PRINTED: 12/14/2012 FORM APPROVED OMB NO. 0938-0391

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

F 279 8S=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial medical nursing, and mental and psychosocial well-being as required under \$483.26; and any services that would otherwise be required under \$483.26 and any services that would otherwise be required under \$483.26 but are not provided due to the resident's exercise of rights under \$483.10, including the right to refuse treatment under \$483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility falled to develop a comprehensive care plan to address bowel elimination in a resident # 90) and also failed to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fleeal impaction.  1) Resident # 90 was admitted to the facility on 7/16/12 with cumulative diagnoses which included	NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOSKIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST ALOKSIE, NO. 27810  STREET ADDRESS, CITY, STATE, ZIP CODE 644 STOKES STREET EAST AND STATE AND STATE AND STATE AND STATE CONSTRUCTION COPPLIANCE COMPREHENSIVE CARE PLANS  1. Resident # 90 had her comprehensive care plan updated to include a Behavior Care Plan. Resident # 90 had her comprehensive care plan updated to include and At Risk for Constipation Care Plan. 2. Residents # 90 had her comprehensive care plan updated to include and the		F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE  ANOSKIE, NO 27810  PRIEFIX (EACH DEFORDERY WIST SEP REPORT OF DESCRIBANCES)  EACH DEFORDERY WIST SEP REPORT OF DESCRIBANCES THAT TWO REPORTANCES TO THE APPROPRIATE DESCRIBANCES AND STATE OF THE APPROPRIATE DESCRIBANCES TO THE APPROPRIATE DESCRIB	STREET ADDRESS, CITY, STATE, ZIP CODE 6N STOKES STREET EAST AHORSKIE, NC 27810   STREET EAST AHOR			245259				· ·
F 279 SS=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's assessment.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25; and any services that would otherwise be required under \$483.26 and any services that would otherwise be required under \$483.10, including the right to refuse treatment under \$483.10(b)(4).  This REQUIREMENT is not met as evidenced by:  Based on observations, record reviews and staff interviews the facility falled to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) and also falled to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) and also flade to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction in 1 of 1 (Resident # 70) and also flade to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) and also flade to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction care plan is updated. Weekly audits will continue for a minimum of three months or until ongoing compliance	FREETY TAG  REGULATORY OR LSC IDENTIFY IN ONE PROMATIONS  FREETY TAG  F 279  SS=D  COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timelables to meet a resident's medical, nursing, and mental and psychosocial medical funding in medical provided due to the resident due to the resident due to the resident searches of rights under \$483.10, including the right to refuse treatment under \$483.10 (h)(4).  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility falled to develop a comprehensive care plan to address bowle illimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction.  1) Resident # 90 had her comprehensive care plan updated to include an At Risk for Constipation care plan.  2. Resident # 90 had her comprehensive care plan updated to include a Denavior Care Plan. Resident # 40 include a Denavior Care Plan. Resident # 50 had her comprehensive care plan as needed to include an At Risk for Constipation care plans. Dehavior care plan as needed per RA1 (resident * Assessment Instrument) manual. DNS or ADNS will audit three resident * Somprehensive care plan as needed per RA1 (resident Assessment Instrument) manual. DNS or ADNS will audit three resident's comprehensive care plan as needed per RA1 (resident & Somprehensive care plan to address bowle allimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction.  1) Resident # 90 had her comprehensive care plan to address bowle alimitation are resident with a diagnosis of fecal impaction.  2) Reside	·		***************************************		604 STOKES STREET EAST		0/2012
A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are ledentified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under \$483.10, including the right to refuse freatment under \$483.10, including the right to refuse freatment under \$483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility falled to develop a comprehensive care plan to address bowel elimination in a resident #90) and also falled to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction.  1) Resident # 90 was admitted to the facility on 7/16/12 with cumulative diagnoses which included	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.26; and any services that would otherwise be required under \$483.25 but are not provided due to the resident's exercise of rights under \$483.10, including the right to refuse treatment under \$483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility falled to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction.  1) Resident # 90 had her comprehensive care plan. Resident # 70 had her comprehensive care plan. At Risk for Constipation care Plan.  2. Residents residing in center had a medical record review to audit resident comprehensive care plans. Behavior and At Risk for Constipation care plans were added as needed.  3. Interdisciplinary Care Team in-serviced to include comprehensive care and pass plans were added as needed.  3. Interdisciplinary Care Team in-serviced to include comprehensive care plan as needed per RA1 (resident Assessment Instrument) manual. DNS or ADNS will audit three resident's comprehensive care plan is updated. Weekly audits will continue for a minimum of three months or until ongoing compliance is sustained. Performance Improvement Committee.  4. Results of weekly audits will be reviewed by center's monthly Performance Improvement Committee.  4. Results of weekly audits will be reviewed by center's monthly Performance Improvement Committee.  5. Resident # 90 had her comprehensive care plan to medical r	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETION
needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocal well-being as required under \$483.25; and any services that would otherwise be required under \$483.26 but are not provided due to the resident's exercise of rights under \$483.10, including the right to refuse treatment under \$483.10(b)(4).  This REQUIREMENT is not met as evidenced by:  Based on observations, record reviews and staff interviews the facility falled to develop a comprehensive care plan to address combative behaviors in 1 of 1 residents (Resident # 90) and also falled to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction.  Risk for Constipation care plans were added as needed.  3. Interdisciplinary Care Team in-serviced to include comprehensive care plan as needed per RA1 (resident Assessment Instrument) manual. DNS or ADNS will audit three resident's comprehensive care plans weekly to validate comprehensive care plans is updated. Weekly audits will continue for a minimum of three months or until ongoing compliance is sustained. Performance Improvement Committee of a minimum of three months or until ongoing compliance is sustained. Performance Improvement Committee will review audits and make recommendations as needed.  1) Risk for Constitution in develop a comprehensive care plan to an update comprehensive care plan to address combative behaviors in a minimum of three months or until ongoing compliance is sustain	needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.26; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by:  Based on observations, record reviews and staff interviews the facility falled to develop a comprehensive care plan to address combative behaviors in 1 of 1 residents (Resident # 90) and also falled to develop a comprehensive care plan to address bowel elimination in a resident with a diagnosis of fecal impaction in 1 of 1 (Resident # 70) sampled residents with a fecal impaction.  1) Resident # 90 was admitted to the facility on 7/16/12 with cumulative diagnoses which included Dementia, Psychosis, Hypertension, Diabetes,	i i	A facility must use the to develop, review an comprehensive plan.  The facility must develop for each residen	CARE PLANS  e results of the assessment d revise the resident's of care.  elop a comprehensive care t that includes measurable	F 279	1. Resident # 90 had her concare plan updated to includ Plan. Resident # 70 had he care plan updated to includ Constipation Care Plan.  2. Residents residing in ce medical record review to a	e a Behavior Care or comprehensive e an At Risk for nter had a udit resident	12/28/12
			needs that are identificances assessment.  The care plan must do to be furnished to attachighest practicable playchosocial well-bei §483.25; and any serbe required under §4 due to the resident's §483.10, including the under §483.10(b)(4).  This REQUIREMENT by: Based on observation interviews the facility comprehensive care behaviors in 1 of 1 realso failed to develop to address bowel elin diagnosis of fecal impro) sampled resident.  1) Resident # 90 was 7/16/12 with cumulations.	escribe the services that are ain or maintain the resident's hysical, mental, and ang as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment  is not met as evidenced ans, record reviews and staff falled to develop a plan to address combative sidents (Resident # 90) and a comprehensive care plan hination in a resident with a paction in 1 of 1 (Resident # s with a fecal impaction.  admitted to the facility on ve diagnoses which included		Risk for Constipation care as needed.  3. Interdisciplinary Care To include comprehensive revand update comprehensive needed per RAI (resident A Instrument) manual. DNS audit three resident's compplans weekly to validate coplan is updated. Weekly aufor a minimum of three moongoing compliance is detecenter's monthly Performation Committee.  4. Results of weekly audit by center's monthly Performation committee for three months or until ongois sustained. Performance Imcommittee will review audited to manufacture will review and recommendations as needed.	plans were added eam in-serviced to iew of resident care plan as assessment or ADNS will rehensive care omprehensive care dits will continue nths or until ermined by the nce Improvement s will be reviewed mance or a minimum of ng compliance is provement its and make	

