STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, cleaning schedule review and staff interviews, the facility failed keep resident care areas and common areas free from offensive odors that resembled urine, stool and sour milk. This was evident in 3 of 3 nursing units (100, 200 and 300) and in the 200 and 300 common areas. The facility staff failed to keep mattresses free from urine odors. This was evident in 1 of 3 nursing units (300 unit). Findings include: Upon entry to the facility at 3:30 PM on 10/16/12, odors that resembled urine were noted all up and down the 200 and 300 hallways. An odor resembling sour milk was noted along the 200 hallway at 3:35 PM and was most pungent outside the kitchen door. During the initial tour at 4:30 PM on 10/16/12 the bathroom in room 338 was observed to have a very strong urine odor. The strong odor of urine remained present through 10/19/12. Observations of the environment on 10/18/12 at 1:45 PM through 2:20 PM were conducted with the housekeeping supervisor. The observations were of mattresses in rooms used by residents: · Observations revealed in room 335 A that the	F 252	F 252 1. The facility replaced the mattresses/overlays of the affected resident's in rooms 333, 334-A, 335-A, 338, 339-C and 340-D. No other mattresses needed to be replaced. 2. A 100% audit of all facility mattresses was conducted by the Housekeeping Manager on November 09, 2012 to ensure all mattresses were free of lingering odors. 100% of the mattresses were cleaned and no other mattresses needed replacement. 3. An in-service was conducted by Housekeeping Manager and Nursing Supervisor on November 09, 2012 through November 30th for all Housekeeping/nursing and new hire orientation employees to monitor for lingering mattress/overlay odors and cleaning them with 1/4 bleach solution when soiled. The facility will follow our policy of bed cleaning when the bed is vacated, once per month, and as needed. The residents with overlays will have their overlays changed daily with compliance from residents. 4. Audits will be conducted by the Housekeeping Department for all facility residents to ensure that mattresses are free of odors. This audit will be conducted three times per week for four weeks, and then weekly until the ventilation system is installed. The results of this audit will be monitored by the Housekeeping Manager and reviewed in the monthly Quality Assurance Committee.	11/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Cooper | TITLE: Administrator | (X6) DATE: 11/28/12

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

VPB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 1 mattress had a strong smell that resembled urine. · Observations revealed in rooms 339C, 334, 333 and 338 A and B ' s mattresses had strong smell that resembled urine. Observations revealed in room 340 D the mattress had white stains and had a strong smell that resembled urine. Interview with the housekeeping supervisor during the environmental tour and at 2:30 PM on 10/18/12 revealed it was the responsibility of the nursing assistant to clean the mattresses when they become soiled. The housekeeping supervisor indicated that the housekeepers wipe the mattresses daily and indicated he conducts monthly deep cleaning. Review of the deep cleaning schedule revealed rooms 111, 112, 113, 114, 333, 334, 335 and 336 were scheduled for deep cleaning. Interview on 10/18/12 at 1:45 PM through 2:20 PM with the housekeeping supervisor indicated that the cleaning of the rooms did not occur because he was short staffed. During the interview the housekeeping supervisor indicated "we (referring to his department) can not be cleaning mattresses all the time because we have other things to do." Interview on 10/18/12 at 2:45 PM with nursing assistant #6 revealed she would call the housekeepers to clean the mattresses or they might give her spray off of their carts.	F 252		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to lock the wheelchair when attempting to transfer Resident #11 to the bed. This was evident in 1 (one) of four (4) sampled residents reviewed for accidents. As a result, Resident #11 sustained a right fractured humerus (fracture of the upper arm bone) and a right intertrochanteric fracture (fractured hip). Findings included: Resident #11 was initially admitted to the facility on 6/6/12 with cumulative diagnoses which included Bipolar disorder, psychosis and hypertension. Review of the June 2012 physician orders included Lisinopril 5 milligrams (mg) by mouth (po) every day to manage hypertension, Lexapro 20 mg every day po(an antidepressant drug) and Zyprexa 2.5 mg po at bedtime (a drug used to treat Bipolar disorder). Review of the medical record revealed the Minimum Data Set (MDS) assessment tool had not been completed by the time of the incident (6/12/12). Review of the admission/nursing evaluation form dated 6/6/12 revealed Resident #11 was alert but	F 323	F-323 1. Resident # 11 was discharged from the facility on 08/22/12. No other residents were affected by the same practices. 2. An In-service of all facility current Licensed Nursing and Nursing Assistants on physical transfer techniques was conducted on November 09, 2012 through November 30, 2012 by the Director of Nursing, Assistant Director of Nursing, Weekend Nurse Supervisor and Physical Therapy on resident transfers from wheelchairs observation with return demonstration will be included in the orientation for Nursing Assistants. 3. The Assistant Director of Nursing will be responsible for investigating falls with transfers to ensure proper techniques were used daily during morning stand up. A 1:1 meeting will be performed with the identified staff to ensure proper techniques were used. If not coaching/counseling will begin by the facility policy. 4. Audits for resident falls will be reviewed by the Director of Nursing daily in the morning interdisciplinary meeting for four weeks and then bi-monthly for three months, for 100% compliance for transfers with tracking and trending. The results will be noted by the Director of Nursing and brought to monthly Quality Assurance Committee for evaluation and suggestions for changes or improvements as indicated.	11/30/12

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	345105	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

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F 323	Continued From page 3	F 323		

confused. Resident #11 was able to comprehend and ambulate with 1-2 persons. Her balance was steady only with stabilization with human assistance when moving from a seated to standing position.

