them something if needed.

Nurse #1 stated in an interview on 7/10/14 at 9:00 AM the NAs (nursing assistants) document whether or not the resident had a BM and if the resident had not had a BM in 2-3 days, they had orders to give them something if needed, especially if they were on pain medication. The Nurse stated she thought that NA #2 looked at the book every morning to monitor when the residents last had a BM.

The Director of Nursing (DON) stated in an interview on 7/10/14 at 9:10 AM that NA #2 checked the BM record every morning and wrote down the names of residents who had not had a BM in 3 days and gave the list to the nurses to give the resident something according to the protocol. The DON was observed to review the July 2014 BM record for Resident #169 and stated that according to the bowel record the resident had not had a BM in 6 days.

The DON stated in an interview on 7/10/14 at 12:13 PM that NA #3 remembered the resident having a BM on 7/5/14 and on 7/8/14 but did not document it.

NA #3 stated in an interview on 7/10/14 at 2:10 PM she remembered the resident having a BM on 7/5/14 and 7/8/14 at the end of her shift. The NA stated she had already completed her

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F 309	Continued From page 16 documentation and did not go back and document the BM on the flow sheet. 2. Resident #131 was admitted to the facility on 11/7/13. Diagnoses included dementia. The most recent Minimum Data Set (MDS) was a quarterly assessment dated 5/15/14. The MDS indicated the resident had severe cognitive impairment, required extensive assistance of 1 person with toileting and was occasionally incontinent of stool. The admission MDS dated 11/14/13 indicated the resident was not constipated. The physician's undated standing orders for constipation for Resident #131 included Milk of Magnesia daily as needed, Dulcolax tablet daily as needed and Colace 100 milligrams twice a day for recurrent constipation. The Nursing Assistant Flow Record for July included designated rows for documentation of the size and number of bowel movements each shift on each day of the month. The form indicated a zero should be documented if the resident had no bowel movement that shift. The documentation on the form indicated Resident #131 had no bowel movements on any shift from July 1st - July 4th. On July 5th the resident had a medium sized bowel movement on the 3-11 shift and a small bowel movement on the 11-7 shift. The form indicated no bowel movements from July 7th through the 7-3 shift on July 10th. Resident #131's July Medication Administration Record (MAR) revealed the resident was on	F 309		

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scheduled Colace 100 mg twice a day and the resident received a Dulcolax 100 mg suppository on 7/10/14 on the 7-3 shift.

On 7/7/14 at 4:30 PM Resident #131 was observed to come out of the bathroom independently. No staff member was in attendance.

The Director of Nursing (DON) stated in an interview on 7/10/14 at 9:10 AM that NA #2 checked the BM record on the Nursing Assistant Flow Record every morning and wrote down the names of residents who had not had a BM in 3 days and gave the list to the nurses to give the resident something according to the protocol.

On 7/10/14 at 4:15 PM, Nursing Assistant (NA) #4 was interviewed and indicated since Resident #131 got up to the bathroom by herself she simply asked the resident if she had a bowel movement. NA #4 indicated the resident was confused but believed the resident was reliable in what she said about her bowels.

During an interview on 7/10/14 at 5:05 PM, the Director of Nursing (DON) stated that Resident #131 should have been on the Laxative List after 3 days without a bowel movement which would have been 7/4/14 and 7/9/14. The DON provided the Laxative List dated 7/10/14 which included Resident #131's name.

On 7/10/14 at 5:36 PM, Nurse #6, accompanied by the DON, volunteered that she recalled Resident #131 having bowel movements on 7/4/14 and 7/9/14 but she did not document them. The DON indicated the facility had a problem with accurately tracking bowel movements.

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F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to be free of a medication error rate of 5% or greater as evidenced by 2 medication errors out of 27 opportunities resulting in a medication error rate of 7.4% for 2 of 5 residents observed during medication pass (Resident #118 and #80). The findings included: 1. Humalog Insulin is a fast acting insulin used to control blood glucose (sugar). The manufacturer's package insert for Humalog Insulin read: "Should be injected 15 minutes before or immediately after the meal." Resident #118 was re-admitted to the facility on 3/6/14 and had diagnoses that included Diabetes Mellitus. On 7/8/14 Nurse #2 was observed to prepare and administer Humalog Insulin 4 units subcutaneously (sq) to Resident #18 at 3:38 PM. The physician's order read: "Humalog Insulin 4 units subcutaneously before supper." The time on the Medication Administration Record revealed the medication was to be given at 4:30 PM. Nurse #2 stated in an interview on 7/8/14 at 3:50 PM that she usually gave insulin ordered before supper around 4:00-4:15 PM and that the resident ate his meals in the main dining room. When it was pointed out to the nurse that she gave the insulin at 3:38 PM, the Nurse stated she did not realize it was that early when she gave the	F 332	1. Resident #118 is receiving Humalog Insulin 15 minutes before or after meals. Resident #80 medications are administered separately with 5 cc of water between each medication. Nurse #2 has been educated by the ADNS regarding administration of insulin and Nurse #3 has been educated regarding administering medications via G-tube. 2. The DNS, ADNS, or SDC will perform a one time audit on Humalog insulin orders to ensure that the medication times are specified (on the MAR) to be administered 15 minuted before or after meals. The DNS, ADNS, or SDC will audit current resident population receiving tube-feeding to ensure that orders are accurately written to administer medications separately with 5 cc of water between each medication. 3. The SDC will re-educate the Licensed Nurses to the facility's policy and procedure for administering insulin's and medications via tube-feeding with an emphasis on meal times and administering the medication separately with 5 cc water in between. The above in-service will be included in the new	8/7/14

