

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law</p> <p>1. Corrective Action: Medicare information has been posted in a readable format and at a height that is accessible to residents in the main lobby. Residents #76, #109, #156 had all been previously discharged.</p> <p>2. Other with Potential to be Affected: Medicare information has been posted in a readable format and at a height that is accessible to residents in the main lobby. The Social Worker / Financial Counselor will discuss and provide the resident / responsible party with the ABN letter within the two day requirement prior to their benefits ending.</p> <p>3. Measure/Systemic Change The Social Worker and/or Financial Counselor will be responsible for issuing the ABN letters. The Financial Counselor will maintain a log documenting resident name, date service ended, date resident/family was notified and confirming completed letter is in financial record.</p>	12/6/11

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

TITLE

(X6) DATE

Loie Leopardi

Administrator

12/7/11

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

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This</p>	F 156	<p>4. Monitoring: The Administrator will review the log weekly for the first 4 weeks and monthly for the next 4 months to ensure compliance. Results of this audit will be reviewed in monthly PI Committee Meeting for follow-up or recommendations. The Administrator is responsible to ensure compliance.</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	<p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide at least a two day notice that Medicare benefits were ending and their right to appeal for three (3) of three (3) sampled residents (Resident #76, Resident # 109, Resident # 156) and failed to post the Medicare information in a readable format. Findings included:</p> <p>1. On 11/2/2011, a random selection of residents was reviewed for appropriate Medicare Discharge Notices. A review of the facility records revealed no Skilled Nursing Facility Advance Beneficiary Notice (ABN) or other notification of termination of Medicare benefits for Resident #76.</p> <p>On 11/2/11 at 10:51 AM., the Financial Counselor and the Vice President of Operations stated the former Administrator left in September 2011 and</p>	F 156			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	<p>Continued From page 3</p> <p>the Social Worker left on 10/14/11. They stated the Social Worker completed the Advance Beneficiary Notices (ABN) and placed them in a big notebook. When the forms were completed the Social Worker was supposed to give them to the Financial Counselor who placed them in the residents' files. The Financial Counselor stated she had asked the Social Worker for the completed ABN forms until the time the Social Worker left the facility but she did not receive any notices. She stated they were unable to find the notebook and did not have any ABN notices.</p> <p>2. On 11/2/2011, a random selection of residents was reviewed for appropriate Medicare Discharge Notices. A review of the facility records revealed no Skilled Nursing Facility Advance Beneficiary Notice (ABN) or other notification of termination of Medicare benefits for Resident #109.</p> <p>On 11/2/11 at 10:51 AM., the Financial Counselor and the Vice President of Operations stated the former Administrator left in September 2011 and the Social Worker left on 10/14/11. They stated the Social Worker completed the Advance Beneficiary Notices (ABN) and placed them in a big notebook. When the forms were completed the Social Worker was supposed to give them to the Financial Counselor who placed them in the residents' files. The Financial Counselor stated she had asked the Social Worker for the completed ABN forms until the time the Social Worker left the facility but she did not receive any notices. She stated they were unable to find the notebook and did not have any ABN notices.</p> <p>3. On 11/2/2011, a random selection of residents was reviewed for appropriate Medicare Discharge</p>	F 156			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	<p>Continued From page 4</p> <p>Notices. A review of the facility records revealed no Skilled Nursing Facility Advance Beneficiary Notice (ABN) or other notification of termination of Medicare benefits for Resident #156.</p> <p>On 11/2/11 at 10:51 AM., the Financial Counselor and the Vice President of Operations stated the former Administrator left in September 2011 and the Social Worker left on 10/14/11. They stated the Social Worker completed the Advance Beneficiary Notices (ABN) and placed them in a big notebook. When the forms were completed the Social Worker was supposed to give them to the Financial Counselor who placed them in the residents' files. The Financial Counselor stated she had asked the Social Worker for the completed ABN forms until the time the Social Worker left the facility but she did not receive any notices. She stated they were unable to find the notebook and did not have any ABN notices.</p> <p>4. On 11/2/11 at 5:15pm, during an interview with Resident # 23, the Resident Council president, she stated that she wasn't certain where the information was posted in the facility for Medicare and Medicaid information. She commented that she passes through the lobby area, in order to go outside on the porch, but couldn't recall seeing that information posted.</p> <p>On 11/2/11 at 5:50pm, during a visit to the lobby, a 8x10 frame was observed hanging on a wall in the lobby, about 6 feet off ground, above a chair. Typed in a small font, was information on How To Apply For Medicare and Medicaid Benefits.</p> <p>The Vice President of Operations was interviewed on 11/2/11 at 6:00pm. She was</p>	F 156			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 5 asked to view the Medicare and Medicaid information; then commented that the sign was not at eye level for residents to read and that it was typed small. She took down the sign, had it retyped with a bigger font and placed it in a larger frame, at eye level on the lobby wall.	F 156		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.	F 159	1. Corrective Action: Residents #164 and #68 were given a copy of their financial statement. 2. Other with Potential to be Affected: Financial statements will be given to the Residents and Responsible Parties quarterly. 3. Measure/Systemic Change: Alert and Oriented residents received a copy of their financial statement immediately. Every quarter, Alert and Oriented residents will receive a copy of their financial statement. The financial counselor will maintain a log of residents who receive their financial statements. 4. Monitoring: The Log will be reviewed by the Administrator after quarterly statements have been given and after statements are given on a quarterly basis. The Administrator and/or Financial Counselor are responsible to ensure compliance. Findings from the audits will be taken to monthly QA for tracking and trending of any issues identified.	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 159	<p>Continued From page 6</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to issue quarterly financial bank statements to 2 of 2 sampled residents (Residents # 68 and # 164), with resident trust fund accounts, who were capable of self-expression and decision making.</p> <p>The findings include:</p> <p>1. Resident #68 was admitted to the facility on 8/4/11 and opened a resident trust fund account after his admission.</p> <p>On 11/2/11 at 2:30pm, Resident #68 expressed concern that he didn ' t know how much money he had. He stated that he transferred funds from a former facility after his admission however; he doesn ' t know how much he has available for personal items and haircuts. He stated that his daughter was listed as his representative but that</p>	F 159			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 159	<p>Continued From page 7</p> <p>he has never received a statement about his account and wasn ' t certain if he even had a resident trust fund account.</p> <p>On 11/3/11 at 3:00pm, Resident #68 ' s business records were reviewed. It revealed that he signed his admission papers and was able to understand matters pertaining to his legal and financial affairs.</p> <p>On his admission Minimum Data Set (MDS) assessment, dated 8/9/11, Resident #68 was listed with a moderate cognitive impairment. It also assessed that Resident #68 had the ability to express his ideas and wants as well as had the clear comprehension to understand others.</p> <p>On 11/4/11 at 12:25pm the Business Office Manager was interviewed. She stated that she does not automatically give financial statements to alert and oriented residents, however if they request one, she has always supplied it. She provided documentation that showed that a 9/30/11 quarterly financial statement was sent to Resident #68 ' s daughter. She relayed that she did not give Resident #68 the statement because he never asked for it.</p> <p>2. Resident #164 was admitted to the facility on 8/8/11 and opened a resident trust fund account after her admission.</p> <p>On 11/3/11 at 12:30pm, Resident #164 was interviewed. She expressed concern that she did not know how much was in her resident trust fund account and was planning to be discharged back into the community. She shared that she has never received a statement. She stated that the</p>	F 159			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 159	Continued From page 8 Business Office Manager acted like it was her money she was spending, instead of it belonging to Resident #164. She expressed an interest in going to the business office to request a statement. On 11/3/11 at 3:00pm, Resident #164 ' s business records were reviewed. It revealed that she had a relative from out of state, listed on her account, but that she had signed several of her admission papers, a month after her admission. A copy of a quarterly financial statement, dated 9/30/11 was sent to a family member of Resident #164 On her admission Minimum Data Set (MDS) assessment, dated 8/15/11, Resident #164 was listed as cognitively intact. On 11/4/11 at 12:25pm the Business Office Manager was interviewed. She stated that yesterday, Resident #164 came to her office to request a copy of her financial statement, which she delivered. She shared that she always prints statements if a resident requested it, but that she does not automatically provide it to alert and oriented residents, who have resident trust fund accounts. She stated that she sent Resident #164 last statement, dated 9/30/11 to a relative.	F 159			
F 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.	F 161	1. Corrective Action: The Surety Bond was corrected during survey to state the residents are the obligee.		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 161	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the failed to list the residents as obligee on the surety bond for the resident trust fund account. The findings include: On 11/1/11 at 2:40pm the Surety Bond for the Resident Trust Fund account was reviewed. It revealed that it was renewed on 7/1/11 and listed The Division of Facility Services as the obligee. On 11/1/11 at 3:05pm the Administrator was notified of the error on the Surety Bond. She was informed that a state agency could not be listed as an obligee on the surety bond for the resident trust fund account. She stated that she would immediately contact their corporate office to have it corrected. On 11/1/11 at 3:15pm the Vice President of Operations stated that they were unaware of the changes regarding who could be listed as an obligee and that they were in the process of contacting the state agency to get clarification. On 11/3/11 at 3:00pm, the Vice President of Operations provided documentation of a Rider to the Surety Bond which listed the Residents in Aggregate of the facility as the obligee.	F 161	2. Other with Potential to be Affected: The Surety Bond has been corrected to state the residents are the obligee. 3. Measure/Systemic Change: The Administrator will check the Surety Bond at every renewal to ensure the obligee is listed correctly. 4. Monitoring: The Surety Bond will be reviewed for appropriate obligee during monthly QAA committee meeting. The Administrator is responsible to ensure continued compliance.	
F 162 SS=B	483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The	F 162	1. Corrective Action: Residents #68, #29 and #16 have been reimbursed for haircuts charged	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 162	<p>Continued From page 10</p> <p>facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter.</p> <p>(This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)</p> <p>During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this subpart. Dietary services as required at §483.35 of this subpart. An activities program as required at §483.15(f) of this subpart. Room/bed maintenance services. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at</p>	F 162	<p>2. Other with Potential to be Affected: The facility will provide the Medicaid residents with one free haircut per month.</p> <p>3. Measure/Systemic Change: The Resident Council has been informed that there will be no charge for one haircut per month for Medicaid residents. All Medicaid resident trust account was audited for the past 12 months and residents have been reimbursed for any haircut charges found. Trust accounts for Medicaid residents will be audited each month by the Financial Councilor for the next 4 months to ensure monthly haircuts are not charged to Medicaid residents.</p> <p>4. Monitoring: The results of the monthly audits will be reviewed at the monthly QAA committee meetings for follow-up and recommendations as needed. The Administrator and/or Financial Counselor will be responsible for compliance.</p>	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 162	<p>Continued From page 11 §483.15(g) of this subpart.</p> <p>Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: Telephone. Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal clothing. Personal reading matter. Gifts purchased on behalf of a resident. Flowers and plants. Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.</p> <p>The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative)</p>	F 162			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 162	<p>Continued From page 12</p> <p>requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility charged 3 out of 3 residents (Residents # 68, # 29 and # 16) receiving Medicaid benefits, fees for monthly haircuts.</p> <p>The findings included:</p> <p>1. Resident #68 was admitted to the facility on 8/4/11 and received Medicaid benefits. On 11/3/11 at 4:30pm, a copy of his financial statement was reviewed and indicated that on 9/7/11 and 10/11/11, he received haircuts and was charged \$15.00 for each service.</p> <p>On 11/2/11 at 2:30pm Resident #68 expressed concern about his dwindling finances. He stated that he was planning to get a hair cut today but didn ' t know how much money he had and has \$15.00 deducted from his account, each time his hair gets cut.</p> <p>On 11/3/11 at 4:30pm, the Business Office Manager was interviewed. She stated that she was unaware that residents receiving Medicaid benefits still were entitled to one free haircut a month. She shared that years ago, she was informed that Medicaid stopped covering the expense of a free haircut for a licensed stylist. She stated that the facility charged everyone \$15.00 for a haircut, regardless of their payment source.</p>	F 162			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 162	Continued From page 13 2. Resident #29 was admitted to the facility on 8/26/11 and received Medicaid benefits. On 11/3/11 at 4:30pm, a copy of his financial statement was reviewed and indicated that on 9/21/11, \$15.00 was deducted from his resident trust fund account for a haircut. On 11/3/11 at 4:30pm, the Business Office Manager was interviewed. She stated that she was unaware that residents receiving Medicaid benefits still were entitled to one free haircut a month. She shared that years ago, she was informed that Medicaid stopped covering the expense of a free haircut for a licensed stylist. She stated that the facility charged everyone \$15.00 for a haircut, regardless of their payment source. 3. Resident #16 was admitted to the facility on 6/17/11 and received Medicaid benefits. On 11/3/11 at 4:30pm, a copy of her financial statement was reviewed and indicated that on 10/5/11, she received a haircut and had \$15.00 deducted from her account, for the service. On 11/3/11 at 4:30pm, the Business Office Manager was interviewed. She stated that she was unaware that residents receiving Medicaid benefits still were entitled to one free haircut a month. She shared that years ago, she was informed that Medicaid stopped covering the expense of a free haircut for a licensed stylist. She stated that the facility charged everyone \$15.00 for a haircut, regardless of their payment source.	F 162			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to inform residents of the location of the Survey Results Book.</p> <p>The findings include:</p> <p>On 11/2/11 at 5:30pm, Resident #23, the president of Resident Council was interviewed. She stated that their group meets monthly and that they do not discuss where to find the survey results. She stated that she would be very interested in reading the survey results and planned to inquire about its location.</p> <p>On 11/2/11 at 5:50pm, a thin green binder was located on the buffet table in the lobby area and was marked survey results. There was no sign in the lobby area to identify the location of the book or observed anywhere else in the facility.</p> <p>On 11/3/11 at 6:00pm, a framed sign was observed hanging on the wall in the lobby, stating</p>	F 167	<p>1. Corrective Action: A sign was posted in the front lobby to identify the survey results folder and residents were informed of the location of survey results via Resident Council.</p> <p>2. Others with Potential to be Affected: Signs have been posted on all units to identify location of the survey results.</p> <p>3. Measure/Systemic Change: All new admissions will be informed of survey results location during the admission process. The Activity Director will incorporate location of survey results in Resident Counsel meetings monthly. Activity Director and/or Social Worker is audit 10 residents per week for knowledge of location of survey book. This will be completed weekly for 4 weeks, then monthly thereafter.</p> <p>4. Monitoring : Results of interviews will be taken to Monthly PI Committee meeting for follow-up and recommendations as needed. The Administration and/or Activity Director is responsible to ensure compliance.</p>	12/6/11

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 242	<p>Continued From page 16</p> <p>These preference questions included " how important is it to you to choose between a tub bath, shower, bed bath or sponge bath?" The resident was coded as needing extensive assistance of two or more people for personal hygiene.</p> <p>Review of the Care Plan for Resident #101 dated 8/30/11 revealed the resident had a Care Plan for " Self Care Deficit Activities of Daily Living (ADL) " with a goal that her ADL needs would be met. Approaches to achieve the goal included " provide assistance with all ADL ' s such as dressing, bathing, personal hygiene and grooming. Encourage resident to do as much as she can for herself while providing assistance as needed to complete tasks. "</p> <p>Review of the Admission/Nursing Evaluation form dated 10/11/11 revealed the resident preferred to go to bed between 10 - 11 PM and to rise at 7 - 8 AM.</p> <p>Review of the Medical Record revealed no early morning appointments for Resident #101.</p> <p>On 10/31/11 at 3:04 PM Resident #101 was interviewed and asked if she was able to choose her own dressing and bathing schedule. She stated that there was a rotating schedule that required some residents to take turns and " have to get washed up at 5:00 AM sometimes ". She also stated that staff woke her up for this and gave her a bed bath but she didn ' t have to get up out of bed at that time. In addition Resident #101 said " It ' s awful and I ' ve told them (the Nursing Assistants that wake her up) that I ' d rather not " but indicated it still happened on</p>	F 242	<p>4. Monitoring</p> <p>Results of the interviews performed by the Social Worker and/or Senior Care Partner will be reviewed in Monthly QAA Committee Meeting for follow-up and recommendations. The Administrator is responsible to ensure compliance.</p>	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 242	Continued From page 17 occasion anyway. On 11/3/11 at 4:45 AM Resident #101 ' s door was noted to be closed with the light on inside the room. Continuous observation started at that time. At 5:00 AM a Nursing Assistant was observed to come out of the room with a bag of trash and a bag of bed linens. On 11/3/11 at 5:15 AM Nursing Assistant #9 who had exited Resident #101 ' s room at 5:00 AM was interviewed. She stated that while in the room she gave Resident #101 a bed bath. She further revealed that it was her first night working on this floor and she had been told by another Nursing Assistant working with her (NA #10) that Resident #101 needed her bed bath done by 5:00 AM, and that the information was in her record. On 11/3/11 at 5:35 AM Nursing Assistant #10 was interviewed and stated that Resident #101 was supposed to receive her bed bath by 5:00 AM every day. When asked if that was requested by the resident, she said night shift was supposed to give 4 baths on their shift and the charge nurse told them which baths to give. On 11/3/11 at 9:00 AM at the Director of Health Services/Director of Nursing (DON) was interviewed and stated that there is no schedule for waking up residents for bed bath around 5:00 AM unless the resident has an early appointment. She was advised that Resident #101 did not have an early appointment and was woken up for a bed bath anyway. The DON revealed that she had not been aware that this had been happening but that it would not happen again.	F 242		
F 272	483.20(b)(1) COMPREHENSIVE	F 272		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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	Continued From page 18 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	1. Corrective Action: A new RAI and CAA's were completed for Residents #120 and #192. Care Plan was updated as needed. 2. Other with Potential to be Affected: Residents care plans have been reviewed and revised as needed by the interdisciplinary team. The most recent assessment for each resident will be reviewed for accuracy, as will each care plan weekly by the Clinical Reimbursements Consultant. 3. Measure/Systemic Change: The most recent assessment for each resident will be reviewed for accuracy, as will each care plan. Modified RAI with CAA's will be completed as required and care plans updated as needed. Results of this audit will be documented and reviewed by the Clinical Reimbursement Consultants.. Audits will continue weekly for 4 weeks and monthly for 4 months. 4. Monitoring Audit results will be reviewed in Monthly PI Committee Meeting for follow-up and recommendations completed as needed. The Administrator is responsible to ensure compliance.	12/6/11

