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 _____	07/14/2016

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the CI # NC00118486, and NC00114083. Event ID # 1FDM11, 7/14/2016.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews the facility failed to maintain residents' rooms in good repair on 4 of 4 resident hall ways. The findings included: 1) Observations of the 100 hall on 7/11/16 at 11:10 AM during the initial tour and again on 7/14/16 at 9:30 AM revealed rooms 101 through 111 had deep scratch marks on the walls near the head of the beds. Room 107 had white repair patches with no paint on them. Rooms 109 through 114 had torn wall paper. 2) Observations of the 200 hall on 7/11/16 at 11:15 AM during the initial tour and again on 7/14/16 at 9:15 AM revealed unpainted white repair patches on the walls in rooms 201, 203, 204, 205, 207, 208, 209, 210, 213 and 214. During an interview with Resident #80 on 7/11/16 at 3:01 PM he stated the patches had been that way as long as he had been in the room. 3) Observations of the 300 hall on 7/11/16 at 11:15 AM during the initial tour and again on 7/14/6 at 9:17 AM revealed rooms 304, 308, 309,310, 311, 312, 313, 314 and 316 had unpainted white repair patches on the walls. On	F 253	1. The Executive Director and Maintenance Director have developed and implemented a schedule of repair to address all areas identified on F-253 of the 2567. 2. The Maintenance Director will conduct environmental rounds to identify maintenance needs and develop a schedule to timely repair items noted during the rounds. The Maintenance Director will review any findings with the Executive Director and a corrective action will be implemented as indicated. 3. The Staff Development Coordinator will in-service the staff on identifying and reporting maintenance needs. The SDC will include information on identifying and reporting maintenance needs in the orientation of new employees. The Executive Director will conduct weekly environmental rounds. Repair items identified on these rounds will be	8/27/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/03/2016

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F 253	Continued From page 1 7/11/16 at 4:01 PM Resident #8 stated the unpainted white patches were present since she was admitted in January of this year and she thought it looked bad. During an interview Resident #122 stated the white repair patches had been present in his room since he arrived in April 2016 and he could not understand why the repair work had not been completed or the room painted. 4) Observations of the 400 hall on initial tour on 7/11/16 at 11:20 AM revealed rooms 401, 402, 404, 405, 407 and 409 all had unpainted white plaster patches which were not painted. In room 405 there was a wall area 2 feet by 2 feet which had been painted with tan paint on a white wall. In room 408 there was an area on the wall which had green tinted paint over a patched area on the white wall. On 7/13/16 at 1:46 PM the Maintenance Director stated he was patching the holes in the walls in the residents' rooms. He stated he had only worked at the facility for the last 8 months and he had to repair the walls frequently. On 7/14/16 at 10:00 AM during an observation of 2 of the rooms on the 200 hall with the Maintenance Director, the Administrator and the Director of Nursing, the Maintenance Director stated painting the rooms required more time than patching the damaged areas with plaster. He stated they had started some painting but had to be aware of the residents with breathing problems. The Administrator stated she had called the corporate office support person to discuss the need for painting and improving the appearance of the residents' rooms. She stated there had been a lapse in maintenance support coverage and they had recently hired a maintenance helper. She added the facility was aware of the need to improve the appearance of	F 253	appropriately communicated to the Maintenance Director. The Executive Director will monitor for ongoing compliance. 4. Data results will be presented by the ED and/or the Maintenance Director, reviewed and analyzed by the Interdisciplinary Team at the centers monthly Quality Assessment and Performance Improvement Meeting for three months for evaluation and recommendation of new interventions, education and auditing as needed to assure compliance is sustained ongoing. The ED is responsible for the overall compliance.	

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F 253	Continued From page 2 the residents' rooms.	F 253		
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 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 code the Minimum Data Set (MDS) assessment for 2 of 15 sampled	F 278	1. The MDS Assessment for resident #40 and #122 was corrected.	8/27/16

