SEP 10 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and review of the Resident Council minutes, the facility failed to resolve a resident concern in a timely manner related to a concern for fresh ice water not being passed voiced in Resident Council Meetings from December 2011 through April 2012. Findings include: During an interview with Resident #58 on 7/24/12 at 2:30 PM, the resident reported residents have complained about fresh ice water not being passed every shift during the Resident Council Meetings and have complained every month. Resident #58 stated the concern has truly never been resolved. Review of the January 2012 Council Meeting Minutes revealed in part: carried over from the December 2011 meeting, water was still not being passed consistently on all shifts. The facility response was completed as: water reinforced to staff! Pass at 5 AM, 2 PM, and 10 PM.	F 244	**F-244 – Resolution of Grievances** 1. Resident # 58 is now receiving ice water each shift. 2. Ice water audits will be conducted five days a week for two weeks on 7-3, 3-11, and 11-7; then weekly 7-3, 3-11, and 11-7 times four weeks, then monthly times three months 7-3, 3-11, and 11-7, then quarterly times two by Administrative staff and Supervisor/ Team leaders (See Attachment A). 3. Systemic changes that have been put in place to ensure resident grievances have been acted upon including the Resident Council meetings will be held prior to monthly PI meeting. When grievances are identified the Activities Director, Senior Care Partner, or designee will hold a follow-up meeting at the next months resident council meeting to ensure resident suggestions/concerns have been addressed.	9/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darryl Taylor	Administrator	8/30/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 244	Continued From page 1 Review of the February 2012 Resident Council Meeting Minutes revealed in part: Nursing: several residents reported that water was still not being passed consistently on all shifts. The Nursing response was documented as: Ice passed at 6 AM, 2 PM, and 10 PM daily, Unit Coordinator to oversee immediately, and in-service started 2/28/12. Review of the March 2012 Resident Council Meeting Minutes revealed in part: several residents reported that water was still not being passed consistently on all shifts. The response to the concern was documented as: re-inservice about ice, Unit Coordinator to oversee daily. Review of the April 2012 Resident Council Meeting Minutes revealed in part: water was still not being changed consistently between shifts. A response was written as: water with ice shall be passed at 6 AM, 10 AM and 2 PM daily. Review of facility in-service material for January through April 2012 revealed staff received in-service training on passing ice water at 6 AM, 2 PM, and 10 PM. An observation of Room 103B on 7/25/12 at 4:43 PM revealed the water pitchers had no ice. An observation with the Director of Nursing (DON) on 7/25/12 at 4:55 PM, revealed the ice pitcher in room 103B had no ice. The DON stated ice was expected to have been passed at 2 PM for the first shift. An interview was conducted with the Unit Coordinator for Transitional Care Unit on 7/26/12 at 2:02 PM. The nurse stated she made rounds	F 244	4. Grievances will be brought to monthly PI meetings by the Activities Director/Senior Care Partner for discussion by the Committee. The Resident Council President will be invited to attend PI meetings once every quarterly starting September 2012 to discuss additional or unresolved resident concerns. Indentified negative trends will be reviewed in monthly PI meetings by the Committee. Additional action plans will be developed as appropriate. The facility PI meeting is monthly and includes all administrative staff. The Medical Director attends quarterly. 5. Educational material was presented to staff on the expectation of ice water pass to residents to include when and how to accomplish this task(See attachment B). 73% of nursing staff attended as of 8-23-12. We will be at 100% as of 9-14-2012. New staff will be educated on the Importance of grievance and resolution during orientation and existing staff will continue to be provided this education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 244	Continued From page 2 at least 3 times a day and monitored the residents to assure they have received fresh water. She stated some residents drank more water than others and she would ask the staff to get more ice for those residents. The nurse stated she didn't document her findings anywhere. During an interview with the DON at 725/12 at 9:14 AM, the DON reported in-services were done with the staff, and the Unit Coordinators monitored daily to make sure the fresh ice water had been passed. They randomly checked rooms but did not document on any monitoring tool. A message to pass ice water at the given time was written on the unit assignment every shift. The DON stated she expected staff to pass ice water at 6 AM, 2 PM and 10 PM. The DON stated the resident's concern for fresh water should not have been a concern for so long.	F 244		9/14/12
F 309 SS=E	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 by: Based on observations, resident and staff interviews, and record reviews the facility failed to assure insulin medication was provided in a timely manner in relation to a meal for 4	F 309	**F-309 – Highest Well Being** 1. Nurse caring for Residents # 23, #98, #114, and #224 has been educated by the Clinical Competency Coordinator on the importance of administering medications as ordered in relation to meals(See attachment C). Residents # 23, #98, #114, and #224 are now receiving insulin medications in a relation to a meal. Staff caring for Resident # 409 has been educated relative to addressing anxiety, elevated blood pressure, and heart rate, and other changes in condition in a professional manner, following MD orders based on standard of care and the nursing practice act. In addition, appropriate disciplinary Action was taken to address this issue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 3 (Residents #23, #98, #114, and #224) of 4 diabetic residents on the 400 Hall, and the facility failed to address a residents anxiety, elevated blood pressure, and heart rate for one of one (#409) sampled residents who was admitted to the facility with a primary diagnosis of Atrial Fibrillation. Findings include: Resident #23 was readmitted to the facility on 7/29/11 with diagnoses to include Neuropathy and Diabetes Mellitus (DM) Type II. 1 Review of July 2012 physician's orders for Resident #23 included Humalog (a quick acting insulin that should be given 15 minutes before a meal or right after a meal) sliding scale insulin coverage with finger stick blood sugar before meals and at bed time. Sliding scale coverage with Humalog for blood sugars were: 150 - 152 give 1 unit 153 - 187 give 2 units 188 - 222 give 3 units 223 - 257 give 4 units 258 - 292 give 5 units 293 - 327 give 6 units 328 - 362 give 7 units 363 - 397 give 8 units 398 - 432 give 9 units Review of the resident ' s July 2012 Medication Administration Record (MAR) revealed the resident received Levemir insulin subcutaneously at bedtime. The MAR indicated a finger sticks for blood sugars was scheduled to be taken at 4:30 PM. The result of the 4:30 PM finger stick of 7/7/23/12 was recorded as 249 milligrams per	F 309	2. Nurses education has been provided to current staff on the importance of administering insulin and in relation to meal times (See attachment D), and response to change of condition. 