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan to include mental health interventions for one resident (Resident # 120) and failed to complete a comprehensive admission assessment within fourteen days of admission for resident #192. Findings included:</p> <p>1. Resident #120 was admitted to the facility on 4/22/10 with a re-admission on 1/12/11. Some of the cumulative diagnoses included: vascular dementia, major depressive disorder: recurrent, severe with psychotic features and dysarthria.</p> <p>During 12/16/10-1/12/11, Resident #120 was hospitalized for paranoia, delusional behaviors and a suicide attempt at the facility.</p> <p>The most current Minimum Data Set (MDS), dated 7/15/11 revealed that Resident #120 was cognitively intact. She acknowledged during a Resident Mood Interview that she experienced depression and hopelessness.</p> <p>On 11/4/11 at 5:45pm, Nurse #4 stated that Resident #120 has become more outgoing but recently she noticed her with non-sensible speech which was related to her mental health disorder.</p> <p>The MDS Nurse was interviewed on 11/2/11 at 12:15pm. She stated that they were late completing some assessments. She shared that there have been a great deal of turnover in her department and that they got behind. She has</p>	F 272			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 20 borrowed MDS staff from other facilities to assist her. On 11/4/11 at 5:50pm, the MDS Coordinator relayed that Resident #120 was care planned on 1/25/11 but it did not include identifying any interventions to address her suicidal behaviors. She shared that since she began her employment in April, there have been many challenges and she has been trying to catch up on assessments. She has not been able to complete the quarterly MDS on Resident #120, which was due in October. 2. Resident # 192 was admitted to the facility 10/6/2011. Current diagnoses included: hypertension, cerebrovascular accident, sacral pressure ulcer, dysphagia, diabetes and depression. The Minimum Data Set (MDS) Admission assessment revealed the assessment reference date as 10/13/11. Section V Care Area Assessment (CAA) summary noting completion of CAA process and completion of the care plan was signed by the MDS Coordinator on 11/1/2011. On 11/2/11 at 12:15 PM., the MDS Coordinator stated they were late completing some assessments. She stated they had a lot of staff turnover and another MDS Coordinator from another building had come to help out last week.	F 272			
F 278 SS=B	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	F 278	1. Corrective Action: A corrected MDS was completed for Residents #68, #140, #143 and #198 and interviews completed as indicated.	12/6/11	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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	<p>Continued From page 21 participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to correctly and completely assess four (4) of eighteen (18) sampled residents. Information on the Minimum Data Sets contained a dash for resident interview of cognitively intact residents or coded incorrectly and/ or the Care Area Assessments were not completed as triggered for assessments (Resident #68, #140, #143 and #198). Findings included:</p> <p>1. Resident #198 was admitted to the facility 9/22/2011. Diagnoses included: cerebrovascular</p>	F 278	<p>2. Other with Potential to be Affected: The most recent MDS will be reviewed for each resident to ensure accuracy and interviews completed as required</p> <p>3. Measure/Systemic Change: The most recent MDS will be reviewed for each resident to ensure accuracy and interviews completed as required. A corrected MDS will be completed for any assessment found not to be accurately completed. The MDS will be tracked daily on the MDS log for review, accuracy and timely completion by the Case Mix Director..</p> <p>4. Monitoring The Case Mix Director will present the MDS log results for review at the Monthly PI Committee Meeting for follow-up and recommendations as needed. The Administrator is responsible to ensure compliance.</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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	<p>Continued From page 22</p> <p>accident with left hemiparesis and chronic renal disease.</p> <p>The Minimum Data Set (MDS) admission assessment dated 9/29/11 indicated a dash for brief interview for mental status resident/ staff assessment (Should brief interview for mental status be conducted, repetition of three words, temporal orientation and recall), Staff assessment indicated short term and long term memory intact with modified independence in cognitive skills. The assessment indicated that Resident #198 had the ability to understand others and could be understood.</p> <p>On 11/4/11 at 11:16 AM., the MDS Coordinator stated they had gotten behind in MDS's and had other nurses who helped complete the MDS. The facility had also hired an MDS nurse who did not work out. On some assessments, they did not do resident interviews for the cognition section. There had been a turnover of social worker staff also and, to expedite the review process, they did the staff assessment for cognition.</p> <p>2. Resident # 143 was admitted on 2/17/11 and readmitted on 6/8/11 with cumulative diagnoses including: right humerus fracture, osteoarthritis, hypertension and chronic kidney disease.</p> <p>The Minimum Data Set (MDS) admission assessment dated 6/18/11 had the resident checked off as " makes self understood " and " is able to understand " however for the Cognitive Patterns section under " Should brief interview for Mental Status be conducted? ", " No (resident is rarely/never understood) " was checked and a staff assessment was conducted for mental status. In addition, a staff assessment</p>	F 278			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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	<p>Continued From page 23</p> <p>for resident mood and resident pain was conducted as the resident was checked as rarely/never understood for these sections as well. The resident was checked as understood for the Activity Preferences section and a resident interview was conducted for this section. This MDS Assessment was signed as accurate and complete by the MDS Nurse on 7/1/11.</p> <p>Interview with Director of Health Services #2 on 11/3/11 at 11:00 AM revealed she was from another facility and one of her MDS Nurses has been coming to this facility to help with completing MDS assessments as this facility was behind. She indicated that if a resident is understood and can understand, like Resident #143, then staff should be conducting resident interviews for the MDS assessment; not staff interviews.</p> <p>On 11/4/11 at 11:16 AM., the MDS Nurse stated they had gotten behind in MDSs and had other nurses who helped complete the MDS. The facility had also hired an MDS nurse who did not work out. On some assessments, they did not do resident interviews for the cognition section. There had been a turnover of social worker staff also and, to expedite the review process, they did the staff assessment for cognition.</p> <p>Interview with the Administrator on 11/4/11 at 4:00 PM revealed she was familiar with Resident #143 and would expect resident interviews to be conducted during the MDS assessments for this resident. She further indicated that not doing a resident assessment when one should be done was inaccurate and would be addressed with the MDS Coordinator.</p>	F 278			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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	<p>Continued From page 24</p> <p>3. Resident #68 was admitted to the facility on 8/4/11 with the following cumulative diagnoses: hypertension, arthritis, cerebral vascular accident and asthma.</p> <p>Minimum Data Set (MDS) assessment dated 8/9/11 indicated that Resident #68 had adequate vision with no corrective lenses under Section B-Hearing, Speech and Vision.</p> <p>Review of his chart documented that at the time of his admission, his personal property inventory sheet, included a pair of eyeglasses.</p> <p>On 11/1/11 at 9:20am, Resident #68 was observed wearing eyeglasses during his resident interview.</p> <p>The MDS Coordinator was interviewed on 11/4/11 at 3:00pm. She stated that when she completed Section B on Resident #68 ' s Admission MDS assessment, she might have made an error when coding him for corrective lenses.</p> <p>4. Resident # 140 was admitted to the facility on 12/22/10 with the following cumulative diagnoses: arthritis and traumatic brain injury.</p> <p>Minimum Data Set (MDS) admission assessment dated 3/7/11 indicated that he had impairments with the range of motion on both sides of his upper and lower extremities. On the quarterly MDS dated 8/3/11 it indicated that Resident #140 had no limitations with the range of motion of his upper and lower extremities.</p> <p>On 10/30/11 at 10:40am, during an interview with the resident ' s mother, she explained that</p>	F 278		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 25 Resident #195 was positioned in a low bed for safety, since he was able to scoot himself off the mattress with the stronger left side of his body. She stated that he can move his left leg and left arm, but still required a specialized flat call bell that he can mash with his palm when he needs to get assistance. On 10/30/2011 at 2:40pm, Nurse #6 stated that Resident #140 's right arm was contracted. The MDS Coordinator was interviewed on 11/4/11 at 3:00pm. She stated the probably made a coding error under section G04000 Range of Motion on the quarterly MDS dated 8/3/11.	F 278			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP 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 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 §483.25 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).	F 279	1. Corrective Action: Care Plans were reviewed and updated for Residents #197, #115, #41 and #120. 2. Other with Potential to be Affected: Resident Care plans have been reviewed and revised by the interdisciplinary team. 3. Measure/Systemic Change: Resident care plans have been reviewed and updated. All care plan team members will receive education from the Clinical Reimbursement Consultant regarding care plan documentation, accuracy and need to continually update. The Director of Health Services and/or Interdisciplinary Team members monitor 10 care plans a week for the first 4 weeks and 15 care plans a month for the next 4 months to ensure accuracy and current needs documented.	12/6/11	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 279	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop, review and revise plans of care for four (4) of eighteen (18) residents (Resident #197, #115, #41, #120). Findings included: 1. Resident #197 was admitted on 1/21/11, discharged on 2/14/11, readmitted on 2/17/11 and discharged without readmission on 3/3/11. The resident ' s cumulative diagnoses included pressure ulcer stage 4, depressive disorder, Alzheimer ' s disease, malnutrition and convulsions. The resident also had a gastrostomy - jejunostomy feeding tube (GJ tube) on the 1/21/11 and 2/17/11 admissions. The MDS Care Area Assessments section revealed the resident triggered for the following care areas: Cognitive Loss/Dementia, Visual Function, Urinary Incontinence, Psychosocial Wellbeing, Falls, Nutritional Status, Feeding Tube, Dehydration/Fluid Maintenance, and Pressure. Review of the Care Area Assessments (CAA) worksheet revealed that assessment summaries for the triggered CAAs were not present and the ' Care Plan Considerations ' section was blank for each triggered CAA. The Minimum Data Set (MDS) admission assessment dated 2/3/11 revealed the resident had short and long term memory problems and was impaired in decision making. Resident #197 was coded as 69 inches tall and as 141 pounds. The MDS indicated he had a feeding tube.	F 279	4. Monitoring The DHS will present the results of the care plan audit in Monthly PI Committee Meeting for follow-up and recommendations. The Administrator and/or Director of Health Services is responsible to ensure compliance		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 279	<p>Continued From page 27</p> <p>The Admission Care Plan was dated 2/3/11. The Admission Care Plan did not address the resident 's GJ Tube.</p> <p>Further review of the medical record revealed a Comprehensive Plan of Care dated 2/18/11. This Plan of care included the following problem areas: 1) impaired skin integrity (stage 1 left heel, redness right heel, stage 4 sacral) 2) risk for additional skin breakdown 3) current skin concerns (scrotum excoriation, penis hypopigmentation). There were no other problem areas addressed in the 2/18/11 Comprehensive Care Plan including no Care Plan for the resident 's GJ tube.</p> <p>Interview with the Regional Vice President on 11/3/11 at 3:00 PM revealed the facility had looked for additional Comprehensive Care plan documentation for Resident #197 but none was located. She also stated that complete documentation had been identified as an issue in the facility and staff was going to be inserviced on completing required documentation by the legal department.</p> <p>Interview with Administrator #2 on 11/3/11 at 4:00 PM revealed she was from another facility and one of her MDS Nurses had been coming to this facility to help with completing MDS assessments as this facility was behind. In addition, she stated that the completed Comprehensive Care Plan and CAAs for Resident #197 were due on day 21 of his admission, which was 2/10/11, and prior to the resident 's initial discharge date of 2/14/11.</p> <p>2. Resident #115 was admitted on 5/23/11 and</p>	F 279			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 279	<p>Continued From page 28</p> <p>had cumulative diagnoses that included: osteoporosis, hip fracture, dementia, depression and urinary tract infection.</p> <p>The Minimum Data Set (MDS) admission assessment dated 6/5/11 revealed Resident #115 had short and long term memory problems and was moderately independent in decision making. The MDS Care Area Assessments section revealed the resident triggered for the following care areas: Cognitive Loss/Dementia, Communication, Functional/Rehabilitation Potential, Urinary Incontinence, Psychosocial Wellbeing, Behavioral Symptoms, Activities, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, and Return to Community Referral. Review of the Care Area Assessments (CAA) worksheet revealed the following statement typed in each triggered care area under the ' Care Plan Considerations ' heading: " Resident discharged prior to completion of the care plan. "</p> <p>Review of the medical record revealed there was no admission or comprehensive care plan present.</p> <p>Interview with the Regional Vice President on 11/3/11 at 3:00 PM revealed the facility had looked for Care Plan documentation for Resident #115 but none was located. She also stated that complete documentation had been identified as an issue in the facility and staff was going to be inserviced on completing required documentation by the legal department.</p> <p>Interview with Administrator #2 on 11/3/11 at 4:00 PM revealed she was from another facility and</p>	F 279			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 279	<p>Continued From page 29</p> <p>one of her MDS Nurses had been coming to this facility to help with completing MDS assessments as this facility was behind. In addition, she stated that the completed Comprehensive Care Plan and CAAs for Resident #115 were due on day 21 of his admission, which was 6/12/11, and prior to his discharge.</p> <p>3. Resident #41 was readmitted to the facility on 4/1/09. Diagnoses included status post cerebrovascular accident (CVA), dysphagia, and Alzheimer ' s disease.</p> <p>The annual Minimum Data Set (MDS) dated 3/30/11 indicated that Resident #41 had limited movement on one side. The quarterly MDSs dated 6/16/11 and 9/12/11 indicated limited movement on both sides. The annual and quarterly MDSs indicated that the resident rarely/never understood, rarely/never understands, had memory problems and severely impaired cognitive skills for daily decision making, and was non-ambulatory.</p> <p>During an interview on 10/31/11 at 12:31 PM, nurse #3 stated Resident #41 had bilateral knee contractures, and that he did not receive range of motion exercises or wear splints.</p> <p>Observation on 10/31/11 at 4:31 PM revealed that Resident #41 had bilateral knee contractures.</p> <p>Review of the care plan, last updated on 11/2/11, revealed no plan of care to prevent contractures.</p> <p>During an interview on 11/4/11 at 11:30 AM, the MDS nurse acknowledged that the resident was not care planned to prevent contractures.</p>	F 279			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 279	<p>Continued From page 30</p> <p>During an interview on 11/4/11 at 3:05 PM, the physical therapist (PT) stated she had evaluated Resident #41 on 11/4/11 and found bilateral knee and hip contractures. The PT stated the plan was possible splints and abduction pillow.</p> <p>4. Resident #120 was admitted to the facility on 4/22/10 and was re-admitted on 1/12/11 with the following cumulative diagnoses: late effect cerebrovascular accident, abnormality of gait, hyperlipidemia, vascular dementia, depress psychosis, major depressive disorder and dysarthria.</p> <p>A record review was conducted and revealed that she had been hospitalized 12/16/10 through 1/12/11 for psychiatric stabilization and was treated for severe depression, paranoia, delusional and guarded behaviors. She had also attempted suicide. She had been prescribed anti-depressants and didn't have anymore recorded incidents since June, 2011. The last quarterly MDS for Resident #120 was completed on 7/15/11.</p> <p>A chart review produced an Admission Care Plan, dated 1/25/11. Resident #120 was care planned as high risk for falls, for the potential of skin breakdown and for having a self-care deficit. There were no interventions to address her mental health condition, even though her depression was deep rooted and extensive.</p> <p>On 11/4/11 at 6:00pm, the MDS Coordinator was interviewed. She shared that there has been turnover in staffing in the MDS department and that she has borrowed staff from other facilities to allow them to catch up on their work. She shared that Resident #120 had an initial care plan</p>	F 279			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 279	Continued From page 31 developed in January, 2011, but had not been reviewed since then.	F 279		
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interview, the facility failed to update a care plan for one (1) of eighteen (18) sampled residents (Resident # 13) and failed to invite the responsible party to participate in care planning for one (1) of three (3) cognitively impaired residents (Resident # 41). Findings included: 1. Resident #13 was admitted to the facility 1/6/11	F 280	1. Corrective Action: A care plan meeting was scheduled for resident #13 and #41 with resident and family to discuss and update care plan. 2. Other with Potential to be Affected: The MDS Coordinator will make a monthly list and generate the care plan letters. The Receptionist will mail letters out to the family the Social Worker and/or the Senior Care partner will invite the Alert and oriented residents. 3. Measure/Systemic Change: The process for inviting residents and families to care plan meeting has been updated. The MDS Coordinator will make a monthly list and generate the care plan letters. The Receptionist will mail letters out to the family the Social Worker and/or the Senior Care partner will invite the Alert and oriented residents. Documentation of letters sent to families and notification to residents will be maintained on care plan log by Social Worker and/or Senior Care Partner. Care plans will be updated during the meeting by the Interdisciplinary team. The log will be audited by the Administrator weekly for 4 months to ensure compliance. Care plans will be audited by the Director of Health Services and/or Unit Managers the following week to ensure that care plans have been reviewed and updates from the previous week x 4 weeks then monthly x 4.	12/6/11