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F 332	Continued From page 19 insulin to Resident #118. A dining schedule provided by the facility revealed the evening meal was to be served in the main dining room at 5:00 PM. The Director of Nursing (DON) stated in an interview on 7/10/14 at 8:13 AM that the nurses have an hour before and after the scheduled time to administer a medication. The DON stated that Humalog Insulin was fast acting but did not know the exact time frame. 2. Resident #80 was re-admitted to the facility on 3/6/14 and had diagnoses including Cerebrovascular Accident (Stroke), Hypertension, Depression and Gastric Tube. The facility was unable to provide a written policy on the administration of medications by gastric tube. The June 2014 monthly physician orders for Resident #80 read: "Flush feeding tube with 5 milliliters of water between each medication." The July 2014 monthly orders were not on the medical record. There were no additional written physician's orders regarding the flushes for the G-tube medications for June or July 2014. On 7/9/14 at 8:27 AM, Nurse #3 was observed to prepare and administer medications to Resident #80. The nurse was observed to dispense 1 (one) 10mg (milligram) tablet of Lisinopril (medication for hypertension), 1 (one) 5mg tablet of Norvasc (medication for hypertension), 1 (one) 50mg tablet of Lopressor (medication for Hypertension), 1 (one) 75mg tablet of Plavix (medication to prevent blood clots), and 1 (one) 20mg tablet of Lexapro (medication for depression) in the same medicine cup. The nurse was observed to empty the cup of medications into a plastic bag and put the bag in the pill crusher and crushed the medications. The nurse was observed to pour the crushed pills into a plastic medicine cup, add	F 332	employee orientation program for Licensed Nurses. 4. The DNS, ADNS, ED and/or the SDC will observe residents receiving Humalog insulin and medication administration via tube-feeding on various hall and various shifts to include weekends 5 x weekly x 4 weeks, 2 x weekly x weeks, 2 x weekly x 4, and monthly x 3 to ensure ongoing compliance. 5.Data results will be reviewed and analyzed at the centers monthly QAPI meeting for three months with a subsequent plan of correction as needed.	

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F 332	Continued From page 20 water to the cup and stir the mixture to dissolve the medications. The nurse was observed to administer the pill mixture to the resident per the resident's gastric tube (G-tube). On 7/9/14 at 8:40 AM Nurse #3 stated in an interview that she was told she could give the pills together when administering medications per G-tube. On 7/10/14 at 8:13 AM, the Director of Nursing (DON) stated in an interview that the medications were to be given one at a time. The DON stated the nurse knew she was supposed to give each medication separately but did what someone had told her in the past instead of following her own instincts.	F 332		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to provide an appropriate barrier between ready to eat food and the servers' bare hands for 2 staff members (NA #2 & NA #5) who picked up bread with their bare hands during 3 of 3 observed meals. The findings included:	F 371	1. NA#2 and NA#5 was in-serviced by the ADNS on safe food handling with an emphasis on touching the residents food without the use of a barrier. 2. The SDC educated the NA's and the Licensed Nurses on the importance of not	8/7/14

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F 371	Continued From page 21 A dining observation was conducted on 7/7/14 at 12:54 PM. NA #2 was observed to place a tray on the dining table for a resident. She then assisted the resident with putting condiments on the hamburger by removing the bun with her bare hands then replacing the bun and holding the hamburger with fingers while cutting it in half. She then handed the resident one half of the hamburger with her bare hands. At 12:55 PM NA #2 was observed to assist another resident by placing condiments on the hamburger the same way. She removed and replaced the bun with her bare hands then adjusted the hamburger on the plate. Afterwards she used the knife and fork to cut the hamburger and feed it to the resident. Continued observations of this lunch period revealed at 12:56 PM NA #5 picked up one half of a hamburger on bun with her bare hands and placed it in a resident's hand. During breakfast service on 7/9/14 at 8:23 AM NA #2 was observed putting jelly on a resident's biscuit. She held the edge of the biscuit with her bare fingers. On 7/10/14 at 8:15 AM NA #2 was observed to pick up each of the 2 slices of toast with her bare hands as she put butter and jelly on them for the resident. She then sanitized her hands and left the dinning room. NA #2 returned pushing a wheelchair. She positioned the resident in the wheelchair at the table, retrieved his tray from the cart and placed it on the table. She then assisted the resident with his tray and used her bare hands to hold his toast in place on the plate and spread the butter and jelly to the toast.	F 371	touching the residents ready to eat food with their bare hands and utlizing an appropriate barrier. This in-service will be included in the new employee orientation program for NA's and Licensed Nurses. 3.The DNS,ADNS, ED, and/or the SDC will observe 5 residents during various meal times in the dining room and resident rooms to include weekends. The monitoring will occur 5 x weekly x 4 weeks, 3 x weekly x 4, weekly x 4, and monthly x 3 to ensure that the staff is not touching ready to each foods and utilizing appropriate barriers during meals. 5. Data results will be reviewed and analyzed at the centers monthly QAPI meeting for three months with a subsequent plan of correction as needed.	