A fall risk assessment was done on 6/6/12 . Review of the fall risk assessment revealed a score of 10. The fall risk form indicted that a score of 10 or more indicates a fall risk and interventions should be promptly put in place.

Review of the interim care plan dated 6/6/12 revealed resident was at risk for falls related to limited mobility, a history of falls and neuropathy (nerve disorder). Some of the interventions included assisting resident with toileting and transferring.

Review of the Resident Incident Report form dated 6/7/12 revealed on 6/7/12 at 5:30 a.m. resident was found on the floor. This form indicated that Resident #11 was confused and disoriented prior to the fall. A second Resident Incident Report dated 6/7/12 revealed on 6/7/12 at 4 p.m. the resident was noted sitting on the floor beside the bed.

Continued review of the careplan revealed written entries that indicated the resident had fallen twice on 6/7/12 and a clip (personal) alarm was implemented.

Review of the nurses' notes (authored by Nurse #1) dated 6/12/12 at 12:05 am revealed NA#5 (nursing assistant) was attempting to transfer Resident #11 from the wheelchair to bed and Resident #11 stood up unexpectedly. Resident

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	345105	A. BUILDING _____ B. WING _____	10/19/2012

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UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

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F 323	Continued From page 4 #11's wheelchair rolled back and she fell down before NA#5 could catch her. ROM (range of motion) was performed and resident #11 was able to move all extremities. By 6/12/12 at 10:40 a.m. Resident #11 right shoulder, arm and leg were painful with swelling noted. " Tylenol " (no dose noted) was given initially. An order was obtained for x-rays of the right arm and hip. Then Ativan 0 .5 mg and Vicodin 5/500 mg were administered for pain management. On 6/12/12 at 7 p.m. the results of the x-rays revealed an acute right humeral fracture and acute right intertrochanteric fracture. The physician was contacted and the resident was transferred to the hospital and admitted. Interview via the phone on 10/19/12 at 3:57 p.m. with Nurse #1 revealed NA#5 called her while she was at the nurses' station informing her that the Resident #11 had fallen. "I assessed her and she did not have problems initially. " Nurse #1 indicated that NA#5 did not lock the wheelchair on attempt to transfer Resident #11. Interview with the administrator on 10/19/12 at 3:20 p.m. indicated that NA#5 failed to lock the wheelchair and indicated that he just addressed the fall issue with NA#5. Interview on 10/19/12 at 4 p.m. via the phone with NA#5 (involved in the incident) revealed " I heard the personal alarm sounding and went into the resident's room to find out what was going on. " NA#5 indicated Resident#11 told her that she had to go to the bathroom. I helped her to the bathroom and was in the process of transferring her (back into the bed). I reached to move the	F 323		

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	345105	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

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F 323	Continued From page 5 bedside table when the resident hopped up out of the wheelchair. The wheelchair rolled and she fell. I did not get a chance to lock her wheelchair before transferring." NA#5 indicated the facility spoke with her regarding the failure to lock the wheelchair during a transfer. Review of the nurses' notes dated 6/18/12 at 12:30 p.m. revealed the resident was readmitted to the facility. Review of the hospital discharge summary dated 6/18/12 revealed Resident #11 had a right hip open reduction (internal fixation) done to repair the fracture. Interview on 10/19/12 at 5:41 pm with the administrator and the director of nurses was held. Their expectations were to have staff be positioned in front of the resident and to lock the wheelchair during a transfer. Interview on 10/19/12 at 4:53 p.m. with the attending physician (MD) and administrator was held. The MD indicated Resident #11 fell at home and had unpredictable behavior at home.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care;	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