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 280	<p>Continued From page 32 and readmitted 9/4/11. Current diagnoses included: left cerebrovascular accident, Diabetes, Hypertension, chronic obstructive pulmonary disease, pain management and asthma.</p> <p>The admission assessment dated 1/18/11 indicated resident was cognitively intact. Extensive assistance was required with bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. Resident was independent with locomotion on and off the unit.</p> <p>The Quarterly Minimum Data Set (MDS) dated 10/7/11 indicated resident was alert and oriented. Extensive assistance was needed with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene. Limited assistance was needed with eating. Total care was required with bathing.</p> <p>A review of Resident #13's Care plan revealed the care plan had not been updated since January 20, 2011.</p> <p>On 11/2/11 at 12:15 pm., the MDS Coordinator stated she completed the care plans and put them on the charts. Care plans were updated quarterly. If something needed to be added, the nurses on the floor could write it on the care plans. She stated, ideally, she expected care plans to be done within the time frame of 21 days of admission and reviewed quarterly. She indicated Resident #13's care plan had not been updated since 01/20/2011.</p> <p>2. Resident #41 was last readmitted to the facility on 4/1/09. Diagnoses included status post cerebrovascular accident (CVA), dysphagia, and</p>	F 280	<p>4. Monitoring</p> <p>The Social Worker will present the results of the audit to the Monthly QAA Committee Meeting for follow-up and recommendations. Care plans will be audited by the Director of Health Services and/or Unit Managers the following week to ensure that care plans have been reviewed and updates from the previous week x 4 weeks then monthly x 4. Results from the audit will be discussed in the monthly QAA meeting.</p> <p>The Administrator and/or Social Worker is responsible for compliance.</p>	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 280	Continued From page 33 Alzheimer's disease. The annual Minimum Data Set (MDS) dated 3/30/11 and quarterly MDSs dated 6/16/11 and 9/12/11 indicated that the resident rarely/never understood, rarely/never understands, had memory problems and severely impaired cognitive skills for daily decision making. Record review revealed no indication that the responsible party had been invited to attend the care plan meetings. The "Care Plan Review" form on the resident's record revealed that a care plan meeting was held on 9/26/11 and no family member attended. During an interview on 10/31/11 at 5:49 PM, the responsible party (RP) for Resident #41 indicated that it had been a long time since she had been invited to a care plan meeting. The RP added that at one time she received invitations regularly. During an interview on 11/4/11 at 11:30 AM, the minimum data set (MDS) nurse indicated that she generated the invitation to care plan letters for the responsible parties but had no record to show that they were sent or when they were sent.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to transcribe an order	F 281	1. Corrective Action: Resident #2 order was corrected immediately. Nurses were educated by the Director of Health Services on checking placement of G-tube 2. Other with Potential to be Affected: Licensed nurses have been in-serviced and completed competencies by the interdisciplinary team(DHS, UM, CCC)	12/6/11	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 281	<p>Continued From page 34</p> <p>for Alprazolam 0.25 mg every evening to the November Physician renewal orders and the November Medication Administration Record for one (1) of three (3) residents reviewed for psychoactive medications (Resident #2). The facility also failed to properly check gastric tube (G tube) placement for 1 of 2 residents (Resident #41) prior to administering medications. Findings included:</p> <p>1. Resident #2 was admitted to the facility 8/9/11. Active diagnoses included: anxiety, depression and chronic obstructive pulmonary disease.</p> <p>The Minimum Data Set (MDS) Admission assessment dated 8/16/11 indicated resident was cognitively intact. No mood problems noted. No behaviors were documented. Wandering occurred 1 to 3 days.</p> <p>Care Area Assessment for behavioral symptoms indicated long standing mental health problems associated with the behavioral disturbances, sensory impairment and resident displayed behavior symptoms that impacted self or others. Analysis of findings indicated resident with short term memory loss. She wandered at times, wandered into other residents' rooms and tried to leave the floor.</p> <p>Physician orders for October 2011 indicated Alprazolam 0.25 milligrams (mg.) one (1) tab by mouth every 8 hours as needed for anxiety/shortness of breath. There was also an order for Alprazolam 0.25mg. 1 tab by mouth (po) every evening (5 PM).</p> <p>Physician orders for November 2011 indicated</p>	F 281	<p>on med administration and checking placement of g-tube.</p> <p>3. Measure/Systemic Change Licensed nurses have been in-serviced and completed competencies interdisciplinary team(DHS, UM, CCC) on med administration and checking placement of g-tube. Audit of med administration via g-tube will be completed by Director of Health Services, Clinical Competency Coordinator and/or Nursing Manager weekly for 4 weeks then monthly for 4 months. Licensed nurses have been in-serviced on transcribing orders. The Director of Health Services, Nursing Manager or Clinical Competency Coordinator will monitor new physician orders for transcription accuracy daily for 4 weeks then weekly for 4 months. Results of audit will be documented on New Order Transcription log.</p> <p>4. Monitoring The results of the New Order transcription log will be reviewed in Monthly QAA Committee Meeting for follow-up and further recommendations. The Director of Health Services is responsible to ensure compliance.</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 281	<p>Continued From page 35</p> <p>Alprazolam 0.25 mg. every 8 hours as needed (prn) anxiety. There was not an order for Alprazolam 0.25 mg. 1 tab every evening at 5 PM.</p> <p>A review of the Medication Administration Record (MAR) for November 2011 revealed Alprazolam 0.25 mg every 8 hours prn anxiety. Alprazolam 0.25 mg. po every 5 PM.. was not on the MAR. Resident #2 had not received Alprazolam 0.25 mg. at 5 PM. from 11/1-11/3/11.</p> <p>On 11/4/11 at 10:00 AM., the Director of Nursing (DON) stated the pharmacy generated the monthly renewal orders and the Medication Administration Records (MAR). She expected the nurse to review all the orders including the orders written from the previous month (telephone orders) and the previous month's renewal orders. The orders were reviewed and signed by one nurse. A second nurse assigned to that resident performed a second check and signed the orders. The MARS were attached to the physician renewal orders so any changes that were done on the orders would be automatically transcribed to the MAR. At changeover, the nurse would compare the November MAR to the October MAR to ensure all medications have been noted. She stated Resident #2 should have received Alprazolam 0.25 mg. at 5 PM. daily.</p> <p>2. The facility policy last revised 4/2005 entitled, "Medication Administration: Enteral Tubes", read in part: "Procedure & Key Points" "5. Verify tube placement using the following procedures: Inject 15-20 cc (cubic centimeters) of air into the tube with the syringe and listen to stomach with stethoscope for distinct 'whoosing' sound. Aspirate stomach contents with syringe."</p>	F 281			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 281	Continued From page 36 Resident #41 was readmitted to the facility on 4/1/09. Diagnoses included status post cerebrovascular accident (CVA), dysphagia, status post G tube placement and Alzheimer's disease. The physician orders indicated that the resident was to receive his medication through his gastric tube. On 11/2/11 at 10:20 AM Nurse #10 was observed during med pass. The nurse checked Resident #41's G tube placement by first injecting air. She did not have a stethoscope or make any attempt to listen for the sound of the air entering the stomach. She then aspirated for stomach content. During an interview on 11/2/11 at 12:25 PM, Nurse #10 stated her usual practice for checking tube placement is to push air into the tube, then aspirate. Nurse #10 acknowledged that she did not regularly listen with a stethoscope when checking tube placement. During an interview on 11/3/11 at 6:37 AM, the director of health services stated she expected her nurses to check G tube placement by auscultation and then aspiration.	F 281			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	1. Corrective Action: Resident # 196 no longer resides in the facility.. 2. Other with Potential to be Affected: Licensed Nurses have been in-serviced by the interdisciplinary team on observation of IV access on admission and obtaining orders upon admission for IV sites	12/6/11	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 37</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to clarify the need for the continuation of an intravenous (IV) access site for 1 (Resident #196) of 1 resident.</p> <p>The findings include:</p> <p>Resident #196 was admitted to the facility on 10/18/11. Cumulative diagnoses included end stage renal disease, diabetes mellitus, status post right below-the-knee amputation and left above-the-knee amputation and dementia.</p> <p>Review of the nursing admission form dated 10/18/11, completed by Nurse #2, revealed that Resident #196 had an IV access device in her left wrist.</p> <p>Review of admission physician orders revealed no order for an IV access or order for IV medications or fluids. Review of subsequent orders revealed no order for the IV access device and no order to discontinue it.</p> <p>During an interview on 11/4/11 at 4:25 PM, the nurse (Nurse #1) on the hall when Resident #196 was admitted indicated that she recalled seeing the IV access device. The nurse stated that it was the admitting nurse's responsibility to contact the physician for any clarifications of orders.</p> <p>During an interview on 11/8/11 at 2:25 PM, Nurse #2 indicated that Resident #196 came from the hospital without any orders. Nurse #2 stated that</p>	F 309	<p>3. Measure/Systemic Change Licensed Nurses have been in-serviced the interdisciplinary team on observation of IV access on admission and obtaining orders upon admission for IV sites. The Director of Health Services, Nursing Manager and/or Clinical Competency Coordinator will complete an audit on all new admissions for IV access and site care. The audit will be reviewed weekly for 4 weeks and monthly for 4 months by the Director of Health Services.</p> <p>4. Monitoring The Director of Nursing will present the audit results to the Monthly QAA Committee Meeting for follow-up and further recommendations. The Administrator and Director of Health Services is responsible to ensure compliance.</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 38 usually if a resident was admitted with an IV access device and no orders for it, she would remove the device. Nurse #2 said that she was the hall nurse on the morning of 10/20/11 and that the resident still had the IV access device. Review of the nurse's notes, care plan and medication administration record from 10/18/11 - 10/20/11 (date of discharge) revealed no documentation that the IV access site was assessed or used. During an interview on 11/4/11 at 4:30 PM, the director of health services (DHS) stated that Nurse #2 should have contacted the physician for clarification of the need for IV access.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide incontinent care for 1 (Resident #119) of 3 residents reviewed for activities of daily living, cleanliness and grooming. The findings include: Resident #119 was readmitted to the facility on 5/10/11. Diagnoses included arthropathy, muscle	F 312	1. Corrective Action: Resident # 119 was provided with incontinent care. 2. Other with Potential to be Affected: Any resident that is up in a chair and that is incontinent has the potential to be affected. Nursing assistants were in-serviced the interdisciplinary team and completed competencies on timely incontinence care. 3. Measure/Systemic Change Nursing assistants were in-serviced and completed competencies on timely incontinence care. The Director of Health Services, Clinical Competency Coordinator and/or Unit Managers will audit residents up in w/c and bed bound incontinent residents to ensure incontinent care is provided in a timely manner.	12/6/11