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 F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 11/30/2012		
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	345359 & REHAB-AHOSKIE	604 S	ADDRESS, CITY, STATE, ZIP CODE STOKES STREET EAST SKIE, NC 27910		( C   C   C   C   C   C   C   C   C   C	
(X4) ID PREFIX TAG	FACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 279	and Respiratory Fail  A review of the 90 dassessment tool dat Resident # 90 was a known and usually undicated Resident # The MDS also reveadependent on staff personal hygiene. Resident # 90 had kicking, hitting, and during the assessm.  A review of the care Resident # 90 reveator Psychotropic Drupsychosis. The goar Resident # 90 would comes or signs/ syrand Resident # 90 woold functional ability.  A review of the median addressing Recare resisting behave a resisting behave a review of the Nurcompleted for Resign/25, 9/28) and Oct 10/16, 10/21) 2012 multiple episodes combativeness, and A review of the Nurcompleted for Resign/25, 9/28) and Oct 10/16, 10/21) 2012 multiple episodes combativeness, and A review of the Nurcompleted for Resign/25, 9/28) and Oct 10/16, 10/21) 2012 multiple episodes occombativeness, and A review of the Nurcompleted for Resign/25, 9/28) and Oct 10/16, 10/21) 2012 multiple episodes occombativeness, and A review of the Nurcompleted for Resign/25, 9/28) and Oct 10/16, 10/21, 2012 multiple episodes occombativeness, and A review of the Nurcompleted for Resign/25, 9/28, and Oct 10/16, 10/21, 2012 multiple episodes occombativeness, and A review of the Nurcompleted for Resign/25, 9/28, and Oct 10/16, 10/21, 2012 multiple episodes occombativeness, and A review of the Nurcompleted for Resign/25, 9/28, and Oct 10/16, 10/21, 2012 multiple episodes occombativeness, and A review of the Nurcompleted for Resign/25, 9/28, and Oct 10/16, 10/21, 2012 multiple episodes occombativeness.	ay MDS (Minimum Data Set) ed 10/22/12 indicated able to make her needs inderstood others. The MDS is 90 was cognitively impaired. aled Resident # 90 was for bathing, dressing, and fine MDS also revealed behaviors which included refusing care for 1-3 days ent period.  In plan dated 9/17/12 for aled the resident was identified and Use for a diagnosis of als of the care plan were due to ensure maximum  dical record revealed no care resident # 90 combative and viors.  ses Aide Flow sheets dent #90 for September (9/9, tober (10/3, 10/5, 10/9, 10/10, indicated Resident # 90 had of agitation, hitting/	F 279				

