JAN 2 8 2014

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

PRINTED: 01/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This complaint investigation survey was conducted by the Division of Health Service Regulation, Nursing Home Licensure and Certification Section on 12/18/13. However, staff interviews were conducted on 01/08/14 to obtain additional information. Therefore, the exit date was changed to 01/08/14.	F 000	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law . It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F 157** **Immediate Corrective Action** Resident #1 is no longer in the facility. **Identification of others with potential to be affected** 100% audits for all current resident's laboratory tests	1/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jacqueline M Quinmore RN LNHA 1-27-14

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
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews with staff, infectious disease nurse, the physician, and laboratory personnel, and record review, the facility failed to notify the attending physician and the infectious disease physician group of elevated kidney function blood tests and elevated antibiotic blood levels while a resident was on intravenous (IV) Vancomycin resulting in the facility giving the medication even while the resident exhibited signs of nephrotoxicity (damage to the kidney) and acute renal failure and resulting in hospitalization of 1 of 3 residents that needed medication monitoring (Resident #1). Findings included: Resident #1 had a hospital stay from 11/22/13 until 12/3/13. Review of the hospital record titled "Interim Summary" of 12/03/13 revealed the resident received IV Vancomycin at the hospital to treat methicillin resistant staphylococcus aureus (MRSA) infection. Review of the Discharge/Transfer Summary signed by the physician on 12/3/13 revealed the resident did have acute renal failure associated with Vancomycin dosing. The resident would need to have continued followup for her creatinine with weekly labs. Resident #1 was admitted from the hospital to the facility on 12/3/13 at 6:26 PM. Her cumulative diagnoses from the hospital included multiple compression fractures, chronic pain, spinal stenosis and a complex fluid collection from a	F 157	***Continue from page 1*** obtained since 12/05/2013 to current will be completed by 01/22/14 by the Director of Health Services, Senior Care Partner, Unit managers, and/or The Unit Coordinator. This audit will comprise, date lab(s) ordered, and completed, date reported to physician, whether there is an order to report results to any other outside physician and if so then this audit will identify the date faxed to that outside specialist. **Systemic Changes/Measures** Director of Health Services, Unit managers and nurse supervisor Initiated in-service education session with licensed nurses on all shifts to stress the importance of ensuring ordered labs are followed through daily and notification are done appropriately and timely	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 possible paraspinal abscess whose culture was positive for MRSA. Review of the facility's Physician Orders dated 12/3/13 revealed an order for "Vancomycin (name of the infectious disease physician group) to dose. (Vancomycin) trough weekly on Wednesdays. Send the results to (name of the infectious disease physician group)." A lab report of 12/5/13 was faxed to the facility on 12/05/13 and included a creatinine of 1.23 and a Vancomycin trough of 24.7. A nurse's note of 12/5/13 on the lab results revealed that the nurse spoke with PA (physician's assistant) from the attending physician's group. New orders were issued to recheck BMP (basic metabolic panel) on 12/09/13 (Monday) and fax to the facility pharmacy. There was no documentation in the resident's record to indicate that the lab results of 12/5/13 were sent to the infectious disease physician group. Review of the facility's "Physician Interim Orders" of 12/6/13 revealed orders to do Vancomycin trough 30 minutes prior to dose administration twice a week on Monday and Thursday, to fax all lab results to the infectious disease physician group within 24 hours and not to change the Vancomycin dose without consulting with the group. A lab report of 12/9/13 was faxed to the facility on 12/09/13 and included a creatinine of 4.20 (high) and a Vancomycin trough of 67.3 (high). There was a statement at the top of the lab report that	F 157	***Continue from previous page*** All licensed nurses will be educated by 01/30/2014. Any licensed nurse not educated by 01/30/2014, will not be allowed to work until educated on the new process. Lab protocol in-services will be added on orientation process for our new clinical staff moving forward. Unit managers will monitor lab completion, notification to physician notification to RP and ensure ordered lab results are filled in resident's clinical records daily M-F, week end supervisor and/or week end clinical manager on duty will monitor on Saturdays and Sunday. DHS/ADHS Nurse supervisor will monitor compliance weekly x 3 moths then monthly afterwards DHS revised the "daily laboratory draw sheet" to include the column for MD/RP notification and weekly lab committee column.