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F 278	Continued From page 3 residents (Resident #40 and #122) whose MDS was reviewed. The findings included: #1. Resident #40 was admitted to the facility on 4/12/2016 with diagnoses to include ankle fracture. The resident's 14 day Minimum Data Set (MDS) assessment dated 4/29/2016 revealed she had clear speech, made herself understood, and had clear comprehension with understanding others. Her Brief Interview for Mental Status (BIMS) score was blank, and was recorded as "unable to complete interview." Her short and long term memory were okay, and she knew the current season, location of her room, staff names and faces, and that she was in a nursing home. The resident's 30 day MDS assessment dated 5/13/2016 revealed she had clear speech, made herself understood, and had clear comprehension with understanding others. Her BIMS score was blank and was recorded as never understood. Her short and long term memory were okay, and she knew the current season, location of her room, staff names and faces, and that she was in a nursing home. An interview was conducted with the nursing assistant (NA #1) on 7/12/2016 at 3:54 PM. The NA stated Resident #40 did not speak English, but was very alert, and knew some words in English. She could tell the staff when she wanted to go to the bathroom, or get up. The NA indicated the resident used words, sounds, hand gestures and pointing to communicate with staff. On 7/13/2016 at 9:33 AM, an interview was conducted with the nurse (Nurse #1). The nurse stated Resident #40 was alert and oriented, and had a communication board in her room. The nurse indicated that if she could not figure out what the resident was saying, the facility had a	F 278	2. The Case Manager and the MDS nurse will perform a one time audit with the current resident population to determine if accuracy of the MDS as it relates to the Brief Interview for Mental Status (BIMS)and Section A relative to the PASSR level. Newly admitted residents will be assessed to ensure the BIMS score and the Section A (PASSR level) of the MDS is coded accurately. Compliance will be monitored weekly in the Case Management Meeting by the District Director of Case Management and/or the Executive Director. 3. The District Director of Case Management will re-educate the Case Manager, MDS Nurse, Social Worker, and the Activities Director on MDS coding accuracy relative to the PASSR level in Section A of the MDS and completion of the BIMS score by 8/19/2016. The Executive Director will audit 5 MDS assessments weekly for three months to validate accuracy of the MDS with results presented to the Quality Assurance Committee. 4. Data results will be presented by the Case Manager and/or the MDS Nurse, reviewed and analyzed by the Interdisciplinary Team at the centers monthly Quality Assessment and Performance Improvement Meeting for three months for evaluation and recommendation of new interventions, education and auditing as needed to assure compliance is sustained ongoing.	

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F 278	Continued From page 4	F 278		

therapy person who would come to her room and translate. The nurse indicated the facility also had a translator phone line they could use to communicate with her at any time.
On 7/13/2016 at 10:05 AM, an interview was conducted with MDS Nurse #1. The MDS nurse stated the resident was alert and oriented. She indicated she or the other MDS nurse were responsible to complete Section B on resident understanding and clear speech, and the Social Worker was responsible to complete the BIMS, Section C. The nurse stated the facility had a therapy person, and 2 workers from the kitchen who could speak Resident # 40's language, so it was not hard to have someone translate for her.
On 7/13/2016 at 10:24 AM, an interview was conducted with the Social Worker (SW). The SW stated she was responsible for completing Section C of the MDS, which included the BIMS score. She indicated the resident's son was not in the facility to translate the day she did the assessment, and she was not able to speak the resident's language so she thought it was okay to just complete the memory portion.
On 7/14/2016 at 10:02 AM, an interview was conducted with the Administrator. The Administrator stated she expected the MDS to be accurate and reflect the resident's status.

#2. Resident #122 was admitted to the facility on 4/7/16 with diagnoses which included Bipolar Disorder, Cauda Equina Syndrome, anxiety disorder and major depressive disorder. His admission Minimum Data Set (MDS) dated 4/17/16 revealed in Section A, the PASRR level II was not marked.
A medical record review revealed a NC MUST screening form which indicated Resident #122

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F 278	Continued From page 5 had a PASRR number which ended with the letter F. The most current form had a start dated of 6/8/16 and an expiration date of 8/7/16. On 7/13/16 at 5:08 PM the MDS nurse stated she was responsible for completing Section A of the MDS. She stated the MDS staff members were not aware that Resident #122 was a level II and the Social Worker (SW) was responsible for obtaining PASRR information. On 7/13/16 at 5:12 PM the SW stated Resident #122 was admitted with a Level II PASRR which had an expiration date. She stated obtaining PASRR information was usually handled by the hospital prior to admission. The SW also stated the facility's admissions staff member would make sure the facility had the correct PASRR information for each resident because every resident was required to have a PASRR determination prior to admission. On 7/14/2016 at 10:02 AM, an interview was conducted with the Administrator. The Administrator stated she expected the MDS to be accurate and reflect the resident's status.	F 278		
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	F 431		8/27/16

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F 431	Continued From page 6 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 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of manufacturer's recommendations, the facility failed to date a perishable multi-dose tuberculin vial for 1 of 1 medication storage refrigerators and failed to date an opened bottle of perishable Lantanoprost eye drops and failed to discard expired Lantanoprost eye drops for 1 of 2 medication carts reviewed. The findings included: 1. A review of the manufacturer's recommendation included: A vial of Tubersol {Tuberculin Purified Protein Derivative [Mantoux]} which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency. Do	F 431	1. The expired medication in the medication cart and the medication storage refrigerator were discarded. 2. The Director of Nursing and/or the Assistant Director of Nursing will perform a one time audit on all of the medication cart and the medication storage refrigerator to ensure there are no expired medications. 3. The Staff Development Coordinator will re-educate the Licensed Nurses on the importance of checking the medication cart and the medication storage	

