STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		8/24/16

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

Electronically Signed | 08/12/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a significant change assessment for Resident #40 who was receiving hospice/palliative care for 1 of 1 resident that was reviewed for hospice. The findings included: Resident #40 was originally admitted to the facility on 5/3/16 with diagnoses including Alzheimers Disease with late onset, Chronic Kidney Disease, stage 4 (severe) and Hypertension. According to the most recent Minimum Data Set (MDS) dated 5/10/16, Resident #40 required extensive to total assistance in most areas of activities of daily living. Review of a doctor's order dated 5/12/16 read, "Palliative Consult for Advanced Dementia." Review of a doctor's order dated 6/17/16, read, "Hospice (named hospice care provider)." Review of doctor's order read, "Pain monitoring using verbal/nonverbal 0-10 scale- every shift for monitoring level of comfort." Review of Resident #40's Hospice Care Plan dated 7/12/16, revealed goals were developed in the areas of Activities of Daily Living (ADLs), Dementia/Mobility/Falls, Nutrition, Skin/Wound, Spiritual Care and Family Support. During an interview on 07/27/2016 at 2:58 PM, Staff Nurse #1 revealed Resident #40 received hospice care. She stated a Nursing Assistant	F 272	This plan of Correction is the center's credible allegation of Compliance: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F272 8/24/2016 1. Resident #40 had a MDS modification completed for a significant change to include hospice. 2. An audit was conducted to ensure current residents with the following diagnosis (Hospice) coded correctly. At the conclusion of the audit, no other residents affected. The MDS team has been in-serviced regarding significant changes to include hospice. 3. The MDS Coordinator with the IDT team will review all new admissions at morning clinical meeting to ensure MDS Coordinator has current residents with an order for hospice. This will be documented on MDS Audit log for residents having the above diagnosis. Once MDS is completed for the resident with the above diagnosis, the completed MDS will be reviewed at the weekly Medicare Meeting weekly before transmission x 4 weeks, then monthly x 3 months for accuracy for change in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 2 from hospice bathed her and took her vital signs and she further stated they called the hospice nurse if they had any concerns. Staff Nurse #1 revealed Resident #40 was up in her wheelchair in the morning and she also attended activities. During an interview on 07/28/2016 at 8:50 AM, Nursing Assistant (NA) #1 stated Resident #40 required total care. He revealed Resident #40 fed herself with assistance, sometimes by cueing. He revealed Resident #40 was involved in a restorative feeding program for breakfast and lunch. He said Resident #40 required assistance with turning in bed. NA #1 revealed when he initially started working with Resident #40, she was able to stand a little and was able to pivot to her wheelchair, however, she now required total assistance. NA #1 said a person from hospice came on Tuesday and Friday and a Nurse from hospice also came. He further stated the hospice aide assisted Resident #40 with bathing. During an interview on 07/27/2016 at 3:30 PM, the facility Minimum Data Set (MDS) Coordinator revealed there was a hospice care plan in Resident #40's chart. She stated this was Resident #40's first admission. She revealed an Admission Assessment was completed on Resident #40 on 5/10/16 and a Significant Change Assessment should have been done within 14 days of Resident #40 being picked up by hospice. The MDS Coordinator said the Significant Change Assessment should have been done by July 1st. She explained that the facility used to have another Care Plan Coordinator, but that person no longer worked in the facility. During an interview on 7/28/16, the facility	F 272	condition. 4. Monthly for a minimum of three months, the MDS Coordinator will report the results of the audits to the QA and Performance Improvement Committee: will review the audits to make recommendations to ensure compliance is sustained ongoing: and determine the need for further auditing, beyond the 3 months period.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 3 Administrator stated changes should be identified as they occur. She revealed the Minimum Data Set (MDS) would be corrected.	F 272		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment for 1 of 16 sampled residents (Resident #180). Findings included: Resident #180 was admitted to the facility on 03/10/16. A record review revealed that the facility completed two MDS documents: 1) an entry tracking MDS assessment dated 03/10/16 at the time the resident was admitted to the facility, and 2) the comprehensive MDS admission assessment dated 03/17/16. There was no documentation or evidence in the medical record that a quarterly MDS had been completed. During an interview on 07/28/16 at 10:03 a.m., the MDS Coordinator confirmed that a quarterly MDS was due on 06/17/16. She indicated that it had not been done and pointed out that it was not listed on the schedule of those to be done. She could not explained why it had not been automatically scheduled by the computer assessment-tracking tool. The MDS Coordinator	F 276	This plan of Correction is the center's credible allegation of Compliance: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F276 8/24/2016 1. Resident #180 had an MDS completed for the Quarterly Assessment. 