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 read "results reported to (name), (facility) receptionist on 12/9/13 at 3:49 PM, Vanct (Vancomycin trough) =67.3 H (high)." Review of the resident's Medication Record revealed the resident received 1500 mg of Vancomycin on 12/9/13, 12/10/13, 12/11/13 and 12/12/13. There was no documentation in the records to show the attending physician or the infectious disease physician group was notified of the elevated laboratory results. An interview with a representative from the lab company on 12/23/13 at 12:30 PM, revealed that the report should not have been given to the receptionist. This was not a standard operating procedure; it should have been given to a nurse. There was no documentation either in the nurse's notes or on the lab report that the results were reported to the infectious disease physician group or to the attending physician. Another lab test was done on 12/12/13 drawn at 5:30 AM. A nurse's note indicated that on 12/12/13 at 4:26 PM the facility received a phone call from the lab for critical Vancomycin trough of 79.6 and creatinine of 4.5. Results were called to the infusion nurse at the infectious disease physician group. The infusion nurse requested and was provided the previous 12/9/13 lab results. A nurse's note of 12/12/13 at 5:49 PM indicated the facility received a call from the infusion nurse at the infectious disease physician group who stated that she spoke with the doctor and he ordered the resident to be sent to the hospital emergency room. A nurse's note dated 12/12/13 at 7:43 PM revealed the resident left the facility on a stretcher via ambulance.	F 157	*Continue from previous page* **Monitoring Process** Unit managers will monitor lab completion, notification to physician notification to RP and ensure ordered lab results are filled in resident's clinical records daily M-F, week end supervisor and/or week end clinical manager on duty will monitor on Saturdays and Sunday. DHS/ADHS Nurse supervisor will monitor compliance weekly x 3 moths then monthly afterwards, unless recommended otherwise by Quality assurance performance improvement committee. Additional action planning will be implemented by the QAPI committee as necessary. **SPACE LEFT BLANK INTENTIANALLY**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 Review of the hospital records revealed the laboratory results from the emergency department on 12/12/13 at 11 PM indicated the resident's creatinine was 4.55 and Vancomycin trough level was at 56.7. The hospital records indicated that the resident received IV fluids. The resident returned to the facility on 12/13/13 at 5:30 AM. Review of the facility nurse's note dated 12/13/13 at 5:30 AM revealed the resident returned to the facility with no new orders and to continue on Vancomycin IV. Review of the nurse's note dated 12/13/13 at 4:20 PM indicated that a Vancomycin trough was done. The laboratory company called and said that it was more than 80 and that the laboratory company will call back and confirm. A physician order was written on 12/13/13 to send the resident to the hospital emergency department for critical Vancomycin level. The hospital records of 12/13/13 revealed, under "Medical decision Making", the resident had acute renal failure that was continually worsening. The Etiology was likely secondary to Vancomycin. The creatinine was 4.6. The hospital history and physical of 12/13/13 revealed the resident had a Vancomycin trough of 74. The resident was given IV fluids and electrolytes. The resident was returned to the facility on 12/20/13. In an interview with the infusion nurse at the	F 157	PAGE LEFT BLANK INTENTIANALLY	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5 infectious disease physician group, on 12/20/13 at 3 PM, she stated that the doctors at their group preferred to do their own dosing and that was why the discharge document stated to fax the results of labs to the group within 24 hours. She stated when she did not hear from the facility on 12/6/13 about the lab test that should have been done on 12/05/13 (Thursday); she called the facility to clarify the group's expectations. During an interview on 01/08/13 at 12:30 PM, the Director of Nursing (DON) stated the infusion nurse from the infectious disease physician group notified him on 12/12/13 that the laboratory results of Vancomycin trough and creatinine were not reported to the infectious disease physician group