84 % of licensed nursing has attended as of 8-23-2012. We will be at 100% by 9-14-2012. Nursing has also been educated by the Clinical Competency Coordinator on the importance of responding to changes in condition, to include administration of medication as appropriate to address anxiety, elevated blood pressure, and heart rate(See Attachment E). All new nurses during orientation will be educated on the same training sessions listed above. 3. The systemic change to ensure Insulin is administered in a timely manner and in relation to a meal is as follows: Nurses are administering Insulin at the time ordered. If the subsequent meal arrives more than thirty minutes after the Insulin is administered, the Resident will be given a snack. To ensure nurses are identifying and responding appropriately to changes in condition, the Nursing Managers are making daily rounds and ensuring changes in condition have been appropriately managed and that medications are being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 4 deciliter (mg/dl). The MAR included documentation of 4 units of Humalog were given for a blood sugar of 249 mg/dl for the 4:30 PM check. The dinner meal tray cart arrived on the 400 hall at 6:29 PM on 7/23/12. The meal tray for Resident #23 was delivered to the resident at 6:31 PM. The resident had her eyes closed, but opened when her name was called. She reported she was not sure how she felt. 2 Resident #98 was re-admitted to the facility on 3/6/11 a diagnosis to include DM II. Review of the July 2012 physician's orders revealed orders for Metformin (an oral anti-diabetic medication) 500 milligrams (mg) 2 tablets (1000mg) by mouth every morning; Metformin 500mg by mouth every evening documented to be given at 5 PM, and Novolog (insulin that is given 5 to 10 minutes before eating a meal) injection 100/ml (milliliters), check finger stick blood sugar before meals and at bedtime, record results, administer sliding scale subcutaneously. Sliding scale coverage with Novolog for blood sugars were: 150 - 152 give 1 unit 153 - 187 give 2 units 188 - 222 give 3 units 223 - 257 give 4 units 258 - 292 give 5 units 293 - 327 give 6 units 328 - 362 give 7 units 363 - 397 give 8 units 398 - 432 give 9 units Review of the resident ' s MAR revealed the residents blood sugar results at 4:30 PM on 7/23/12 were documented as 184 ml/dl and the	F 309	administered as appropriate. Residents are also being interviewed by administrative staff daily , utilizing a Rounds Audit (See attachment F) to determine if Residents are expressing any issues with nurse response time to requests or with administration of medications as ordered. Residents that are confused will be assessed for signs and symptoms of change in condition and appropriate reactions are made. 4. To monitor that insulin is administered timely and in relation to a meal and that there is appropriate response to changes in condition, Nursing Manager findings from rounds and from interviews will be reviewed monthly times three months by the Performance Improvement Committee and then the plan will be re-evaluated. Developed PI plans will be revised as needed. The facility PI meeting is the 2nd Tuesday of each month and includes all administrative staff. The Medical Director attends quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 5 resident received 2 unites of the Novolog insulin. During an interview with the resident on 7/23/12 at 6:38 PM, the resident reported she was " ok, but felt tired " . The dinner meal tray cart arrived on the 400 hall at 6:29 PM on 7/23/12 and Resident #98 received her dinner tray at 6:43 PM. 3 Resident #114 was admitted to the facility on 7/6/12 with a diagnosis to include DM II, Review of the resident ' s admission orders revealed the resident received finger stick blood sugar before meals and bedtime with Humalog sliding scale insulin coverage. Sliding scale coverage with Humalog for blood sugars was: 150 - 152 give 1 unit 153 - 187 give 2 units 188 - 222 give 3 units 223 - 257 give 4 units 258 - 292 give 5 units 293 - 327 give 6 units 328 - 362 give 7 units 363 - 397 give 8 units 398 - 432 give 9 units The resident also received Lantus 30 units subcutaneously every bedtime and Humalog insulin 6 units subcutaneously scheduled for 8 AM, 12:00 PM, and 5 PM in addition to sliding scale coverage. Review of the resident ' s July 2012 MAR revealed the resident ' s blood sugar at 4:30 PM on 7/23/12 was documented as 114 ml/dl and was given no coverage. Review of the MAR revealed the resident was given 6 units of Humalog at 5 PM per physician ' s orders.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 6 The dinner meal tray cart arrived on the 400 hall at 6:29 PM on 7/23/12. Resident # 114 received his tray at 6:47 PM and requested meatloaf as he didn't prefer the meal that was delivered and staff went to the kitchen to get the resident meatloaf. 4 Resident #224 was admitted to the facility on 12/13/11 with a diagnosis to include DM II. Review of physician's orders for July 2012 revealed orders for Lantus 20 units subcutaneously every morning that was scheduled for 9 AM; and Novolog 4 units subcutaneously before lunch and dinner that was scheduled for 11:30 AM and 4:30 PM. Additional orders were received for Novolog, check finger stick blood sugar before meals and bedtime, record results, administer sliding scale coverage. Sliding scale coverage with Novolog for blood sugars were: 150 - 152 give 1 unit 153 - 187 give 2 units 188 - 222 give 3 units 223 - 257 give 4 units 258 - 292 give 5 units 293 - 327 give 6 units 328 - 362 give 7 units 363 - 397 give 8 units 398 - 432 give 9 units Review of the resident ' s MAR revealed a documented blood sugar of 224 on 7/23/12 at 4:30 PM and was given 4 unites of Novolog insulin coverage. In addition, the resident also received the scheduled dose of Novolog insulin of 4 units. The dinner meal tray cart arrived on the 400 hall	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 7 at 6:29 PM on 7/23/12 and the resident received his meal tray at 6:43 PM. he was alert and verbal and appropriate During an interview with Nurse #2 on 7/23/12 at 6:21 PM, the nurse reported she gave insulin coverage to Resident #114 between 5 PM and 5:30 PM and that it was his scheduled dose. The nurse stated she provided insulin coverage to Resident #98 at 5 PM; Resident 224 was given his scheduled insulin with coverage at about 5 PM or a little after; Resident #23 received insulin coverage at about 5 PM. The nurse reported she used Humalog and Novolog insulins. Nurse # 2 stated that " by now, I'm sure their blood sugars have dropped without having a meal yet " and she " should recheck their sugars, which now would probably be a good time or in the next 15 minutes " . Review of Resident #23 ' s MAR revealed a blood sugar was completed at 7:30 PM on 7/23/12 and was recorded as 294. Review of Resident #98 ' s MAR revealed a blood sugar was completed at 7:30 PM on 7/23/12 and was recorded as 227 ml/dl. Review of Resident #114 ' s MAR revealed a blood sugar was completed at 7 PM on 7/23/12 and was recorded as 92 ml/dl. Review of Resident #224 ' s MAR revealed a blood sugar was completed at 7:30 PM on 7/23/12 and was recorded as 99 ml/dl. During an interview with the Director of Nursing at 6:55 PM on 7/23/12, the DON stated the meal	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 8 trays were late on 7/23/12. The DON stated the time the residents ' insulin was given in relation to the arrival of the dinner meal cart was a medication error. During an interview with the Assistant Director of Nursing at 3:10 PM on 7/27/12, the nurse revealed the facility had no policy on giving insulin in relation to a meal, therefore, the facility followed manufacturer recommendations for administering insulin. 