2. An audit was conducted to ensure current residents had a quarterly assessment completed. At the conclusion of the audit, there were no other residents affected. 3. The MDS Coordinator with the IDT team was in-serviced regarding assessment schedules. The MDS Coordinator with the IDT team will review	8/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 276	Continued From page 4 said that she would complete the missing assessment. In an interview on 07/28/16 at 10:13 a.m., the DON said that she expected that all MDS assessments would be completed by their due dates. She also shared her expectation that a functional tracking system for upcoming assessments be in place and that the schedule be followed.	F 276	the MDS schedule weekly at Medicare Meeting to ensure current residents have an OBRA assessment scheduled. The schedule will be reviewed and attached to the MDS OBRA audit weekly. Once OBRA MDS is completed and transmitted for residents, the batch results will be reviewed weekly at the next Medicare meeting x 4 weeks; and then monthly x 3 months for completion of OBRA assessments. 4. Monthly for a minimum of 3 months, the MDS Coordinator will report the results of the audits to the QA and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing, beyond the 3 months period.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		8/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately asess and document a stage 4 pressure ulcer on admission for 1 of 3 residents (Resident #5) reviewed for pressure ulcer, and failed to assess a resident under section I for an active diagnoses for 2 of 16 residents (Resident #53 and #28). The findings included: 1. Review of a quarterly Minimum Data Set (MDS) assessment dated 3/25/16 revealed Resident #5 was admitted to the facility on 3/4/16 with cumulative diagnoses that included a stage IV pressure ulcer, diabetes mellitus, and anemia. Review of Resident #5 ' s most recent comprehensive MDS dated 6/24/16, was coded as an annual assessment. The assessment coded the resident as having a stage IV pressure ulcer that was not present upon admission. Review of the weekly wound care records for resident #5 revealed the stage IV pressure ulcer	F 278	This plan of Correction is the center's credible allegation of Compliance: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F278 1. Resident #5 had an MDS modification completed to include the Stage IV pressure ulcer present upon admission. Resident #53 had an MDS modification to include diagnosis Traumatic Brain Injury. Resident #28 had an MDS modification completed to include diagnosis of GERD and depression. 2. An audit was conducted to ensure current resident with the following diagnosis: Stage IV pressure ulcer, TBI, GERD and depression have been coded	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 was present upon admission. During a staff interview on 07/27/2016 at 1:04 PM, the MDS nurse stated that the stage IV pressure ulcer was present upon admission. The MDS nurse further stated the MDS dated 6/24/16 which coded the stage IV pressure ulcer as not present upon admission was an oversight. During a staff interview on 07/28/2016 at 9:45 AM, the wound care physician stated the stage IV sacral pressure ulcer was present upon admission to the facility. During a staff interview on 07/28/2016 at 10:00 AM, the DON stated the stage IV sacral pressure ulcer coded on the MDS dated 6/24/16 was present upon entry to the facility and should have been coded as such. The DON further stated her expectation is that pressure ulcer assessments were coded correctly. 2. Resident #53 was admitted to the facility on 4/18/16 with diagnoses of dementia secondary to traumatic brain injury with behavioral issues and delirium. A review of the admitting diagnoses dated 4/18/16 on the medical chart revealed Resident #53 had a diagnose of dementia secondary to traumatic brain injury. A review of the admission Minimum Data Set (MDS) assessment dated 4/25/16 revealed the resident was severely cognitively impaired. The admission MDS was not assessed under Section I - Active Diagnoses as having traumatic brain injury. On 7/28/16 at 9:10 AM the MDS Coordinator stated she had not done the admission	F 278	correctly. At the conclusion of the audit, current resident with the above diagnosis not included on section I to be modified. The MDS Coordinator with the IDT team was inserviced on ICD diagnosis. 3. The MDS Coordinator with the IDT team will review all new admissions at morning clinical meeting to ensure MDS Coordinator has correct ICD10 codes for newly admitted residents to include the following diagnosis: pressure ulcers, TBI, depression and GERD. This will be documented on MDS Audit Log for residents having above diagnosis. Once MDS is completed, the completed MDS will be reviewed weekly x 4 weeks, : then monthly x 3 months for accuracy. 4. Monthly for a minimum for 3 months , the MDS Coordinator will report the results of the audits to the QA and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained: and determine the need for further auditing beyond the 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7	F 278		