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 312	<p>Continued From page 39</p> <p>weakness and dementia. The quarterly assessment dated 8/11/11 indicated that the resident had long and short term memory problems, moderately impaired cognitive skills for daily decision making, required extensive assistance with toileting and personal hygiene, total assistance with bathing and was incontinent of urine and bowel. The care plan dated 11/1/11 indicated a problem of self care deficit. Approaches included incontinent care after any incontinent episodes. Goals included that resident will be kept clean and dry.</p> <p>On 11/3/11 at 7:55 AM, NA#2 was observed providing a bed bath, including incontinent care, to Resident #119. No redness was observed in the resident's perineal area and buttocks.</p> <p>On 11/3/11 at 10:40 AM, Resident #119 was observed up in her wheelchair in the activity/dining room. She was sitting on a lift pad. At 3:00 PM, the resident was observed sitting up in her wheelchair on a lift pad in her room.</p> <p>During an interview on 11/3/11 at 3:20 PM, NA#2 stated she had not checked Resident #119 for incontinence since getting her up at 10:30 AM. NA#2 indicated that it was lunch time after the activity, then everyone was busy and she did not have an opportunity to check the resident.</p> <p>On 11/3/11 at 3:53 PM, NA#3 and NA#4 were observed transferring Resident #119 back to bed via total lift machine. The resident's incontinent brief was wet and her buttocks and perineal area were red. NA#3 and #4 provided incontinent care, and NA#4 applied a moisture barrier cream to the resident's buttocks and perineal area.</p>	F 312	<p>The audits will be completed daily for 4 weeks and then week for 4 months.</p> <p>4. Monitoring The Director of Health Services will present the Audit results to the Monthly PI Committee Meeting for follow-up and further recommendations. The Administrator and/or Director of Health Services is responsible to ensure compliance.</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 312	Continued From page 40	F 312			
F 318 SS=D	<p>On 11/3/11 at 3:30 PM, the director of health services stated she expected staff to perform incontinence checks every 2 hours and as needed.</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide services to prevent contractures for 1 (Resident #41) of 2 residents.</p> <p>The findings included:</p> <p>Resident #41 was readmitted to the facility on 4/1/09. Diagnoses included status post cerebrovascular accident (CVA), dysphagia, and Alzheimer's disease.</p> <p>The annual Minimum Data Set (MDS) dated 3/30/11 indicated that Resident #41 had limited movement on one side. The quarterly MDSs dated 6/16/11 and 9/12/11 indicated limited movement on both sides. The annual and quarterly MDSs indicated that the resident rarely/never understood, rarely/never</p>	F 318	<p>1. Corrective Action: Resident #41 was assessed for contractures. A contracture care plan is now in place and resident is receiving Therapy Services for contractures.</p> <p>2. Others with potential to be Affected; Resident who triggered a decline on the MDS have been assessed by the Therapist and treatment plans written as indicated.</p> <p>3. Measure/Systemic Change: Residents that triggered for potential contractures on the MDS were assessed by Therapy Services. The residents have care plans in place to prevent contractures and treat any existing contractures. When ever an MDS triggers for potential for contractures, a therapy screen will be completed, if resident is not already being seen by therapy. A care plan for contracture prevention will be put in place with appropriate services to meet the resident's needs. A monthly contracture audit will continue based on MDS triggers and completed by Therapy Services for the next 4 months.</p>	12/6/11	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 318	Continued From page 41 understands, had memory problems and severely impaired cognitive skills for daily decision making and was non-ambulatory. Review of the care plan, last updated on 11/2/11, revealed no plan of care to prevent contractures. During an interview on 10/31/11 at 12:31 PM, nurse #3 stated Resident #41 had bilateral knee contractures, and that he did not receive range of motion exercises or wear splints. Observation on 10/31/11 at 4:31 PM revealed that Resident #41 had bilateral knee contractures. During an interview on 11/4/11 at 3:05 PM, the physical therapist (PT) stated she had evaluated Resident #41 and found bilateral knee and hip contractures. The PT stated the plan was possible splints and abduction pillow.	F 318	4. Monitoring: The Therapy Director will present the Contracture Audit to the Monthly PI Committee Meeting for follow-up and recommendations. The Administrator and/or TOC is responsible to ensure compliance.		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES- RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide tube feedings through jejunostomy portion of the gastrostomy -	F 322	1. Corrective Action: Resident # 197 no longer resides in the facility. The Facility currently has no residents with a G/J tube. 2. Other with Potential to be Affected: Licensed nursing staff have been in-serviced via med pass video on proper use of G-J tube. Upon receiving a resident with a G/J tube nursing staff will be educated by the Clinical Competency Coordinator and/or Director of Health Services on proper use, marking of tube and obtaining orders related a G/J tube.	12/6/11	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 322	<p>Continued From page 42</p> <p>jejunostomy feeding tube (GJ tube) for one (1) of one (1) residents with a GJ tube at high risk of aspiration (Resident #197).</p> <p>According to the Department of Developmental Services (State of Connecticut), Medical Advisory #98-7: Recommendations to Prevent Aspiration Pneumonia. " Aspiration pneumonia is a common cause of morbidity and mortality in the population of people with physical and mental disabilities. The normal swallowing mechanisms that protects the airway from solid or liquid material may be impaired in dysphagic individuals. Hence, unwanted substances enter the trachea and lung that can cause a chemical inflammation and subsequent infection that can result in pneumonia. This can lead to serious illness and is a common cause for death. "</p> <p>The advisory also noted that " The gastrostomy tube is the most common method of artificial long term nutritional support. The tube is placed through the abdominal wall into the stomach. " " A feeding tube passed into the jejunum, through the gastrostomy tube, may need to be considered in individuals in whom there is significant regurgitation of the stomach contents up into the esophagus or ineffective gastric emptying. Some individuals who have had a gastrostomy tube placed who present with recurrent vomiting or aspiration may benefit from a jejunostomy feeding tube. " " Complications do occur with feeding tubes. They may become blocked or dislodged and require replacement or repositioning. "</p> <p>Resident #197 was admitted on 1/21/11 and readmitted on 2/17/11. The resident ' s</p>	F 322	<p>3. Measure/Systemic Change: Upon receiving a resident with a G/J tube nursing staff will be educated by the Clinical Competency Coordinator and/or Director of Health Services on proper use, marking of tube and obtaining orders related a G/J tube. The Director of Nursing will audit on all G-J tubes to ensure tubes are marked, orders are correct, specific and followed weekly for four weeks then monthly for four months..</p> <p>4. Monitoring Upon receiving a resident with a G/J tube nursing staff will be educated by the Clinical Competency Coordinator and/or Director of Health Services on proper use, marking of tube and obtaining orders related a G/J tube. The Director of Nursing will present the G-J tube audit results at the Monthly QAA Committee Meeting for further follow-up and recommendations. The Administrator and/or Director of Health Services is responsible to ensure compliance.</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 322	<p>Continued From page 43</p> <p>cumulative diagnoses included pressure ulcer stage 4, depressive disorder, Alzheimer ' s disease, malnutrition, history of esophageal strictures with multiple dilations, history of aspiration pneumonia, and convulsions. The resident also had a gastrostomy - jejunostomy feeding tube (GJ tube).</p> <p>The Hospital Discharge Summary dated 1/21/11 indicated the resident had a GJ tube placed and was doing well on tube feedings through the J port of the GJ tube. Medications were being given through the G port of his GJ tube.</p> <p>The Minimum Data Set (MDS) admission assessment dated 2/3/11 revealed the resident had short and long term memory problems and was impaired in decision making. It also indicated that he had a feeding tube.</p> <p>Review of the Medical Record revealed there was no care plan for the resident ' s GJ tube or nutritional and hydration status.</p> <p>Review of the Physician ' s Orders between 1/21/11 and 2/14/11 revealed the port to be used (G or J port) for the ordered tube feedings and the ordered water flushes was not specified. In addition, these orders were not clarified.</p> <p>Review of the Physician ' s Orders and Medication Administration Records between 1/21/11 and 2/14/11 revealed medications that were ordered to be given via tube, but the port to be used (G or J port) was not specified. In addition, these orders were not clarified.</p> <p>The Regional Dietician ' s Enteral Feeding</p>	F 322			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 322	<p>Continued From page 44</p> <p>progress Notes Dated 1/31/11 indicated the route of Resident #197 ' s tube fees as " via peg pump. " The port to be used (G or J port) was not specified.</p> <p>The MAR for 2/1/11 - 2/28/11 (page 3) had a handwritten transcribed order for " Jevity 1.2 at 70 ml/hr (milliliters per hour) continuous " ; the administration port was not specified. Further review of the MAR revealed that between 2/1/11 and the date of transfer to the emergency room (2/14/11), the 11-7 feeding was initialed as given consistently, the 7 - 3 feeding was initialed as given on 10 out of 14 days and the 3 - 11 tube feeding was initialed as given on 8 out of 13 days. The tube feed port (G or J tube) was not specified. The 2/1/11 - 2/28/11 MAR also had a hand written transcribed order for " Free H2O flushes 250 ml via g tube q4h. " There was no indication that the J tube was flushed.</p> <p>The 2/13/11 Skilled Daily Nursing note (3:00 PM) read, in part, " G tube patent. Jevity 1.2 ongoing (illegible) at 70 ml/hr. (Name of NP) stated that it is okay to use the G-Tube and to write in PEC (Physician Communication book) book that J tube is not working so MD (Medical Doctor) will be aware. Aspiration precautions observed. HOB (Head of Bed) maintained elevated. No residual taken. " There was no documentation in the medical record indicating precisely when the J tube became clogged or why.</p> <p>The Physician ' s Interim Orders dated 2/13/11 read " May use G port. " There was no other detail present.</p> <p>The Physician ' s Interim Orders (undated) read "</p>	F 322			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 322	<p>Continued From page 45</p> <p>Clarification order for GT " , " Jevity 1.2 at 70 ml/h via GT (G tube). "</p> <p>The 2/14/11 Skilled Daily Nursing (11 PM-7AM) note read, in part, " feeding tube patent infusing well via feeing pump G-tube flushed (with) 170 cc (cubic centimeters) water patent but J tube blocked. "</p> <p>The 2/14/11 Skilled Daily Nursing Note (7AM-3PM) read, in part, " Resident taken to PT (Physical Therapy) and returned to unit in satisfactory condition. (Family member) visiting. "</p> <p>The 2/14/11 Skilled Daily Nursing Note (3AM - 11PM) read, in part " Resident alert and responsive. Came back from PT (Physical Therapy) and was running low sats (oxygen saturation) of 84%. Administered)2 via nasal canula at 2L/min (liters per minute). " " Pt taken to (name of hospital via ambulance at 1600 (4:00 PM). " The resident ' s oxygen saturation when sent to hospital was listed as 87%.</p> <p>The 2/14/11 Skilled Daily Nursing note (5:30 PM) read, in part, " Resident had low BP (blood pressure) of 84/50 after PT (Physical Therapy). Resident placed in bed and rechecked about 20 minutes later. BP was 111/59 but O2 (oxygen saturation) was 84% on RA (room air). Nurse on floor called and received order for x-ray. " The note also indicated that 30 minutes later the family requested transfer to the hospital and the resident was sent out.</p> <p>The Physician ' s Interim Orders dated 2/14/11 read " Send to (name of hospital) ER (Emergency Room) per family request for</p>	F 322			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 322	<p>Continued From page 46 evaluation of decreased O2 (oxygen). "</p> <p>Review of the Resident transfer Form (undated) revealed Resident #197 was transferred from the facility to the (name of hospital) Emergency Room and the reason for transfer was listed as " clot tube. "</p> <p>Review of the Hospital Admission Data document dated 2/15/11 revealed that Resident #197 " presented to the ED (Emergency Department) for evaluation of hypotension and hypoxemia and developed septic shock. " In addition it read, in part, " He has a history of MRSA (Methicillin-resistant Staphylococcus aureus), lives in an SNF (Skilled Nursing facility) and also has a history of aspiration pneumonia. Will treat for HCAP (Health Care Acquired Pneumonia). "</p> <p>Review of the hospital ' Discharge to Outside Facility ' MD (Medical Doctor) document dated 2/17/11 revealed the residents discharge diagnoses were " pneumonia, sacral decubitis ulcer, chronic aspiration. " In addition the document read, in part., " Please use the G port for medications. Please use the J tube for feedings. DO NOT USE THE J PORT FOR MEDICATIONS. " " If the G-J tube malfunctions or cannot be declogged, please call (name of hospital) Vascular Interventional Radiology to make an appointment to have it exchanged. "</p> <p>Review of the hospital ' Discharge to Outside Facility ' Nursing document dated 2/17/11 revealed the residents feeding tube type was a " J-Tube. Location: G-J tube. Medications to be flushed through G tube. Tube feeds via J-tube. " In addition, the listed precautions included</p>	F 322			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 322	<p>Continued From page 47 aspiration precautions.</p> <p>The Hospital Discharge Summary dated 2/17/11 revealed, in part, " Final Diagnoses: 1) Aspiration 2. Malfunction of gastrojejunostomy feeding tube. " Under the heading ' Brief Summary of Clinical Course ' for the problem of aspiration pneumonia it read, in part, " It is likely that this pneumonia is secondary to aspiration. The patient is at high risk of aspiration due to his advanced dementia, and his facility has been giving him his tube feeds via the G tube because the J tube was clogged, which might have increased his risk of aspiration. The patient should have strict aspiration precautions at all times and only receive feeding via his J tube. " Under the Diet heading it read " Tube feeding, Isosource 1.5, 65 mL (milliliters) an hour around the clock. Please use the G port for medications and the J port for tube feedings. Do not use the J port for medications. "</p> <p>The 2/22/11 Enteral Feeding Progress Note revealed, in part, " return from hospital d/t (due to) aspiration pneumonia, clogged tube. " " Will feed patient in J tube to prevent aspiration pneumonia. "</p> <p>Interview with Nurse # 9 on 11/3/11 at 11:30 AM revealed he did not start working in the facility until around the time the resident was discharged. He stated that he may have worked one shift with the resident but did not remember him. No other nurses that worked with the resident were identified during the survey. Nurse # 9 stated that there were current residents with G-Tubes and on questioning he was familiar with administering medication and feedings via G-Tubes and strategies to reduce the risk of aspiration. He did</p>	F 322			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 322	<p>Continued From page 48</p> <p>not know what the difference between the G tube and J tube ports of a GJ tube (the gastrostomy port exits into the stomach while the J tube port exits into the small intestine). He did not know which port was more appropriate for feedings of residents at high aspiration risk and which port was more appropriate for medications.</p> <p>Interview with the Regional Dietician on 11/4/11 at 10:20 AM revealed that she saw many residents at more than one facility and was at this facility about 3 days a week. Despite reviewing her notes she stated she did not specifically remember Resident #197.</p> <p>Interview with the Director of Health Services/Director of Nursing (DON) on 11/4/11 at 2:00 PM revealed the facility had turned over a lot of the nursing staff and had identified a number of issues that were being addressed through the Performance Improvement process. It was her expectation that staff would be aware of how to provide feedings and medications for resident 's with a GJ tube according to facility policy and physician orders. She also noted that she recently identified that some the new graduate nurses in the facility, from a particular nursing school, seemed to lack some knowledge base although they passed their registration examinations. She indicated that these nurses would be reeducated in the areas where they were lacking knowledge or experience. The DON had started at the facility after the resident was discharged and was not aware of any information available to clarify when and how the resident 's GJ tube became clogged.</p> <p>Interview with the Administrator on 11/4/11 at</p>	F 322		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 322	Continued From page 49 4:00 PM and incident logs provided by her revealed no known incidents concerning Resident #197.	F 322		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, emergency medical technician interview, and record review, the facility failed to properly secure 1 (Resident #196) of 4 residents during transport via facility van resulting in a fall; and failed to prevent a resident to resident altercation of two cognitively intact residents (Residents # 13 and # 62). Immediate jeopardy began on 10/20/11 and was identified on 10/27/11 at 4:27 PM. Immediate jeopardy was removed on 10/28/11 at 2:20 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy). The findings included: The facility manual for the wheelchair securement	F 323		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	Continued From page 50 and occupant restraint read in part, "Securing the Wheelchair" "With the occupant facing the front of the vehicle, center the wheelchair between the floor tracks or plates. Apply the wheel locks." "Once you have the wheelchair centered and locked between the floor tracks of plates, you are ready to attach the rear straps. Remember: for the best securement the straps should form about a 45 degree angle between the floor tracks and where the straps attach to the wheelchair. Install the track fitting end into a slot in the floor track. Use a slot just to the inside of the rear wheel. Pull on the strap to ensure the fitting is firmly engaged and locked into the slot. If you are using an S-Hook system, press the red release button and pull the web out of the Retractor. Let go of the release button and attach the S-Hook to a structural frame member of the wheelchair, as close to the corner junction of the seat cushion and seatback as possible. Then push the button on the Retractor to remove the slack. Repeat this process for the other rear strap. "Installing the front strap is similar. Install the track fitting end of the front strap into the floor track or plate. Use a slot that's at least 3" outside the wheel. This prevents the strap from interfering with the footrest and gives better stability. Then pull on the strap to ensure that it's engaged firmly. Next, attach the S-Hook to a structural member of the wheelchair. Then push the button on the Retractor to remove the slack and crank it down for extra tension. Repeat this process for the other front strap. Once you have all four straps attached, release the brakes on the wheelchair and check for movement. Once secured, the wheelchair shouldn't move more than 2" front to back or side to side. Reapply the brakes." "Securing the Occupant" read in part, "Integrated	F 323	1. Corrective Action: Resident #196 no longer resides in the facility. 2. Others with Potential to be Affected: All residents have the potential to be affected. The only facility van was removed from transport from 10/21/11 to present. The only facility van was check by Van Products of Raleigh to check all seat belts in the van for proper latches and all locked properly – this includes the device locking into the floor. Van Products of Raleigh released the van for use on 10/21/11. The van driver was suspended. A Motor Vehicle Safety Program was implemented on 10/21/11 for any van drivers. The motor vehicle safety program includes inspection of vehicles, authorized driving requirements including drivers history report, current drivers license, basic safe driving and vehicle operation rules, accident of loss of company vehicle, what to do if a resident has an untoward event. On 10/21/11 the DHS and Administrator began educating CNAs on van safety to include; what to do in an emergency situation, which includes if a resident falls or becomes unresponsive or complains of chest pain the van driver needs to pull van to the side of road and 911 needs to be called, in the event of any adverse or abnormal occurrence, the van driver needs to pull van to the side of road and 911 needs to be called. The van driver will have a cell phone available during every transport. CNAs will not be able to ride as a passenger until the van safety education is completed, including what to do in an emergency situation.	12/6/11