5) A record review revealed resident #409 was admitted to the facility on 7/16/12 following an acute hospital stay for Atrial Fibrillation with rapid ventricular response with controlled rate. Other diagnoses included: hypertension, pulmonary edema with hypoxia, obstructive apnea and muscle weakness. There was no Minimum Data Set (MDS) information available for resident #409 due to the new admission status. An interim care plan dated 7/16/12 indicated resident #409 had generalized weakness and used oxygen for pulmonary edema. The care plan also indicated resident #409 was at risk for bleeding due to anticoagulation therapy (medications used to prevent blood clotting by causing the blood to become thinner) due to Atrial Fibrillation. A review of physician orders revealed	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 9 medications for resident #409 which included: Coumadin (an anticoagulant medication), Cardizem CD (used to treat hypertension, chest pain, and certain heart rhythm disorders),Amiodarone (used to treat cardiac arrhythmias), Metoprolol (used to treat high blood pressure), and Lasix (used to treat fluid retention). The physician orders also indicated resident #409 was to wear continuous oxygen and receive physical and occupational therapies for strengthening and endurance. An observation on 7/24/12 at 9:00 AM of resident #409 revealed the resident was in her room sitting on her bed with her oxygen on. During an interview, on 7/24/12 at 9:00 AM resident #409 revealed she was not feeling well and had declined therapy that morning due to diarrhea. Resident #409 also indicated she had requested something to help with the diarrhea from the nurse and it had been about an hour and she had not yet received anything. Resident #409 also indicated she felt very anxious and told the nurse that as well. The resident was not sure when the nurse would return. The nurse and the medication cart were observed to be at the room next door and resident #409 indicated she would wait for the nurse since she was so close. On 7/24/12 at 5:00 PM an observation of resident #409 revealed she was sitting in the hallway on her walker seat outside her room with her oxygen on. The medication cart was next to her and the nurse was not in view. On 7/24/12 at 5:00 PM during an interview with resident #409 indicated she had been very anxious all day and had asked nurse #1 for	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 10 something to help the anxiety around 3:00 PM. Resident #409 indicated she had not received anything for anxiety yet and had just asked nurse#1 again (5:00 PM). Resident #409 indicated the nurse told her the doctors were gone for the day. During the interview the physician ' s assistant (PA) walked by and nurse #1 returned to the medication cart at that time. On 7/24/12 at 5:05 PM Resident #409 was observed to ask nurse #1 if she had talked with the doctor or PA. Nurse #1 then indicated she had spoken to the PA and indicated the PA would look at her chart and would order something. Nurse #1 indicated she would not give resident #409 any medication for anxiety until the PA gave her an order. Resident #409 indicated to nurse #1 that she hoped it would be soon because she was really anxious. A record review revealed there were no nurses ' notes or vital signs recorded for resident #409 for 7/24/12 for the 7:00 AM to 7:00 PM shift. A review of the Medication Administration Record (MAR) for resident #409 dated 7/24/12 indicated her Blood Pressure (BP) at 9:00 AM indicated resident #409 BP was 138/68 HR 76. In addition, on the 7:00 PM -7:00 AM shift (no exact time was documented) BP 150/84 Heart Rate 87. In addition, Ativan 0.5 mg was given at 9:00 PM. The physician's order was noted by the night shift nurse at 10:00 PM. There was a new physicians order written 7/24/12 indicated as noted at 10:00 PM which indicated resident #409 ' s Blood Pressure was elevated. The order indicated check Blood	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 11 Pressure (BP) at 7:00 PM (an hour and a half after scheduled (Metoprolol) blood pressure medication was given). The order also read " please check BP with heart rate (HR) two times a day for 5 days-BP elevated. " In addition, Clonidine 0.1mg by mouth every 8 hours as needed for a systolic blood pressure greater than 180 or a diastolic blood pressure of greater than 100. In addition, a physician ' s order was written on 7/24/12 and noted by the nurse at 10:00 PM for Ativan 0. 5 milligrams (mg) three times a day as needed for anxiety / restlessness and Ativan 0.5 mg by mouth at bedtime for insomnia. On 7/25/12 at 8:40 AM an interview with resident #409 revealed she did not receive medication for the anxiety until 11:00 PM last night. The nurse on the 7:00 PM to 7:00 AM shift administered the medication. Resident #409 indicated she felt much better today and she had slept well. On 7/25/12 at 10:00 AM the SDC revealed the nurses should document any change in condition and if new orders were added. In addition, the SDC revealed vital signs should be recorded for a resident that had an order for BP monitoring and medication changes due to an elevated BP. The SDC indicated she would review the medical record for resident #409 and review the physician orders and nurses documentation. On 7/25/12 at 1:50 PM an interview with Unit Coordinator TCU revealed her expectations would be Nurse #1 should have documented in resident #409 ' s medical record why the Ativan was started and the elevated BP should have been documented.