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F 431	Continued From page 7 not use after expiration date. Observation of the medication storage room on 7/14/16 at 8:50 AM revealed an open vial of Tubersol 5U/0.1ml (a solution used to test for Tuberculosis) in the refrigerator. There was no date of opening recorded on the vial label. An interview was conducted on 7/14/16 at 8:51 AM with Nurse #2. She stated the vial of Tubersol solution should be dated by the nurse when it was opened. An interview was conducted on 7/14/16 at 8:54 AM with the Director of Nursing. She stated Nurse #3 acted as Infection Control nurse and was responsible for educating staff on protocol for opened medications. Nurse #3 joined the interview. She stated opened vials of Tuberculin solution should have an opened date on them and were good for 30 days from the date opened. She stated there was a sign on the desk at the nurse's station designating a nurse on each shift to check the medication storage refrigerator for expired medications. An interview was conducted on 07/14/2016 at 9:19 AM with the Executive Director. She stated it was her expectation for tuberculin vials to be dated when opened. #2. A review of the Lantanoprost manufacturer's recommendation included: Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks. a. Resident #81 was admitted to the facility 10/6/14 with diagnoses which included glaucoma. A review of the July 2016 physician orders indicated Lantanoprost (a medication to reduce pressure in the eye) 1 drop to both eyes at bedtime.	F 431	refrigerator and properly discarding of expired medications by 8/19/2016. The DNS, ADNS, and /or the RN Supervisor will audit medication carts and medication storage refrigerators 3 times weekly for three months to ensure compliance with properly discarding expired medications with results presented to Quality Assurance Committee. 4. Data results will be presented by the DNS and/or the ADNS, reviewed and analyzed by the Interdisciplinary Team at the centers monthly Quality Assessment and Performance Improvement meeting for three months for evaluation and recommendation of new intervention, education and auditing as needed to assure compliance is sustained ongoing.	

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A review of the July 2016 Medication Administration Record (MAR) indicated Resident #81 received Lantanoprost eye drops on 7/2/16, 7/3/16, and 7/5/16 through 7/13/16.

Observation of the medication cart for the 400 hall was made on 7/14/16 at 9:44 AM. A container was labeled with Resident #81's name and contained an opened bottle of Lantanoprost eye drops. There was no opened date on the label of the container or the eye drop bottle. A sticker applied to the container in which the bottle was stored indicated the medication should be discarded 42 days after opening.

An interview was conducted at the time of the observation with Nurse #4. She stated Lantanoprost eye drops expire after 6 weeks and should be dated when opened.

b. Resident #32 was admitted to the facility on 4/1/14 with diagnoses which included glaucoma.

A review of the July 2016 physician orders included Lantanoprost 1 drop in both eyes at bedtime.

A review of the July 2016 MAR indicated Resident #32 received Lantanoprost eye drops at bedtime July 1 through 13th.

Observation of the medication cart for the 400 hall was made on 7/14/16 at 9:44 AM. A container was labeled with Resident #32's name and contained an opened bottle of Lantanoprost with an opened date of 5/21/16 written on the top of the bottle. A sticker applied to the container in

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which the bottle was stored indicated the medication should be discarded 42 days after opening. The expiration date was 7/2/16.

An interview was conducted 7/14/16 at 10:00 AM with Nurse #4. She stated Lantaprost eye drops expire after 6 weeks. She stated there were no other bottles of Lantanoprost eye drops for Resident #32 and if she had received eye drops on 7/13/16 they were expired.

c. Resident #55 was readmitted 6/26/16 with diagnoses which included glaucoma.

A review of her July 2016 physician orders included Lantanoprost 1 drop in both eyes at bedtime.

A review of the July 2016 MAR indicated Resident #55 received Lantanoprost eye drops 7/1/16 through 7/13/16.

Observation of the medication cart for the 400 hall was made on 7/14/16 at 9:44 AM. A container was labeled with Resident #55's name and contained an opened bottle of Lantanoprost with an opened date of 5/27/16 written on the top of the bottle. A sticker applied to the container in which the bottle was stored indicated the medication should be discarded 42 days after opening. The expiration date was 7/8/16.

An interview was conducted 7/14/16 at 10:00 AM with Nurse #4. She stated Lantanoprost eye drops expire after 6 weeks. She stated there were no other bottles of Lantanoprost eye drops for Resident #55 and if she had received eye drops on 7/13/16 they were expired.

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F 431	Continued From page 10 An interview was conducted on 7/14/16 at 10:10 AM with the Director of Nursing. She stated her expectation was for staff to date eye drops when opened and to monitor for expiration and discard. An interview was conducted 7/14/16 at 10:21 AM with the Executive Director. She stated the facility pharmacy consultant comes quarterly to conduct in services and cart checks. She stated her expectation was for the staff to be knowledgeable of when medications expire and keep them ordered so they do not use expired medications.	F 431		