DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES LATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C FEB 0 8 2012 B. WING 345551 01/07/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5935 MOUNT SINAI ROAD UNIHEALTH POST-ACUTE CARE - CAROLINA POINT** DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) This plan of correction constitutes F 226 483.13(c) DEVELOP/IMPLMENT F 226 ABUSE/NEGLECT, ETC POLICIES a written allegation of compliance. SS=E Preparation and submission of this plan The facility must develop and implement written of correction does not constitute an policies and procedures that prohibit admission or agreement by the provider mistreatment, neglect, and abuse of residents of the truth of the facts alleged or the and misappropriation of resident property. correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and This REQUIREMENT is not met as evidenced submitted solely because of 2/1/12 by: requirements under state and federal Based on record review and staff interviews, the facility failed to screen new employees before law. offering employment by not verifying licenses for F 226 -4of 6 nurses (Nurses #1, #3, #4 & #5) and not Immediate action taken: conducting criminal background checks for 2 of 5 1. All Certified Nursing Assistant (NA#5 & NA#6) new employees. and Licensed Nurses licenses where verified as current and The findings include: criminal background screens where checked to ensure for On 1/5/2012 the facility's Abuse Policy dated completion. December 2001, with a revision date of July, 2. Employees found to have an 2009 was reviewed. Under the section Screening inactive license and or missing and Hiring, it read "The screening of all background screening have applicants will involve the following been removed from the schedule pre-employment screenings, and as outlined in until verification has been the Human Resources policies: Criminal records received as completed. check and licensure/certification verification." Action taken for others with potential 1. On 1/7/2012 a record review was conducted to to be affected: 1. All employees background verify licenses of nurses on staff. It revealed that Nurse #1 was hired on 8/22/2011 as a Registered screening has been verified as Nurse. Her license was verified on 8/23/2011. On complete. 2. All Licensed and Certified 10/31/2011, Nurse #1's license expired. On 1/7/2012 at 3:00pm, it was noted that there was Nursing Assistant licenses have no evidence of Nurse #1's license renewal. been validated as active. therefore new verification was requested to 3. All employees found with an Administrative Staffs #4 and #5. On 1/7/2012 at inactive licenses or missing 6:05pm, Administrative Staff #5 was able to background screening have ODATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

If continuation sheet Page 1 of 45

PRINTED: 01/23/2012

PRINTED: 01/23/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WNG 01/07/2012 345551 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5935 MOUNT SINA! ROAD UNIHEALTH POST-ACUTE CARE - CAROLINA POINT DURHAM, NC 27705 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 226 been removed from the schedule F 226 Continued From page 1 produce written documentation that the license until screening have returned as renewal was verified on 12/6/2011. active. Measures and Systemic Changes On 1/7/2012 at 3:30pm, Administrative Staff #4 1. All new employee Licenses are was interviewed. She shared that she became validated prior to the first day of concerned last month that the former financial work. counselor did not perform thorough employment All new employee background screenings for new hires and developed an checks are completed prior to Action Plan for him, in order to become compliant first day of work. with the state and federal regulations. She 3. All new employee reference provided a copy of a Performance Improvement checks are completed prior to Action Plan, dated 12/29/2011 which stated that the employees first day of work. the personnel files were not meeting the standard 4. The Administrator is required to set forth by the Administrator, state regulations or sign off on all new employee files federal regulations. Her goal was to complete a prior to their first day work to 100% audit of all employee files and make validate the reference checks. corrections, as necessary. In addition, all 100% of license verification and employee files would be accurate according to background checks have been state and federal guidelines. Approaches to be used included hiring a new financial counselor completed and received. and ensuring that all 100% of employee files Monitoring: 1. All audited findings from the nd would be completed by 1/13/2012. She shared that she had a new financial counselor in place Administrator audits related to this week and hoped to quickly address the the pre-employment screening problem. process will be reviewed in the monthly Performance 2. On 1/7/2012 a record review was conducted to Improvement committee meeting verify licenses of nurses on staff. It revealed that for patterns and trends and Nurse #3 was hired on 10/10/2011 as a

11/1/2011.

Registered Nurse. Her license was verified on

On 1/7/2012 at 3:30pm, Administrative Staff #4 was interviewed. She shared that she became concerned last month that the former financial counselor did not perform thorough employment screenings for new hires and developed an Action Plan for him, in order to become compliant further interventions developed

as necessary to ensure

continued compliance

		ND HUMAN SERVICES					RM APPROVED NO. 0 <u>938-0391</u>
STATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE S	SURVEY
		345551	B. WIN	IG_		01	C I/07/2012
	OVIDER OR SUPPLIER TH POST-ACUTE CARE	CAROLINA POINT	•		REET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	provided a copy of a Action Plan, dated 12 the personnel files we set forth by the Admit federal regulations. How audit of all emprocrections, as necess employee files would state and federal guidused included hiring and ensuring that all would be completed that she had a new fit this week and hoped problem. 3. On 1/7/2012 a recoverify licenses of nur. Nurse #4 was hired of Practical Nurse. Her 8/24/2011. On 1/7/2012 at 3:30p was interviewed. She concerned last montic counselor did not personnel files were set forth by the Admit federal regulations. How a did federal regulations, as necessity and the personnel files were set forth by the Admit federal regulations, as necessity.	deral regulations. She Performance Improvement 1/29/2011 which stated that here not meeting the standard histrator, state regulations or her goal was to complete a bloyee files and make hisary. In addition, all 100% of he accurate according to helines. Approaches to be he a new financial counselor high 1/3/2012. She shared hancial counselor in place hord review was conducted to his ses on staff. It revealed that his n 8/15/2011 as a Licensed hicense was verified on high Administrative Staff #4 high shared that she became high that the former financial from thorough employment hires and developed an high order to become compliant hieral regulations. She Performance Improvement high 2/29/2011 which stated that here not meeting the standard histrator, state regulations or her goal was to complete a highly effect of the standard histrator, state regulations or her goal was to complete a highly effect of the standard histrator, state regulations or her goal was to complete a highly effect of the standard histrator, state regulations or her goal was to complete a highly effect of the standard histrator, state regulations or her goal was to complete a highly effect of the standard histrator, and dition, all 100% of highly effect of the standard histrator and highly effect of the standard highly	F	226			

PRINTED: 01/23/2012 FORM APPROVED

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/23/2012 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	D
		345551	B. WIN	G		ì	7/2012
	OVIDER OR SUPPLIER	CAROLINA POINT			REET ADDRESS, CITY, STATE, ZIP CODE 936 MOUNT SINAI ROAD		
UNINEAL	IN POST-ACOTE CARE	- CAROLINA I OIII I		D	DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	used included hiring and ensuring that all would be completed that she had a new fi this week and hoped problem. 4. On 1/7/2012 a recoverify licenses of num Nurse #5 was hired of Practical Nurse. Her 11/1/2011. On 1/7/2012 at 3:30p was interviewed. She concerned last monticounselor did not personal for new had not personal files were set forth by the Admifederal regulations. If 100% audit of all emcorrections, as neces employee files would state and federal gui used included hiring and ensuring that all would be completed that she had a new federal regulations.	delines. Approaches to be a new financial counselor 100% of employee files by 1/13/2012. She shared nancial counselor in place to quickly address the ord review was conducted to ses on staff. It revealed that on 10/1/2011 as a Licensed license was verified on order to be seen that the former financial form thorough employment ires and developed an norder to become compliant deral regulations. She Performance Improvement 2/29/2011 which stated that ere not meeting the standard inistrator, state regulations or eler goal was to complete a ployee files and make sary. In addition, all 100% of the accurate according to delines. Approaches to be a new financial counselor 100% of employee files by 1/13/2012. She shared inancial counselor in place it to quickly address the	F.	226			

5. On 1/6/2012 a record review was conducted to

problem.

		ND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345551	B. WIN	G_			//2012
	OVIDER OR SUPPLIER TH POST-ACUTE CARE	- CAROLINA POINT			REET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705	***	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	verify screening prac Nurse Aide #5 was h criminal background Nurse Aide on 11/3/2 On 1/7/2012 at 3:30, was interviewed. Sho concerned last mont counselor did not pe screenings for new h Action Plan for him, with the state and fe provided a copy of a Action Plan, dated 1 the personnel files we set forth by the Adm federal regulations. 100% audit of all em corrections, as nece employee files would state and federal gu used included hiring and ensuring that al would be completed that she had a new this week and hope problem. 6. On 1/6/2012 a re- verify pre-screening employees. Nurse A 11/7/2011. A criminal	tices for all new employees. ired on 10/31/2011. A check was requested for	F	226			

On 1/7/2012 at 3:30pm, Administrative Staff #4 was interviewed. She shared that she became concerned last month that the former financial counselor did not perform thorough employment

