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

MAY 25 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/04/2012

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

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F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, the facility failed to keep a call bell accessible for 1 of 3 sampled residents (Resident #2). The findings included: Resident #2 was readmitted to the facility on 1/25/12. Cumulative diagnoses included spinal cord disease, quadriplegia and tendon contractures. The quarterly Minimum Data Set (MDS) dated 3/9/12 indicated that Resident #2 was cognitively intact, required extensive assistance of 2 people for bed mobility and had impaired range of motion in all extremities. On 5/4/12 at 9:20 AM, Resident #2's call bell was observed to be wrapped around the side rail of her bed. The resident stated she was unable to reach the call bell. She added that the night shift had placed the call bell on the side rail when they last turned her, around 6:45 AM, and no one had been in her room since.	F 246	F 246 1. Corrective Action: Call bell clip has been replaced on Resident #2's call bell chord enabling staff to position call bell within her reach. 2. Others with Potential to be Affected: All rooms in facility have been audited for call bell clips – any found missing have been replaced. All call bells in facility can be secured within reach of all residents.	5/7/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lorie Leopardi — TITLE: Administrator — (X6) DATE: 5/25/12

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

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F 246	Continued From page 1 The nursing assistant (NA#1) who was assigned to Resident #2 on the 7-3 shift was interviewed on 5/4/12 at 9:25 AM. NA#1 acknowledged that she had not been in Resident #2's room. NA#1 added that another NA had just delivered the resident's breakfast tray and was going to feed her. Observation on 5/4/12 at 9:48 AM, with Administrative Nurse #1 in attendance, revealed the call bell wrapped around the resident's side rail. Administrative Nurse #1 stated that call bells should be clipped in place and never wrapped around a side rail. Administrative Nurse #1 indicated there was no clip on the resident's call bell cord but one would be obtained. Administrative Nurse #1 then unwrapped the cord from the side rail and positioned the call bell so Resident #2 could reach it. Observation on 5/4/12 at 4:25 PM, with Nurse #1 in attendance, revealed Resident #2 up in a chair in her room. The call bell was lying on the bed. When asked, the resident stated she was unable to reach the call bell.	F 246	3. Measure/Systemic Change All staff in each department have received education regarding the need for call bells to have clips and be secured within reach of all residents. Weekly audits will be completed by Administrator of designee, in all rooms to ensure clips are present and call bells are within reach of residents. Weekly audits will be completed for the next 4 weeks and then monthly thereafter. 4. Monitoring: The Administrator will review all audit results after each audit to ensure compliance. Audit results will be reported at monthly PI meeting for follow-up or recommendations. The Administrator is responsible to ensure compliance.	5/28/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		

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F 309	Continued From page 2 by: Based on observation, record review, resident and staff interviews, the facility failed to assess the positioning needs for 1 of 3 non-ambulatory residents (Resident #1), in a timely manner. The findings include: Resident #1 was admitted to the facility on June 30, 2010 and later re-admitted on June 1, 2011. Some of her diagnoses include abnormal posture, muscle weakness, convulsions and brain injury. On the most recent quarterly Minimum Data Set (MDS) dated March 13, 2012 she was assessed as being cognitively intact and totally dependent on staff to transfer her. She had limitations with her lower extremities on both sides. A review of her medical record was conducted and revealed in a Social Progress Note, dated February 10, 2012, a family meeting was held with the resident, her relatives, the social worker and director of nursing (DON) present. A discussion followed and a request was made by the responsible party (RP) to make sure that Resident #1 doesn ' t continue to slip in her wheelchair. On May 2, 2012 at 3:30 pm, the DON was interviewed. The DON mentioned that staff has to constantly pull Resident #1 up in her wheelchair because she sits on a pad used during a mechanical lift transfer and it causes her to slide. She shared that she wasn ' t sure if they have modified the wheelchair to keep her from slipping forward. She stated that she thought the rehab department was considering using a non-slip pad or exploring giving the chair a pelvic tilt, but she	F 309	F 309 1. Corrective Action: Resident #1 was given a different wheel chair, an anti thrust cushion and a lift sling that can be removed from under her when she is up in her wheel chair. 5/4/12 2. Others with Potential to be Affected: All non-ambulatory residents will be screened by a therapist for proper positioning and need for assistive devices to prevent sliding, when appropriate. All Nursing staff will receive education regarding proper positioning of residents and notification of Unit Managers when a resident needs to be frequently repositioned 6/8/12	