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. (X2) MULTIPLE ( A. BUILDING B. WNG	CONSTRUCTION	(X3) DATE S COMPLE	ETED C	
	OVIDER OR SUPPLIER	345359 & REHAB-AHOSKIE	STREET ADDRESS, CITY, STATE, ZIP CODE 604 STOKES STREET EAST AHOSKIE, NC 27910				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE	
F 279	hitting, scratching, a the Nurses Progress episodes of Resident Interview with NA # resident # 90 on 11// Resident # 90 on 11// Resident # 90 had to care and NA #2 in re-approach Resider revealed at times Rerefused care and showhen that occurred. Interview with Nurse revealed Resident # medication without Interview with the control of care.  An interview with the Control of care.	veness which included and punching staff. In addition, a notes also revealed multiple at #90 refusal of care.  2 who was familiar with 29/12 at 11:20 AM revealed mes when she was resistant addicated she would try to at a later time. NA #2 esident #90 absolutely e would let the nurse know at #2 on 11/29/12 at 11:35 AM #90 usually took her difficulties or resistance.  2 an Director of Nursing (DON) are vealed a care plan should ed for Resident #90 to tive behaviors and resistance at 8:40 AM revealed she was 5 process and was training a tor. The ADON indicated the ethe behavior care plans for propriate. The ADON also or care plan should have been dent #90 due to the usage of cations and diagnoses and not sure why it wasn't	F 279				
	2) Resident # 70 w 10/1/12 for diagno	ras admitted to the facility on ses which included Dementia,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED C	
		345359	B. WIN			11/3	0/2012
	OVIDER OR SUPPLIER TRANSITIONAL CARE	& REHAB-AHOSKIE		60	EET ADDRESS, CITY, STATE, ZIP CODE 04 STOKES STREET EAST LHOSKIE, NC 27910		
(X4) ID PREFIX TAG	/FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 279	A record review of 10/9/12 revealed Resident Emergency Room impaction.  A record review of 10/11/12 Resident A record review of 10/11/12 Resident Emergency Room impaction.  A record review of 10/11/12 Resident Emergency Room impaction.  A record review of 10/11/12 Resident Emergency Room impaction.  A record review of 10/11/12 Resident Emergency Room impaction.  A record review of 10/16/12 Resident Emergency Room impaction.  A record review redischarged and reference and re	eary Tract Infection, Cerebral and Hypertension.  ealed the 5 day Admission and Data Set (MDS)  dent #70 revealed she was eads known and had short memory deficits. The MDS #70 required extensive staff member for tolleting and frequently incontinent of	F	279			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER (X1) PROVIDER/SUPPLIER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345359	B. WAN			11.	C /30/2012
	ROVIDER OR SUPPLIER			604 8	ADDRESS, CITY, STATE, ZIP CODE STOKES STREET EAST DSKIE, NC 27910	1 11	
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F 279	assistance of one significance on staff for personal A record review rev	Itaff member for tolleting. The Resident #70 was dependent all hygiene and bathing.  Italian between the was no care plan address the bowel elimination oring related to her history and italian between the feet of a fecal impaction.  Italian between the was no care plan address the bowel elimination oring related to her history and italian between the was not a fecal impaction.  Italian between the was no care plan address the bowel movements was not related to her history and italian between the was never all the was a resident was a resident bathroom close at the was incontinent at times of the was incontinent	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						c	;
		345359	B. WIN	G		11/30	/2012
	ROVIDER OR SUPPLIER TRANSITIONAL CARE &	REHAB-AHOSKIE		6	EET ADDRESS, CITY, STATE, ZIP CODE 04 STOKES STREET EAST HOSKIE, NC 27910		
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F 441	process and was ass coordinator. The ADC should have been in p for Resident # 70. 483.65 INFECTION C SPREAD, LINENS  The facility must esta Infection Control Prografe, sanitary and corto help prevent the de of disease and infection Control F	s involved in the MDS Isting training a new MDS Isting training a new MDS IN Indicated a care plan clace for bowel elimination CONTROL, PREVENT  Istinate and maintain an gram designed to provide a infortable environment and evelopment and transmission on.  Program blish an Infection Control		279 441	F 441  1. Bath basins, bed pans and urina following rooms 117, 207, 208, 22 224, 313, 314, 317, 319 and 320 w discarded are replaced with new or were properly labeled and stored in South Hall shower chair was discareplaced with a new chair in good Licensed Nurse #1 is currently was hands before and after administering.	rere which had bags. rded and repair. shing her	12/28/2012
	(1) Investigates, contribute facility; (2) Decides what proceed should be applied to a callons related to infection for the infection of the infection determines that a resignment the spread of isolate the resident. (2) The facility must proceed contact will direct contact will direct contact will tran (3) The facility must resident.	rols, and prevents infections redures, such as isolation, an individual resident; and of incidents and corrective ctions.  I of Infection a Control Program dent needs isolation to infection, the facility must rohibit employees with a e or infected skin fesions h residents or their food, if smit the disease.			medication.  2. Staff has been in-serviced on pulabeling and storage of bath basins pans, urinals, monitoring of equipuensure it is in good repair and does present an infection control risk an washing before and after medication administration. During their orien period, newly hired nursing staff verviced on proper labeling and stobath basins, bed pans, urinals and of equipment to ensure that it is in repair and does not present as an incontrol risk. During their orientation newly hired Licensed Nurses will serviced on hand washing before a medication administration.  3. Nurse #1 has been observed we medication administration pass to appropriate hand washing before a	roper s, bed ment to s not ad hand on tation vill be in- orage of monitoring good nfection on period, be in- and after ekly on validate	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML	JUTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL	DING			
		345359	B. WING	3		f	C 0/2012
	ROVIDER OR SUPPLIER TRANSITIONAL CARE 8	REHAB-AHOSKIE		60	EET ADDRESS, CITY, STATE, ZIP CODE 14 STOKES STREET EAST HOSKIE, NC 27910		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ.	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	(c) Linens Personnel must handl transport linens so as Infection.  This REQUIREMENT by: Based on observation record reviews, the far resident bath basins, i stored in a sanitary ma (Rooms 117, 207, 208 317, 319, and 320) of the facility failed to ma shower chair in good of 1 vinyl padded show failed to ensure 1 (Nur wash her hands before medications to 3 (Resi #148) and of 11 reside during the medication  Findings include:  1) Observations were bathrooms throughout 11/29/12 at 10:02 Room 117, the shelf he inside another basin w partially worn off. The covering. The room w was not shared with ar 11/29/12 at 10:44 between private rooms 224, revealed 1 bath b	is not met as evidenced  Is not met as evidenced  Is not met as evidenced  Is, staff interviews, and cility failed to assure pedpans, and a urinal were anner for 11 bathrooms  Is, 221, 222, 224, 313, 314, 11 bathrooms observed; and an a vinyl padded condition for 1 (South Hall) wer chairs; and the facility and after administering dents #87, #147, and ants that were observed pass.  In ade of resident the facility that revealed:  AM, in the bathroom of ad a bath basin stacked lith a resident 's name basins had no protective as a semi-private room and	FA	141	medication administration. Nurse observed weekly on medication administration pass for four week validate appropriate hand washin and after medication administratia after, Nurse #1 will be observed a medication administration pass for additional months to validate app hand washing before and after medication. DNS, ADNS or Sconduct five resident room and strounds three times weekly to validabeling and storage of bath basin pans, urinals, monitoring of equivalidate it is in good repair and depresent an infection control risk a washing before and after medicate administration. Weekly audits with for a minimum of three months of ongoing compliance is determine center's monthly Performance Improvement Committee.  4. Results of weekly audits will be by center's monthly Performance Improvement Committee for a mithree months or until ongoing consustained. Performance Improve. Committee will review audits and recommendations as needed to surongoing compliance.	as to g before on. There nonthly on or two ropriate edication DC will nower roon date proper as, bed oment to oes not and hand ion II continue r until d by the aprovement oe reviewed inimum of npliance is ment I make	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mi A. BUIL	JLTIPLE C DING		(X3) DATE SURVEY COMPLETED	
		345359	B. WIN	G		11/	C 30/2012
	ROVIDER OR SUPPLIER		· ·	604 S	ADDRESS, CITY, STATE, ZIP CODE TOKES STREET EAST SKIE, NC 27910		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 441	Room 207, a private bathroom shelf had resident name with robedpan with no residence overing. The bathroom, Room 11/29/12 at 11:2 bathroom shelf over with brownish golde was not labeled with bottle had no plastic 11/29/12 at 11:3 semi-private room, a toilet had a stack of labeled with a smeasemi-private room. 11/29/12 at 11:3 bathroom shelf had inside one other, with unbagged; a teal collabeled with a residunbagged and had was a semi private 11/29/12 at 11:3 bathroom shelf had bagged, with no visibed pans, bagged, names. The room shared with Room 11/29/12 at 12:3 stall area had an ivin an L-shape. Ins	is AM, an observation of room, revealed the a bath basin labeled with a no protective covering, and a dent name or a protective oom was shared with another 208.  24 AM, Room 221, the the toilet had a urinal bottle in residue on the bottom and a resident name. The urinal protective cover.  29 AM, Room 319, a bath basins, unbagged, and a bathroom shelf over the 3 bath basins, unbagged, and ared resident name. This was shared with Room 320, a say AM, Room 317, the 2 gold colored basins stacked the no resident name and were blored basin was unbagged, ent name; and a gold basin no resident name. The room	F.	441			