PRINTED: 01/23/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B. WNG 01/07/2012 345551 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5935 MOUNT SINAI ROAD UNIHEALTH POST-ACUTE CARE - CAROLINA POINT DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 226 Continued From page 5 F 226 screenings for new hires and developed an Action Plan for him, in order to become compliant with the state and federal regulations. She provided a copy of a Performance Improvement Action Plan, dated 12/29/2011 which stated that the personnel files were not meeting the standard set forth by the Administrator, state regulations or federal regulations. Her goal was to complete a 100% audit of all employee files and make corrections, as necessary. In addition, all 100% of employee files would be accurate according to state and federal guidelines. Approaches to be used included hiring a new financial counselor and ensuring that all 100% of employee files would be completed by 1/13/2012. She shared that she had a new financial counselor in place this week and hoped to quickly address the problem. F 279 483,20(d), 483,20(k)(1) DEVELOP F 279 COMPREHENSIVE CARE PLANS SS=J A facility must use the results of the assessment F 279 to develop, review and revise the resident's Immediate action taken for involved comprehensive plan of care. resident: Resident #3 was transferred to the The facility must develop a comprehensive care plan for each resident that includes measurable hospital and now resides in a sister objectives and timetables to meet a resident's facility. medical, nursing, and mental and psychosocial Action taken for others with potential to needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's

highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WNG

345551

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD **UNIHEALTH POST-ACUTE CARE - CAROLINA POINT** DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) be affected: Continued From page 6 F 279 Care plans have been reviewed by the Director of Nursing, Unit due to the resident's exercise of rights under Managers, Wound care nurse §483.10, including the right to refuse treatment and clinical reimbursement under §483.10(b)(4). director beginning on 1/7/12 and revised accordingly if This REQUIREMENT is not met as evidenced interventions have not been previously identified. Based on staff interviews and record review, the The Certified Nursing Assistant facility failed to develop a comprehensive care care guides have been reviewed plan for 1(Resident #3) of 3 cognitively impaired by the Director of Health residents with a history of falls and who received Services, Unit Managers, Wound antiplatelets drugs (aspirin & Plavix). Care Nurse and Senior Nurse The findings include: Consultant beginning on 1/7/12,

The immediate jeopardy began for Resident #3 on 12/05/2011(the date the comprehensive care plan was due after her admission) and was identified on 1/6/2012 at 7:55pm. Immediate Jeopardy was removed on 1/7/2012 at 9:00pm, after the Credible Allegation was validated through staff interviews, record review and observations. The facility will remain out of compliance at a level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy)

Resident #3 was admitted to the facility on 11/14/2011 with the following diagnoses: vascular dementia, general muscle weakness, abnormal posture, hypertension, a history of falls and multiple cerebrovascular accidents. She also had 81mg of aspirin and 75mg of Plavix administered to her daily, which are antiplatelet drugs used to prevent blood clots; a contributor of strokes. The Admission Minimum Data Set (MDS) was not completed; however there was a nursing assessment, dated 11/22/2011 which indicated that Resident #3 was confused with short term

- The residents interventions related to fall prevention has been added to the C.N.A. care guide.
- The Director of Nursing, Unit Manager, and/or Clinical Care Competency Coordinator began education related to interventions placed on the C.N.A care guide was started on 1/6/12 and will continue until all staff has been educated. The nursing assistant is to check the ADL care guide prior to each shift; the ADL care guides are located at the nurse's station in a specific binder and the ADL care guide is updated by the charge nurses, Clinical reimbursement director, Director of Health Services, and/or Unit Managers with order changes and significant change of condition. All nursing staff will receive education on the ADL

PRINTED: 01/23/2012

01/07/2012

PRINTED: 01/23/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WNG 01/07/2012 345551 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5935 MOUNT SINAI ROAD **UNIHEALTH POST-ACUTE CARE - CAROLINA POINT** DURHAM, NC 27705 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) care guide prior to beginning their next scheduled shift. F 279 Continued From page 7 F 279 Education related to the memory problems. She was totally dependent on assistance the resident requires one person to assist her with bed mobility and for transfers was started on totally dependent on two persons to assist her 1/6/12 that included placement of with transfers. the assistance the resident requires for transfers on the ADL A review of Resident #3's chart revealed a Fall care guide and will continue until Risk Assessment completed on 11/14/2011 with all staff has been completed. a score of 14. The guideline on the assessment stated that when residents score 10 or more. Nursing Assistants will receive interventions should be promptly put in place. education prior to beginning their next scheduled shift. This The Interim Care Plan dated for 11/14/2011 education was provided by the indicated that she was at risk for falls. Her goal Director of Nursing, Unit was to not sustain injury related to falling over the Manager and/or Clinical next 30 days. Approaches to be used included a Competency Coordinator. Fall Risk Screen on admission; to keep the 5. The Director Health Services, environment safe and utilize safety devices such Unit Managers, Senior Care as bed and chair alarms. Partner, Clinical Competency Coordinator, Senior Nurse The nurse's notes were reviewed. It revealed that Consultant are observing on 11/15/2011, between 10:00pm and 6:00am, certified nursing assistants to Resident #3 was very confused and attempted to validate they are transferring get out of bed several times. She was confused residents according to the care and a bed alarm was put into place. On 11/16/2011, the notes recorded that a new order plan and ADL care guide, this is to include the utilization of has been written for physical therapy services for support or unsupported trunk evaluation and treatment. Resident #3 was control and amount of assistant recommended to receive gait training, wheelchair required during transfers. This management secondary to weakness and falls. observation began on 1/7/12 "Patient still very confused and tries so many

times to get out of bed. Patient on total for

transfers and activities of daily living (ADL)."

On the 11/16/2011 Physical Therapy Plan of

Care, Therapist #1 indicated a recent referral to

physical therapy due to Resident #3 showing a

significant decline in bed mobility, transfer, and

gait over several months due to medically

Monitoring and Systemic Changes:

been added to the general

and Certified Nursing

Assistance.

Education related to updating care plans, C.N.A care guides

related to resident transfers has

orientation for Licensed Nurses

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDEMIII IOMIONI NOMBER	A. BUILDING			С		
		345551	B. WIN	G		i	7/2012	
	ROVIDER OR SUPPLIER TH POST-ACUTE CARE	- CAROLINA POINT	- "	59	ET ADDRESS, CITY, STATE, ZIP CODE 35 MOUNT SINA! ROAD JRHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	Continued From pag complex conditions reproblems. She was liprecaution, including modified independer side to side); bed modified independer side to side without balas supports). She need transfer from bed to on the 11/17/2011 F. Therapist #2 Reside exhibit sliding her hip leaning to the side with further stated that posture in wheelchacomplete all function assistance. On 11/2 Therapy Daily Treating "Patient needs maxiplacement with poor forward." On the 12/8/2011 O. Progress Report, The Resident #3 was recovered weakness and abnot tolerate upright stan postural alignment a minutes to increase standing tolerance a her environment. Sheffective postural alignment as needeforward in chair and	e 8 esulting from medical sted as a balance a falls risk. She had noe with bed mobility (rolling obility (supine-sit) and ing balance (able to maintain noe loss or upper extremity ed maximum assistance to wheelchair. Plan of Care Assessment by not #3 was mentioned to be forward in a chair and while seated in her wheelchair, she demonstrated decreased in the forward in a chair and while seated in her wheelchair, she demonstrated decreased in the work of the	F	279	2. Care plans will be re /or revised in the dai meetings Monday th by the Director of Nu Managers, and/or Concurrences and/or change of condition. 3. Case Mix Directors I educated on develor initiating and accurate comprehensive care Clinical Reimbursern Coordinator. Monitoring: 1. The Clinical Reimbursern Consultant will audit significant change I care plans for accurator for four weeks then thereafter. 2. The Senior Nurse Conditions and important interventions interve	ly morning rough Friday Irsing, Unit ase Mix Ints with significant Inave been ping, by of the plan by the nent Irsement Ithe facilities IDS's and acy weekly monthly Inavestigation investigation inve		

PRINTED: 01/23/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 01/07/2012 345551 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5936 MOUNT SINAI ROAD UNIHEALTH POST-ACUTE CARE - CAROLINA POINT DURHAM, NC 27705 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) partner regarding resident observation to ensure the Continued From page 9 F 279 F 279 certified nursing assistants are providing care in accordance An undated Nursing Assistant Care Record with the resident care plan will be revealed that Resident #3 needed the assistance conducted daily for seven days of one for transfers and needed the assistance of then weekly for four weeks then one to two persons, for repositioning. Safety monthly. The results of the devices to be used included a bed and chair alarm, which should be in place throughout the observation audits will be monitored monthly by the day. Performance Improvement Administrative Staff #1 was interviewed on committee for compliance. 1/6/2012 at 11:40am. She relayed that Resident 5. Daily and weekly audits of the #3 should have never been sitting on the side of documentation of all occurrences the bed on 12/30/2011. She stated that Resident and all significant changes, the #3 had poor trunk control and was known to lean Clinical Reimbursement forward. In addition, she added that Nurse Aide Consultant accuracy audits and #4 could have reviewed her ADL book for the Senior Nurse Consultant information on the resident or come talk to a audit of the occurrence logs for nurse. interventions, implementation and investigations will be On 12/25/2011 at 12:00am, the nurse's notes monitored monthly by the revealed that Resident #3 was observed on the Performance Improvement floor with no apparent injury. She was assisted back to bed and attempted to get out of bed Committee for compliance.

12/25/11.

twice. She was brought to the nurse 's station for monitoring. The fall investigative summary, dated

12/25/2011 relayed that the charge nurse had to

reposition Resident #3 after she made two

The Interim Care Plan reflected the fall on

attempts earlier to get out of bed, unassisted.

Later that shift, Resident #3 was found on the

floor on the side of her bed by the charge nurse.