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 12 On 7/25/12 at 2:05 PM an interview with the DON and SDC revealed Nurse #1 would be coming into the facility to document on resident #409 ' s medical record as a late entry for 7/24/12. On 7/25/12 at 2:40 PM an interview with Nurse #3 revealed she was caring for resident #409 from 7:00 AM to 7:00 PM on 7/25/12 and she received a verbal report resident #409 ' s BP was elevated on 7/24/12. Nurse #3 also indicated there were new orders to monitor resident #409 ' s BP and the physician had also written a new order for Ativan to relieve resident #409's anxiety. Nurse #3 also revealed resident #409 had received Ativan at bedtime on 7/24/12. Nurse #3 indicated the documentation was divided between the two shifts. Nurse #3 indicated documentation should be done if anything abnormal occurs, there was a change in condition and new orders were written. Nurse #3 indicated there should have been documentation in resident #409 ' s medical record that reflected the change in resident #409 and the interventions put in place by the physician. On 7/25/12 at 4:20 PM an interview with Nurse # 1 revealed resident #409 told her on 7/24/12 at 8:00 AM that she was not feeling well. Resident #409 complained of diarrhea with stomach upset and anxiety. Nurse #1 indicated she gave resident #409 anti diarrhea medication at around 9:30 AM and the resident had no further complaints of diarrhea or stomach upset. Nurse #1 revealed at 3:00 PM resident #409 had complained of anxiety and she told resident #409 she would let the doctor know. Nurse #1 indicated she did not call the physician at that time and was unsure why she did not call the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 13 physician. Nurse #1 indicated during her routine medication pass at 5:00 PM resident #409 complained again of anxiety and Nurse #1 had a NA check resident #409 BP and it was 180/111 with a HR of 101. Nurse #1 gave resident #409 her scheduled BP medication (Metoprolol) and recalled the time between 5:30 PM and 6:00 PM. Nurse #1 then went to find the PA to report resident #409 ' s elevated BP, HR and anxiety. Nurse #1 indicated the PA told her she would review resident #409 chart and to recheck her BP in 1.5 hours after the scheduled Metoprolol was given. Nurse #1 indicated she gave report to the oncoming nurse at the change of shift 7:00 PM. Nurse #1 also indicated she told the night nurse to recheck resident #409's BP at 7:00 PM. Nurse #1 indicated she should have documented on resident #409 medical record but had to leave. Nurse #1 revealed she should have documented resident #409's symptoms and she also revealed she should have contacted the physician at 3:00 PM when resident #409 complained of anxiety. On 7/25/12 at 5:00 PM Nurse #1 documented late entry for 7/24/12 7:00 AM to 7:00 PM the late entry note indicated resident #409 had an elevated BP at 9:00 AM 172/109 with a HR 109 and gave Pepto-Bismol for upset stomach/diarrhea. The note also indicated resident #409 complained of anxiety. The note also indicated at 5:00 PM resident #409 was outside of her room and complaining of anxiety. Nurse #1 indicated in the note that she rechecked resident #409 ' s BP and it was 180/111 HR 101. The note indicated Nurse #1 gave resident #409 her 6:00 PM scheduled BP medication and told resident #409 she would notify the physician. The note also revealed	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 14 Nurse #1 reported the elevated BP and anxiety at 5:30 PM to the PA and then informed resident #409 the PA would review her medical chart. Nurse #1 also documented in the late entry that she had given report to the night nurse. On 7/25/12 at 5:07 PM an interview with Nurse #1 revealed that on 7/24/12 resident #409 ' s BP and HR had been elevated in the morning and Nurse #1 gave resident #409 her scheduled BP medications and did not inform the physician of the elevated BP and HR at that time. Nurse #1 indicated she rechecked resident #409 ' s BP and HR again at 5:00 PM and found was elevated again and then reported it to the PA. Nurse #1 indicated she should have reported the elevated BP and HR to the PA the morning of 7/24/12. On 7/25/12 at 5:15 PM an interview with the DON revealed the BP and HR should have been reported to the physician in the morning of 7/24/12 when it was found to be elevated and resident #409 was complaining of anxiety. The DON ' s expectations were that nurses document all changes in condition in the nurses ' notes and contact the physicians with any abnormal symptoms. The DON ' s expectations were resident #409 should not have had to feel anxious all day; there should have been a quicker response from the nurses to report it to the physician. On 7/26/12 at 10:45 AM an interview with Nurse #1 indicated she could not recall what the BP or HR was and might not have been accurate in her late entry note for resident #409. Nurse #1 indicated she could not recall the BP entry she	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 15 made in the MAR for 7/24/12 at 9:00 AM for resident . During the interview Nurse #1 could not recall if resident #409 ' s BP and HR was elevated in the morning as documented in her late entry note. On 7/26/12 at 11:15 AM the DON and SDC indicated Nurse #1 was confused and resident #409's BP and well being should have been accurately documented when the symptoms first occurred and the physician should have been notified of resident #409's anxiety and elevated BP and HR.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to consistently provide range of motion services to 2 (Residents #166 and #210) of 2 sampled residents with Restorative nursing programs. Findings include: 1 Resident #166 was re-admitted to the facility on 3/8/12 with diagnoses to include late effects of Cerebrovascular Accident (stroke), muscle	F 318	**F-318 – Prevent Decrease in ROM** 1. Residents #166 and Resident #210 are receiving restorative Nursing program as indicated. 2. All residents in restorative nursing program have been reviewed by the Restorative Nursing Coordinator/Nursing Manager and discussion with RNAs and evaluation of documentation will occur to ensure compliance with program. Any identified issues have been reported to the Director of Health Services for resolution (See attachment G).	8/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 16 weakness-general, and difficulty walking. Review of the resident ' s most recent Minimum Data Set (MDS), a quarterly assessment of 6/12/12, revealed the resident required minimal assistance of one staff member for transfer and walking in the room and corridor. The resident ' s balance was assessed as not steady, unable to stabilize without human assistance when moving from a seated to standing position, walking, and surface to surface transfers. The resident was assessed as having no functional limitations of upper or lower extremities. Review of Resident #166 ' s "Nursing Restorative Care Plan and Flow Record" for July 2012, revealed programs for Range of Motion (ROM) to Upper extremities for 6 times a week and ROM to Lower Extremities 6 days per week. The record indicated the resident received the services 7/11/12, 7/12/12, 7/18/12, 7/23/12, and 7/25/12. During an observation of the resident on 7/26/12 at 8:43 AM, the resident was seated in his wheel and self propelling in his room. The resident then moved down the hall in his wheelchair with no assistance. During an interview with NA # 3 on 7/26/12 at 8:49 AM, the NA reported the resident was able to do his upper body for dressing and bathing, but needed help to wash his feet and legs and put his pants on over his feet. The NA reported the resident required minimal assistance with transfer and was independent in locomotion in his wheelchair.	