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		С		
		345359	B. WIN	G		11/3	0/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CARE 8	& REHAB-AHOSKIE		604	ET ADDRESS, CITY, STATE, ZIP CODE 4 STOKES STREET EAST HOSKIE, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	up an over the top of long. The front right was cracked 5 " wid bottom of the seat. seat was cracked 5 " bottom of the seat. seam above it were the shower wall at the floor was filled with be walls and back wall. bar of soap, not wrate seat. On the sink to shampoo without a rebody bath concentration it. A large, opaquid was on the seat of was no name labele.  During an observation of the walls have the shower seat rewith tears and black the shower walls have buildup. The Admin seat needed replace and blackened build baby shampoo and needed discarded; a discarded as it shou inside the whirlpool.  During an interview #3 on 11/30/12 at 3 were expected to late.	the seat 5 " 3 " and 2 " corner of the seat 's front e between the top and the The outside left corner of the ' between the top and The cracked corner and the filled with blackened matter. he bottom where it met the prownish residue on the side There was a reddish pink pped or contained, on the p were a bottle of baby resident name, and a bottle of the without a resident name are drinking mug + with a blue of the whirlpool tub. There d on the mug.  on of the South Hall shower histrator on 11/30/12 at 11:30 boto and body bath ed on the sink; the opaque e whirlpool tub; the padded, mained in the same condition tened matter; and the base of d darkened brown matter histrator stated the shower ed due to the splits in the vinyl flup; the personal items of body bath concentrate and the mug needed uld not have been stored	F	441				