An Incident Fall Report, 12/26/2011, documented

that Resident #3 was observed at 4:00pm on the

apparent injury. Under the section equipment in

floor beside her bed. She stated that she slid

from her wheelchair and fell. She had no

6. All audited findings from the

documentation of occurrences

and significant changes, CRC

charts for interventions and

general orientation will be reviewed in the monthly

Performance Improvement

interventions developed as

and trends and further

accuracy, and SNC review of the

implementation of interventions

and investigation, education in

committee meeting for patterns

necessary to ensure continued

DHS/Administrators

		ND HUMAN SERVICES					APPROVED 0938-0391
		MEDICAID SERVICES	1		THE CONTROL OF THE CO	(X3) DATE SUR	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	COMPLETE	D
		345551	B. WIN	IG_	100	01/07	J
NAME OF PR	OVIDER OR SUPPLIER	<u> </u>	L	STE	REET ADDRESS, CITY, STATE, ZIP CODE		
				1	5935 MOUNT SINAI ROAD		
UNIHEAL	TH POST-ACUTE CARE	- CAROLINA POINT		E	DURHAM, NC 27705		-
040.15	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 279	Continued From page	e 10	F	279	compliance.		
	use, not applicable w 12/26/2011 Follow-U confirmed that Resid wheelchair. It indicate was unable to recall	ras written. On the p Investigation summary, it					
	7:45am, nurse aide that Resident #3 had room. She told her the Resident #3 on the sent while repositioning head Bleeding was noted hematoma on her the noted no loss of consurse practioner who immediately notified assess Resident #3	nurse's notes revealed that at #4 (NA#4) notified Nurse #1 fallen on the floor in her hat she had positioned ide of her bed. NA#4 told ade sure she was stable er wheelchair, but Resident first and on to the floor. from her upper lip and a eright side of her eye. She sciousness and that the was in the building was and came to the room to f s injuries. A call was made port and she was taken to the					
	reviewed. It stated the spoke with NA #4 are unsecure residents to unsupported could record the spoke with the spoke with the spoke with the spoke are spoke at the spoke are spoke as the spoke are spoke with the spoke are spok	unable to sit on side of bed esult in resident's harm. I to never leave resident bed or standing if resident If. Employee further					
	The hoenite s emer	gency denartment notes were					

PRINTED: 01/23/2012

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING			(X3) DATE SURVEY COMPLETED			
			A. BOILDING			С
		345551	B. WING	 	01/	07/2012
	ROVIDER OR SUPPLIER	E - CAROLINA POINT	593!	T ADDRESS, CITY, STATE, ZIP CODE 5 MOUNT SINAI ROAD RHAM, NC 27705	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 279	reviewed and reveal admitted on 12/30/2 and treatment after assessment noted to hematoma inside hematoma noted to she received suture. The Inpatient Consistated that Aspirin a least one week due note also stated that be operative." The dated 1/6/2012 reported in the Intensification of the maxillofacial which confirmed a swith blood in the left of the maxillofacial which confirmed as with blood in the left of the maxillofacial comminuted fracture orbit extending into orbital plate). It note the right maxillary stragments were min. On 1/6/2012 at 12:2 was interviewed. She the assessments (a were done for Residulation of the Interim Countil a comprehensi She acknowledged.	alled that Resident #3 was 2011 at 8:42am for evaluation her fall. The initial physical hat she had a large er upper lip as well as a large the right eye. At 11:39am, as for facial laceration repair. All the Note, dated 12/31/2011 and Plavix would be held for at to a head bleed. The consult at the all the the laceration are so for subdural hematoma. The analysis of subdural hematoma. The analysis included a CAT scan at the lamina papyracea (thin the lamina papyracea (thin are the lamina papyracea (thin and that there was blood within and that there was blood within and the lamina papyracea. The Administrative Staff #2 are acknowledged that some of ctivities and social services) dent #3 on 11/22/2011 but she a MDS, including the Care CAA) until 1/5/2012. She	F 279			

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/23/2012 APPROVED : 0938-0391		
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345651	B, WIN	IG_		l l	7/2012		
NAME OF PR	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE				
UNIHEALT	TH POST-ACUTE CARE	CAROLINA POINT		5935 MOUNT SINAI ROAD DURHAM, NC 27705					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 279	Continued From page	e 12	F	279			The state of the s		
	occupational support interview on 1/6/2012 not have concerns at wheelchair, but state-could not sit upright vommented, "If she will tumble backward momentum." Therapists #1 and #4 1/6/2012 at 1:17pm. Resident #3 participe 4x a week. Therapist lower extremities werigid however, she will will be a stated that during general decline in Rementioned to the nur practioner that Reside and seemed to be reshared that on one on Resident #3 leaning she was seated in the trying to reach for so shoes. She further sith have trunk control or without back support had very much safet. On 1/10/2012 at 10:3 was conducted with that she worked with the time of her admission.	Therapist #4 stated that ated in physical therapy about #1 added that Resident #3's re fairly weak and sometimes as not paralyzed. Therapist their sessions she noted a resident #3's abilities and she se as well as the nurse ent #3 was not improving gressing. Therapist #1 ccasion; she recalled seeing over in her wheelchair, while re hallway, as if she was mething, like maybe her ated that Resident #3 did not stability to sit up by herself. She also didn't think she							

Resident #3's health conditions but that she knew that she had dementia, couldn't walk but was told

		ND HUMAN SERVICES					M APPROVED O. 0938-0391
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	N2) M	I II Ti	IPLE CONSTRUCTION	(X3) DATE SU	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUI			COMPLETED	
		345551	B. WIN	IG_			C 07/2012
		1 070001		Τ.		1 0170	J. J. LOIL
NAME OF PR	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD		
UNIHEALT	H POST-ACUTE CARE	- CAROLINA POINT		1	DURHAM, NC 27705		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ΙĐ		PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
F 279	Continued From page	e 13	F	279	9		- - -
	• -	with assistance. She stated					
		source of information to care					
		e nurse or she could go read					
		Aide Care Guide, she					
İ		ot in the nourishment room					
	closet and it provided	l information about the type					
	of assistance the res						
		int #3 was that she was					
		, needing one staff to assist					
		ld sit on her own. She stated					}
		not require a mechanical lift					
	for transfers.						
	NA #4 continued by	saying that although she was					
		sident #3 twice, she had					
	observed her previou	ısly, while she sat on the hall					
		om. She recalled that					
	Resident #3 could si						
		't slouch. She would witness					
		ge of her chair and would					
		er and tell her to scoot back in ared that she had seen					
	****	ard in her wheelchair, with					
		mrest as if she wanted to get			1		1
		he honestly didn't know if					
	she was a high fall ri	sk and that she felt that					
		t on the side of the bed.					
	During the interview.	Nurse Aide #4 explained					
	that on the morning	of 12/30/2011 she was giving					
	Resident #3 a bed b	ath and getting her dressed.					
	She shared that Res	ident #3 was alert and they					
		se. She stated that after she					
		sat her up on the side of the					
		ont of her, repositioning her					
		er hair. NA #4 had the					
		ehind her, as the aide stood.	ĺ				
	Sne stated that the b	ed was placed at standard	ŀ				1

PRINTED: 01/23/2012

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUII	DING)
		345551	B. WIN	G			//2012
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1.000	
IGNIELEAL	TH DOOT ACUTE CADE	CAROLINA BOINT		59:	35 MOUNT SINAI ROAD		
UNINEAL	TH POST-ACUTE CARE	- CAROLINA FOINT		DL	JRHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	height and that Resi the soles of her feet Nursing Assessmen that Resident #3 sto by stating that she d #3 while she provide minutes period, beca maintain good trunk that when she remo #3's shoulders, in or the wheelchair, Resi her seated position of the floor. On 1/13/12 at 11:37 interview was condu- that aides can becor needs by viewing th- resident's closet or to aide during their shift therapy had informe "leaner", who could assistance. She con it said that she (Res transfer but if you co leaning, then you we help you." On 1/17/12 at 12:17 interview was condu- #2. She commented nurse immediately u- with writes down interviews the plan and Administrative Staff that she can transfe	dent #3 was able to sit with touching the floor. (The t dated 11/22/2011 indicated od 5'4" tall.) She continued id not have to hold Resident ad grooming over a 3 to 5 ause she was able to control. However she stated wed her hands from Resident der to turn around and move ident #3 had fell forward from on the bed and hit her face on am, a follow up telephone acted with NA #1. She stated me familiar with a resident's e care guide located in each the nurse's will instruct the fit report. She shared that d her that Resident #3 was a pivot but would need tinued by saying, "On paper ident #3) was a one person buildn't handle all of the build need someone else to pm, a follow up telephone acted with Administrative Staff I that when a fall occurs, the updates the interim care plan erventions. The Unit Manager d the nurses make #2 aware of any changes so	I.	279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/23/2012

FORM APPROVED

		ND HUMAN SERVICES				FORM	: 01/23/2012 APPROVED . 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR' COMPLETE	:D
		345551	B, WIN	G		01/07	/ //2012
	OVIDER OR SUPPLIER	CAROLINA POINT		59	EET ADDRESS, CITY, STATE, ZIP CODE 035 MOUNT SINA! ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	after Resident #3 fell to the nurse's station on 12/26/11, staff into alarm on her wheelch On 1/17/12 at 1:00pn interview was conducted #1. She shared that a update the nurse aid information about fall used. She added that the resident's closet of the resident's worked with Resident of the ground, closer to the ground, touch the floor, which and kept her trunk processed the resident of the reside	out of bed, by bringing her for supervision. After her fall ervened by placing a chair nair. In, a follow up telephone sted with Administrative Staff all licensed staff are able to e care guides with any is and interventions to be at the care guides are kept in or in the ADL book. Prviewed by telephone on the stated that he primarily it #3 to strengthen her ability and to assist her with toilet is. On 11/21/11 and id her wheelchair by adding a which was then lowered thus allowing her feet to in helped her to self-propel toperly aligned. He shared if 3 was transferred out of her id sit for a few seconds, but lit comfortable taking my was still max assist for	F	279			
	The Administrators v Immediate Jeopardy facility provided a Cr Compliance on 1/7/2 allegation of complia	on 1/6/2012 at 7:55pm. The edible Allegation of 012 at 9:00pm. The					

Credible Allegation of Compliance: Others with Potential to be effected:

PRINTED: 01/23/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B. WING 345551 01/07/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5935 MOUNT SINAI ROAD UNIHEALTH POST-ACUTE CARE - CAROLINA POINT DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ΙĐ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 279 F 279 Continued From page 16 1. Care plans have been reviewed by the Director of Nursing, Unit Managers, Wound care nurse and clinical reimbursement director on 1/7/12 and revised accordingly if interventions have not been previously identified. The Director of Nursing, Unit Manager, and/or Clinical Care Competency Coordinator began education related to interventions placed on the N.A care guide was started on 1/6/12 and will continue until all staff has been educated. The nursing assistant is to check the ADL care guide prior to each shift; the ADL care guides are located at the nurse's station in a specific binder and the ADL care guide is updated by the charge nurses, Clinical reimbursement director, Director of Health Services, and/or Unit Managers with order changes and significant change of condition. All nursing staff will receive education on the ADL care guide prior to beginning their next scheduled shift. 3. Education related to the assistance the resident requires for transfers was started on 1/6/12 that included placement of the assistance the resident requires for transfers on the ADL care guide and will continue until all staff has been completed. Nursing Assistants will receive education prior to beginning their next scheduled shift. This education was provided by the Director

of Nursing, Unit Manager and/or Clinical

 Education related to updating care plans, Nurse Aide care guides related to resident transfers has been added to the general orientation for Licensed Nurses and Nursing

2. All accidents occurrences will be brought to

Competency Coordinator.