assessment and did not know why the diagnoses of traumatic brain injury was not under Section I. The MDS Coordinator stated that Resident #53 was admitted with traumatic brain injury.
On 7/28/16 at 10:40 AM the Administrator stated the MDS needs to accurately assess the resident ' s condition and his active diagnoses on admission was trauma

3. Resident #28 was originally admitted to the facility on 1/3/08 and was readmitted on 7/22/16 with diagnoses including Depression and Gastroesophageal Reflux Disease (GERD).

a. Review of the Quarterly Minimum Data Set (MDS) dated 1/29/16 and the most recent Quarterly Minimum Data Set (MDS) dated 6/16/16, identified Resident #28's memory as being intact. Resident # 28 was not assessed under Section I - Active Diagnoses as having Depression.

Review of a July's Physician's Orders documented an order for Effexor XR Capsule Extended Release 24 hour 75 mg. (Venlafaxine HCl ER), one capsule by mouth one time a day for Depression.

During an interview on 07/28/2016 at 9:48 AM, the Assistant Director of Nursing (ADON) revealed the start date for Effexor (Venlafaxine) was 9/21/13.

During an interview on 07/28/2016 at 9:47 AM, the Minimum Data Set (MDS) Coordinator revealed the diagnosis for depression was not checked in Section I of the MDS. She stated she did not do the assessment. The MDS Coordinator reported that the previous MDS Coordinator was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8	F 278		

responsible for completing Resident #28's assessment.

During an interview on 07/28/2016 at 10:51 AM, the facility Administrator stated her expectation was for an appropriate diagnosis according to the resident's medication should be checked on the MDS. She said going forward corrections would be in place.

b. Review of the Quarterly Minimum Data Set (MDS) dated 1/29/16 and the most recent Quarterly Minimum Data Set (MDS) dated 6/16/16, identified Resident #28's memory as being intact. Resident # 28 was not assessed under Section I - Active Diagnoses as having Gastroesophageal Reflux Disease (GERD).

Review of July's Physician's orders documented an order for Omeprazole Tablet Delayed Release 20 mg.,one tablet by mouth one time a day for Gastroesophageal Reflux Disease (GERD).

During an interview on 07/28/2016 at 9:48 AM, the Assistant Director of Nursing (ADON) revealed the start date for Omeprazole was 4/26/16.

During an interview on 07/28/2016 at 9:47 AM, the Minimum Data Set (MDS) Coordinator revealed the diagnosis for depression was not checked in Section I of the MDS. She stated she did not do the assessment. The MDS Coordinator reported that the previous MDS Coordinator was responsible for completing Resident #28's assessment.

During an interview on 07/28/2016 at 10:51 AM, the facility Administrator stated her expectation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9 was for an appropriate diagnosis according to the resident's medication should be checked on the MDS. She said going forward corrections would be in place.	F 278		