PRINTED: 12/14/2012 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			C 1/30/2012
		345359				<u> </u>	1/30/2012
	OVIDER OR SUPPLIER TRANSITIONAL CARE &	REHAB-AHOSKIE		604	ET ADDRESS, CITY, STATE, ZIP CODE STOKES STREET EAST SOSKIE, NC 27910		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 441	(DON) on 11/30/12 at the staff were expect pans in clear plastic resident 's name.  3) The facility policy Administration ", da's should be washed pimedication for administration for administration on 1 a container of hand cart attended by Nur.  An observation on 1 Nurse #1 did not was sanitizer and proceed medications to administration then returned the medication cart.  An observation on 1 Nurse #1 did not was sanitizer and documented medications to resident medications and cart and documented the medications resident #148. The Nurse #1 returned to documented the medication of Reside the room of Reside	with the Director of Nursing at 3:35 PM, the DON stated ted to store basins and bed bags and label them with the stitled "Medication ted 8/31/12, indicated hands rior to preparing the histration to each resident.  1/29/12 at 8:35 AM revealed sanitizer on the medication rese #1.  1/29/12 at 8:45 AM revealed sh her hands or use hand add to prepare the inister to resident #87. The evealed Nurse #1 administered if returned to the medication of the dent #87. The nurse pushed to the room of Resident #148.  11/29/12 at 9:05 AM revealed ash her hands or use hand eded to prepare resident #148.  11/29/12 at 9:05 AM revealed ash her hands or use hand eded to prepare resident #148.  11/29/12 at 9:05 AM revealed ash her hands or use hand eded to prepare resident #148.  11/29/12 at 9:05 AM revealed ash her hands or use hand eded to prepare resident #148.  11/29/12 at 9:05 AM revealed ash her hands or use hand eded to prepare resident #148.  11/29/12 at 9:05 AM revealed ash her hands or use hand eded to prepare resident #148.  11/29/12 at 9:05 AM revealed ash her hands or use hand eded to prepare resident #148.  11/29/12 at 9:05 AM revealed the medication cart and edication pass to resident ushed the medication cart to	F	441			
1	1		1				