Measures and Systemic Changes

		ND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SUR COMPLETE	:VEY
		345551	B. WIN	G		C 01/07/2012	
	OVIDER OR SUPPLIER	CAROLINA POINT		593	ET ADDRESS, CITY, STATE, ZIP CODE 35 MOUNT SINAI ROAD IRHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 279	Friday by the unit ma occurrence document interventions and sun 3. Care plans will be the dally morning meriday by the Director and/or Case Mix Director and/or Case Mix Director of Health Clinical Competency Care Partner will obstacled the Nursing Aresident care in accorplan. Monitoring 1. The Director of Hadministrator will audoccurrences for interventions and significant changidentified on the ADL daily for seven days then monthly thereaft 2. The Clinical Reim (CRC) will audit the family the seven the month occurrence logs a interventions and impand investigation were monthly thereafter. 4. The Director of Hadministrator with the month occurrence logs a interventions and impand investigation were monthly thereafter.	daily Monday through nagers for review of the tation for completeness, amarization. The reviewed and for revised in etings Monday through of Nursing, Unit Managers, ctor of all residents with significant change of the Services, Unit Managers, Coordinator and/or Senior erve 10 residents per day to Assistants are providing redance with the resident care dealth Services (DHS) and/or lit documentation of the investigation completion es to ensure they have been care guide and care plan, then weekly for four weeks er. Inbursement Consultant acilities significant change has for accuracy weekly for they thereafter. The Consultant (SNC) will audit and review the charts for elementation of interventions ekly for four weeks then the self Risk assessments,	F	279			

PRINTED: 01/23/2012

DEPARTMENT OF HEALTH AN	ID HUMAN SERVICES					D: 01/23/2012 M APPROVED
CENTERS FOR MEDICARE &						O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED
	245554	B. WIN	G			С
	345551				01/0	07/2012
NAME OF PROVIDER OR SUPPLIER				ITY, STATE, ZIP CODE		
UNIHEALTH POST-ACUTE CARE	CAROLINA POINT		5935 MOUNT SINA DURHAM, NC 2			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH	OVIDER'S PLAN OF CORREC I CORRECTIVE ACTION SHO REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
weekly for four weeks 5. The audits condu Health Services, Unit Competency Coordina partner regarding resi the certified nursing a in accordance with the conducted daily for se four weeks then mont observation audits will the Performance Impr compliance. 6. Daily and weekly of all occurrences and Clinical Reimburseme audits and the Senior the occurrence logs fo implementation and in monitored monthly by Improvement Committ 7. All audited finding DHS/Administrators di occurrences and signi accuracy, and SNC re interventions and impl and investigation, edu will be reviewed in the Improvement committe trends and further inte necessary to ensure of The credible allegation 7:00pm, as evidenced preventing falls, review	then monthly thereafter. Incted by the Director of Managers, Clinical Intervention to ensure Interventions, vestigations will be Intervention of Intervention	F	279			

A BUILDING B. WING O1/07/2 STREET ADDRESS, CITY, STATE, ZIP CODE 5936 MOUNT SINAI ROAD UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6935 MOUNT SINAI ROAD	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE A	(X5) COMPLETION DATE
F 279 Continued From page 19 Review of in-service records for Performing Safe	2/1/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUI COMPLET	
		345551	B. WING			C
NAME OF PR	OVIDER OR SUPPLIER	343001		STREET ADDRESS, CITY, STATE, ZI		7/2012
UNIHEAL.	TH POST-ACUTE CARE	- CAROLINA POINT		6935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE DTO THE APPROPRIATE DIENCY)	(X5) COMPLETION DATE
F 287	(2) Transmitting data completes a resident must be capable of tr System information for the MDS in a format record layouts and dapasses standardized the State. (3) Transmittal requir a facility completes a facility must electroni accurate, and complet System, including the (i) Admission assessi (ii) Annual assessme (iii) Significant correct (v) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, and (viii) Background (factionitial transmission of does not have an address an alternate RAI format specified by the CMS. This REQUIREMENT by: Based on record reviews are sidently in the complete of the complete	Within 7 days after a facility assessment, a facility ansmitting to the CMS or each resident contained in that conforms to standard at a dictionaries, and that edits defined by CMS and ements. Within 14 days after resident's assessment, a cally transmit encoded, be MDS data to the CMS of following: ment. Int. F 28	1. Clinical Rein Consultants transmittals MDS sched 2. Administrate log and transensure com 3. All audited fichinical reim Consultants audits will be monthly Per Improvement for patterns autits with the consultants audits will be monthly Per Improvement for patterns audits will	s are reviewing weekly against the ule. or is reviewing MDS smittals daily to pliance. indings from the abursement and Administrator e reviewed in the formance at committee meeting and trends and rentions developed y to ensure		

PRINTED: 01/23/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WNG 345551 01/07/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5936 MOUNT SINAI ROAD UNIHEALTH POST-ACUTE CARE - CAROLINA POINT **DURHAM, NC 27705** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 21 F 287 Data Set (MDS) for 1 of 4 residents (Resident # The findings include: Resident #3 was admitted to the facility on 11/14/2011 with the following cumulative diagnoses: vascular dementia, depression, hypertension, cerebrovascular accident, history of falls and abnormal posture. Review of her chart revealed that the Admission MDS assessment was omitted. On 1/6/2012 at 12:21pm, the Administrative Staff #2 was interviewed. She shared that a partial MDS admission assessment was done on 11/22/2011 for Resident #3, but the Admission MDS did not get transmitted until 1/5/2012. F 323 Immediate Action taken: On 1/7/12 at 8:44pm, Administrative Staff #5 was Resident was transferred to the interviewed and relayed that the facility planned to hospital and currently resides in bring in a clinical team to work on MDS our sister facility. assessment and that part of their plan was to do Action taken for others with potential to a 100% chart audit to ensure that everything was be affected: current. She shared that there would be weekly 1. All residents fall risk visits to the facility to review the previous week's assessments have been assessments to check for accuracy. reviewed and revised as F 323 483.25(h) FREE OF ACCIDENT F 323 required, by the Director of HAZARDS/SUPERVISION/DEVICES SS=J Health Services, Unit Managers, Wound Care Nurse and Senior

prevent accidents.

The facility must ensure that the resident

as is possible; and each resident receives adequate supervision and assistance devices to

environment remains as free of accident hazards

Nurse Consultant to identify the

high fall risk residents on 1/7/12.

63 out of 109 residents have

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , ,		E CONSTRUCTION	(X3) DATE SUR\ COMPLETE	
			A. BUILE	DING		C	;
		345551	B. WING	·	•		/2012
	OVIDER OR SUPPLIER H POST-ACUTE CARE	CAROLINA POINT		593	ET ADDRESS, CITY, STATE, ZIP CODE 35 MOUNT SINA! ROAD IRHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETION DATE
F 323	by: Based on observation review of medical and failed to establish the the transfer mode for #3) reviewed for falls aides used a safe trainjuries. The immediate jeopa on 12/30/2011 and with 7:55pm. Immediate Jin 1/7/2012 at 9:00pm, was validated through review and observation out of compliance at with the potential for is not immediate jeopa. The findings include: Resident #3 was adminimated with the findings include: Resident #4 was adminimated with the findings include	is not met as evidenced n, staff interviews and the d hospital records, the facility transfer needs as well as 1 of 4 residents (Resident and to ensure that nurse insfer technique to prevent rdy began on Resident #3 as identified on 1/6/2012 at eopardy was removed on after the Credible Allegation in staff interviews, record ons. The facility will remain a level D (no actual harm more than minimal harm that eardy) nitted to the facility on following diagnoses: vascular uscle weakness, abnormal in, a history of falls and ular accidents. She also had r5mg of Plavix administered hission Minimum Data Set eleted; however there was a dated 11/22/2011 which ent #3 was confused with roblems. She was totally erson to assist her with bed ependent on two persons to	F3	323	been identified as high rist falls. The Fall Risk assess includes resident's level of conscious, history of falls, ambulation status, vision is gait/balance, blood pressure medications and predisposed disease. 2. Residents identified with a fall risk have been evaluated interventions and implement of the interventions to prefurther occurrences are in i.e., mat, alarms, positioning devices on 1/7/12. 3. Residents identified as a historia who have not previous been screened for trunk been screened for trunk been screened by United Rehab Department for trunk control and balance beging 1/7/11 and continuing until high risk residents have been completed. 4. Care plans have been reviously the Director of Nursing, Managers, Wound care nuand clinical reimbursement director on 1/7/12 and reviaccordingly if interventions not been previously identificated for the Director of Health Services, Unit Managers, Care Nurse and Senior Nut Consultant on 1/7/12, The residents interventions related prevention has been according to the previous related to the previ	status, are, sing high ed for entation vent place ng high fall sly salance wed Unit arse t sed shave ied. Stant riewed Wound arse ated to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CON	ISTRUCTION	(X3) DATE SUF	
ANDFLANO	CONNECTION	(SERVILLON HOLLINGER)	A. BUILDING			١,	c
		345551	B. WNG				7/2012
NAME OF PE	OVIDER OR SUPPLIER	100	STR	EET AD	DRESS, CITY, STATE, ZIP CODE		
IINIHFAI '	TH POST-ACUTE CARE	- CAROLINA POINT	59	935 MO	OUNT SINAI ROAD		
OMITEAE	THI OUT-HOUTE OAKE		D	URHA	M, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LÐ BE	(X5) COMPLETION DATE
	A review of Residen Risk Assessment co a score of 14. The g stated that when resinterventions should The Lift Evaluation F 11/14/2011, stated t and could follow sim moderate upper boo The Interim Care Plaindicated that she w was to not sustain ir next 30 days. Appro Fall Risk Screen on safe and utilize safe chair alarms. The nurse's notes w on 11/15/2011, betw Resident #3 was ve get out of bed sever and a bed alarm wa 11/16/2011, the note has been written for evaluation and treat recommended to remanagement secon "Patient still very cotimes to get out of be	t #3's chart revealed a Fall impleted on 11/14/2011 with uideline on the assessment idents score 10 or more, be promptly put in place. Form, completed on hat she could bear weight uple commands and had	F 323	6.	to the C.N.A. care guide. The Director of Nursing, L Manager, and/or Clinical of Competency Coordinator education related to intervioled on the C.N.A care was started on 1/6/12 and continue until all staff has educated. The nursing as is to check the ADL care prior to each shift; the AD guides are located at the station in a specific binde the ADL care guide is upon by the charge nurses, Clinical reimbursement director, I of Health Services, and/o Managers with order charant significant change of condition. All nursing staff receive education on the care guide prior to beginn their next scheduled shift	Jnit Care began ventions guide d will been sistant guide L care nurse's r and dated nical Director r Unit nges f will ADL ning equires on ement of nt the ADL nue until ted.	UAIL.
	Care, Therapist #1 physical therapy dura significant decline in	Physical Therapy Plan of indicated a recent referral to e to Resident #3 showing a bed mobility, transfer, and onths due to medically		8.	next scheduled shift. This education was provided I Director of Nursing, Unit Manager and/or Clinical Competency Coordinator The Director Health Serv	by the	