on 12/09/13. The DON stated he started an investigation. The DON revealed the receptionist denied receiving any laboratory results on 12/09/13. The DON then called the facility laboratory company and they stated the information about leaving it with the receptionist was printed on the lab reports of 12/09/13. The DON stated that the laboratory results should only be given to nursing staff. This has been entered into the lab's record system. He stated he could not prove either story. He was unsure where the laboratory results had been stored from 12/09/13 to 12/12/13. But when the laboratory results of 12/12/13 came in, a nurse was notified and she did contact the infectious disease physician group. When the infusion nurse asked on 12/12/13 for the previous lab values of 12/9/13, the facility nurse was able to find them on the chart and convey them to the infusion nurse. The DON stated that the nurse that did not send the 12/09/13 reports to the infectious disease physician group was no longer employed at the facility. Interview with this staff member was not	F 157	PAGE LEFT BLANK INTENTIANALLY	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 6 possible. The DON felt the nurse did not follow the physician order of 12/06/13 to fax all lab results to the infection disease physician group. As a result, the resident continued to receive 1500mg of Vancomycin a day. An interview with the attending physician on 12/20/13 at 10:30 AM revealed she received a call from infectious disease physician group, saying that they were to dose the Vancomycin and a clarification telephone order was written on 12/06/13 to shift in responsibility of Vancomycin dosing to the infectious disease physician group.	F 157	**SPACE LEFT BLANK INTENTIANALLY**	
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F 329** **Corrective Action** Resident #1 is no longer in the facility. **Identification of others with potential to be affected** 100% Audit will be completed by Director of Health Services, Unit managers and Unit coordinators for all residents with intravenous Vancomycin order(s) to ensure no other residents had received intravenous Vancomycin dose while the trough level is elevated and/or without physician approval. This audit will be completed on or before 1/22/2014	1/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interviews with staff, infectious disease nurse, the physician, and laboratory personnel, and record review, the facility failed to monitor kidney function and antibiotic blood levels while a resident was on intravenous (IV) Vancomycin resulting in the facility giving the medication even while the resident exhibited signs of nephrotoxicity (damage to the kidney) and acute renal failure and resulting in hospitalization of 1 of 3 residents that needed medication monitoring (Resident #1). Findings included: Lexi-Comp Geriatric Dosage Handbook, 17th edition revealed that Vancomycin's monograph designated this medication as a "High Alert Medication: The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drug classes which have heightened risk of causing significant patient harm when used in error." Monitoring of Vancomycin was described as "initial intravenous dosing should be based on actual body weight; subsequent dosing adjusted based on serum trough (lowest level before next dose) of Vancomycin." Lexi-Comp monograph for Vancomycin revealed that it may cause nephrotoxicity, if serum creatinine concentrations demonstrate increase of 50% from baseline in 2 or more sequential lab tests. The patient should be identified as having Vancomycin induced nephrotoxicity.	F 329	*Continue from previous page* **Systemic Changes/Measures** Moving forward residents with a physician orders for intravenous Vancomycin will be tracked on a "Intravenous Vancomycin log" to ensure that resident's Vancomycin dose is administered appropriately and not unnecessarily. Director of Health Services and unit managers will educate licensed nurses on the necessities of ensuring Intravenous Vancomycin is not administered before identifying resident's blood level (specifically trough level) All licensed nurses will be educated by 01/30/2014. Any licensed nurse not educated by 01/30/2014, will not be allowed to work until educated on the process to be followed for resident with Intravenous Vancomycin orders. Intravenous Vancomycin log utilization education will be added on orientation process for our new clinical staff moving forward	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	6935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 8 Resident #1 had a hospital stay from 11/22/13 until 12/3/13. Review of the hospital record titled "Interim Summary" of 12/03/13 revealed the resident received IV Vancomycin at the hospital to treat methicillin resistant staphylococcus aureus (MRSA) infection. The resident had a