Facility ID: 923205

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245250	B. WING			С
NAME OF I	PROVIDER OR SUPPLIER	345359			11/3	0/2012
	D TRANSITIONAL CARE	€ & REHAB-AHOSKIE	İ	REET ADDRESS, CITY, STATE, ZIP CODE 604 STOKES STREET EAST AHOSKIE, NC 27910		
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F 441 F 465 SS=E	Nurse #1 did not was sanitizer and procest to administer to resident to resident administer to resident administer to resident administer to resident administer of the hand sanitizer of the interview with New Yould usually wash sanitizer before and medications to each An interview on 11/3 Director of Nursing (expected nurses was after administering mater als. The facility must proving facility must proving anitary, and comfort residents, staff and the	ash her hands or use hand aded to prepare medications dent #147.  29/12 at 9:24 AM with Nurse got to wash her hands or use in her medication cart. During urse #1, she revealed she her hands or use hand after administering resident.  29/12 at 9:30 AM with the DON) revealed she shed their hands before and hedications to a resident.  2/SANITARY/COMFORTABL.	F 442	I. Gas Clothes Dryer have 2. Laundry staff has been is observe dryers prior to use are clean. Laundry Staff inwire brush in drum as needed and debris. Laundry Staff in notify the Laundry Supervise Director or ED if the dryers cleaning. During orientation Laundry staff will be in-serviced to use to ensure During orientation, newly his staff will be in-serviced to use to ensure During orientation, newly his staff will be in-serviced to use to ensure During orientation, newly his staff will be in-serviced to not the control of t	been cleaned, n-serviced to to ensure dryers est to remove lint n-serviced to or, Maintenance need additional , newly hired viced to observe dryers are clean, red Laundry se wire brush in nt and debris, red Laundry otify the	12/28/12
	by: Based on observatio	is not met as evidenced in and staff interviews, the ain 3 of 3 gas clothes dryers		Laundry Supervisor, Mainte or ED if the dryers need addi 3. ED or Laundry Superviso inspect clothes dryers five tip validate dryers are clean. Ma Director will be contacted as	nance Director tional cleaning. r will visually nes weekly to sintenance needed for	
	An observation was m dryers on 11/30/12 at Housekeeping and La 3 dryers, on the left of	nade of the facility's clothing 11:12 AM with the undry Director. The first of the set, revealed a tan uilt up on the drum of the		additional cleaning. Weekly a continue for a minimum of th until ongoing compliance is dithe center's monthly Perform Improvement Committee.  4. Results of visual inspection reviewed by center's monthly	ree months or letermined by ance	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING C B. WING 345359 11/30/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **604 STOKES STREET EAST** KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE AHOSKIE, NC 27910 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX JEACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY Improvement Committee for a minimum of F 465 | Continued From page 11 F 465 three months or until ongoing compliance is machine. The area measured 5" In diameter and sustained. Performance Improvement was raised and hardened. The Director used a Committee will review audits and make pen knife to pry the matter from the drum and recommendations as needed to sustain stated it was probably a melted disposable glove. ongoing compliance. Additional debris on the drum included a rust colored matter and a scarred, blackened ring throughout the entire circumference of the drum. An observation of the center dryer revealed blackened scarring and rust colored debris build-up throughout the drum. A quarter was stuck to the drum and was removed using a pen knife to lift it from the surface by the Director. A penny was observed stuck to the drum in the midst of rust-colored debris that was built up at the rail of the drum. An observation of the third dryer, on the right of the 3, revealed a build up of blacked and rust colored matter through out the drum. An Interview was conducted with the Laundry Director on 11/30/12 at 11:17 AM. The Director stated laundry staff alerted maintenance when the dryers needed cleaned since maintenance had to turn off the gas for the dryers, and maintenance cleaned the machines.

During an interview with the Laundry worker on 11/30/12 at 11:25 PM, the laundry worker stated when the dryers showed build up of matter in them, she ran a brush over the drums to clean any debris from the inside the dryer. The laundry aide indicated it had been more than 2 weeks since she last used the brush in the dryers.

A telephone interview was conducted with the Maintanance Director on 12/3/12 at 1:18 PM.