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	<p>Continued From page 51</p> <p>Lap Belts: take the Snap Hook end of the belt and attach it directly to the D-Ring on the rear securement strap assembly. Adjust the lap belt through the adjusters by pulling on the free end to make the fit firm yet comfortable. The integrated lap belt attaches to the rear wheelchair securement system." "The last belt to attach before you're on your way is the shoulder belt. Bring the triangular fitting of the shoulder belt over the passenger's shoulder, past the collar bone, and diagonally across the upper chest. Attach it to the stud of the lap belt latch plate. Pull the loose end through the adjuster to achieve firm yet comfortable tension. Pull on the belt to ensure that everything is properly secured."</p> <p>Resident #196 was admitted to the facility on 10/18/11. Cumulative diagnoses included end stage renal disease, diabetes mellitus, status post right below-the-knee amputation and left above-the-knee amputation and dementia. The interim admission care plan dated 10/18/11 indicated the resident was at risk for falls and required assistance with transfers.</p> <p>An incident report dated 10/20/11 at 3:30 PM indicated that the facility van driver notified the facility that during transport (from the dialysis center) the resident's wheelchair flipped back. Emergency Medical Services (EMS) was notified and transported Resident #196 to the emergency department (ED).</p> <p>The EMS report written by emergency medical technician (EMT) #1 read in part, "UPA (upon arrival) found pt. (patient) on her right side on the floor of a wheelchair van. No signs of trauma noted."</p>	F 323	<p>3. Measure/Systemic Change</p> <p>The facility implemented the Motor Vehicle Safety Program on 10/21/11. All van drivers must complete the program prior to driving the van. The Administrator or Financial Counselor will ensure the Motor Vehicle Safety Program is completed for each new driver. The facility implemented a driver check off list incorporating use of the lift on the van, locking the wheelchair and securing the resident in a wheelchair on 10/21/11. All van drivers must complete this program prior to driving the van. The drivers check off list includes return demonstration to the Maintenance Director for all new drivers on the use of van lift, securing a wheelchair in the van, and what to do if there is a traffic accident, stolen van, resident falls out of chair, becomes unresponsive, any emergency occurs with a passenger. As of 10/21/11 new van drivers will be observed by the Maintenance Director or Housekeeping Director for securing the three residents accurately daily for one week, three residents weekly for four weeks then three residents monthly for four months.</p> <p>The Housekeeping Director was trained on 10/28/11 by the Maintenance Director on properly securing a resident and the observation check list to validate the driver has properly secured the resident. The van driver double checks themselves' after securing the resident into the van; this is documented on the Validation check sheet with each resident placed on the van.</p>	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	Continued From page 52 Resident #196's Emergency Department (ED) report dated 10/20/11 indicated the physical assessment and diagnostic testing including computerized axial tomography (CT) scans of the head, cervical spine and abdomen/pelvis revealed no injury. The resident was admitted to the hospital for monitoring and was not in the facility at the time of the investigation. A hospital "Interim Discharge Summary" dated 10/27/11 indicated that the resident remained hospitalized primarily because of a new diagnosis atrial fibrillation with rapid ventricular response that was proving difficult to manage. The summary revealed that the resident was also newly diagnosed with breast cancer and a bladder mass. Consults were provided for palliative care, cardiology and nephrology. A statement dated 10/20/11, signed by the facility van driver, indicated that as the van was going up a hill to a stoplight, Resident #196 and her wheelchair tipped backward. The statement read that the resident remained strapped in the wheelchair when EMS arrived. During an interview on 10/27/11 at 11AM, the facility van driver indicated that she was a nursing assistant and a trained van driver. She stated that she started working at the facility on 8/31/11 as a van driver, and had worked for another nursing facility as a van driver prior to starting at this facility. The van driver stated that when she first started working for the facility, another nursing assistant (NA#1) rode in the van during transports and helped her secure the residents with strapping in the wheelchair and buckling seat belts and shoulder straps, but for the last few	F 323	Monthly the validation log is validated by the Housekeeping or Maintenance Director to ensure residents are secured properly in the van by observing the resident in the van prior to or upon return to the facility. The Maintenance Director was trained by Van Products of Raleigh on May 4 th 2011 of the proper way to secure a resident in the van. Training included installing the track fitting end of the securing strap into the rear slot in the floor track; place the straps onto the structural frame member of the wheel chair as close to the corner junction of the seat cushion and seat back as possible. Then push the button on the retractor to remove the slack. The front straps include installing the fitting end at least 3 inches outside the wheel, attaching the S- Hook to a structural member of the wheel chair, pushing on the retractor to remove the slack. The front straps include installing the fitting end at least 3 inches outside the wheel, attaching the S-Hook to a structural member of the wheel chair orientation completed, pushing on the retractor to remove the slack and crank it down for extra tension. Check for movement and apply wheel chair brakes. Apply seat belt as low and snug across the occupant's pelvic zone, with the junction of lap and shoulder belts located near the wearer's hip. The safety of residents to include what to do in an emergency situation on the van has been added to general orientation for all new staff members as of 10/21/11; new van drivers will receive educational instruction by the Maintenance Director and are required to	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 53</p> <p>weeks she was doing the transports by herself. The van driver indicated that she had not been trained on how to secure residents in the van by anyone at the facility, but she knew the procedure. In October a corporate staff person evaluated her and there were no problems. The van driver indicated she kept a daily validation checklist which included seatbelts, shoulder straps and the straps used to secure the wheelchair in the van.</p> <p>A facility "Van Drivers Training" form, dated 10/7/11, indicated that the van driver received training on securing residents in van, demonstrated proper securing of residents in the van, stated what to do in an emergency, and demonstrated proper way to load residents in the van. The form was signed by a corporate staff member as having been the trainer.</p> <p>During an interview on 10/27/11 at 1:14 PM, NA#1 confirmed that she rode in the van during transports from July until sometime in September. NA#1 stated she had been trained by the previous driver on how to secure residents during transport. NA#1 explained that wheelchairs were secured in the van by 4 straps - 2 in front and 2 in back. The straps were secured to tracks in the floor of the van with one track for the front straps and one for the back. The straps could be removed from the tracks and repositioned as needed. The track-fitting ends of the straps made a clicking sound when they locked into the tracks. To secure the wheelchair, the back straps were secured to the frame of the wheelchair, then the front straps. The resident was secured with the seatbelt and then shoulder strap.</p>	F 323	<p>return demonstrate on the Motor Vehicle Safety Program, Van Safety to include what to do in a emergency situation, van driver check off (loading and securing wheel chairs), securing , the resident validation logs. Also included in training; securing of residents via the validation of seat belts in van tool, this includes restraint properly secured on frame X4 (2 front and 2 back) seat belt and shoulder strap are secured properly, locking wheel chair and ensuring grips are locked. The Administrator and/or Financial Counselor will complete a van driver identification log, identifying all areas of training and demonstration to maintain resident safety in the van, has been completed. This details that the new van driver has a current drivers license, evidence of insurance, completed a drivers history form, has been placed on company insurance for van, general signed copy of motor vehicle safety program, road test, van driver check off and signed job description for CNAs and transportation.</p> <p>The facility van will remain out of service until a new van driver has been trained. Johnston Ambulance Service will provide non emergent transport for appointment. The facility van will remain out of service for 30 days and beyond that time corporate will decide if its use will be resumed.</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	Continued From page 54 When asked for a copy of the driver's checklist for 10/20/11, the administrator stated on 10/27/11 at 4:04 PM that the driver told her she did not have time to do the checklist on 10/20/11 but said she followed procedure on securing all residents that day. In continuation of the interview on 10/27/11 at 11AM, the van driver explained the procedure she used for securing Resident #196 in the van prior to leaving the dialysis clinic: (1) Locked her wheelchair into position. (2) Hooked the back straps to the wheelchair frame. (3) Fastened seat belt. (4) Hooked the front straps to the crossbar under the wheelchair. (5) Fastened the shoulder strap. (6) Double check all locks for tightness. The van driver acknowledged that she was trained to hook the front straps to the frame of the wheelchair, but thought that hooking them to the crossbar would give the resident more stability since she did not have legs and had no anti-tippers on her wheelchair. The driver recalled turning a corner, heard a boom and saw that the wheelchair had flipped backward. The driver stated the resident remained in the chair and all belts and straps were in place. She said she immediately stopped and called 911. The driver said she did not move the resident or the wheelchair. During an interview on 10/27/11 at 2:49 PM, EMT #1 stated that he found Resident #196 lying directly on the floor of the van on her right side. EMT #1 stated that the wheelchair was sitting upright in the van but he was not sure if the chair was secured to the floor of the van. The resident was lying with her head toward the back of the	F 323	4. Monitoring The van driver validated (double check) with each resident transport the securing of residents via the validation of seat belts in van took, this includes restraint properly secured on frame X4 (2 front and 2 back), seat belt and shoulder strap are secured properly, wheel chair is locked and grips are locked. This tool is compared to the daily van transportation log to ensure all residents are identified on the transportation log are also identified on the double check validation of seat belts in van log. These logs are reviewed and analyzed by the Administrator and/or Maintenance Director. results are reviewed in the Monthly PI Committee Meeting for potential revisions to tool as needed. Monthly validations of securing the resident will be monitored monthly by the PI Committee for compliance with securing the resident in the van by the van driver. The Financial Counselor will present van drivers verification log to the PI Committee to ensure all van drivers have been properly trained and documentation is complete. New van drivers will be observed by the Maintenance Director and/or Housekeeping Director daily for one week, weekly for 4 weeks, then monthly for 4 months for securing the residents accurately.	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 55 van.</p> <p>On 10/27/11 at 11:30 AM, the van driver was observed demonstrating, in the facility van, how she secured residents. The driver (1) positioned the wheelchair between the front and back tracks and locked the wheelchair; (2) positioned the back straps securely in the tracks and secured the "S hook" end of the straps to the wheelchair frame, then tightened the straps using the retractor button on each strap; (3) positioned the front straps securely in the tracks and hooked them to the crossbars under the seat, tightened the straps using the retractor button on each strap; (4) buckled the seat belt and (5) buckled the shoulder strap. The wheelchair did not move or tip when manual force was exerted.</p> <p>During an interview on 10/27/11 at 4:07 PM, the corporate staff (CS) who trained the driver on 10/7/11 indicated that drivers were required to complete a motor vehicle safety program (MVSP) and be checked off for properly securing residents in the van. The CS acknowledged that the MVSP did not include instruction on securing residents in the van. The CS stated that checklists were used to complement the MVSP. The checklists included validation that the wheelchair was secured at 4 points and that the seat belt and shoulder strap were secured. The driver must complete the checklist with each resident transport. The CS added that double checks were to be done randomly as directed by the administrator, and anyone who was trained in transport was qualified to perform the double check.</p> <p>During an interview on 10/27/11 at 4:30 PM, the</p>	F 323	<p>The Maintenance Director will present the findings to the monthly PI Committee. All audited findings from the transportation logs, van drivers verification logs, van observation logs and education in general orientation will be reviewed in the monthly PR Committee Meeting for patterns and trends and further interventions developed as necessary to ensure continued compliance. The facility alleged compliance as of 10/28/11.</p> <p>The Administrator will review the audits of the van and altercation audit to the monthly performance improvement committee for review and recommendations monthly. The Administrator is responsible to ensure compliance</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	<p>Continued From page 56</p> <p>administrator indicated that the maintenance director (MD) was a trained back-up driver and responsible for performing double checks on the driver. The administrator added that she was not sure how often the double checks were being done as she was new to the facility and the double check system had already been put into place.</p> <p>During an interview on 10/28/11 at 8:13 AM, the MD stated he was unaware that he should have been doing audits/double checks on the drivers. He added that he now understood that the audits were to be his responsibility.</p> <p>During an interview on 10/27/11 at 10:44 AM the administrator indicated that immediately following Resident #196's fall, the van was taken in for inspection of all tie-downs, lap and shoulder belts, for function and safety. No problem was found with the equipment/devices that were in use. The administrator produced a report dated 10/21/11 of the inspection findings. The administrator added that the van has not been used to transport residents since the incident of 10/20/11.</p> <p>The administrator was notified of the immediate jeopardy on 10/27/11 at 4:26 PM. The facility provided a credible allegation of compliance on 10/28/11 at 1:59 PM. The allegation of compliance read:</p> <p>"Credible Allegation of Compliance for Van Uni-Health Post Acute Care of Durham This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the</p>	F 323	<p>1. Corrective Action: Resident #67 was discharged from the facility on 9/27/11. Resident #13 does not presently have issues with any other residents and is comfortable in the facility.</p> <p>2. Potential to effect others: The Administrator provided all staff with in-service training regarding resident abuse, neglect, mistreatment and resident to resident abuse. Staffs have been trained to intervene on any resident argument or physical altercation and their responsibilities to report and investigate, and keep all residents safe from harm. The Ombudsman will be providing further education for staff related to resident to resident altercations on Dec 7th and 8th.</p> <p>3. Measure/Systemic Change The Director of Health Services (DHS) and/or Management Nursing team will review occurrence reports daily and the 24 hour report to ensure there were no resident to resident altercations. If resident to resident occurs chart will be reviewed in am meeting to ensure proper interventions were put in place. The social worker and/or Senior Care Partner will follow up with the residents and family. The DHS will conduct investigation.</p> <p>4. Monitoring DHS will track and trend findings and take to monthly QAA.</p>	12/8/11