Vancomycin Trough (blood Vancomycin levels within 30 minutes of the next scheduled dose) of 16.9 {target level of 10-20 ug (micrograms/ ml)} and creatinine (a laboratory test used to check kidney function) level of 1.27 (Normal Range for a creatinine test would be 0.5-1.0 mg/deciliter) on 12/2/13. Review of the Discharge/Transfer Summary signed by the physician on 12/3/13 revealed the resident did have acute renal failure associated with Vancomycin dosing. The resident did improve after IV hydration and that she would need to have continued followup for her creatinine with weekly labs. Resident #1 was admitted from the hospital to the facility on 12/3/13 at 6:26 PM. Her cumulative diagnoses from the hospital included multiple compression fractures, chronic pain, spinal stenosis and a complex fluid collection from a possible paraspinal abscess whose culture was positive for MRSA. The resident arrived at the facility with hospital discharge orders of 12/3/13 for "Vancomycin 1500 mg (milligrams) to be infused intravenously daily for 4 weeks. Check Vancomycin trough levels, complete blood count (CBC), basic metabolic chemistry (BMP) once a week- goal is [(creatinine) level of 10-20 ug (micrograms/ ml)]." A BMP is necessary to obtain a value for creatinine. Review of the facility's Physician Orders dated	F 329	***Continue from previous page*** Likewise Director of health Services and Unit managers will educate both Licensed nurses and Certified nursing assistants on identification of early signs of toxicity All licensed nurses and Certified nursing assistants will be educated by 01/30/2014. Any licensed nurse or Certified nursing assistants not educated by 01/30/2014, will not be allowed to work until educated on the identification of early signs of toxicity Education on identification of early signs of toxicity will be added on orientation process for our new nursing staff moving forward **Monitoring Process** Unit managers will monitor Intravenous Vancomycin log daily M-F, week end supervisor and/or week end clinical manager on duty will monitor on Saturdays and Sunday.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 9 12/3/13 revealed an order for "Vancomycin (name of the infectious disease physician group) to dose. (Vancomycin) trough weekly on Wednesdays. Send the results to (name of the infectious disease physician group)." Record review of the attending physician's progress note dated 12/4/13 at 10:27 AM revealed, under assessment and plan: "MRSA bacteremia [blood infection] Patient currently on Vanco(mycin) for 4 weeks; (facility) pharmacy to dose. Vanco; f/u (follow- up) with (the infectious disease physician group) in 4 weeks." A lab report of 12/5/13 was faxed to the facility on 12/05/13 and included a creatinine of 1.23 and a Vancomycin trough of 24.7. A nurse's note of 12/5/13 on the lab results revealed that the nurse spoke with PA (physician's assistant) from the attending physician's group. New orders were issued to recheck BMP (basic metabolic panel) on 12/09/13 (Monday) and fax to the facility pharmacy. There was no documentation in the resident's record to indicate that the lab results of 12/5/13 were sent to the infectious disease physician group. Review of the facility's "Physician Interim Orders" of 12/6/13 revealed orders to do Vancomycin trough 30 minutes prior to dose administration twice a week on Monday and Thursday, to fax all lab results to the infectious disease physician group within 24 hours and not to change the Vancomycin dose without consulting with the group.	F 329	*Continue from previous page* DHS and/or Nurse supervisor will monitor compliance weekly x 3 moths then monthly afterwards, unless recommended otherwise by Quality assurance performance improvement committee. Additional action planning will be implemented by the QAPI committee as necessary. **SPACE LEFT BLANK INTENTIANALLY**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10 A lab report of 12/09/13 was faxed to the facility on 12/09/13 and included a creatinine of 4.20 (high) and a Vancomycin trough of 67.3 (high). There was a statement at the top of the lab report that read "results reported to (name), (facility) receptionist on 12/9/13 at 3:49 PM, Vanct (Vancomycin trough) =67.3 H (high)." Review of the resident's Medication Record revealed the resident received 1500 mg of Vancomycin on 12/9/13, 12/10/13, 12/11/13 and 12/12/13. An interview with a representative from the lab company on 12/23/13 at 12:30 PM, revealed that the report should not have been given to the receptionist. This was not a standard operating procedure; it should have been given to a nurse. There was no documentation either in the nurse's notes or on the lab report that the results were reported to the infectious disease physician group or to the attending physician. Another lab test was done on 12/12/13 drawn at 5:30 AM. A nurse's note indicated that on 12/12/13 at 4:26 PM the facility received a phone call from the lab for critical Vancomycin trough of 79.6 and creatinine of 4.5. Results were called to the infusion nurse at the infectious disease physician group. The infusion nurse requested and was provided the previous 12/9/13 lab results. A nurse's note of 12/12/13 at 5:49 PM indicated the facility received a call from the infusion nurse at the infectious disease physician group who stated that she spoke with the doctor and he ordered the resident to be sent to the hospital emergency room. A nurse's note dated 12/12/13 at 7:43 PM revealed the resident left the facility on a stretcher via ambulance.	