F 318	3. The Director of Health Services is ensuring appropriate Number of Restorative C.N.A.s are assigned to carry out restorative programs to ensure the alleged deficient practice does not recur. The facility has 4 Full time restorative aides working. Their schedule is (2) 7-3 & (2) 10-6 with rotating weekend. Restorative training program/competency for CNA's has been completed (See Attachment H). 100% of restorative NA's has completed training and in addition we have trained 40 CNAs as of 8-23-2012 for backups. The Restorative Nursing Coordinator/designee will reviewing restorative nursing documentation five times a week for two weeks, then weekly for four weeks, then monthly for three months, then quarterly for two quarters to ensure restorative services are being administered and documented.(Attachment G). Any identified issues will be reported to The Director of Health Services for resolution. 4. The Director of Nursing will present trends to the PI Committee for its review and intervention monthly. The facility PI meeting is the 2nd Tuesday of each month and includes all administrative staff. The Medical Director attends quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 17 During an interview with Restorative Aide (RA) #1 on 7/26/12 at 10:05 AM, the RA reported the resident was to receive restorative services 6 days a week, but didn't like to participate in the restorative programs on the weekends. The RA stated she was on vacation from 7/1/12 through 7/10/12 and was off the weekend. The NA reported she was unaware of what happened during that time and could not explain why the restorative programs weren't done. The RA stated some of the days the programs were not completed were her days off or she was pulled to the floor to work as a NA. The RA stated there were 2 RAs and when one was pulled the facility tried to leave one for restorative, but stated one RA couldn't do all of the programs, so it was pick and choose as to which programs were going to get done. During an interview with the Restorative Nurse on 7/26/12 at 10:38 AM, the nurse reported there were changes in RA staffing recently and the RAs were pulled to the hall. The nurse stated the Director of Nursing (DON) was aware the restorative programs were not getting done. An interview with the DON on 7/26/12 at 2:12 PM revealed the facility was in the process of hiring RAs and expected an improvement. The DON stated she expected the restorative programs to be done. 2 Resident #210 was re-admitted to the facility on 11/23/11 with diagnoses to include muscle weakness.	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 18 Observation of the resident on 7/24/12 at 4:21 PM revealed the resident had no hand contractures, but rolled his fingers toward the palms. An additional observation on 7/26/12 at 11:30 AM revealed the resident was able to wave his hand by raising his arm to a 45 degree angle. The resident ' s hand was outstretched and the fingers fully extended. Review of the facility ' s Restorative Nursing Services Record revealed Resident #210 was documented to receive restorative services for wheelchair mobility if out of bed 6 times a week; bed mobility; Active Assisted Range Of Motion (AAROM) to both upper extremities and Passive Range Of Motion (PROM) to both lower extremities. Review of the flow record for Resident #210 revealed the services had been performed on 7/11/12; 7/12/12; 7/17/12 and 7/20/12 for bed mobility and range of motion Review of June 2012 Nursing Restorative Care Plan and Flow Record for Resident #210 revealed bed mobility was documented to begin 6/15/12. Service was documented as having been provided 6/21/12, 6/25/12, and 6/27/12 Review of June 2012 Nursing Restorative Care Plan and Flow Record for Resident #210 for AAROM and PROM were documented as having been initiated 6/15/12 and were documented has having been provided 6/25/12 and 6/27/12 The resident ' s MDS, a quarterly assessment of 7/17/12, revealed the resident had no limitations in range of motion. The resident was assessed	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 19 as having required extensive assistance of 2 or more staff for bed mobility, was totally dependent of 2 or more staff for transfer, totally dependent on one staff member for dressing, toilet use, and personal hygiene. During a review of the Restorative Flow Record for Resident #210 with RA #1 on 7/26/12 at 10:11 AM, the RA reported the services for bed mobility and AROM to both arms and legs were not done July 1, 2012 through July 10, 2012 since she was on vacation and was not aware of who was scheduled to work in the restorative programs. The RA reported there was no indication of how many times a week the treatments were to be done, but she tried to do them at least 5-6 days a week. The RA stated some of the past 5 days restorative services were not done was due to her days off, doing monthly and weekly weights, and having been pulled to the units to work as a Nursing Assistant. The RA reported she told the Restorative Nurse she was not able to do all of the restorative treatments and was told they were going to do group sessions and get as many done at one time and do the best you can. The RA reported they knew she had been pulled to the units. During an interview with the Restorative Nurse on 7/26/12 at 10:38 AM, the nurse reported there has been a change in RA staffing. The Restorative Nurse stated the RAs are pulled to the hall to work as a nursing assistant. The nurse stated the DON was aware the restorative programs were not getting done. An interview with the DON on 7/26/12 at 2:12 PM revealed the facility was in the process of hiring	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 20 RAs and expected an improvement. The DON stated she expected the restorative programs to be done.	F 318		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	**F-356 Posted Nurse Staffing** 1. No specific residents were cited for this alleged deficient practice. 2. 11-7 supervisor / Team leader will complete and post the daily posted staffing and the Director of Health Services will place in a binder in the Director of Health Services office. 4. The Administrator/Assist Administrator will monitor the staffing binder weekly for six weeks and then monthly for six months to determine that the staffing sheets are being consistently filed and maintained (See attachment I). The Director of Nursing will present trends to the PI Committee for its review. The facility PI meeting is the 2nd Tuesday of each month and includes all administrative staff. The Medical Director attends quarterly	8/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 356	Continued From page 21 by: Based on observations, staff interviews and facility records the facility failed to maintain Nursing Posting Information forms and did not have Nursing Posting form information available for May, June and July of 2012. Findings include: During the initial tour and throughout the survey the Nurse Posting Information form was completed and visible to the public. On 7/26/12 at 9:15 AM the months of May, June and July were requested for observation to ensure sufficient staffing. During an interview with the DON on 7/26/12 at 1:30 PM it was revealed the night shift supervisor completed the Nursing Posting Information forms daily. The DON also indicated they were not available for observation and the facility had not maintained the Nurse Posting Information forms. During an interview on 7/26/12 at 2:20 PM with the NHA and Corporate VP it was revealed the facility had not maintained the Nurse Posting Information forms.	