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					: 01/23/2012 APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLET	ΞD
		345551	B. WIN	G			7/2012
NAME OF PR	OVIDER OR SUPPLIER		1	STDE	EET ADDRESS, CITY, STATE, ZIP CODE	•	
Terme or The	OVIDERCOROUTTELERC				35 MOUNT SINAI ROAD		
UNIHEALT	TH POST-ACUTE CARE	CAROLINA POINT			URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	side to side); bed mole exhibited a static sitting balance without balar supports). She needed transfer from bed to without balar supports). She needed transfer from bed to without balar supports. She needed transfer from bed to without a support with the side with the side with the stated that support in wheelchair complete all functions assistance. On 11/25 Therapy Daily Treatm "Patient needs maxim placement with poor forward." On the 12/8/2011 Oc Progress Report, The Resident #3 was received weakness and abnorate upright stand postural alignment arminutes to increase upon the state of the sta	esulting from medical sted as a balance a falls risk. She had be with bed mobility (rolling bility (supine-sit) and ang balance (able to maintain noce loss or upper extremity and maximum assistance to wheelchair. an of Care Assessment by at #3 was mentioned to be forward in a chair and hile seated in her wheelchair. The demonstrated decreased by the year of the was able to be at transfers with maximum bility an Occupational ment Note stated that hum cues for hand posture and leaning	F	323	Unit Managers, Senior of Partner, Clinical Competed Coordinator, Senior Number Consultant are observir certified nursing assistated validate they are transferesidents according to the plan and ADL care guided to include the utilization support or unsupported control and amount of a required during transfered observation began on 19. Education related to Evereporting to include involved from the event occur started on 1/6/12 for all Nurses, certified nursing assistance and other a staff will continue until has been completed. Licensed and Nursing receive education prior beginning their next so shift. This education we provided by the Director Health Services, Unit Mand/or the Clinical Concoordinator. Measures and Systemic Changer.	etency rse ag ints to erring he care le, this is of trunk assistant rs. This l/7/12 rent estigation red was I Licensed g ncillary all staff All staff will to heduled ras or of Managers npetency ges: gation	
	her environment. She effective postural alig	e would also achieve nment while seated in hours utilizing adaptive			form that identifies who resident was doing price occurrence, statement resident of what occurrence statements from staff to	or to the from red and	

unavailable for interview.

forward in chair and leaning to side. During the

survey, Therapist #2 was on vacation and was

statements from staff members

with a synopsis of what led to the

occurrence has been initiated on

1/6/12. This occurrence

PRINTED: 01/23/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 345551 01/07/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINA! ROAD **UNIHEALTH POST-ACUTE CARE - CAROLINA POINT** DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) investigation is to be initiated by F 323 Continued From page 25 F 323 the Charge Nurse on duty at the time of the occurrence. 2. The Administrator and/or An undated Nursing Assistant Care Record Director of Health Services will revealed that Resident #3 needed the assistance review and summarize each of one for transfers and needed the assistance of one to two persons, for repositioning. Safety occurrence investigation daily devices to be used included a bed and chair Monday through Friday with alarm, which should be in place throughout the summarization on the day. investigation form. Education related to updating On 12/15/2011, the chart reflected that a care plans, C.N.A care guides physician's telephone was written for a bed and related to resident transfers has chair alarm on at all times for safety. been added to the general orientation for Licensed Nurses On 12/25/2011 at 12:00am, the nurse's notes and Certified Nursing revealed that Resident #3 was observed on the Assistance. floor with no apparent injury. She was assisted 4. Education related to Occurrence back to bed and attempted to get out of bed investigations and Occurrence twice. She was brought to the nurse 's station for reporting has been added to monitoring. The fall investigative summary, dated general orientation for all staff. 12/25/2011 relayed that the charge nurse had to 5. All occurrences will be brought to reposition Resident #3 after she made two the stand up meeting daily attempts earlier to get out of bed, unassisted. Monday through Friday by the Later that shift, Resident #3 was found on the floor on the side of her bed by the charge nurse. unit managers for review of the The Interim Care Plan reflected the fall on occurrence documentation for 12/25/11. completeness, interventions and summarization. An Incident Fall Report, 12/26/2011, documented 6. Care plans will be reviewed and that Resident #3 was observed at 4:00pm on the /or revised in the daily morning floor beside her bed. She stated that she slid meetings Monday through Friday from her wheelchair and fell. She had no by the Director of Nursing, Unit

apparent injury. Under the section equipment in

12/26/2011 Follow-Up Investigation summary, it

wheelchair. It indicated when asked, Resident #3

was unable to recall why she slid out of the chair.

use, not applicable was written. On the

confirmed that Resident #3 slid from her

The Interim Care Plan reflected the fall on

Managers, and/or Case Mix

Director of all residents with

7. Director of Health Services, Unit

change of condition.

occurrences and/ or significant

Managers, Clinical Competency

Coordinator and/or Senior Care

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
			A. BUILDING	-	c	Į
		345551	B. WING		01/07/	2012
	OVIDER OR SUPPLIER TH POST-ACUTE CARE	- CAROLINA POINT	59	EET ADDRESS, CITY, STATE, ZIP CODE 936 MOUNT SINAI ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	12/26/11. On 12/30/2011, the n 7:45am, nurse aide # that Resident #3 had room. She told her th Resident #3 on the si Nurse #1 that she ma while repositioning he #3 fell forward, head Bleeding was noted fhematoma on her the noted no loss of consurse practioner who immediately notified assess Resident #3's for emergency transphospital at 8:15am. The fall investigation reviewed. It stated the spoke with NA #4 and unsecure residents unsupported could recomply the instructed to have all equipment/supplies reviewed and reveale admitted on 12/30/20 and treatment after the assessment noted the hematoma inside her	urse's notes revealed that at #1 (NA#1) notified Nurse #1 fallen on the floor in her at she had positioned ide of her bed. NA#1 told ide sure she was stable or wheelchair, but Resident first and on to the floor. From her upper lip and a eright side of her eye. She is ciousness and that the was in the building was and came to the room to injuries. A call was made fort and she was taken to the report from 12/30/2011 was at Administrative Staff #1 d "Advised her that inable to sit on side of bed esult in resident's harm. It to never leave resident bed or standing if resident if. Employee further necessary prior to resident was in the initial physical initial physic	F 323	Partner will observe 10 per day to validate the Nursing Assistants are resident care in accord the resident care plan. 8. The facility DHS, Unit No case mix directors, active administrator, Senior No Consultant, United Reference and the Senior Partner attended a meet the representative from on 1/30/12 for an approfour hour meeting. Add education is being provided the CCME representative Nurse managers as a total trainer opportunity and education to the front line on February 9th for two with front line staff. Monitoring: 1. The Director of Health and/or Administrator will documentation of occur for intervention and implementation of the interventions and invest completion and signific changes to ensure they been identified on the Aguide and care plan, do seven days then weekl weeks then monthly the 2. The Clinical Reimburse Consultant will audit the significant change MDS care plans for accuracy	Certified providing ance with Managers, ivities, lurse hab or Care eting with a CCME eximate litional vided by ive for the rain the also he staff sessions Services ill audit rrences Services ill audit rrences ADL care ally for y for four ereafter. ement e facilities S's and	
	nematoma noted to t	he right eye. At 11:39am,		for four weeks then mo		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	-	С	
		345551	B. WING		01/07/201	2
	OVIDER OR SUPPLIER TH POST-ACUTE CARE	CAROLINA POINT	59	EET ADDRESS, CITY, STATE, ZIP CODE 035 MOUNT SINAI ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JFD BE COW	(X5) PLETION DATE
F 323	The Inpatient Consult stated that Aspirin an least one week due to note also stated that be operative." The hated 1/6/2012 report treated in the Intensive discharge diagnosis of Radiology reports find (computerized axial to which confirmed a single which confirmed as in with blood in the left to of the maxillofacial (in comminuted fracture orbit extending into the right maxillary single fragments were minimally wheelchair; she with Resident #3 and wheelchair; she with the right who had used a wheelchair, where it is a single fragment w	for facial laceration repair. Note, dated 12/31/2011 d Plavix would be held for at a head bleed. The consult "fractures do not appear to pospital discharge summary, ted that Resident #3 was been care Unit and had a consult and had a consult and hematoma. The dings included a CAT scan comography) of the head hall right subdural hematoma ateral ventricle. A CAT scan chid-face) revealed a through the floor of the right he lamina papyracea (thin that there was blood within hus. As well as fracture mally inferiorly displaced. In Nurse Aide #1 was hed that she used to work that when she sat in her essed her leaning forward or mented that Resident #3 did be and had trouble moving the floor of the right had an alarm on it is would lean in her chair. The Nurse Aide #2 was ared that she worked with that she often summoned that she often summoned	F 323	thereafter. 3. The Senior Nurse Conaudit the occurrence to review the charts for interventions and imple of interventions and inweekly for four weeks monthly thereafter. 4. The Director of Nursing Manager will audit the assessments, Care Pla ADL care guides for fa prevention intervention seven days, weekly for weeks then monthly the Director of Health Serv Managers, Clinical Coracordinator and/or Serpartner regarding resid observation to ensure certified nursing assists providing care in accorwith the resident care providing care in according to a conducted daily for seven the weekly for four we monthly. The results of observation audits will monitored monthly by the Performance Improven committee for compliar to and all significant chan Clinical Reimbursement Consultant accuracy at the Senior Nurse Consultant accuracy at the Senior Nurse Consultant of the occurrence	ementation vestigation then g / Unit Fall Risk ans and II s daily for four ereafter. by the ices, Unit inpetency nior care ent the ents are dance olan will be een days teks then the be he nent ice. s of the ocurrences ges, the t dits and ultant	
	the help of another a	ide to use a mechanical lift to		interventions, implement	•	181