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F 371	Continued From page 22 During an interview with NA #2 on 7/10/14 at 8:30 AM she stated she picked up the toast with her bare hands and should not have touched the resident's toast with her bare hands. She said should have worn gloves.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of 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. 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. 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. 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	F 431		8/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 07/10/2014

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

(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 23 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy review, the facility failed to remove expired insulin from a medication cart for one of four medication carts and failed to store unopened insulin in the refrigerator for one of four medication carts. The findings included: The facility policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles dated 12/1/07, number 4 read: "Facility should ensure that medications and biologicals: 4.1 Have an expiration date on the label and 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines." The manufacturer's package insert for Lantus Insulin read: "Opened LANTUS vials must be discarded after 28 days even if they contain insulin." On 7/10/14 at 10:15 AM, an observation of the medication cart for the 300 hall was made with Nurse #4. One bottle of Lantus Insulin was dated as opened on 6/6/14 and an expiration date written on the bottle of 7/3/14. Nurse #4 stated a bottle of Lantus Insulin was good for 28 days after it was opened and that the bottle of insulin had expired. The nurse was observed to dispose of the bottle of insulin in the sharps container on the medication cart. 2. The facility's policy on medication storage did not specifically address the storage of insulin. The manufacturer's package insert for Humalog insulin read: "Store all unopened HUMALOG in a	F 431	1. The expired Lantus and the (3) unrefrigerated unopened vials of Humalog insulin were discarded. 2. The ADNS and DNS performed a medication cart audit on the facility med carts to identify expired or un-opened/unrefrigerated insulins. No other expired insulins were found during the medication cart audit. 3. The SDC re-educated the Licensed Nurses to the centers policy and procedure regarding medication storage with an emphasis on expiration dates and refrigerating unopened insulins. This in-service will be included in the new employee orientation program for Licensed Nurses. 4. The DNS, ADNS, and/or the SDC will audit 4 medication carts 2 x weekly for 4 weeks and weekly x 4 then monthly x 3 to ensure ongoing compliance with medication storage of insulin. 5. Data results will be reviewed and analyzed at the centers monthly QAPI meeting for three months with a subsequent plan of correction as needed.	

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F 431	Continued From page 24	F 431		

refrigerator at 36 degrees Fahrenheit to 46 degrees Fahrenheit. Throw away an opened vial after 28 days of use."
On 7/10/14 at 10:35 AM, an observation of the medication cart for the 400 hall was made with Nurse #5. There were 3 unopened bottles of Humalog Insulin that contained a pharmacy dispense date of 7/8/14. Nurse #5 stated that unopened insulin was supposed to be stored in the refrigerator.
The Director of Nursing (DON) stated in an interview on 7/10/14 at 10:51 AM that unopened insulin should be stored in the refrigerator until ready to be opened.
3. The facility's policy on medication storage did not specifically address the storage of insulin.
The manufacturer's package insert for Lantus insulin read: "Unopened LANTUS vials should be stored in a refrigerator between 36 degrees Fahrenheit and 46 degrees Fahrenheit. Opened LANTUS vials must be discarded after 28 days."
On 7/10/14 at 10:35 AM, an observation of the medication cart for the 400 hall was made with Nurse #5. There were 3 unopened bottles of Lantus insulin stored in the top drawer of the medication cart. The 3 vials contained a pharmacy dispense date of 7/8/14. Nurse #5 stated that unopened insulin was supposed to be stored in the refrigerator.
The Director of Nursing stated in an interview on 7/10/14 at 10:51 AM that unopened insulin should be stored in the refrigerator until ready to be opened.
4. The facility's policy on medication storage did not specifically address the storage of insulin.
The manufacturer's package insert for Levemir insulin read: "Unused (unopened) LEVEMIR should be stored in the refrigerator between 36 degrees Fahrenheit and 46 degrees Fahrenheit.

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F 431	Continued From page 25 LEVEMIR vials should be discarded 42 days after they are first kept out of the refrigerator." On 7/10/14 at 10:35 AM an observation of the medication cart for the 400 hall was made with Nurse #5. There was 1 unopened bottle of Levemir insulin stored in the top drawer of the medication cart. The vial contained a pharmacy dispense date of 7/8/14. Nurse #5 stated that unopened insulin was supposed to be stored in the refrigerator. The Director of Nursing stated in an interview on 7/10/14 at 10:51 AM that unopened insulin should be stored in the refrigerator until ready to be opened.	F 431		