F 356		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced	F 364	**F-364 – Food Temps** 1. Resident #58 is receiving meals at the correct temperature.	9/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 364	Continued From page 22 by: Based upon observations, resident and staff interviews and record reviews the facility failed to maintain warm food temperatures for residents in 1 of 1 dining rooms and resident room meal trays. Findings Include: An initial facility tour was conducted on 7/23/12. A resident on hall 300 at 3:25 PM revealed the meals were always lukewarm upon service. On 7/24/12 a Resident interview on hall 600 at 8:44 am revealed the vegetables were cold for the dinner meal last night. On 7/24/12 a Resident interview on hall 300 at 9:36 am revealed the breakfast meals were always cold. Another Resident interview on hall 300 at 10:34 am revealed the meals were always lukewarm. On 7/24/12 a Resident interview on hall 200 at 11:44 AM revealed the soups were not warm. An interview with Resident # 58 on 7/24/12 at 2:30 pm revealed there were complaints of cold foods. Resident #58 stated she would eat her meals in the dining room because if she ate in her room, she would receive a cold tray. The Resident revealed she didn't always want to eat in the dining room, but she didn't want a cold tray either. The Resident stated staff would heat up her food, but this would take too long. An initial observation of the fine dining area of the main dining was conducted on 7/23/12. At 4:27	F 364	2. For all residents having the potential to be affected by the alleged deficient practice, the following actions have been initiated. 89% of Dietary Staff has been in-serviced by the Registered Dietician on 7-26-2012. We will be at 100% by 9-14-2012. This same education will be provided to all new dietary staff while in orientation. Material presented on the importance of following the many important steps during the process of preparing and serving food in which time and temperature must be controlled(See attachment J). 3. To ensure the alleged deficient Practice does not recur. Food Temperatures are verified by thermometer prior to beginning the service line for each meal. (Hot Foods verified to be 141 degrees or higher) Any items not reaching appropriate Temperature are taken off the line and Reheated to the proper temperature. Test trays will be conducted by Certified Dietary Manager/Designee once weekly for four weeks and re-evaluated (See attachment K). Hot holding equipment, including plate Warmers and steam table will be checked Monthly by CDM/designee to ensure equipment is operating within expected temp ranges. Requests willbe made to maintenance staff as needed to address needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 364	Continued From page 23 pm Residents were observed seated in the fine dining area. All of their food orders had been obtained by a Dietary Aide. The meal service had begun at 5:03 PM by the Dietary Aide. An initial observation of the larger section of the main dining room was conducted on 7/23/12. At 5:24 pm Residents were seated in this dining area. The meal service had begun at 6:06 pm by the Nursing Assistants (NA). A Resident had been waiting for service of soup. The soup was served at 6:25 PM. An initial observation of dinner room trays was conducted on 7/23/12 for hall 400. The dinner meal tray cart arrived on 400 hall at 6:29 pm. The first meal tray was passed at 6:30 PM. The last meal tray was delivered at 6:47 pm. A record review of the facility meal schedule revealed main dining room service for dinner was 4:25 pm to 4:40 pm. The dinner meal times for hall 400 was 5:05 pm to 5:30 pm An interview with the Director of Nursing on 7/23/12 at 6:55 pm revealed it was a long period of time before the meal trays were delivered and they had come late. A record review of the Resident Council minutes revealed the December 2011 meeting indicated several Residents reported their eggs were not hot upon delivery to their rooms. The May 2012 meeting indicated that several Residents that eat in the fine dining section complained after their food orders were taken; it would take a long time before food was served. The resolution was for the Diet Aide to serve the food as soon as the	F 364	Random Audits of C.N.A. response time to tray delivery are conducted by DHS/Nurse Managers/ designee three times per week for four weeks on random rotating halls to ensure entire facility is reviewed for each meal on a weekly basis. (See attachment L). 4. To monitor the process of residents receiving food at the correct temperature, results of audits will be submitted to the Director of Health Services and the Administrator weekly for review. All results will be submitted to the Performance Improvement Commiittee monthly for further action planning as needed. The facility PI meeting is monthly and includes all administrative staff. The Medical Director attends quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 364	Continued From page 24 food was plated instead of waiting for every meal tray to be plated. The June 2012 meeting indicated that the lunch and dinner meals for the main dining room continued to take too long to be served. The follow-up to this concern was that there was only one Diet Aide for dining room service and the Residents were requested to be patient. An observation on 7/26/12 revealed the large section of the main dining room meal tray preparation was completed at 8:11 am. A test tray was prepared for the main dining room. The main dining room meal tray cart was delivered to the main dining room at 8:14 am. There were Residents present in the main dining room at 8:14 am. The NA staff had begun meal tray service at 8:25 am. The last meal tray was served at 8:42 am. The meal test tray had begun at 8:43 am with the Dietary Manager (DM). There were scrambled eggs, bacon, a doughnut, grits, orange juice and coffee on the meal tray. The eggs, bacon and grits were cold. The grits had a gelatinous form to it. The DM indicated the grits could have been creamier. An interview with the DM on 7/26/12 at 8:59 am revealed cold foods have been an ongoing issue. She has conducted in-servicing to staff related to meal tray set-up and delivering meal trays. In the last month, there have been at least 15 grievances related to cold foods. Also a survey that was sent out to Residents and the families of Residents indicated there were issues with cold foods. When there were multiple concerns that come up about cold foods, she would conduct a meal test tray. The food temperatures for the meal test trays indicated they would have a	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 364	Continued From page 25 decrease