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	Continued From page 57 provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Corrective action: a. Driver stopped van immediately and called 911. b. Resident was taken to hospital ER via EMS. c. Van was removed from service. d. Van driver was suspended pending investigation. e. Van was taken to a company specializing in safety devices for wheel chair transport for service on 10/21/11. Others with potentials to be affected a. The only facility van was removed from transport from 10-21-2011 through present. b. The only facility van was checked by a company specializing in safety devices for wheel chair transport to check all seat belts in the van for proper latches and all locked properly this includes the device locking into the floor. The company released the van for use on 10/21/11. c. The van driver was suspended. d. A Motor Vehicle Safety Program was implemented on 10/21/11 for any van drivers. The motor vehicle safety program includes inspection of vehicles, Authorized driving requirements including drivers history report, current drivers license, Basic safe driving and vehicle operation rules, Accident or loss of company vehicle, what to do if a resident has an untoward event. e. On 10/21/11, the Director of Health Services and Administrator began educating Nursing Assistants on van safety, to include what to do in an emergency situation, which includes: if a resident falls the van driver needs to pull van to	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	Continued From page 58 the side of road and 911 needs to be called, if resident becomes unresponsive, the van driver needs to pull van to the side of road and 911 needs to be called, if resident complains of chest pain the van driver needs to pull van to the side of road and 911 needs to be called, in the event of any adverse or abnormal occurrence the van driver needs to pull van to the side of road and 911 needs to be called. The van driver will have a cell phone available during every transport. f. Nursing Assistants will not be able to ride as a passenger until the van safety education is completed. Including what to in emergency situations. Measures and systematic changes a. The facility implemented the Motor Vehicle Safety Program on 10/21/11; all van drivers must complete the program prior to driving the van. The Administrator and/or Financial counsel will ensure the Motor Vehicle Safety Program is completed for each new driver b. The facility implemented a Driver check off list incorporating use of the lift on the van, locking the wheelchair and securing the resident in a wheelchair on 10/21/11. All van drivers must complete this program prior to driving the van. The drivers check off list includes return demonstration to the Maintenance Director for all new drivers on the use of van lift, securing a wheelchair in the van, and what to do if there is: traffic accident, stolen van, resident falls out of chair, resident becomes unresponsive, any emergency occurs with a passenger. As of 10/21/11 new van drivers will be observed by the Maintenance Director and/or Housekeeping Director for securing the three residents accurately daily for one week, three residents weekly for four weeks then three residents	F 323		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	Continued From page 59 monthly for four months. c. The Housekeeping Director was trained on 10/28/11 by the Maintenance Director on properly securing a resident and the observation check list to validate the driver has properly secured the resident. d. The van driver double checks them-selves after securing the resident into the van; this is documented on the Validation check sheet with each resident placed on the van. e. Monthly the validation log is validated by the Maintenance Director and/or Housekeeping Director to ensure residents are secured properly in the van by observing the resident in the van prior to or upon return to the facility. f. The Maintenance Director was trained by a company specializing in safety devices for wheel chair transport on May 4th, 2011 of the proper way to secure a resident in the van. Training included installing the track fitting end of the securing strap into the rear slot in the floor track; Place the straps onto the structural frame member of the wheel chair as close to the corner junction of the seat cushion and seat back as possible. Then push the button on the retractork to remove the slack. The front straps include installing the fitting end at least 3 inches outside the wheel, attaching the S-hook to a structural member of the wheel chair, pushing on the retractork to remove the slack and crank it down for extra tension. Check for movement and apply wheel chair brakes. Apply seat belt as low and snug across the occupant's pelvic zone, with the junction of lap and shoulder belts located near the wearer's hip. g. The safety of residents, to include what to do in an emergency situation, on the van has been added to general orientation for all new staff	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	Continued From page 60 members as of 10/21/11. h. New van drivers will receive educational instruction by the Maintenance Director and are required to return demonstrate on the Motor Vehicle Safety Program, Van Safety, to include what to do in an emergency situation, Van Driver check off (loading and securing wheel chairs), securing the resident validation logs. Also included in training : securing of residents via the validation of seat belts in van tool, this includes restraint properly secured on frame X4 (2 front and 2 back), seat belt and shoulder strap are secured properly, locking wheel chair and ensuring grips are locked. i. The Administrator, and/or Financial Counselor will complete a "van driver verification log" identifying all areas of training and demonstration to maintain resident safety in the van, has been complete. This details that the new van driver has a current drivers license, evidence of insurance, completed a drivers history form, has been placed on company insurance for van, general orientation completed, signed copy of motor vehicle safety program, road test , van driver check off , and signed job description for Nursing Assistant and Transportation. j. The facility van will remain out of service until a new van driver has been trained. An ambulance service will provide non emergent transport for appointment. The facility van will remain out of service for 30 days, and beyond that time corporate will decide if its use will be resumed. Monitoring The van driver validated (double check) with each resident transport the securing of residents via the validation of seat belts in van tool, this includes restraint properly secured on frame X4 (2 front and 2 back), seat belt and shoulder strap	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 61</p> <p>are secured properly, wheel chair is locked and grips are locked. This tool is compared to the daily van transportation log to ensure all residents are identified on the transportation log are also identified on the double check validation of seat belts in van log . These logs are reviewed and analyzed by the Administrator and/or Maintenance Director, results are reviewed by in the monthly Performance improvement committee meeting (includes the Administrator, Medical Director, Director of Health Services, Financial Counselor, Maintenance Director, Housekeeping/Laundry Director, Medical Records and Social Worker) for potential revisions to tool as needed. Monthly validations of securing the resident will be monitored monthly by the Performance Improvement committee for compliance with securing the resident in the van by the van driver.</p> <p>The Financial Counselor will present van drivers verification log to the performance improvement committee to ensure all van drivers have been properly trained and documentation is complete.</p> <p>New van drivers will be observed by the Maintenance Director, and/or Housekeeping Director daily for one week, weekly for four weeks the monthly for four months for securing the residents accurately. The Maintenance Director will present the finding to the monthly Performance Improvement committee members.</p> <p>All audited findings from the transportation logs, van drivers verification logs, van observation logs and education in general orientation will be reviewed in the monthly Performance improvement committee meeting for patterns and</p>	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 62</p> <p>trends and further interventions developed as necessary to ensure continued compliance.</p> <p>The facility alleged compliance as of 10/28/2011"</p> <p>The credible allegation was verified on 10/28/11 beginning at 12:34 PM. Six of the seven nursing assistants who were questioned regarding van safety training indicated that they had recently received training. Nurses and the staff responsible for scheduling appointments indicated they contacted the outside agency for non-emergency transportation.</p> <p>Review of inservice sheets indicated 17 nursing assistants had received training on 10/28/11 on van safety.</p> <p>Review of the "Double Check Validation of Seat Belts in Van" checklist revealed the addition of the column "Wheel Chair Locked and Floor grips locked".</p> <p>2. Resident # 13 was admitted to the facility on 1/6/11, and then re-admitted on 2/1/11 with the following cumulative diagnoses: cerebrovascular accident, late effect hemiplegia, hypertension, diabetes mellitus, neuropathy, depression and asthma.</p> <p>On the quarterly Minimum Data Set (MDS) dated 10/7/11, she was assessed as being cognitively intact with no moods or behaviors and limitation with her range of motion on one side of her upper and lower extremities.</p> <p>During an interview with Resident #13 on 11/2/11 at 9:53am she shared that she was assaulted by a former resident while eating dinner in the dining</p>	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	<p>Continued From page 63</p> <p>room, during August, 2011. She stated that Resident # 62 didn't like her and would say vulgar sexual comments to her and make other derogatory statements that included profanity in front of anyone. She stated from the first day that he met me, he seemed to hate her. She commented that often, when she sat in the dining room to eat her meal, he would look at her, shaking his head and tell her, "I can't stand you" .</p> <p>She continued by saying that on 8/19/11 at 6:00pm, there were several residents in the dining room as well as several nurse aides. Nurse Aide # 5 remained in the dining room alone with the residents. Resident #13 stated that she was sitting at a table close to Resident #62 when he became angry with her and accused her of stealing his cookies, two weeks beforehand. She denied that she stole his cookies, but Nurse Aide #5 challenged her, asking her, why did she steal his cookies?</p> <p>Resident #13 stated that she started to argue back with Resident #62 who continued to call her names. After several minutes, she became uncomfortable with the language Resident #62 directed toward her and left the dining room in her wheelchair to report the incident to the nurse. She stated that she told the nurse (couldn't identify her name); "Would you please tell him to stop bothering me. He's being rude and nasty to me." The nurse told her that she would tell Resident #62 to leave Resident #13 alone, but she didn't see her approach the resident. When Resident #13 went back to resume eating her meal, she stated that Resident #62 threw a chair at her, which hit her in the face, leaving a black and blue mark on her forehead. At that point, she left the</p>	F 323		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 64</p> <p>dining room and went to the nurse's station to make a police report at 6:11pm.</p> <p>A copy of the police report was obtained and it revealed that the local police came to the facility to interview Resident #13 on 8/20/11 at 1:30pm. Resident #13 reported that on 8/19/11 she went to the dining room to eat dinner at 6:00pm. She initially approached the table of a female resident but was cursed at by this resident and was told that she could not sit there. Resident #13 moved to another table, which was adjacent to Resident #62. Resident #62 also began to curse at Resident #13, as she ate her food, trying to ignore him. After she ate her food, she told the police officer that Resident #62 stood up and threw a chair at her and it hit her in the head. Nurse Aide #5 was in the dining room but did not witness the chair being thrown. The officer recorded that Resident #13 had a small bump on her forehead.</p> <p>The police report stated that the officer proceeded to interview Resident # 23, who's alert and oriented and who witnessed the incident on 8/19/11. Resident #23 saw Resident #13 get yelled at by a male and female resident in the dining room. She saw Resident #13 attempt to ignore them, but she eventually tried to leave the dining room when Resident #62 stood up and threw a chair at Resident #13, hitting her on her leg. She wasn't sure if she saw the chair hit Resident #13 in the head. She also mentioned that there were no nurses or supervisors in the dining room when Resident #13 was hit.</p> <p>The police report indicated that next the officer interviewed NA #5. She relayed that Resident</p>	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 65</p> <p>#62 was cursing at Resident #13 and accusing her of stealing his food. She stated that because Resident #13 was able to ignore Resident #62, she continued to feed her resident, who needed her assistance. At one point, she stated that it sounded like a cup fell on the floor, but she did not see Resident #62 throw a chair at Resident #13. The police took no further action.</p> <p>The facility's investigation file was reviewed. It revealed that on 8/20/11 a 24 hour report was filed with the state and on 8/25/11 a 5 Working Day Report was filed as well, substantiated resident abuse.</p> <p>The investigation report contained statements from staff on duty during the incident on 8/19/11. On 8/19/11, NA # 11 provided a written statement which stated that during dinner on 8/19/11 she heard Resident #13 and Resident #62 going back and forth, calling each other names. Once their trays were delivered, she stated that they were spoken to and the residents were calmed down, so that they could begin to eat their food. NA #5 remained in the dining room with the residents, while NA #11 resumed passing trays on the hall. NA #11 attended an In-Service on Resident to Resident Protocol and Resident to Resident Abuse for Alert and Oriented Residents, held (8/20/11-8/22/11).</p> <p>The personnel file of NA #11 was reviewed and it indicated that NA #11 had resigned from the facility on 10/27/11. A phone call was attempted on 11/3/11 however; NA #11 could not be reached by phone for an interview.</p> <p>NA # 6 worked on 8/19/11 and recorded in her</p>	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	<p>Continued From page 66</p> <p>written statement that when she walked into the dining room she heard Resident #62 yell a vulgar sexual request to Resident #13 and she heard Resident #13 snap back at him. She did not witness any other activity.</p> <p>On 11/3/11 at 3:19pm, NA #6 was interviewed. She stated that Resident #62 was confrontational all the time with anyone that made him upset. He used disrespectful language toward the nursing staff and toward Resident #13. She stated that she has witnessed Resident #13 yell back at him, and would then try to separate them but Resident #62 wouldn't listen. He would channel his anger toward her and begin to call NA #6 names too. She would report his behavior to the nurse, who could calm him down.</p> <p>NA #7 worked on 8/19/11 and recorded in her written statement when she walked in the dining room, she saw Resident #13 bumped into a female resident, who began to curse at her and told Resident #13 to get away from her. At that point, Resident #62 began to instigate, and started yelling at Resident #13, accusing her of stealing his cookies. Even after Resident #13 denied it, Resident #62 continued to curse at her. She then saw Resident #13 leave the dining room and NA #7 stated that she left to assist a resident.</p> <p>On 11/4/11 at 10:19am, Nurse #7 was interviewed. She stated that she was the Second Shift Nurse Supervisor on 8/19/11 and was working on the floor where Residents #13 and #62, ate in the dining room. She shared that she was doing rounds at dinner when she was approached by Resident #13. She was told that Resident #62 was saying bad words to her and</p>	F 323		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	<p>Continued From page 67</p> <p>made her feel uncomfortable. She also reported that Resident #62 kept accusing her of stealing his cookies, which she denied because she's diabetic. Resident #13 told her that Resident #62 had thrown a chair at her and that it hit her on the knee. Nurse #7 examined the knee, but could not find any injury, redness or swelling at the site. She asked Resident #13 if there were any witnesses and she mentioned Aide #5, so she went into the dining room to interview her. The aide admitted that she heard the two residents arguing. Nurse #7 stated that she didn't believe that Resident #62 had enough upper body strength to throw a chair in the air at the distance between the tables. She thinks that it was possible that he might have thrown a lighter object at her instead.</p> <p>Nurse #7 did not approach Resident #62 to interview him about the incident and did not try to obtain a witness account from any other alert and oriented sitting in the dining room that evening. She stated that another nurse, (who's no longer employed at the facility) went to speak with Resident #62 and was asked to stay away from Resident #13. She stated that there were no other incidents that evening.</p> <p>Nurse #7 stated that her expectations would be for the nurse aide to calm down the residents by talking to them. If they continued to yell at each other, then the police should be called. She also stated that the nurse aide should attempt to separate the residents and go ask for help. She didn't ask the aide if she had tried to separate the residents. She stated that both of the residents were paralyzed so she didn't think that they could make direct contact with each other, unless an</p>	F 323		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 68 item was thrown.</p> <p>On 11/4/11 at 9:35am, NA #5 was interviewed. She stated that she was a new employee, beginning her employment on 6/16/11. She indicated that she had received training on abuse but did not recall getting specific training on resident to resident altercation. On 8/19/11 she was assigned to the dining room on the third floor. She was feeding a resident who required extensive assistance. She stated that she was the only aide in the dining room with about six residents. She begun to hear Resident #62 argue with Resident #13 and asked him what's wrong. He told her that Resident #13 had stolen his cookies two weeks ago.</p> <p>NA #5 stated that the residents argued for about two minutes. She asked Resident #13 if she stole his cookies and she responded, no. She stated that I had attempted to calm them down by talking to them and noticed that Resident #13 was able to ignore Resident #62 and saw her leave the dining room. Then she thought she heard a cup drop and Resident #13 told her that Resident #62 threw a chair at her. She didn't see a chair being thrown and doubted that Resident #62 had the strength to throw a chair. She thought that perhaps, he might have shoved a chair at her. She did not go over to the residents to investigate. She stated that no other nursing staff entered the dining room to assist and she did not request anyone's assistance because she felt that she had control over the situation.</p> <p>NA #5 shared that if two residents got into a verbal altercation again, she would inform the nurse sooner. Nurse Aide #5 attended an</p>	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 323	<p>Continued From page 69</p> <p>In-Service on Resident to Resident Protocol and Resident to Resident Abuse for Alert and Oriented Residents, held (8/20/11-8/22/11).</p> <p>Nurse #8 was interviewed on 11/3/11 at 3:30pm. She stated that she was working on 8/19/11 and was on passing medications when she learned of the incident between Residents #13 and #62. She stated that she was at the far end of the hall, a considerable distance away from the dining room and could not hear the residents arguing. She shared that no one alerted her to what was taken place in the dining room, however, if they did, she would have tried to separate the residents, removing Resident #62 first, since he was in a manual wheelchair. After Resident #13 reported that she was hit, she went to speak with Resident #62 who denied hitting Resident #13. She advised him to keep his distance from Resident #13 and they stayed apart, the rest of her shift.</p> <p>On 11/2/11 at 5:15pm, Resident #23 was interviewed. She stated that on 8/19/11 she was in the dining room during dinner, sitting near the doorway closest to the nursing station. She heard a female resident, yelling at Resident #13, as she strolled past her table. She stated that Resident #62 was friends with the female resident and interfered by calling Resident #13 names. She stated that they were sitting at different tables in the corner of the dining room. She can't recall if she saw him throw a chair at Resident #13, but remember that he was very upset and had a fork in his hand, and appeared threatening.</p> <p>A progress note dated 8/20/11 recorded that the former Administrator made contact with Resident and wanted to assure that she felt safe. Resident</p>	F 323		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 70</p> <p>#13 stated that she felt safe and declined to move to another floor, once the offer was made. Resident #13 was being monitored by staff, as of 8/19/11 for neurological checks since she indicated that she had been hit in the head by a chair.</p> <p>Resident #62 was admitted to the facility on 1/4/08 and re-admitted on 6/17/11 with the following cumulative diagnoses: end stage renal disease, legally blind, diabetes mellitus ketoacidosis, hyperglycemia, depressive disorder, adjustment disorder and cerebrovascular accident. On his annual MDS, dated 6/27/11, he was assessed as cognitively intact, with highly impaired vision, depressed moods and no limitations with his range of motion. He was independent with walking and transfers but used a wheelchair.</p> <p>Record review of a care plan, dated 8/20/10, and then revised 8/19/11 identified that Resident #62 had periods of anger at resident and/or staff. It also stated that he got into a physical altercation with another resident on 8/19/11. Staff were expected to monitor him for persistent anger and if he was not easily redirected, then he should be assessed for signs or symptoms of hypoglycemia, hyperglycemia and/or urinary tract infection as these have a tendency to cause him to have mood changes. Staff should observe him for change in mental status; document and report any decline to physician. Medications should be administered as ordered by physician. Observe for and document any adverse side effects. Review behavior-altering medication regime. If resident became agitated with another resident, he should be relocated to another area/redirect</p>	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011	
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 71 psyche consult offered, resident declined.</p> <p>The chart revealed that Resident #62 had received mental health supports while residing at the facility. On 5/3/11 a Psychotropic Medication Management Progress Note recorded that Resident #62 was being treated for periodic episodes of agitation with staff, peers and visitors. He took medications for depression, insomnia as well as a mood stabilizer. He was formerly prescribed an anti-anxiety drug but it was discontinued on 4/15/11. A new anti-anxiety drug was prescribed for him on 5/3/11 for anxiety and agitation, which would be administered only as needed. Resident #62 had commented during his session, " People bug me all the time " and admitted to feeling anxious at times.</p> <p>A progress note revealed that on 8/20/11, the former Administrator interviewed Resident #20 via telephone. He admitted to arguing with Resident #13 during dinner on 8/19/11 but stated that nothing else had happened. He denied throwing a chair at her, stating that the chair slipped out of his hand by mistake. He was then asked if he needed to speak with anyone about his issues with anger, and he stated no, assuring the Administrator that it was an accident. Resident #62 was asked if he would move his room to another floor, away from Resident #13 and he agreed to move.</p> <p>On 8/25/11, a social services progress note revealed that a meeting was held with Resident #62, his family and the administrative staff. A decision was reached that Resident #62 would be discharged from the facility and return home, as soon as placement could be secured for him at a</p>	F 323		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	<p>Continued From page 72</p> <p>dialysis center in the community. There were no other recorded incidents regarding Resident #62 and any other residents, in the nurse's notes or social worker progress notes, before his discharge home on 9/27/11.</p> <p>On 11/3/11 at 9:55am, the Regional Nurse Consultant and Vice President of Operations were interviewed. The Regional Nurse Consultant, who was most familiar with Resident #62's history, stated that in the past, 2010, Resident #62 had been in the middle of confrontations between two female residents. They had placement for him but was never successful. He was counseled by the management and re-educated on the rules at the facility. She stated that everything had pretty much "died down" since that time.</p> <p>She shared during the incident on 8/19/11, her expectations were for staff to have separated the residents, notify a supervisor and put interventions in place. Also, moving the residents, to different locations should be explored. If the supervisor failed to respond to the situation, then disciplinarian actions should take place.</p> <p>The Vice President of Operations stated that after the incident on 8/19/11, they developed an Action Plan. They in-serviced many of the nursing staff over 8/20/11-8/22/11 about their Resident to Resident Protocol, where staff was given specific instructions on separating residents, notifying management, sending the aggressor to the Emergency Room for evaluation then placing the aggressor on One on One Supervision until an alternate placement is found. Further, witness statements would be collected from all staff in the</p>	F 323			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 323	Continued From page 73 building and care plans would be updated with interventions. The Social Worker would follow up with both residents involved and a referral would be made for psychiatric services if needed. The In-Service also included directions on how to prevent Resident on Resident Abuse for Alert and Oriented Residents. Staff would ensure safety for all residents. Remove involved residents from the abusive situation immediately. Assess residents involved for injuries, and provide first aid if required. Notify the physician. Notify the Power of Attorney, if applicable. Get statements from all staff assigned to area. Call proper authorities. Notify Administrator and Director of Health Services. Complete incident report and nurses notes in both residents' charts. Monitor both residents for non obvious physical injuries and document emotional effect on both residents over the next several days.	F 323			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	1. Corrective Action: Resident #68 – 2 medications have had medical diagnosis added to written orders and 3 rd was discontinued.. Resident #67 – Nurse received written discipline for not following MD orders to take BP prior to med administration. 2. Others with Potential to be Affected: Nurses have received education regarding taking vitals prior to med administration when ordered.	12/6/11	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 74</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, pharmacy and staff interviews, the facility failed to provide medical justification for the use of 3 medications for 1 of 10 sampled residents (Resident #68) and failed to monitor vital signs prior to medication administration as ordered for 1 (Resident #67) of 10 residents.</p> <p>The findings include:</p> <p>1. Resident #68 was admitted to the facility on 8/4/11 with the following cumulative diagnoses: hypertension, arthritis, cerebrovascular accident and chronic obstructive pulmonary disease.</p> <p>On his admission Minimum Data Set (MDS) assessment, dated 8/9/11, Resident #68 was listed with a moderate cognitive impairment. Throughout the survey, Resident #68 was observed to be able to make his needs known to staff during meal times and had a mild disposition.</p> <p>Record review was conducted and revealed the following. On 8/5/11, Resident #68 was</p>	F 329	<p>3. Measure/Systemic Change:</p> <p>Nurses have receive education regarding taking vitals prior to med administration when ordered. Nurses will receive education regarding ensuring a diagnosis is written for all medications. MD, NP and PA will also receive education regarding the need for medical diagnosis when writing any medication orders. Education for Nurses will be provided as directed by the state agency. The Director of Nursing Services and/or Nurse Manager will review the orders on a daily basis to ensure diagnosis is included for all new medication orders. All MARs have been reviewed to ensure medical diagnoses are written for all current medications. Any orders found to be written without medical justification will be documented on audit and corrected immediately by Nurse Manager or DHS. MARs will be audited monthly at change order to ensure all medications have medical justification. Pharmacy Consultants will audit all medications on monthly basis to ensure all medications have medical justification.</p>	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 75</p> <p>prescribed Loratadine (an anti-histamine drug) 10mg daily; Risperidone (an anti-psychotic drug) 0.25mg daily and two 0.25mg tablets at bedtime and Baclofen (muscle relaxer) 10mg three times a day. There were no diagnoses listed for the use of these medications.</p> <p>On 9/1/11, a physician progress note revealed that Resident #68 was examined, however his chart was not updated to include a medical justification for the use of Loratadine, Risperidone and Baclofen.</p> <p>On 9/25/11, a pharmacy review was conducted. Recommendations were made to the physician to provide diagnoses for Risperidone, Loratadine and Baclofen.</p> <p>On 10/20/11, a physician progress note revealed that Resident #68 was examined, however his chart was not updated to include a medical justification for the use of Loratadine, Risperidone, Baclofen and Singulair.</p> <p>On 11/4/11 at 2:00pm, Nurse #6 stated that she thought that Resident #68 was on Risperidone for moods. She explained that at night he would get easily agitated when the nurse aide had to assist with him with activities of daily living or the nurse had to administer an enema. She mentioned that she wasn't sure why he received Loratadine.</p> <p>On 11/4/11 at 2:30pm, the pharmacy consultant was interviewed. He stated that in September as well as today, both him and his colleague made recommendations to the doctor to provide a diagnosis for a few particular drugs. He shared that if the doctor couldn't justify a reason for</p>	F 329	<p>4. Monitoring:</p> <p>Medication and Diagnosis Audits will be reviewed at Monthly PI Committee Meeting to ensure corrections have been made. Results of Pharmacy Consultation will be reviewed in Monthly PI Committee Meeting to ensure all medications have medical justification. The Administrator and/or Director of Health Services is responsible to ensure compliance</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 76</p> <p>Resident #68 to take them, then he shouldn't be on the drug. Today, he was recommending a gradual dose reduction for the Risperidone to 0.25mg twice a day. He stated that ideally, the doctor was expected to address recommendations made by the pharmacist within a week.</p> <p>On 11/4/11 at 4:00pm, the Director of Health Services #1 stated that she became aware that Resident #68 needed medical justification for some of his medications and spoken to the nurse practitioner today. The doctor has decided to discontinue the order for Risperidone. He also provided clarification for the use of Loratadine and Baclofen for muscle spasms</p> <p>2. Resident #67 was last readmitted to the facility on 1/11/11. Cumulative diagnoses included hypertension.</p> <p>Review of Resident #67 ' s November 2011 physician orders revealed an order for metoprolol 37.5 mg (milligram) twice a day. Lexi-Comp ' s " Drug Information Handbook " , 8th Edition lists metoprolol as a beta blocker prescribed to treat hypertension; adverse reactions include slow heart rate. Instructions were included with the order to hold for systolic blood pressure less than or equal to 110 and pulse less than or equal to 60.</p> <p>Review of Resident #67 ' s October and November Medication Administration Records (MARs) revealed the order for the metoprolol with the parameters. No space was allotted on the MAR to record the blood pressure and pulse.</p>	F 329			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 77 On 11/1/11 at 5:10 PM, Nurse #8 was observed during med pass. The nurse administered the metoprolol to Resident #67 without checking the resident ' s blood pressure or pulse. During an interview on 11/1/11 at 5:25 PM, Nurse #8 stated that she did not check Resident #67 ' s blood pressure and pulse prior to administering the metoprolol; rather, she relied on a list of vital signs that the day shift nurse recorded. When asked, Nurse #8 could not produce the list. During an interview on 11/1/11 at 5:35 PM, the physician assistant stated that she expected the resident ' s blood pressure and pulse to be checked just prior to administration of the metoprolol and recorded on the MAR. During an interview on 11/1/11 at 6PM, the director of health services (DHS) said that when medication was ordered with vital sign parameters, she expected the nurses to check the vital signs and record them on the MAR prior to administering the drug.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility medication error rate was 9.8% as evidenced by 5 errors (Residents #41, #67, #144 and #127) out of 51 opportunities for error.	F 332	1. Corrective Action: Physician notified of medication discrepancies for resident # 41, #67, #144, #127. 2. Others with Potential to be Affected: Nanette Lavoie-Vaughan, MSN, APN, will complete 1:1 medication passes with nurses and education as needed on December 12-16, 2011. Licensed Nurses to complete a Medication Administration education by the Board of North Carolina Nursing	12/6/11 12/16/11