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
							c
		345551	B. WIN	IG		01/0	7/2012
		ATEMENT OF DEFICIENCIES	ID	59 D	EET ADDRESS, CITY, STATE, ZIP CODE 935 MOUNT SINAI ROAD URHAM, NC 27705 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPRODEFICIENCY)		DATE
F 323	transfer Resident #3. #3 was paralyzed from that whenever she plus sure that she laid ver pillows behind her bat commented that she "Because I think she her on the side. She Furthermore, she state lean to her left side wand she would see he couldn't rise from her On 1/6/2012 at 10:13 interviewed. She shate Resident #3 often on weekends. She state extensive assistance person was capable observed Resident #3 he was also known wheelchair, so a chathe morning of the awas called to the roo Resident #3 on the fiftom her mouth and a forehead. Resident # her name. She took if the nurse practioner, immediately transport assessment and treat Administrative Staff #1/6/2012 at 11:40am #3 should have never the bed on 12/30/20:	She thought that Resident in the waist down and stated aced her in bed, she made tically on the mattress with ck for support. She took that measure would fall out of bed if I sat doesn't have good tone." ted that Resident #3 would thenever she sat in her chair er trying to stand up but she seat. Itam, Nurse #1 was red that she worked with first shift weekdays and on d that Resident #3 needed with transfers, yet one of transferring her. She had 3 leaning in her wheelchair. To scoot forward in her ir alarm was always in place. Ccident on 12/30/2011, she im by NA #1. She found oor and saw blood coming a hematoma on her is was not able to respond to her vital signs and contacted to examine her. She was ted to the hospital for thment. If was interviewed on . She relayed that Resident in been sitting on the side of 11. She stated that Resident introl and was known to lean	F	323	and investigations will be monitored monthly by the Performance Improvemer Committee for compliance. 7. All audited findings from to DHS/Administrators documentation of occurre and significant changes, concuracy, and SNC review charts for interventions an implementation of intervention and investigation, educating general orientation will be reviewed in the monthly Performance Improvement committee meeting for path and trends and further interventions developed as necessary to ensure continuously compliance.	nt e. he nces CRC v of the d ntions on in t terns	

		ND HUMAN SERVICES					M APPROVED O. 0938-0391
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(72) 14	T)	PLE CONSTRUCTION	(X3) DATE SU	
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUII			COMPLE	TED
		345551	B. WIN	iG_		01/6	C 07/2012
NAME OF PR	OVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIHEALT	TH POST-ACUTE CARE	CAROLINA POINT			5936 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	transfer her from the addition, she added to reviewed her ADL bo resident or come talk. On 1/6/2012 at 12:21 was interviewed. She the assessments (active done for Resided did not complete the stated that whenever assessment gets complan. The Interim Cauntil a comprehensive She acknowledged the plan for Resident #3. Therapist #3 also we providing occupation during an interview of she did not have contin her wheelchair, but probably could not sit support. She comme support she will tumb toward the momentum. Therapists #1 and #4 1/6/2012 at 1:17pm. Resident #3 participation where we will be resident #4 participation where we will be resident #4 participation where we will be resident where we will be resident where we will be resident #4 participation where we will be resident where we	set prior to attempting to bed to the wheelchair. In hat the aide could have ok for information on the to a nurse. pm, Administrative Staff #2 acknowledged that some of tivities and social services) ent #3 on 11/22/2011 but she MDS until 1/5/2012. She a comprehensive inpleted, she must do a Care re Plan stays on the chart e care plan gets developed. In the comprehensive care was completed on 1/5/2012. In the with the resident all supports. She stated in 1/6/2012 at 12:41pm, that cerns about her positioning it stated that Resident #3 tupright without back in the position of the posi	F	323			

general decline in Resident #3's abilities and she mentioned to the nurse as well as the nurse practioner that Resident #3 was not improving PRINTED: 01/23/2012

		ND HUMAN SERVICES					APPROVED . 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			****		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
			7. 501	DINO		(·
		345551	B. WIN	G		01/0	7/2012
NAME OF PR	OVIDER OR SUPPLIER		-	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
		CAROLINA BODIT		59	936 MOUNT SINAI ROAD		
UNIHEALT	TH POST-ACUTE CARE	- CAROLINA POINT		D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	added that on one or Resident #3 leaning she was seated in the trying to reach for sofurther stated that Recontrol or stability to support. She also did safety awareness. Nurse Aide #3 was in 2:53pm. He stated the Resident #3 in Decer 2nd and 3rd shifts. If mechanical lift for trasometimes assist NA her. He felt that Respositioning in her wher lean forward where the positioning in her where an incomplete with the time of her admissions she stated that she worked with the time of her admissions she stated that she was resident #3's health that she had dement that she pathers her for a resident from the chart. The Nurse commented were ke	gressing. Therapist #1 casion, she recalled seeing over in her wheelchair, while e hallway, as if she was mething like her shoes. She esident #3 did not have trunk sit up by herself without back In ' t think she had very much atterviewed on 1/6/2012 at eat he began to work with mber and worked with her on ele shared that she needed a ensfers and he would elechair, but he would see en she got sleepy. Bram, a telephone interview Nurse Aide #4. She stated the resident twice; around esion and on 12/30/2011. evasn't that familiar with conditions but that she knew ia, couldn't walk but was told with assistance. She stated source of information to care the nurse or she could go read Aide Care Guide, she put in the nourishment room dinformation about the type	F	323			
	considered total care	ent #3 was that she was e, needing one staff to assist					

that Resident #3 did not require a mechanical lift

PRINTED: 01/23/2012

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	COMPLETE	ED
		345551	B. WIN	G		01/07	7/2012
	OVIDER OR SUPPLIER	- CAROLINA POINT		59	EET ADDRESS, CITY, STATE, ZIP CODE 936 MOUNT SINAI ROAD URHAM, NC 27706		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 323	for transfers. NA #4 continued by sonly assigned to Resobserved her previous or in the television rong Resident #3 could sift wheelchair, and didn her sitting on the edge have to reposition he her chair. NA #4 sha Resident # lean forw both hands on her arrup. She stated that she was a high fall rivyellow wrist band, what to alert staff that a regrisk. She felt that Reside of the bed. During the interview, that on the morning of Resident #3 a bed by She shared that Resident #3 a bed by She shared that Resident #3 a bed by She shared that Resident #4 she bed, then stood in froction to the she shared that the bed, then stood in froction shared that the bed, then stood in froction shared that the bed, then stood in froction shared that Resident #3 stood in the soles of her feet. Nursing Assessment that Resident #3 stood stating that she did now hile she provided gominutes period, because.	saying that although she was sident #3 twice, she had usly, while she sat on the hall om. She recalled that it on her own in her 't slouch. She would witness go of her chair and would are and tell her to scoot back in ared that she had seen ard in her wheelchair, with mrest as if she wanted to get he honestly didn't know if sk because she didn't wear a nich was used as an indicator sident was identified as a fall sident #3 could sit on the Nurse Aide #4 explained of 12/30/2011 she was giving ath and getting her dressed. ident #3 was alert and they see She stated that after she sat her up on the side of the ont of her, repositioning her er hair. NA #4 had the ehind her, as the aide stood. ed was placed at standard dent #3 was able to sit with touching the floor. (The dated 11/22/2011 indicated od 5'4" tall.) She continued by not have to hold Resident #3 rooming over a 3 to 5	F	323			
	.						1