in their temperature. After dietary prepared the meal trays and delivered to the floors, the room trays sit in the dining room and on the hallway floors for 25 to 30 minutes without being delivered. It does take dining longer for tray set-up due to the change in job duties with dining. She has a Performance Improvement Plan (PIP) for food temperatures. A record review of the grievance logs from April 2012 to July 2012 was conducted. A grievance dated 6/18/12 revealed the food was always cold. The resolution was for dining to check the meal tray temperatures. A grievance dated 7/2/12 revealed the food was consistently cold. Another grievance dated 7/2/12 revealed the food was good but the temperature of the food was not at the correct temperature. A grievance dated 7/6/12 revealed the main dining room food was sometimes cold. The breakfast meal was the meal that was usually cold. A grievance dated 7/9/12 revealed the food remained cold in the main dining room. A grievance dated 7/16/12 revealed the food was sometimes cold. A record review of dining in-services revealed there were in-services conducted on 3/27/12, 7/9/12, 10/7/11 and 12/8/11. The in-services indicated to keep the meal tray cart doors closed during tray service and to delivery the trays upon arrival to the unit to maintain the food temperatures. A record review of a facility PIP for improving meal temperatures on the hallways indicated an issue date of February 2012. The opportunities to correct were the decrease of satisfaction with food temperatures from residents, the residents	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 364	Continued From page 26 complaints of the food being cold, food temperatures should be taken daily for each meal by the cooks, keep the food cart doors closed during meal tray delivery and meal trays not being delivered timely. There were goals and approaches indicated. The PIP opportunities for concern remained in July 2012 PIP. An interview with the Staff Development Coordinator on 7/26/12 at 10:27 AM revealed there was always a Nurse in the main dining room. Sometimes ancillary staff assisted in the main dining room, so it should not take longer than 15 minutes to pass out the trays. There was usually one NA left on the hall for tray delivery. The NA on the halls was assisted by ancillary staff and a Nurse on the hallways as needed. She would expect the meal trays to be delivered between 15-30 minutes on the hallways. The staff would reheat the food for residents, but she would not foresee this as a standard for correction of cold meal trays and could see how residents would not like requesting on a regular basis to have their food reheated. An interview with the Director of Nursing on 7/26/12 at 1:54 PM revealed she would not expect to have cold foods served to residents.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F-371 – Sanitary Conditions** 1. No specific residents were cited in this alleged deficient practice. 2. For those residents having the potential to be affected by this alleged deficient practice, the following actions have been taken. 100% of Dietary staff was in-serviced by the Registered Dietitian /designee by 08/23/12 regarding maintaining the kitchen in a sanitary condition and cleaning schedule. New hires will receive same education as part of their orientation. (See attachment M).	8/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 371	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to do the following: 1. Maintain a clean fryer for food preparation, 2. Label and date opened food items and 3. store canned food items without damage. Findings Include: 1. An initial kitchen tour on 7/23/12 with the Dietary Manager (DM) at 10:49 AM revealed a thick yellow substance build-up on both sides of the fryer. There was a dark substance that hung from the bottom edges of the fryer. Some of the yellow substance was able to be scraped off by hand. An interview with the DM on 7/23/12 at 10:49 AM revealed the health department was at the facility two weeks ago and noticed the fryer. She was in the process of getting the equipment to scrap off the fryer. An observation on 7/25/12 at 11:07 AM revealed there was a thick yellow substance build-up on the both sides of the fryer. There was a dark substance that hung from the bottom edges of the fryer. An interview with the DM on 7/25/12 at 11:07 AM revealed that the Kitchen Supervisor who was currently out of work at this time, tried to clean the fryer about one month ago with the degreaser	F 371	3.Cleaning schedules have been posted for all kitchen appliances (See attachment N) The Certified Dietary Manger is ensuring adherence to the schedule by conducting kitchen sanitation checklist weekly for four weeks and then r e-evaluate frequency (see attachment O). The kitchen sanitation checklist will include, among other items, noting any dented cans, unlabeled food items and cleanliness of all kitchen equipment. Dietary staff is now noting a delivery date and a date opened on food items. 4. To monitor performance, kitchen sanitation will be discussed at monthly Performance Improvement Meetings and additional action items implemented as necessary. The facility PI meeting is monthly and includes all administrative staff. The Medical Director attends quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 371	Continued From page 28 but it did not work. The facility would need a stronger degreaser. She has ordered the new degreaser yesterday. She had talked with the Maintenance person for a scrapper to scrape off the yellow substance build-up. An interview with the DM on 7/26/12 at 1:05 pm revealed she would not expect the fryer to be in that condition. She had requested for a special degreaser from supply. The degreaser was ordered but had sat in supply for a couple of days. She should have checked with supply. An interview with the Central Supply Clerk on 7/26/12 at 2:54 pm revealed the company had sent out an email to him about two to three weeks ago regarding the switch to a new degreaser. It was indicated that this degreaser worked better. He had ordered the new greaser. It had been delivered to the facility last week. 2. An initial kitchen tour on 7/23/12 with the DM at 10:56 am revealed there were three bags of opened bran cereal, two bags of opened oat cereal, one bag of opened corn flake cereal and one opened bag of rice cereal on the dry storage room shelf. There was no label and dating for these cereal items. At 11:00 AM, there was an opened block of butter on the shelf in the walk-in refrigerator. The butter did not have a label and date. At 11:02 AM there was a bag of prepared corn in the walk-in freezer. The corn did not have a label and date. An interview with the DM on 7/23/12 at 11:02 AM revealed the corn was cooked by the dining staff and was flash frozen.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 371	Continued From page 29 An interview with the DM on 7/26/12 at 1:05 PM revealed she had in-serviced dining staff about label and dating opened food items after the initial kitchen tour. She said she would want her staff to label and date opened food items. 3. An initial kitchen tour on 7/23/12 at 10:58 am with the Dietary Manager (DM) revealed there was a #10 can size of peach halves and mandarin oranges with dents. These #10 food cans were stored on the canned food rack in the dry storage room. An interview with the DM on 7/26/12 at 1:05 pm revealed that dining staff were in-service by her after the initial kitchen tour for the dented #10 size food cans. They were provided with information on how to mark the #10 size food cans to prevent the use of dented food can items.	F 371		