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 332	<p>Continued From page 78</p> <p>The findings included:</p> <p>1a) Resident #41 was readmitted to the facility on 4/1/09. Diagnoses included status post cerebrovascular accident (CVA), dysphagia, status post gastric feeding tube (G-tube) insertion, hypertension and Alzheimer's disease.</p> <p>On 11/2/11 at 10:20 AM, Nurse #10 was observed to give clonidine 0.2 milligram (mg) via G tube.</p> <p>Review of November 2011 physician orders revealed an order for clonidine 0.2 mg via G tube three times a day.</p> <p>Review of the Medication Administration Record (MAR) revealed clonidine was scheduled to be given at 6AM, 2PM and 10PM. The MAR revealed that the 6AM dose of clonidine had been given.</p> <p>During an interview on 11/2/11 at 12:25 PM, Nurse #10 acknowledged that she should not have given the clonidine. She added that the schedule had been changed and that she was used to giving it at 10AM.</p> <p>During an interview on 11/3/11 at 6:37 AM, the director of health services (DHS) stated she expected her nurses to check the MAR prior to administering medication.</p> <p>1b) Resident #41 was readmitted to the facility on 4/1/09. Diagnoses included status post cerebrovascular accident (CVA), dysphagia, status post gastric feeding tube (G-tube)</p>	F 332	<p>on Dec 20th and 21st, 1:1 in-services from Jones Professional Service Inc. on December 19, 2011. Wake AHEC will Provide additional training in January.</p> <p>3. Measure/Systemic Change: Licensed Nurses are to complete a mandatory medication administration education program presented by the North Carolina Board of Nursing. United Pharmacy Services are conducting medication passes with Licensed Nurses to validate compliance with medication standards. The Director of Health Services, Clinical Competency Coordinator and/or Nurse Managers will continue to conduct medication passes weekly with Licensed nurses to ensure compliance. This medication audit will be conducted weekly for eight weeks then monthly for 8 months.</p> <p>4. Monitoring: The Director of Health Services will present the medication error rate percentage trend to the monthly Performance Improvement Committee for review and revision as needed. The Administrator and/or Director of Health Services is responsible to ensure compliance.</p>	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 332	<p>Continued From page 79 insertion, hypertension and Alzheimer's disease.</p> <p>Review of November 2011 Physician Orders revealed an order for KCl (potassium chloride) 25 mEq (milli-equivalent) daily via G-tube.</p> <p>The Medication Administration Record (MAR) included the KCl order with the notation that 18.75 ml (milliliter) of liquid KCL equaled 25 mEq. The bottle of KCl was labeled as 18.75 ml (milliliter) equaled 25 mEq.</p> <p>On 11/2/11 at 10:20 AM, Nurse #10 was observed measuring the KCl liquid in a 30 ml medication cup. The markings on the cup included 5 ml, 7.5 ml, 10ml, 15 ml 20 ml, 25 ml and 30 ml. The amount of KCl poured into the cup was between the 15 and 20 ml markings.</p> <p>During an interview on 11/2/11 at 12:25 PM, Nurse #10 acknowledged that the dosage of KCl she gave was an estimate because the medication cup was not marked for 18.75 ml. She stated that she did not know how she could measure out exactly 18.75 ml.</p> <p>During an interview on 11/3/11 at 6:37 AM, the director of health services (DHS) stated that drug dosages should not be estimated. The DHS added that she would contact the physician to discuss an order change.</p> <p>2. Resident #67 was last readmitted to the facility on 1/11/11. Cumulative diagnoses included hypertension.</p> <p>Review of Resident #67's November 2011</p>	F 332			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 332	<p>Continued From page 80</p> <p>physician orders revealed an order for metoprolol 37.5 mg (milligram) twice a day. Hold if systolic blood pressure less than or equal to 110 and pulse less than or equal to 60.</p> <p>Review of Resident #67's November 2011 Medication Administration Record (MAR) revealed the order for the metoprolol and to hold if systolic blood pressure less than or equal to 110 and pulse less than or equal to 60.</p> <p>On 11/1/11 at 5:10 PM, Nurse #8 was observed during med pass. The nurse administered the metoprolol to Resident #67 without checking the resident's blood pressure or pulse.</p> <p>During an interview on 11/1/11 at 5:25 PM, Nurse #8 stated that she did not check Resident #67's blood pressure and pulse prior to administering the metoprolol; rather, she relied on a list of vital signs that the day shift nurse recorded. When asked, Nurse #8 could not produce the list.</p> <p>During an interview on 11/1/11 at 5:35 PM, the physician assistant stated that she expected the resident's blood pressure and pulse to be checked just prior to administration of the metoprolol and recorded on the MAR.</p> <p>During an interview on 11/1/11 at 6PM, the director of health services (DHS) said that when medication was ordered with vital sign parameters, she expected the nurses to check the vital signs and record them on the MAR prior to administering the drug.</p> <p>3. Resident #144 was admitted to the facility on 12/23/10. Cumulative diagnoses included</p>	F 332			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 332	<p>Continued From page 81</p> <p>gastroesophageal reflux disease (GERD).</p> <p>Physician orders dated 11/1/11 included an order for metoclopramide 7.5 mg (milligram) four times: daily 30 minutes before meals and at bedtime.</p> <p>Resident #144's Medication Administration Record (MAR) listed metoclopramide to be given at 8AM, 12PM, 4PM and 8PM.</p> <p>On 11/2/11 at 5:02 PM, Nurse #8 was observed to administer the metoclopramide to Resident #144 while the resident was eating supper.</p> <p>During an interview on 11/2/11 at 5:04 PM, Nurse #8 said that the medication should have been given before she ate, but trays came early.</p> <p>Review of the facility "Meal Cart Delivery Schedule" dated 1/21/11 revealed that meal trays were scheduled to arrive at 4:45 PM and 5:00 PM on the floor where Resident #144 resided.</p> <p>4. Resident #127 was admitted to the facility on 1/6/11. Cumulative diagnoses included hypothyroidism.</p> <p>Review of the November 2011 Medication Administration Record (MAR) revealed a hand written entry for Synthroid 150 mcg (microgram) daily.</p> <p>On 11/3/11 at 5:30 AM, Nurse #11 was observed to prepare the Synthroid for administration. The nurse read aloud the dosage on the MAR as 150 mcg and pulled the Synthroid card labeled for Resident #127 from the med cart. The Synthroid dosage was 175 mcg. The nurse indicated that</p>	F 332			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 332	Continued From page 82 the dosage of the tablets on the medication card did not match what was on the MAR, so she borrowed three 50 mcg tablets from another resident to administer to Resident #127. Physician orders were then reviewed to reconcile the med pass. An order dated 10/11/11 revealed an order to discontinue Synthroid 150 mcg (microgram) daily and start Synthroid 175 mcg daily, and to recheck a TSH (thyroid stimulating hormone) level in 6 weeks. During an interview on 11/3/11 at 5:35 AM, Nurse #11 reviewed the physician orders and stated that the MAR was incorrect and that she had given the wrong dosage of Synthroid. During an interview on 11/3/11 at 6:37 AM, the director of health services (DHS) stated she expected her nurses to check the physician orders on the chart prior to giving a medication when there was a discrepancy between what was on the MAR and what was supplied in the medication cart. The DHS acknowledged that there was a transcription error from the October MAR to the November MAR.	F 332		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334	1. Corrective Action: Residents #67, #13 and #119 were re-educated by the Senior Care Partner and offered the annual flu vaccine. All three declined and have signed a declination form stating same.	12/6/11

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(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 334	<p>Continued From page 83</p> <p>annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of</p>	F 334	<p>2. Others with Potential to be Affected: Residents who original decline d have been re-educated by the Director of Health Services and Unit Manger regarding immunizations. The residents resigned a decline sheet if appropriate.</p> <p>3. Measure/Systemic Change: All residents who were on the original decline list or who did not receive a flu vaccine were approached by the Director of Health Services and Unit Manager regarding receiving flu vaccine. Education was provided and if they did refuse vaccine, residents or families signed the declination form indicating same. Newly admitted residents will receive education by the admission director regarding the annual flu vaccine and will either sign a consent form to receive vaccine or sign a declination form for refusal. A flu vaccine log book was developed to document all residents receiving the vaccine and to hold all declination forms for refusals. Newly admitted residents are added to the book on admission by the Clinical Competency Coordinator. The flu vaccine log book will be reviewed weekly by DHS for next 4 weeks and monthly for next 4 months.</p>	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 334	<p>Continued From page 84</p> <p>pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy, the facility failed to provide documentation that residents and responsible parties who refused the annual influenza vaccination were educated on the risks and benefits for 3 of 5 residents. (Residents #67, #13 and #119).</p> <p>The findings included:</p> <p>The facility policy dated February 2008 entitled "Influenza (Flu) Vaccinations" read in part: "An annual flu vaccine will be given to each patient/resident who resides in the healthcare center during flu season (October- March) unless contraindicated by their physician or refused by the patient/resident. If the patient/resident is cognitively impaired as evidenced by scoring on the patient/resident's MDS, the responsible party will be contacted and their wishes will be followed</p>	F 334	<p>4. Monitoring:</p> <p>The Director of Health Services will present the Flu vaccine log book to the Monthly PI Committee Meeting for follow-up and recommendations. The Administrator and DHS is responsible to ensure compliance</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 334	<p>Continued From page 85</p> <p>in this matter." "Permission of refusal to receive the vaccine will be obtained on admission and will remain in place unless revoked by the physician, patient/resident or family."</p> <p>1. Resident #67 was admitted to the facility on 1/11/11. Diagnoses included delusional disorder, quadriplegia and contracture of tendons.</p> <p>The quarterly minimum data set (MDS) dated 9/27/11 indicated that Resident #67 had no memory problems and was independent in daily decision-making.</p> <p>Physician's orders for October and November 2011 included "May have flu vaccine with physician and family approval in fall of year."</p> <p>Record review revealed no documentation that the resident had been educated and offered the annual influenza vaccine in the fall of 2011.</p> <p>During an interview on 11/4/11 at 4PM, the Director of Health Services (DHS) and nurse liaison revealed a list of residents/responsible parties who had verbally refused the annual influenza vaccine for 2011. Resident #67 was on the list. The DHS indicated that all had been provided the CDC (Center for Disease Control) education sheet for the 2011-2012 influenza vaccine but were not asked to sign an informed declination. The DHS acknowledged that the policy needed to be changed to include that yearly consent or refusal of the vaccination must be obtained after provision of the current risk/benefit education, and that informed consent/declination must be on the record.</p>	F 334			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 334	<p>Continued From page 86</p> <p>2. Resident #13 was admitted to the facility on 2/1/11. Diagnoses included cerebrovascular accident, diabetes and hypertension.</p> <p>The quarterly minimum data set (MDS) dated 10/7/11 indicated that Resident #13 was cognitively intact.</p> <p>Physician's orders for October and November 2011 included "May have flu vaccine with physician and family approval in fall of year."</p> <p>Record review revealed no documentation that the resident had been educated and offered the annual influenza vaccine in the fall of 2011.</p> <p>During an interview on 11/4/11 at 4PM, the Director of Health Services (DHS) and nurse liaison revealed a list of residents/responsible parties who had verbally refused the annual influenza vaccine for 2011. Resident #13 was on the list. The DHS indicated that all had been provided the CDC (Center for Disease Control) education sheet for the 2011-2012 influenza vaccine but were not asked to sign an informed declination. The DHS acknowledged that the policy needed to be changed to include that yearly consent or refusal of the vaccination must be obtained after provision of the current risk/benefit education, and that informed consent/declination must be on the record.</p> <p>3. Resident #119 was admitted to the facility on 2/24/11. Diagnoses included arthropathy, muscle weakness and dementia.</p> <p>The quarterly assessment dated 8/11/11 indicated that the resident had long and short</p>	F 334			