PRINTED: 12/14/2012

FORM APPROVED

	345359	A. BUIL			(X3) DATE SURVEY COMPLETED	
1	<b>340303</b>	B. WING	3		C 0/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & I	REHAB-AHOSKIE	. '	STREET ADDRESS, CITY, STATE, ZIP CODE 604 STOKES STREET EAST AHOSKIE, NC 27910		V.2V.1	
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORE	HOULD BE	(X5) COMPLETION DATE	
checked the inside of the 11/20/12; and the last the scraped clean was 11/10 Director stated no one of dryers were in need of the dryers were in need of the dryers with the Director 11:30 AM, the DON state looked nasty and expected the dryers to be condition.  During an interview with 11/30/12 at 4:20 PM, the expected the dryers to be condition.  183.75(g) EMPLOY QUENT PROFESTIVE TO SULT PR	last time maintenance the dryers was 11/19/12 or ime the dryer drums were 14/12 or 11/15/12. The had reported to him the cleaning.  Ind observation of the ref Nursing (DON) at sted the inside of the dryers cted the dryers to have the Administrator on the Administrator stated he be maintained in a clean UALIFIED FESSIONALS  If you a full-time, part-time are professionals necessary and of these requirements.  In the licensed, certified, or the with applicable State the with applicable State and staff interviews the Medication Aide 2 Medication Aides was an inister medications.	F4	F 499  1. NA #3 is currently working Nursing Assistant. Her certification the NCNAR Carolina Nurse Aide Registry 2. Current SDC, ADNS, and been in-serviced on NC Medication. The center empirement of the certification in the certification has been verification has been verification has been verification. She is currently list substantiated findings on the Nursing Aide I and NC Medication Aide positions and NCNAR as a Nurse Aide I and Medication Aide prior to maid to the complete Meetings monthly performance Improved Committee Meetings monthly minimum of three months or compliance is sustained.	ication has . (North /) DNS have ication Aide loys one her l on the ted with no NCNAR as a cation Aide. ls applying for e listed on the ad NC king a job offer e reviewed in //ement // for a	12/28/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	S FOR MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		ULTIPI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A BUILDING			c	
		345359	B. WIN	IG		11/30/2012		
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE				60	EET ADDRESS, CITY, STATE, ZIP CODE 04 STOKES STREET EAST HOSKIE, NC 27910			
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F 499	for the 7 AM to 3 PM nurses aide schedule on the 7 AM to 3 PM 21, 22, 24, 25, 26, 2 Medication Aide. Th NA#3 was scheduled for the remainder of December 13, 2012.  An interview with the (NSS) on 11/30/12 at "M3" indicated Me medications on Unit NA #3 had given her Medication Aide to the Development Coord directed by the SDC orientation for the MNSS indicated NA#3 a Registered Nurse her training to admir facility.  An interview with the on 11/30/12 at 11:40 received orientation position based on the former SDC. The Distance of the SDC orientations. The Document of the Nurses Aide Recertificate. The DOC Nurses Aide Regist certified to administration of the American State of the SDC orientation.	sheduled as a "Med aide" shift. A review of the e revealed NA #3 had worked shift on November 19, 20, 7, and 29, 2102 as a e schedule documented dias a Medication Aide "M3" the schedule period ending the schedule period ending Nursing Staff Scheduler to 11:00 AM revealed the code dication Aide to administer and the Nash also indicated to proof of certification as a me previous Staff inator (SDC). The NSS was to schedule NA#3 for edication Aide position. The shad supervised NA#3 during hister medications in the edication Aide necertificate provided to the incommon to t	F	499	1. NA #3 is currently working as a Nursing Assistant. Her certification been verified on the NCNAR. (No Carolina Nurse Aide Registry)  2. Current SDC, ADNS, and DNS been in-serviced on NC Medication certification. The center employs Medication Aide at this time; her certification has been verified on NCNAR. She is currently listed a substantiated findings on the NCN Nursing Aide I and NC Medication. Aide positions are lis NCNAR as a Nurse Aide I and N Medication Aide prior to making 4. Verification Audits will be remonthly Performance Improvement Committee Meetings monthly for minimum of three months or unticompliance is sustained.	a Certified on has orth  S have on Aide one the with no NAR as a on Aide. oplying for ted on the CC a job offer. viewed in ent r a	12-28-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

A BUILDING  346359  NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION NUMBER:  A BUILDING  B. WNG  STREET ADDRESS, CITY, STATE, ZIP CODE  604 STOKES STREET EAST  AHOSKIE, NC 27910  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUL  PREFIX TAG (EACH CORRECTIVE ACTION SHOUL  TAG DEFICIENCY)  DEFICIENCY)	LD BE COMPLETIC		
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX PREFIX PROPRIED BY FULL PROPRIED BY FULL PREFIX PREFIX PREFIX PROPRIED BY FOR PROPRIED BY FULL PREFIX PREFIX PREFIX PROPRIED BY FULL PROPRIED BY FULL PREFIX PREFIX PROPRIED BY FULL PROPRIED BY FULL PREFIX PREFIX PROPRIED BY FULL PROPRIED BY FULL PREFIX PROPRIED BY FULL PROPRIED BY FULL PREFIX PROPRIED BY FULL	ION (X5)		
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	SHOULD BE COMPLETION		
F 499 Continued From page 14 a Medication Aide.  An interview with NA#3 on 11/29/12 12:20 PM revealed NA#3 had taken a course to become a Certified Medication Aide. NA#3 indicated she had given her certificate of successful completion of the course to the former SDC. NA#3 revealed the SDC arranged for her to start orientation as a Medication Aide. NA#3 indicated she started training at the facility to administer medications under the supervision of a Registered Nurse. NA#3 indicated she administered medication and signed them off in the Medication Administration Record. NA#3 revealed she had worked 8 shifts as a Medication Aide.  An interview with the DON on 11/30/12 at 12:30 PM revealed her expectation was for all medications administered in the facility be administered by qualified staff only.			