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.	F 441	**F-441-Infection Control** 1. Nurses are still utilizing the single-use declogger for Resident # 73's feeding tube but nurses have been educated by the Clinical Competency Coordinator and are only using once and discarding according to manufacturer instructions. (See attachment P).	9/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 30 (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 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to discard single use equipment for 1 (Resident #73) of 2 gastrostomy feeding tube residents observed. Observation in Resident #73 in room 104B on 07/23/12 at 11:15 AM, revealed a piece of equipment known as an enteral feeding tube declogger on the over bed table. The paper backing was separated from the plastic sleeve at one end and yellow debris was observed in the plastic sleeve, indicating it had been used to unclog the gastrostomy tube. Imprinted on the paper backing " The Declogger	F 441	2. For those residents having the potential to be affected by the same alleged deficient practice, nurses have been in serviced by the Clinical Competency Coordinator with 84% attendance as of 8-23-12. We will have 100% training of all licensed nursing staff by 9-14-2012. All new licensed nursing staff will receive Same education as part of new orientation. (See Attachment P). 3. Measures put in place to prevent recurrence of the alleged deficient practice include decloggers being kept secured in Central Supply and not readily available for staff without requesting the piece of equipment. This practice allows Director of Health of Health Services or her designee to be aware when a declogger will be in use to ensure it is disposed of correctly. 4. Monitoring of use of any declogger is Conducted by Nursing Managers five Times a week for two weeks then weekly for four weeks, then monthly for three months, then quarterly for two quarters (See attachment Q). Any negative trends discovered during Audits will be discussed and action planned During monthly Performance Improvement meetings. The facility PI meeting is monthly and includes all administrative staff. The Medical Director attends quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 31 is intended for single use only, " meaning it was to be discarded after one use. Observations were continued on 7/24/12 at 9:15 AM and 4:20 PM, and revealed the declogger remained in the plastic sleeve, the top was opened and the plastic sleeve contained yellow debris. Observation of the declogger on 07/25/12 at 3:15 PM revealed the opened plastic sleeve with yellow debris remained on the over bed table. The unit manager was taken to the room on 7/26/12 at 3:30 PM to conduct an observation. She stated she was unaware that a declogger had been used and had been laying on the over bed table for three days instead of being discarded. In an interview with the nurse working the hall on 07/26/12 at 4 PM, he stated he had not seen the declogger as he made rounds and passed medications. In an interview with the Director of Nursing (DON) on 07/26/12 at 4:30 PM, the DON stated that her expectation was that staff would discard equipment after use and that she would collect all the decloggers in central supply and keep them to her office.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING 01 - MAIN BUILDING B. WING	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V protected construction, and is utilizing North Carolina Special Locking arrangements. The facility is equipped with an automatic sprinkler system.	K 000		
K 029 SS=E	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/23/2012 the following item was observed as noncompliant, specific findings include: The facility had a buildup of dust and lint in the combustion chamber of the gas fired dryers in the laundry.	K 029	K029 Dryer units in combustion chamber area were cleaned immediately. All dryers were checked to ensure no other life safety issues can arise from this same practice. Changed our existing PI log to to 1 X per week cleaning instead of the monthly cleaning that had been our policy. PI log showing cleaning activity for combustion area of dryers will be presented at PI meetings and presented along with any comments to verify if actions are sufficient to maintain a dust free combustion area for the dryers.	8/23/12 9/4/12
K 038 SS=E	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/7/12

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING 01 - MAIN BUILDING B. WING	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/23/2012 the following item was observed as noncompliant, specific findings include: The required short exit leading from the nurses station on the 400 hallway is utilizing North Carolina Special Locking arrangements. This exit does not have a simple on off switch as the other doors in the facility. This required exit egress door has a key operate switch. All staff do not have this key to operate the exit egress door in an emergency event other than fire. CFR#: 42 CFR 483.70 (a)	K 038	K038 Vendor was contacted same day to change the existing deactivation switch for the Mag Lock door on 400 hall from a keyed switch to a simple on off toggle switch.. All other doors in facility were checked at the time of the Life Safety Survey to ensure they had simple toggle on off switches. No other doors were found to have a keyed switch. The deficient practice should not occur again unless physical additions are made to building adding additional exit doors. No need to monitor for a practice that will not occur again.	8/23/12 8/29/12
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/23/2012 the following item was observed as noncompliant, specific findings include: The facility had not conducted a smoke sensitivity test in the past two years as required. CFR#: 42 CFR 483.70 (a)	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING 01 - MAIN BUILDING B. WING _____	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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
			K052 Vendor was contacted same day of survey and notified to come on site and complete smoke detector sensitivity testing. Vendor arrived and completed testing of smoke detector. Vendor then replaced all detectors that did not meet manufacturer specifications for sensitivity testing. There is no potential for this practice to affect other residents. Vendor was informed to place us on Schedule of Bi Annual sensitivity testing of smoke detectors. Dir of Maintenance will ensure BI Annual testing of smoke detectors occurs and results reported to PI committee as sensitivity testing occurs.	8/23/12 8/29/12 8/31/12