F 329	PAGE LEFT BLANK INTENTIANALLY	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 11 Review of the hospital records revealed the laboratory results from the emergency department on 12/12/13 at 11 PM indicated the resident's creatinine was 4.55 and Vancomycin trough level was at 56.7. The hospital records indicated that the resident received IV fluids. The resident returned to the facility on 12/13/13 at 5:30 AM. Review of the facility nurse's note dated 12/13/13 at 5:30 AM revealed the resident returned to the facility with no new orders and to continue on Vancomycin IV. Review of the nurse's note dated 12/13/13 at 4:20 PM indicated that a Vancomycin trough was done. The laboratory company called and said that it was more than 80 and that the laboratory company will call back and confirm. Review of the nurse's note dated 12/13/13 at 6:02 PM revealed the resident was sent to the hospital for critical Vancomycin level. A physician order was written on 12/13/13 to send the resident to the hospital emergency department for critical Vancomycin level. The hospital records of 12/13/13 revealed, under "Medical decision Making", the resident had acute renal failure that was continually worsening. The Etiology was likely secondary to Vancomycin. The creatinine was 4.6. The hospital history and physical of 12/13/13 revealed the resident had a Vancomycin trough of 74. The resident was given IV fluids and	F 329	PAGE LEFT BLANK INTENTIANALLY	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	6935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 electrolytes. The resident was returned to the facility on 12/20/13. In an interview with the infusion nurse at the infectious disease physician group, on 12/20/13 at 3 PM, she stated that the doctors at their group preferred to do their own dosing and that was why the discharge document stated to fax the results of labs to the group within 24 hours. She stated when she did not hear from the facility on 12/6/13 about the lab test that should have been done on 12/05/13 (Thursday); she called the facility to clarify the group's expectations. During an interview on 01/08/13 at 12:30 PM, the Director of Nursing (DON) stated the infusion nurse from the infectious disease physician group notified him on 12/12/13 that the laboratory results of Vancomycin trough and creatinine were not reported to the infectious disease physician group on 12/09/13. The DON stated he started an investigation. The DON revealed the receptionist denied receiving any laboratory results on 12/09/13. The DON then called the facility laboratory company and they stated the information about leaving it with the receptionist was printed on the lab reports of 12/09/13. The DON stated that the laboratory results should only be given to nursing staff. This has been entered into the lab's record system. He stated he could not prove either story. He was unsure where the laboratory results had been stored from 12/09/13 to 12/12/13. But when the laboratory results of 12/12/13 came in, a nurse was notified and she did contact the infectious disease physician group. When the infusion nurse asked on 12/12/13 for the previous lab values of 12/09/13, the facility nurse was able to find them on the chart and convey them to the infusion nurse. The	F 329	PAGE LEFT BLANK INTENTIANALLY	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 DON stated that the nurse that did not send the 12/09/13 reports to the infectious disease physician group was no longer employed at the facility. Interview with this staff member was not possible. The DON felt the nurse did not follow the physician order of 12/06/13 to fax all lab results to the infection disease physician group. As a result, the resident continued to receive 1500mg of Vancomycin a day. An interview with the attending physician on 12/20/13 at 10:30 AM revealed she received a call from infectious disease physician group, saying that they were to dose the Vancomycin and a clarification telephone order was written on 12/06/13 to shift in responsibility of Vancomycin dosing to the infectious disease physician group.	F 329	PAGE LEFT BLANK INTENTIANALLY	