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/23/2012 M APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345551	B. WIN	IG		l l	7/2012
NAME OF PF	OVIDER OR SUPPLIER		• • • • • • • • • • • • • • • • • • • •	i .	ET ADDRESS, CITY, STATE, ZIP CODE		
UNIHEAL	TH POST-ACUTE CARE	- CAROLINA POINT		i	5 MOUNT SINAI ROAD RHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	#3's shoulders, in ord the wheelchair, Residher seated position of the floor. On 1/13/12 at 11:37a interview was conducted that aides can becomeeds by viewing the resident's closet or the aide during their shift worked with Resident wore a yellow wrist brisk for falls. She shiften formed her that Rewho could pivot but a continued by saying, (Resident #3) was a you couldn't handle a would need someons shared that she never Resident #3 demons informed of her stand. On 1/17/12 at 12:17 interview was conducted that she never that the continued that she never that the same that she can transfer interventions onto the shared that on a after Resident #3 fell	ed her hands from Resident der to turn around and move dent #3 had fell forward from in the bed and hit her face on the familiar with a resident's ecare guide located in each the nurse's will instruct the export. When NA #1 the the the treport. When NA #1 the the treport when the familiar with a resident's ecare guide located in each the nurse's will instruct the export. When NA #1 the the the the treport when the the the said that she and, to help identify her as at eared that therapy had sident #3 was a "leaner", would need assistance. She "On paper it said that she one person transfer but if all of the leaning, then you expert had transfer techniques for trated to her, but was ding deficit. The m, a follow up telephone coded with Administrative Staff that when a fall occurs, the podates the interim care plan exventions. The Unit Manager I the nurses make #2 aware of any changes so	F	323			

on 12/26/11, staff intervened by placing a chair

		ID HUMAN SERVICES			FOR	D: 01/23/2012 RM APPROVED O. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	TED
345551			B. WING	9	01/	C 07/2012
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST-ACUTE CARE - CAROLINA POINT				STREET ADDRESS, CITY, STATE, ZIP 5935 MOUNT SINAI ROAD DURHAM, NC 27705	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED)		(X5) COMPLETION DATE
F 323	alarm on her wheelch that wrist bands are rat risk for falls. She s Falls Risk Assessme Resident #3 with a hid her admission, which On 1/17/12 at 1:00pn interview was conducted #1. She stated that the band system to idented She shared that all like update the nurse aid information about fall used. The care guid closet or in the ADL I on 12/26/11; a chair intervention, after Resident of the property of the prope	nair. She further commented not used to identify residents tated that they rely on their nt, which had scored gh score of 14 at the time of placed her at risk for falls. In, a follow up telephone cted with Administrative Staff ne facility does not use a lify residents at risk for falls. It can see a see kept in the resident's cook. She also shared that alarm was added as a fall sident #3 fell that day. In one interview conducted on and 4:45pm, with Therapist #4, pist can make all decision and Resident #3 She shared that Resident #3 It with her transfer skills, she needed max assist of other days, she needed less. It #4 never gave any specific to transfer Resident #3 to the	F3	323		

concerns that Resident #3 had a functional decline with the nurse (name unknown) and

CENTERS FOR MEDICARE & WEDDAND GETTY-STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	COMPLETED			
AND PLAN OF	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERCEIA (X1) PROVIDER/SUPPLIERCEIA (X1) PROVIDER/SUPPLIERCEIA (X2) PROVIDER/SUPPLIERCEIA (X3) PROVIDER/SUPPLIER		A. BUILDING		С	
			B. WNG	01/07/2012		
l .	ROVIDER OR SUPPLIER		593	ET ADDRESS, CITY, STATE, ZIP CODE 55 MOUNT SINAI ROAD IRHAM, NC 27705		
UNIHEAL				BROWNER'S PLAN OF CORRECT	TION (X5)	
(X4) ID PREFIX TAG	A CONTRACTOR MI	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	
F 323	nurse practioner; sh	ge 34 he reiterated her concerns to known) on 12/18/11.	F 323			
	Therapist #1 was in 1/18/12 at 12:12pm worked with Reside to sit in a wheelchal and grab bar transfer instructions to the rused to transfer he wheelchair. He addrecognized that Rewheelchair, so that the ground and this feet firmly on the floor 11/22/11 he must he assistance of to 2 inches, to preforward in her whealigned properly. #3 was transferred could sit for a few never felt comforts she was still max On 1/18/12 at 12: interview was constated that Residem echanical lift be transfer, stand are and (human) supcommented that the nurse aides of without back suppose.	terviewed by telephone on the stated that he primarily in the stated that he primarily in the stated that he primarily in and to assist her with toilet iters. In his role, he never gave murse aides on the manner of the state o				
	On 1/18/12 at 12 in a follow up tel	::26pm, Therapist #1 participated ephone interview. She shared				

CENTERS FOR MEDICARE & N STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			,
		345551	B. WIN		T ADDRESS, CITY, STATE, ZIP CODE	1 01/07	/2012
	OVIDER OR SUPPLIER TH POST-ACUTE CARE	- CAROLINA POINT		5935	S MOUNT SINAI ROAD RHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY S	FATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETION DATE
F 323	that she was the eva #3 whereas Therapi care. She shared the #3 were all within further did not have any coneed upper extremi (i.e. wheelchair back that depending on the Resident #3, she mone or two persons demonstrate any transcribe aides, since inconsistent with her the Administrators Immediate Jeopard facility provided a Compliance on 1/7 allegation of compliance on 1/7 allegation of compliance. Credible Allegation 1. Resident #3 where Practioner. An order was transferred to the inconsistent #3 where was t	aluating therapist for Resident st #4 administered the plan of at the extremities of Resident nctional limits and that she intractures. However, she did ty support from something k) or someone. She added he day that you worked with light need the max assist of ansfer techniques to any of the Resident #3 was so ar transfers. Were notified of the ly on 1/6/2012 at 7:55pm. The Credible Allegation of 1/2012 at 9:00pm. The iance indicated:	F	323			
	12/30/11. 5. The employed verbally counseled involved turned as reposition the when resident fell to the	e involved in the occurrence was d and no longer is employed. tion identified that the employee way from the resident to sel chair for transfer and					

PRINTED: 01/23/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 01/07/2012 345551 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **6935 MOUNT SINAI ROAD** UNIHEALTH POST-ACUTE CARE - CAROLINA POINT DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 F 323 Continued From page 36 1. All residents fall risk assessments have been reviewed and revised as required, by the Director of Health Services, Unit Managers, Wound Care Nurse and Senior Nurse Consultant to identify the high fall risk residents on 1/7/12. Sixty-three out of One Hundred and Nine residents have been identified as high risk for falls. The Fall Risk assessment includes resident 's level of consciousness, history of falls, ambulation status, vision status, gait/balance, blood pressure, medications and predisposing disease. Residents identified with a high fall risk have been evaluated for interventions and implementation of the interventions to prevent further occurrences are in place i.e., mat, alarms, positioning devices on 1/7/12. 3. Residents identified as a high fall risk who have not previously been screened for trunk balance will be screened by United Rehab Department for trunk control and balance beginning on 1/7/11 and continuing until all high risk residents have been completed. 4. Care plans have been reviewed by the Director of Nursing, Unit Managers, Wound care nurse and clinical reimbursement director on 1/7/12 and revised accordingly if interventions have not been previously identified. 5. The Nursing Assistant care guides have been reviewed by the Director of Health Services, Unit Managers, Wound Care Nurse and Senior Nurse Consultant on 1/7/12, the residents ' interventions related to fall prevention has been

added to the Nurse Aide care guide.
6. The Director of Nursing, Unit Manager, and/or Clinical Care Competency Coordinator began education related to interventions placed on the C.N.A care guide was started on 1/6/12 and will continue until all staff has been educated.

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D; 01/23/2012 M APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345551		B. WIN	۷G		1	C 7/2012
NAME OF PE	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIHEAL	TH POST-ACUTE CARE	- CAROLINA POINT		1	5935 MOUNT SINAI ROAD DURHAM, NC 27705		1111
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΉX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	The nursing assistan guide prior to each sare located at the nurbinder and the ADL ocharge nurses, Clinic Director of Health Sewith order changes a condition. All nursing on the ADL care guidenext scheduled shift. 7. Education relateresident requires for 1/6/12 that included the resident requires care guide and will obeen completed. Nureducation prior to be shift. This education of Nursing, Unit Man Competency Coordinator, Senior Care Partner, Coordinator, Senior observing certified nuthey are transferring care plan and ADL of the utilization of supprontrol and amount of transfers. 9. Education relatered include investigation was started on 1/6/1 nursing assistance a continue until all staff Licensed and Nursin prior to beginning the education was provided.	t is to check the ADL care hift; the ADL care guides rse's station in a specific rare guide is updated by the ral reimbursement director, rvices, and/or Unit Managers and significant change of staff will receive education be prior to beginning their d to the assistance the transfers was started on colacement of the assistance for transfers on the ADL continue until all staff has rsing Assistants will receive riginning their next scheduled was provided by the Director ager and/or Clinical	F	32	23		

CENTERS FOR MEDICARE & MEDICALD SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING C B. WNG 345551 01/07/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6935 MOUNT SINAI ROAD** UNIHEALTH POST-ACUTE CARE - CAROLINA POINT DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 38 F 323 Competency Coordinator. Measures and Systemic Changes 1. An incident occurrence investigation form that identifies what the resident was doing prior to the occurrence, statement from resident of what occurred and statements from staff members with a synopsis of what led to the occurrence has been initiated on 1/6/12. This incident occurrence investigation is to be initiated by the Charge Nurse on duty at the time of the occurrence. 2. The Administrator and/or Director of Health Services will review and summarize each incident occurrence investigation daily Monday through Friday with summarization on the investigation form. 3. Education related to updating care plans, Nurse Aide care guides related to resident transfers has been added to the general orientation for Licensed Nurses and Nursing Assistance. 4. Education related to incident occurrence investigations and incident occurrence reporting has been added to general orientation for all staff. 5. All incident occurrences will be brought to the stand up meeting daily Monday through Friday by the unit managers for review of the occurrence documentation for completeness, interventions and summarization. 6. Care plans will be reviewed and /or revised in the daily morning meetings Monday through Friday by the Director of Nursing, Unit Managers, and/or Case Mix Director of all residents with occurrences and/ or significant change of condition. Director of Health Services, Unit Managers, 7. Clinical Competency Coordinator and/or Senior Care Partner will observe 10 residents per day to validate the Nursing Assistants are providing