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 334	Continued From page 87 term memory problems and moderately impaired cognitive skills for daily decision making. Physician's orders for October and November 2011 included "May have flu vaccine with physician and family approval in fall of year." Record review revealed no documentation that the resident had been educated and offered the annual influenza vaccine in the fall of 2011. During an interview on 11/4/11 at 4PM, the Director of Health Services (DHS) and nurse liaison revealed a list of residents/responsible parties who had verbally refused the annual influenza vaccine for 2011. Resident #119 was on the list. The DHS indicated that all had been provided the CDC (Center for Disease Control) education sheet for the 2011-2012 influenza vaccine but were not asked to sign an informed declination. The DHS acknowledged that the policy needed to be changed to include that yearly consent or refusal of the vaccination must be obtained after provision of the current risk/benefit education, and that informed consent/declination must be on the record.	F 334			
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide the diet as ordered by the physician for four (4) of	F 367	1. Corrective Action: Residents #40, #118, #168 and #192 have had diet orders clarified and are receiving the MD ordered diets prescribed	12/6/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 367	<p>Continued From page 88</p> <p>nine (9) residents observed (Resident #40, Resident #118, Resident # 168, Resident #192). Findings included:</p> <p>1. Resident #168 was admitted to the facility 7/7/2011. Diagnoses included: Cerebrovascular accident, diabetes and dysphagia.</p> <p>Minimum Data Set (MDS) Admission assessment dated 7/14/11 indicated resident was cognitively intact. Resident required limited assistance with eating. Swallowing disorder was noted with loss of liquids/ solids when eating or drinking, holding food in mouth, cheeks or residual food in mouth after meals, and coughing or choking during meals. Height was noted at 66 inches; weight at 144 lb. No weight loss was noted. Resident was on a mechanically altered therapeutic diet.</p> <p>Physician orders dated 10/20/11 indicated diet: Mechanical soft with chopped meats and thin liquids.</p> <p>An observation on 10/30/11 at 1:05 PM. Revealed Resident #168's tray slip stated mechanical soft chopped. There were ham slices on her tray.</p> <p>On 11/2/11 at 2:42 PM, the Dietary Manager stated the diet slip is looked at, called out and placed on the tray at the beginning of the tray line First trays came out according to consistency-pureed, ground, chopped, then regular. She stated "What is on the slip should be what is on the tray."</p> <p>2. Resident # 192 was admitted to the facility 10/6/2011. Current diagnoses included:</p>	F 367	<p>2. Others with Potential to be Affected: The Consulting Registered Dietician has educated the dietary staff regarding the importance of serving the diet as prescribed</p> <p>3. Measure/Systemic Change: The Consulting Dietician will in-service all Dietary Staff on the importance of serving the diet ordered on the diet slip, communicating to partners on the tray line and double checking appropriate diet at the end of the tray line before the meal leaves the kitchen. Dietary staff will also be educated on diet consistencies. A current list of each resident's prescribed diet will be maintained in the kitchen for dietary staff to check at all times – to eliminate the need for a slip to be returned when an alternate is requested. Tray accuracy audits will be completed by Dietary Staff in the kitchen and Nursing Staff on the floors. 5 trays per day from both Dietary and Nursing will be checked for accuracy for the next 4 weeks. 10 trays per month for Dietary and Nursing will then be checked each month for the next 4 months. Any discrepancies found will be immediately addressed and documented on audit form.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 367	<p>Continued From page 89</p> <p>cerebrovascular accident, dysphagia, diabetes and malnutrition status post a PEG tube.</p> <p>Physician orders for November 2011 indicated diet: (10/20/11) Mechanical soft diet with ground meat. Nectar thickened liquids.</p> <p>On 11/2/11 at 9:00 AM., NA #8 brought a covered plate to Nurse # 9. There was two pureed items (one brown/ one white) on the plate. NA #8 stated this was sent to Resident #192 for breakfast. The diet slip stated mechanical soft ground NAS liberalized diabetic diet. NA #8 took the plate to the kitchen and obtained another breakfast for resident. Dietary staff stated it was pureed bread and eggs--no explanation was given regarding why resident received pureed instead of diet ordered.</p> <p>On 11/2/11 at 2:42 PM, the Dietary Manager stated the diet slip is looked at, called out and placed on the tray at the beginning of the tray line First trays came out according to consistency-pureed, ground, chopped, then regular. The Dietary Manager stated there was an error regarding Resident #192's tray this morning and she did not know how it happened. She stated "What is on the slip should be what is on the tray."</p> <p>3. Resident #118 admitted to the facility on 9/28/11. Diagnoses included status post cerebrovascular accident (CVA) and dysphagia.</p> <p>Review of physician orders dated 10/26/11 revealed a diet order to advance to mechanical soft chopped solids.</p> <p>On 10/30/11 at 1:03 PM, Resident #118 was</p>	F 367	<p>4. Monitoring:</p> <p>The Dietary Director will present the tray accuracy audits at the Monthly PI Committee Meeting for follow-up and recommendations. The Administrator and Certified Dietary Manager is responsible to ensure compliance</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 367	<p>Continued From page 90</p> <p>observed eating lunch. His meal included whole slices of ham. The dietary slip on his tray read, "Mechanical Soft Chopped".</p> <p>During an interview on 11/1/11 at 3:06 PM, the dietary manager (DM) indicated that residents with mechanical soft chopped diet orders should receive their food in bite sized form. The DM added that she did not work on 10/30/11 and did not know why the resident's ham was not chopped.</p> <p>4. Resident #40 was readmitted to the facility on 3/17/11. Diagnoses included diabetes mellitus and a central nervous system demyelinating disease.</p> <p>Review of physician orders dated 10/1/11 revealed a diet order for no added salt, liberalized diabetic and mechanical soft consistency.</p> <p>On 10/31/11 at 12:16 PM, Resident #40 was observed to receive her lunch. The dietary slip on her tray read, "Mechanical Soft Chopped". The resident looked at her food which included chopped hamburger, and told the staff she wanted the alternate. At 12:40 PM, she received the alternate meal which included slices of chicken.</p> <p>During an interview on 11/1/11 at 3:06 PM, the dietary manager (DM) indicated that residents with mechanical soft chopped diet orders should receive their food in bite sized form. The DM added that when nursing assistants request alternate meals for residents, she expected them to return the tray slip from the original tray back to the kitchen to ensure that the correct diet will be</p>	F 367			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DUR		
(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 367	Continued From page 91 provided.	F 367			
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and pharmacy consultant interview, the pharmacy consultant failed to report the lack of monitoring of vital signs for 1 (Resident #67) of 10 residents as well as the physician failed to respond to recommendations by the pharmacist to provide medical justifications, as required for 3 medications for 1 (Resident #68) of 10 residents.</p> <p>The findings included:</p> <p>1. Resident #68 was admitted to the facility on 8/4/11 with the following cumulative diagnoses: hypertension, arthritis, cerebrovascular accident and chronic obstructive pulmonary disease.</p> <p>The Physician 's Orders, dated 8/5/11 stated that Resident #68 was prescribed Loratadine (an anti-histamine drug) 10mg daily; Risperidone (an anti-psychotic drug) 0.25mg daily and two 0.25mg</p>	F 428	<p>1. Corrective Action: Resident #68 received medical justification for 2 medications and the 3rd medication was discontinued by MD. Resident #67 now has vital signs listed on MAR to be completed and recorded prior to administration of Metoprolol.</p> <p>2. Others with Potential to be Affected: Medication Administration Records have been audited by Registered Nurses and a double check by Registered Pharmacist to ensure diagnosis and vital signs are listed for medications as appropriate</p> <p>3. Measure/Systemic Change: Resident MARs will be audited weekly x 4 then monthly for recording of vital signs with beta blockers and medical diagnosis with medication orders. All corrections will be completed with MD. The Pharmacy Consultant will provide a second check to audit to ensure all orders have been reviewed and corrections made if required. MAR checks and Pharmacy Consultant checks will continue monthly. Nurses will receive education regarding taking vital signs when giving beta blockers or when ordered prior to med administration.</p>	12/6/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 428	<p>Continued From page 92</p> <p>tablets at bedtime and Baclofen (muscle relaxer) 10mg three times a day. There were no diagnoses listed for the use of these medications.</p> <p>On 9/25/11, a pharmacy review was conducted. Recommendations were made to the physician to provide diagnoses for Risperidone, Loratadine and Baclofen.</p> <p>On 10/20/11, a physician progress note revealed that Resident #68 was examined; however his chart was not updated to include a medical justification for the use of Loratadine, Risperidone and Baclofen.</p> <p>On 11/4/11 at 2:30pm, the pharmacy consultant was interviewed. He stated that in September as well as today, both him and his colleague made recommendations to the doctor to provide a diagnosis for a few particular drugs. He stated that ideally, the doctor was expected to address recommendations made by the pharmacist within a week.</p> <p>On 11/4/11 at 4:00pm, the Director of Health Services #1 stated that she became aware that Resident #68 needed medical justification for some of his medications and had spoken to the nurse practitioner today. The doctor decided to discontinue the order for Risperidone. He also provided clarification for the use of Loratadine for allergies and Baclofen for muscle spasms</p> <p>2. Resident #67 was last readmitted to the facility on 1/11/11. Cumulative diagnoses included hypertension.</p> <p>Review of Resident #67's November 2011 physician orders revealed an order for metoprolol 37.5 mg (milligram) twice a day. Lexi-Comp's</p>	F 428	<p>Education will also be completed for all Nurses regarding need for medical diagnosis for all medications ordered, when they receive order as will all Medical Staff</p> <p>4. Monitoring:</p> <p>Results of monthly audits will be reviewed in Monthly PI Committee Meeting for follow-up and recommendations. The Administrator and Director of Health Services is responsible to ensure compliance</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 428	<p>Continued From page 93</p> <p>"Drug Information Handbook", 8th Edition lists metoprolol as a beta blocker prescribed to treat hypertension; adverse reactions include slow heart rate. Instructions were included with the order to hold for systolic blood pressure less than or equal to 110 and pulse less than or equal to 60.</p> <p>Review of Resident #67's Medication Administration Record (MAR) from September - November 2011 revealed the order for the metoprolol with the parameters. No space was allotted on the MARs to record the blood pressure and pulse.</p> <p>Resident #67's record revealed no record of daily vital signs.</p> <p>Record review revealed monthly review notes by a pharmacy consultant. The notes did not indicate that a recommendation had been made regarding lack of documented checks of blood pressure and pulse prior to administration of the metoprolol.</p> <p>During an interview on 11/1/11 at 6PM, the director of health services (DHS) said that when medication was ordered with vital sign parameters, she expected the nurses to check the vital signs and record them on the MAR prior to administering the drug. The DHS indicated that she was not aware of a pharmacy recommendation regarding lack of documented blood pressure and pulse checks for Resident #67.</p> <p>During an interview on 11/2/11 at 3:15 PM, the pharmacy consultant stated he was helping out</p>	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 428	Continued From page 94 with the monthly drug regimen reviews but was not the regular pharmacy consultant for the facility. He stated that for Resident #67's metoprolol, he would expect to see vital signs on the MAR. If he could not find a record that vital signs were checked before administering the metoprolol he would write a recommendation to the director of nursing.	F 428			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	1. Corrective Action: NA #2 was educated by the Director of Health Service regarding proper infection control procedures when linen touches the floor. Resident was provided with clean bedspread. 2. Others with Potential to be Affected: Nursing Staff were educated, by the interdisciplinary Team, regarding proper Infection Control procedures 3. Measure/Systemic Change: Nursing Staff were educated regarding proper Infection Control procedures when providing a bed bath or linen touches the floor or other potentially contaminated surface. Competencies for all CNAs in providing a bed bath and process to reuse linen were completed.	12/6/11	

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 441	<p>Continued From page 95</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy, the facility failed to change linens after contact with the floor for 1 of 3 residents (Resident #119) .</p> <p>The findings included:</p> <p>An undated facility policy entitled, "Nursing: Bed Making/Occupied Bed", read in part: "6. Loosen top bedding at the foot of the bed. Remove the blanket and bedspread leaving resident covered by top sheet. Fold the blanket and bedspread and put them on the chair (if to be used again)."</p> <p>On 11/3/11 at 8:20 AM, NA#2 was observed providing a bed bath to Resident #119. The resident ' s bedspread and top sheet were pulled back over the foot of the bed and partially dragging on the floor.</p> <p>Upon completion of the bath, NA#2 put a clean top sheet on the bed but pulled the bedspread back up onto the bed.</p> <p>During an interview on 11/3/11 at 8:30 AM, NA#2 said that any linens touching the floor should be</p>	F 441	<p>Observation of 5 rooms on each shift will be audits will be completed by the Clinical Competency Coordinator or Nursing Manager daily for four weeks then weekly for four weeks then monthly thereafter. Education to be provided immediately if issues found. Results of audits will be recorded on Nurses Aid Observation Audit sheets.</p> <p>4. Monitoring:</p> <p>The Director of Nursing will present results of audits to the Monthly PI Committee Meetings for follow-up and further recommendations. The Administrator and / or Director of Health Services is responsible to ensure compliance</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/04/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(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 441	Continued From page 96 removed and clean linens applied. NA#2 stated she saw that the bedspread was partially on the floor but did not think to change it.	F 441			

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

PRINTED: 12/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____	<div style="border: 2px solid black; padding: 5px; display: inline-block;"> RECEIVED DATE SURVEY COMPLETED DEC 20 2011 12/02/2011 </div>
--	--	---	--

NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM	STREET ADDRESS, CITY, STATE, ZIP 3100 ERWIN ROAD DURHAM, NC 27705
---	---

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

K 029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation on Friday 12/2/2011 between 11:30 AM and 3:30 PM the following was noted:</p> <p>1) There are PVC pipe penetrations in the one hour rated wall, and through the ceiling in the soiled utility rooms on first and second floor that were not equipped with a UL rated fire assembly. (Fire Collar)</p> <p>2) The dry storage room in the kitchen was found to tied open preventing it from closing.</p> <p>3) The corridor door to Kitchen did not close, latch and seal. One of the two double doors was cracked and broken at the top and was separating.</p> <p>4) The equipment room corridor door on third floor was not self closing. 42 CFR 483.70</p>	K 029	<p>K 029</p> <p>Corrective Action: PVC pipe penetrations will be contained with a fire collar (UL rated fire assembly) in soiled utility rooms on 1st and 2nd floor. The tie, hold open device has been removed from the dry storage room door. A new door has been ordered to replace the Kitchen door that was cracked and broken at the top and separated. A self closing device has been installed on the third floor equipment room door.</p> <p>Other with Potential to be Affected: All hazardous areas have been inspected for PVC pipe penetrations, hold open devices, breaks in the fire rating of all doors to hazardous areas and need for self closing devices. Any areas found will be corrected.</p> <p>Measure/Systemic Change All staff will be inserviced regarding not using hold open devices on hazardous area doors. Monthly audits will be completed of all hazardous areas to ensure areas are protected, enclosed with fire-rated barrier and doors are self closing and in good repair. Audits will be reported at Monthly PI Committtee Meeting for follow-up or further recommendations. The Director of Maintenance will be responsible for audits and corrections.</p>	1/16/11
K 052 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p>	K 052	<p>K 052</p> <p>Measure/Systemic Change All staff will be inserviced regarding not using hold open devices on hazardous area doors. Monthly audits will be completed of all hazardous areas to ensure areas are protected, enclosed with fire-rated barrier and doors are self closing and in good repair. Audits will be reported at Monthly PI Committtee Meeting for follow-up or further recommendations. The Director of Maintenance will be responsible for audits and corrections.</p>	

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

Noe Leopardi, Administrator 12/18/11

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

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

PRINTED: 12/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 1	K 052	Monitoring: The Administrator will review the audit each month to ensure compliance. Results of this audit will be reviewed in monthly PI Committee Meeting to ensure all areas of concern have been corrected. The Director of Maintenance is responsible to ensure compliance.	1/16/11
K 056 SS=D	<p>This STANDARD is not met as evidenced by: Based on observation on Friday 12/2/2011 between 11:30 AM and 3:30 PM the following was noted: 1) Upon testing the sprinkler tamper alarm supervisory signal at the Fire Alarm Control Panel the panel did not provide an audible signal when the valves were closed for sprinkler tamper alarm # 19 and #20 42 CFR 483.70</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>This STANDARD is not met as evidenced by: Based on observation on Friday 12/2/2011 between 11:30 AM and 3:30 PM the following was noted: 1) There are sprinkler heads in the kitchen</p>	K 056	<p>K 052 Corrective Action: The sprinkler tamper alarm supervisory signal will be corrected to provide an audible signal when the valves are closed for sprinkler tamper alarms #19 and #20 by BFPE (outside sprinkler alarm company).</p> <p>Other with Potential to be Affected: The Sprinkler Inspector - BFPE will inspect all sprinkler tamper alarms and will correct any other alarms found to not provide an audible signal when the valves are closed.</p> <p>Measure/Systemic Change: During quarterly sprinkler inspections, all alarms will be tested to ensure all sprinkler tamper alarms are providing an audible signal when the valves are closed. Any alarms found deficient will be immediately corrected. Inspection reports will be maintained by the Director of Maintenance in fire safety log book.</p>	1/16/11

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

PRINTED: 12/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 2 freezer rated for Intermediate Temperature Classification, Glass Bulb Color of Yellow temperature rating of (175°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red (155°F). 42 CFR 483.70	K 056	Monitoring: The Log Book with inspections will be reviewed by the Administrator after every inspection and will be reported to the PI Committee in monthly PI Committee Meetings to ensure compliance. The Director of Maintenance is responsible to ensure compliance.	1/16/11
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation on Friday 12/2/2011 between 11:30 AM and 3:30 PM the following was noted: 1) Sprinkler heads installed in the Kitchen smoke compartment were a mixture of quick response heads and standard fused heads. NFPA 101, 4.6.12.1 Every required sprinkler system shall be continuously maintained improper operating condition. NFPA 13, 5-3.1.5.2 42 CFR 483.70	K 062	K 056 Corrective Action: The sprinkler heads in the kitchen freezer will be replaced with Ordinary Temperature Classification Glass Bulb Color of Red (155 degree F) sprinkler heads by BFPE. Other with Potential to be Affected: This is the only walk in freezer located in the facility, no other areas are affected. Measure/Systemic Change: BFPE will inspect sprinkler heads on quarterly basis to ensure sprinkler heads are compliant and functioning. Director of Maintenance will assist with inspection and report any non-compliance to Administrator. Inspection reports will be maintained in fire safety log book. Any sprinkler heads that are not compliant will be repaired/replaced by BFPE when found.	1/16/11
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower	K 074		

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

PRINTED: 12/04/2011
FORM APPROVED
OMB NO.: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2011
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 076	Continued From page 4 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 This STANDARD is not met as evidenced by: Based on observation on Friday 12/2/2011 between 11:30 AM and 3:30 PM the following was noted: 1) In Therapy Services room, ground floor full and empty oxygen cylinders were found stored together. Empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] 2) On first floor in the oxygen storage room there was an unsecured cylinder. 42 CFR 483.70	K 076	Monitoring: The results of the quarterly audits will be reviewed at the quarterly PI committee meetings to ensure compliance. The Director of Maintenance will be responsible for compliance. POC for K074 and K076 on attached Sheet.	1/16/11	

K074

1. Corrective Action:
Shower curtains for 1st and 2nd floor shower rooms with 18 inch mesh tops have been ordered to replace non-compliant shower curtains. 1/16/11

2. Others with Potential to be Affected:
3rd floor shower rooms and spa room shower curtains have been audited to ensure shower curtains are complaint. All found not to meet the requirements of 18 inch mesh top will be replaced. A list of all rooms/showers where the curtain is non-complaint will be maintained. As curtains are replaced, this will also be recorded on the log so that total compliance will be recorded and maintained.

3. Measure/Systemic Change:
All shower curtains in stock will be complaint, 18 inch mesh top shower curtains to ensure that when replaced, they will meet the requirements. All non-complaint shower curtains will be removed from the building.

4. Monitoring :
Results of the log will be taken to Monthly PI Committee meeting to review for compliance . The Housekeeping Director is responsible to ensure compliance. 1/16/11

K076

1. Corrective Action:
Another empty oxygen storage container will be purchased for the therapy room so that empty and full oxygen cylinders can be labeled and stored separately. The oxygen cylinder on 1st floor in the oxygen storage room has been secured. 1/16/11

2. Other with Potential to be Affected:
All therapy staff will be inserviced regarding storing full and empty oxygen containers separately. All other staff will be inserviced regarding securing all oxygen tanks at all times.
3. Measure/Systemic Change:
Weekly audits of oxygen storage rooms, therapy room and resident rooms will be completed to ensure all oxygen tanks are properly stored. Weekly audits will be completed for the next 4 weeks, then monthly audits for 4 months to ensure compliance. Any oxygen tanks found not properly stored will be immediately addressed with responsible staff.
4. Monitoring .
Results of the audits will be reviewed in Monthly PI Committee meetings to ensure compliance. The Director of Maintenance is responsible for compliance.

1/16/11