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

DEC 2 8 2011

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 ______	C 11/30/2011

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

DEC 2 8 2011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based upon observations, staff and family interviews and record reviews the facility failed to properly apply a belted pommel cushion for 1 of 1 sampled Resident (Resident #3) at risk for falls. Findings Include: Resident #3 was admitted to the facility on 1/15/09 with diagnoses of anemia, hypertension, asthma, urinary tract infections and muscle weakness. The Minimum Data Set (MDS) dated 10/20/11 indicated Resident #3 cognition was severely impaired and required total assistance with activities of daily living. The MDS also indicated the mobile device used was a wheelchair and that a fall had occurred since admission or on a prior admission. The care plan indicated Resident #3 to be a fall risk. A record review of the facility fall risk assessments dated 8/8/11 and 11/8/11 indicated Resident #3 was at high risk for falls. A record review of the facility incident log report dated August 2011 to November 2011 revealed	F 323	This Plan of correction is respectfully Submitted as evidence of our allegation of compliance. This plan of correction is not an admission that the deficiency actually existed or that we are in agreement with the deficiencies cited. It is however our expression of a desire To comply and correct any deficiency cited. **Corrective Action Affected Resident:** Resident #3 Resident #3 was assessed by Therapy. The Pommel cushion was discontinued. Physical therapy was started to ensure proper Positioning and comfort. **Corrective Action for Those with Potential to be affected:** A resident audit was completed to ensure that all cushions currently being used are applied correctly. This audit revealed no negative findings. Staff have been in-serviced about the Proper use of pulla cushion by the Clinical Competency Coordinator.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Thompson RN ADS for Darry Taylor | TITLE: Administrator | (X6) DATE: 12-23-11

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

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

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 ______	C 11/30/2011

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 323	Continued From page 1 the resident experienced a fall on 11/8/11. A record review of the facility incident report dated 11/8/11 indicated Resident #3 appeared to have scooted out of her wheelchair and was found laying on the floor on her right side. There was bruising found to her right hip. An interview and observation on 11/30/11 at 10:55am with Resident ' s #3 Family Private Sitter revealed Resident #3 wearing a black belt around her waist with an attachment in front to hold the belt together. The Private Sitter indicated she wears this belt daily. An interview on 11/30/11 at 11:02am with Nursing Assistant (NA) #1 revealed Resident #3 wore a belt around her waist due to she wiggled a lot. Resident #3 has attempted to get up by herself and when lying in bed, slides down to the foot of the bed. Resident #3 was unable to remove the belt herself due to contractures of the hands. An observation on 11/30/11 at 1:57pm occurred for Resident #3. Resident #3 had contractures of the hands. A black belt was attached around her waist with the belt buckle located in the front. Resident #3 was asked to remove the belt upon command. Resident #3 responded " yes " and " no " . She did not reach for or unfasten the belt. An interview on 11/30/11 at 2:36pm with a prior Falls Prevention Nurse #1 revealed falls were discussed weekly. She indicated Resident #3 did not have a self release belt. She indicated it would be a problem having on a self release belt, if a resident was unable to remove it themselves.	F 323	**Systematic Changes to prevent Deficient Practice:** Staff have been educated on how to properly Use of a pommel cushion: straps on a pommel Cushion should never be used to strap on Residents. Cushion straps are to be strapped Properly on wheelchairs to keep cushion in place. Staff also instructed to review residents Care cards before attacking or assisting Residents with positioning device. Staff must verify with nurse prior to Applying a seatbelt. Nursing staff will refer to therapy prior to Initiating a seat belt to ensure all other interventions have been used. **How will Corrective Action be monitored?** An audit was developed by The DHS. The DHS Or designee will audit cushions and application Correctly weekly times four weeks, the monthly times three months. All audit outcomes will be discussed at Monthly performance improvement Meeting for four months and further Action will be carried out as indicated. **Completion Date for Corrective Action Will be 12-23-11.**	12/23/11

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 ______	C 11/30/2011

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 323	Continued From page 2 She indicated there must be a mix up with a different wheelchair, when they were cleaned. She indicated she would follow-up on this. An interview and observation on 11/30/11 at 2:56pm with a Physical Therapist (PT) and Nurse #1 revealed that it was a pommel cushion with a belt attachment instead of a self release belt on Resident #3 wheelchair. The PT indicated the belt attachment should be connected to the back of the wheelchair instead of the Resident. Nurse #1 indicated NA #1 needed education on proper fastening of the pommel cushion. The PT indicated the wheelchair cushion was there to prevent Resident #3 from sliding out. An interview on 11/30/11 at 3:27pm with NA #2 revealed she has seen wheelchair cushions before but is unaware of the pommel cushions with belt attachments. An interview on 11/30/11 at 3:35pm with NA#3 revealed pommel cushions with belts are attached to the wheelchair for safety and comfort. The pommel cushion belt attachment should not be attached to the resident ' s waist. An interview on 11/30/11 at 4:01pm with the Staff Development Coordinator revealed she had in-serviced staff on restraints. If belts are not indicated on the care guides and care plan, staff should not use belts on residents. A record review of the facility care guides for Resident #3 did not indicate a wheelchair cushion with a belt attachment to be used. An interview on 11/30/11 at 4:16pm with the	F 323		

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 ______	C 11/30/2011

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 323	Continued From page 3 Director of Nursing (DON) revealed a lot of staff was new and there were few residents with a pommel cushion with a belt attachment. She has not had an opportunity at this time to educate staff on proper attachment and information regarding a pommel cushion with a belt attachment. The DON acknowledged that shift nurses should have noticed the belt fastened and that there was nothing on the care plan about a use of a belt. The pommel cushion should have been fastened to the back of the wheelchair. Resident #3 was placed at risk due to improper pommel cushion attachment.	F 323		