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F 309	Continued From page 3 wasn ' t sure. She commented that Resident #1 was able to make her needs known and she has witnessed her asking staff, to assist and pull her up. The DON stated that at times, it was hard to detect when Resident #1 starting slipping in her chair due to her posture, but she was good at notifying staff when she started to slide down in her chair. On May 3, 2012 at 10:15 am, Resident #1 remained in the dining room after finishing breakfast. She sat in her wheelchair, pulled up to a table. She was heard calling out to Nurse # 2 that passed her by, that she needed to be pulled up in her wheelchair. She was sitting on top of a mechanical lift pad and had begun to slide in her wheelchair, which has extended leg rests, to keep her legs elevated at all times. Resident #1 was observed sitting at about a 45 degrees angle. Nurse #2 summoned the help of Nurse # 3who went to her wheelchair to assist. Resident #1 remained sitting in a slanted position and had some noticeable body tremors on her right side. The Administrative Nurse #3 joined the nurses in pulling Resident #1 up erect in her wheelchair. Resident #1 was able to indicate that she was now comfortable in her sitting position. On May 3, 2012 at 10:45 am the Rehabilitation Director stated that she just evaluated the wheelchair of Resident #1 and will add a higher anterior raise, which will help to keep Resident #1 ' s hips back in the chair. She also planned to order an anti-thrust cushion, which will raise the front of the chair by 2 to 3 inches and allowed Resident #1 to sit one inch lower in the back. These actions would keep her hips pushed back	F 309	3. Measure/Systemic Change: Audits will be completed weekly for 4 weeks and monthly thereafter to ensure residents are properly positioned. Audits will be completed by Unit Managers or designee. 4. Monitoring: Director of Health Services will review all audits and report findings to PI Committee at monthly meetings for follow-up and further recommendations. The Director of Health Services is responsible for compliance. 6/8/12	

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F 309	Continued From page 4 and would prevent her from sliding forward, unless it was determined that her thrusting movements were intentional, and not a positioning problem. She indicated that it might take a week for the part to arrive. The Director of Nursing indicated on May 3, 2012 at 12:15 pm, that the facility had obtained a new anti-thrust seat cushion but it was the wrong fit for Resident #1 ' s wheelchair. She stated that the width was 2 inches too small and the cushion doesn ' t raise the hips up enough to prevent sliding. Therefore, they will order another brand. On May 4, 2012 at 5:20 pm, Resident #1 was observed sitting in a new wheelchair, in the dining room. She stated that the new chair gave her better posture and she was sitting on a new seat cushion.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy, the facility failed to use	F 315		

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F 315	Continued From page 5 proper technique while providing urinary catheter care for 1 of 1 sampled resident (Resident #2). The findings included: The facility policy entitled, "Catheters: Care and Anchoring, Changing of," last revised 1/07, read in part, "9. For the female patient/resident, use a gloved hand and washcloth or disposable washcloth with peri-wash to cleanse the labia. Use only one section of the washcloth for each downward cleansing stroke. Next, cleanse around the urethral meatus with a different part of the washcloth." Resident #2 was readmitted to the facility on 1/25/12. Cumulative diagnoses included urinary tract infection, spinal cord disease, quadriplegia, neurogenic bladder with chronic urinary catheter, and tendon contractures. The quarterly Minimum Data Set (MDS) dated 3/9/12 indicated that Resident #2 was cognitively intact, required extensive assistance of 2 people for bed mobility and hygiene, and had impaired range of motion in all extremities. Observation on 5/4/12 at 10:13 AM revealed Resident #2 in bed receiving morning care. The urinary catheter was draining cloudy yellow urine with mucus. Nursing assistant (NA) #1 provided catheter care by herself to Resident #2. NA#1 was unable spread Resident #2's legs due to the resident's contractures. NA#1 wiped from the vagina upward toward the urinary meatus. A yellow-brown substance was observed on the white washcloth after wiping.	F 315	F 315 1. Corrective Action: The Nursing Assistant caring for Resident #2 was re-educated regarding proper catheter care. Resident #2 was assessed for the need for 2 staff members to assist when catheter care is completed. 5/4/12 2. Other with Potential to be Affected: All residents with catheters have the potential to be affected, therefore all Nursing staff will be re-educated regarding proper catheter care. 3. Measure/Systemic Change: Observation audits will be completed while Nursing staff are providing catheter care. Audits will be completed weekly for 4 weeks and monthly thereafter by the Clinical Competence Coordinator or designee. 4. Monitoring: Results of these observations audits will be reviewed by Director of Health Services. Results will also be discussed and reviewed at monthly PI Meeting for follow-up and recommendations. The Clinical Competency Coordinator is responsible for compliance. 6/1/12	

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F 315	Continued From page 6 During an interview on 5/4/12 at 10:40 AM, NA#1 indicated that she had been taught to always wipe downward from the catheter and thought she had done so. NA#1 also indicated that it was difficult to clean Resident #2 by herself due to the resident's contractures. During an interview on 5/4/12 at 11:00 AM, Administrative Nurse #2 indicated that she expected staff to wipe downward, away from the catheter insertion point towards the vagina, when providing catheter care. Administrative Nurse #2 also indicated that Resident #2 may require 2 staff to provide catheter care.	F 315		