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PRINTED: 01/02/2013 FORM APPROVED

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES COMPLETED 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION A BUILDING B. WING 12/20/2012 345359 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 604 STOKES STREET EAST KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE AHOSKIE, NC 27910 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 000 K 000 INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483,70(a); using the Existing Health Care section of the LSC and its referenced THISTRUCTO publications. This building is Type V 111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: K 012, K 012D LSC Unprotected PVC Conduits NFPA 101 LIFE SAFETY CODE STANDARD K 012 SS≍D Building construction type and height meets one 1. The PVC Conduit penetrating the of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4. Nursing Supply Room across from 19,3,5,1 the business office was sealed using LCC Firestop Collar. 2. Other conduit penetrations were checked This STANDARD is not met as evidenced by: and found to be in compliance with the A, Based on observation on 12/20/2012 there Standard. were unprotected PVC conduites penetrating the ceiling of the Nursing Supply Room across from 3. Any future conduit penetrations will be the business office. supervised by maintenance Supervisor 42 CFR 483.70 (3) NFPA 101 LIFE SAFETY CODE STANDARD K 029 and subsequently scaled with LCC K 029 SS=0 Firestop. One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 4. The Maintenance staff will make and/or 19.3.5.4 protects hazardous areas. When visual observations monthly to check the approved automatic fire extinguishing system and monitor potential non-compliant option is used, the areas are separated from conduit penetrations. other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are

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.

TITLE

(X8) DATE

LABORATORY DIRECTOR'S ON PROVIDER/SURPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 01/02/2013 FORM APPROVED OMB NO. 0938-0391

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

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION A. BUILDING B, WING\_ 12/20/2012 345359 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 604 STOKES STREET EAST KINDRED TRANSITIONAL CARE & REHAB-AHOSKIE AHOSKIE, NC 27910 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) .... K029 D Self Closing Door K 029 Continued From page 1 K 029 permitted. 19,3.2.1 1. The door to the dry storage room failed to close and latch. A piece of metal had prevented the door was closing completely. This STANDARD is not met as evidenced by: Metal was removed and door A. Based on observation on 12/20/2012 the door to the dry storage room in the kitchen failed to closed as required. close and latch. 42 CFR 483.70 (a) 2. Other doors within the facility Were checked and closed per the LSC standard. 3. Any future door installation or maintenance will be checked for proper closure. 4. Maintenance personnel will check and monitor doors per our monthly PM Checklists.

PAGE 05/07

PRINTED: 01/02/2013

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO.	0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			/X2) N	MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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K 000	INITIAL COMMENTS		K 000				:
	conducted as per at 42 CFR 483.70( Care section of the publications, This	ode(LSC) survey was The Code of Federal Register (a); using the Existing Health ELSC and its referenced building is Type V 111 story, with a complete r system.	Andreas of the control of the contro				
	are as follows Bas	etermined during the survey ed on observation and staff re no LSC deficiencles noted.	A CONTRACTOR OF THE PROPERTY O				

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.

TITLE

Facility ID: 923205

(X8) DATE

LABORATATA PIRECTOR'S OF ROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

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PRINTED: 01/02/2013 FORM APPROVED OMB NO. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	0938-0391
		& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) A	AULTI)	PLE CONSTRUCTION	OX3) DATE S	JRVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	ILDIN		COMPLETED		
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		RE & REHAB-AHOSKIE			04 STOKES STREET EAST HOSKIE, NC 27910		1
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K 000	INITIAL COMMEN	TS	К	000			
	conducted as per at 42 CFR 483.70( Care section of the publications, This construction, one automatic sprinkle  The deficiencies dare as follows Bas	rode(LSC) survey was The Code of Federal Register (a); using the Existing Health e LSC and its referenced building is Type V 111 story, with a complete er system.  Retermined during the survey sed on observation and staff are no LSC deficiencies noted.					
ABORMIN	Y NRECTOR'S OR PROV	ADER/SUPPLIER REPRESENTATIVE'S SI	GNATUR	E -<	TITLE		KA) DATE

Any deficiency statement endiring 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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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION  05 - REPLACEMENT BUILDING	(X3) DATE SURVEY COMPLETED	
		345359	B, Wil			12/20/2012	
	ROVIDER OR SUPPLIER	RE & REHAB-AHOSKIE		60	EET ADDRESS, CITY, STATE, ZIP CODE 4 STOKES STREET EAST		
KINDRED				Al	HOSKIE, NC 27910  PROVIDER'S PLAN OF CORRECT	TION	(X6) COMPLETION
(X4) ID PREFIX TAG	たんかい わにだいだんかく	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION
K 000	INITIAL COMMEN	TS	к	000			
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TITLE

**Pacility ID: 923205** 

(X6) DATE

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