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/23/2012

FORM APPROVED

		ND HUMAN SERVICES				FORM	0: 01/23/2012 I APPROVED 0: 0938-0391
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULT	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345551	B. W/	1G_		i	7/2012
NAME OF PR	OVIDER OR SUPPLIER	<u> </u>		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIHEALT	TH POST-ACUTE CARE	- CAROLINA POINT		ı	5935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	plan. Monitoring 1. The Director of FAdministrator will aud occurrences for intended of the interventions a and significant changidentified on the ADL daily for seven days then monthly thereaft 2. The Clinical Reir (CRC) will audit the fMDS 's and care pla four weeks then mon 3. The Senior Nurse the occurrence logs a interventions and impand investigation were monthly thereafter. 4. The Director of Naudit the Fall Risk as ADL care guides for it daily for seven days, monthly thereafter.	dealth Services and/or dit documentation of vention and implementation and investigation completion les to ensure they have been care guide and care plan, then weekly for four weeks ter. Inbursement Consultant acilities significant change and for accuracy weekly for thly thereafter. The Consultant (SNC) will audit and review the charts for blementation of interventions ekly for four weeks then Nursing / Unit Manager will sessments, Care Plans and fall prevention interventions weekly for four weeks then	F	32	3		
	Competency Coordin partner regarding res the nursing assistant accordance with the conducted daily for s four weeks then mon observation audits with the conducted daily for seconducted daily for sec	nator and/or Senior care ident observation to ensure s are providing care in resident care plan will be even days then weekly for ithly. The results of the ill be monitored monthly by					
	compliance.	y audits of the documentation					

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	0:-01/23/2012 1 APPROVED 0: 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345551	B. WIN	1G		1	C 7/2012
NAME OF PR	OVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT				5	5936 MOUNT SINAI ROAD		
OMBIEAE		· OAROLINA POINT		[DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Continued From page	≥ 40	F	323			
		d all significant changes, the	,	0_0			
		ent Consultant accuracy					
		Nurse Consultant audit of					
	the occurrence logs for						
	implementation and in monitored monthly by	•					
	Improvement Commit						
	7. All audited findin						
	DHS/Administrators of						
	_	ificant changes, CRC					
	<u>-</u> -	eview of the charts for					
		lementation of interventions ucation in general orientation					
		e monthly Performance					
		tee meeting for patterns and					
		erventions developed as					
	necessary to ensure	continued compliance.					
		in was verified 1/7/2012 at					
		d by staff interviews on					
		wing Certified Nurse Aide					
	and reviewing Fall Ris	ting fall investigation reports	1				
	and leviewing I all IVE	on assessinents.					
	Review of in-service	records for Performing Safe					
		orting (to include how the					
		Developing Care Plans,	İ				
		sessments, and Updated					
		d participation by 48% of			The state of the s		
		g, dietary and therapy staff. ified and re-screened by					
		to determine if they were at					
		lance while sitting, 69			1		
		ified as high risk and/or with					
		Their charts were reviewed					
		es, care plans, fall risk					

assessments as well as observation of interventions to be used to prevent falls.

PRINTED: 01/23/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WNG 345551 01/07/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5935 MOUNT SINAI ROAD UNIHEALTH POST-ACUTE CARE - CAROLINA POINT** DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 323 Continued From page 41 F 323 A revision dated 1/7/2012 was made to the Incident Fall Report to include an Accident Occurrence Investigation Summary that identifies what the resident was doing prior to the occurrence, statement from the resident of what occurred and statements from staff members with a synopsis of what led to the occurrence. F 496 483.75(e)(5)-(7) NURSE AIDE REGISTRY F 496 VERIFICATION, RETRAINING SS=D F 496 Immediate action taken: Before allowing an individual to serve as a nurse 1. All Certified Nursing Assistants aide, a facility must receive registry verification licenses where verified as that the individual has met competency evaluation current requirements unless the individual is a full-time 2. Employees found to have an employee in a training and competency inactive license have been evaluation program approved by the State; or the removed from the schedule until individual can prove that he or she has recently verification has been received as successfully completed a training and competency evaluation program or competency completed. Action taken for others with potential to evaluation program approved by the State and be affected: has not yet been included in the registry. 1. All Certified Nursing Assistant Facilities must follow up to ensure that such an individual actually becomes registered. licenses have been validated as active. Before allowing an individual to serve as a nurse 2. All employees found with inactive aide, a facility must seek information from every licenses have been removed State registry established under sections 1819(e) from the schedule until screening (2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program. there has been a continuous period of 24

consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and

DEPART	MENT OF HEALTH AI	ND HUMAN SERVICES					: 01/23/2012 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PF					PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345551	B. WiN	IG			
		340001		T		01/07	//2012
NAME OF PE	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT				l	935 MOUNT SINAI ROAD PURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 496	by: Based on record revifacility failed to ensure #7 & NA #8) maintain registrations, before volume and the findings include: 1. On 1/7/2012, a reof the employee person (NA #7) was hired on registration expired on Nurse Aide I Registry revealed that her registration expired on 12/6/11. The daily nursing associated and it reveals that her registration and it reveals the for 1st shift worked her assignment on 1/7/12 at 4:00pm, 4 and #5 were informexpired on 12/31/11 are sidents. They were documentation that sidents are sponsibilities of vericertifications. She addeveloping a system of the system o	on program or a new on program. It is not met as evidenced sew and staff interviews, the set that 2 of 4 nurse aides (NA ed current nurse aide vorking with residents. Second review was conducted onnel files. Nurse Aide #7 5/3/2011. Her nurse aide in 12/31/2011. A copy of the Verification of Listings stration was last verified on signments for 1/6/12, were led that NA #7 was on the (6:00am-2:00pm) and had int. Ithe Administrative Staffs # ned that NA #7's registration and continued to work with a saked if they had any new nowed that NA #7's renewed. Administrative he recently took over the	F	496	have returned as activ 3. All certified nursing as licenses are verified p first day of employmen nursing assistant with licenses will not be ab employment until licer been activated. Measures and Systemic Chart. All new employee Lice validated prior to the first day work. The Administrator is resign off on all new emprior to their first day walidate the, license whave been completed received. Current Employees Lievalidated the month preceived. Current Employees Lievalidated the month preceived. Certified Nursing Assistant placed on the schework if they allow their lapse. The Clinical Competer Coordinator is responsination all certified in assistant licenses and expiration dates. Monitoring: All audited findings from Administrator audits restricted in the pre-employment seprocess will be review monthly Performance Improvement committed.	sistant rior to the nt. Certified inactive le to start ises have leses are rist day of equired to ployee files vork to erification and censes are rior to their stants are edule to license to ursing monitor m the elated to creening ed in the	

they became aware on 1/7/12 that NA #7's

for patterns and trends and

further interventions developed

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES					ED: 01/23/2012 RM APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345551	B. WIN	IG			C
NAME OF DR	OVIDER OR SUPPLIER	040001		Г		01	/07/2012
	TH POST-ACUTE CARE -	CAROLINA POINT		51	REET ADDRESS, CITY, STATE, ZIP CODE 1936 MOUNT SINAI ROAD DURHAM, NC 27706		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.D BE	(X6) COMPLETION DATE
F 496	On 1/7/12 at 6:30pm, produced a copy of N. documented that she 5:59am to 2:02pm and 8:32am. 2. On 1/7/2012, a re of the employee perso (NA #8) was hired on expired on 12/31/2011 I Registry Verification registration was last v. The daily nursing assi reviewed and it reveal schedule for 2nd shift worked his assignment. On 1/7/12 at 4:00pm, and #5 were informed expired on 12/31/11 a residents. They were documentation that she registration had been staff #5 shared that she responsibilities of verifications. She add on developing a syste Administrative Staff #4 realized that NA #8's rand released him from home.	ed, they released her from er home. Administrative Staff #4 A #7's time card which worked on 1/6/12 from d on 1/7/12 from 6:10am to ecord review was conducted onnel files. Nurse Aide #8 9/6/2011. His registration 1. A copy of the Nurse Aide of Listings revealed that his erified on 12/6/11. gnments for 1/6/12, were ed that NA #8 was on the (2:00pm-10:00pm) and had at. the Administrative Staffs #4 that NA #8's registration and continued to work with asked if they had any new lowed that NA #8's renewed. Administrative the recently took over the	IF.	496	as necessary to ensure continued compliance. 2. The Clinical Competency Coordinator will audit all cenursing assistant licensure monthly and report findings the performance improveme committee for patterns and trends and further interventideveloped to ensure continucompliance.	to ent ions	
	produced a copy of NA						

DEPAR	MENT OF HEALTH AN	ND HUMAN SERVICES					ED: 01/23/2012	
		MEDICAID SERVICES					RM APPROVED NO. 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
	!	345551	B. WI	۱G_		C 01/07/20		
NAME OF P	ROVIDER OR SUPPLIER			91	TREET ADDRESS, CITY, STATE, ZIP CODE	01,	07/2012	
UNIHEAL	TH POST-ACUTE CARE -	CAROLINA POINT		l	5936 MOUNT SINAI ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 496	Continued From page documented that he w 1:54pm to 10:01pm; 1 8:38pm and 9:16pm to 1:58pm to 10:08pm ar 2:12pm.	orked on 1/2/12 from	F	496	6			