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F 328	Continued From page 6 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review the facility failed to provide colostomy (external stool collection apparatus) care to a resident dependent on the staff for all activities of daily living. This was evident for 1 of 1 resident with a colostomy. (Resident # 6) The findings: Resident # 6 was readmitted to the facility on 5/20/12 with multiple wounds, contractures of hands and feet and spasms, pressure ulcers, supra pubic urinary tube and colostomy. According to the assessment dated 5/20/12, Resident # 6 was alert and oriented and able to make his needs known. He was totally dependent on the staff for assistance with all ADL care needs. A review of the care plan for self care deficit updated on 08/20/12 revealed the resident required total staff assistance for all his care needs due to his diagnosis of contractures of his hands, left wrist and generalized weakness. A review of the care plan for colostomy care documented " Has colostomy- needs staff assist with care " . One of the approaches documents " change stoma wafer as needed, monitor stoma site for color and size " . An observation on 10/18/12 at 2:48 PM of Resident # 6 was lying in bed, his colostomy wafer tape was noted to have dark brown staining on the adhesive. The resident stated it had been like this since his colostomy was emptied	F 328	F 328 1. Resident #6's external stool collection apparatus was changed on 10/19/12. The order was added to the Treatment Administration Record and modified to care for daily and as needed if external stool collection apparatus is soiled. This will be cared for and monitored by the Licensed Nurses. 2. A 100 percent audit of all residents with external stool collection apparatus was done by the Director of Nursing. No one else was affected by the deficient practice. The Treatment nurses and Charge nurses will be responsible for changing the external stool collection apparatus for all resident's with the external stool collection apparatus. 3.The Director of Nursing, Assistant Director of Nursing and Weekend Nurse Supervisor will in-service the Nursing Staff, new hire nurse orientation participants and Treatment Nurses from November 09, 2012 through November 30, 2012 on providing ADL care for external stool collection apparatus according to the physicians order. The physicians order was placed into the Treatment Book. 4. These audits will be monitored daily by the Director of Nursing/ Weekend Nurse Supervisor (Monday through Sunday) for four weeks, then bi-weekly for three months to ensure compliance with colostomy care per policy. The results of these audits will be monitored by the Director of Nursing for tracking and trending and reviewed monthly in our Quality Assurance Committee for evaluation and suggestions for changes or improvements as indicated.	11/30/12

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	345105	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

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F 328	Continued From page 7 yesterday. He was told by the NA that the nurse would change this but it has not been changed yet. An observation on 10/19/12 at 11:30 AM after the resident had received morning personal care the colostomy wafer and tape was noted to have dark brown staining on the adhesive. The resident stated " this still had not been changed I told the nurse " . During an interview with NA # 4 on 10/19/12 at 11:45 AM, he indicated he did not care for the colostomy, which was done by the nurse. He does empty it each shift. He further indicated he did not notice any staining to the wafer tape. A review of the Medication Administration Record (MAR) dated October 2012 revealed an order for Colostomy Care PRN. There was no documentation in the allotted section for initials of the nurse that provided care for the resident. During an interview on 10/19/12 at 12:30 PM with the treatment nurse she indicated the nurse on the hall does the care for the colostomy and should be checked each shift. She further indicated that the supplies are in the supply room and they should be changing and assessing the site when the stoma wafer was changed. It should be documented on the MAR when care was provided. During an interview with hall Nurse # 2 on 10/19/12 at 12:20 PM she does not care for the colostomy the treatment nurse was responsible to change the wafer each day. If it was soiled or needed care the NA should tell the treatment nurse. The nurse reviewed the October 2012 MAR and noted the documentation for care of the colostomy, she stated, " I guess I should check his colostomy if it is listed on the MAR. " During an interview with the DON (director of	F 328		

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F 328	Continued From page 8 nursing) on 10/19/12 at 2:55 PM she indicated her expectation was that the NA would assess the wafer after the colostomy was emptied and if there was any stool that leaked on the wafer or adhesive, the NA would notify the nurse and it would be changed by the nurse on the hall. The nurse should document on the MAR when care was provided.	F 328		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-HIGH POINT	3030 N MAIN STREET HIGH POINT, NC 27265

RECEIVED JAN 03 2013 CONSTRUCTION SECTION

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/28/2012 there was an unprotected three (3) inch PVC vent passing through the rated ceiling of the laundry. 42 CFR 483.70 (a)	K 012	1. A collar was installed to protect the 3 inch PVC vent that passes through the rated ceiling of the laundry. 2. Any new construction or renovations will be inspected to ensure that it functions properly. 3. The collar on the PVC vent will be checked on a monthly basis during preventive maintenance checks. 4. Preventive Maintenance logs will be reviewed monthly during our Performance Improvement Committee by the Maintenance Director for suggestions and recommendations for change and improvements.	11/29/12
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/28/2012 the facility had NC Special Locking on the exit doors but there was no Master release switch/switches at the nurses stations. 42 CFR 483.70 (a)	K 038	1. Estimates for installing an Master Release switch/switches at the nurses stations will be installed. 2. Any new construction or renovations will be inspected to ensure that the proper releasing of the exit doors. 3. All Master release switches will be checked on a monthly basis during preventive maintenance checks. 4. Preventive Maintenance logs will be reviewed monthly during our Performance Improvement Committee by the Maintenance Director for suggestions and recommendations for change and improvements.	SEE LETTER FOR TEMPORARY WAIVER REQUEST
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Cooper — TITLE: Administrator — (X6) DATE: 12/26/12

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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

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K 061	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 11/28/2012 the tamper alarms on the sprinkler riser valves , located in the employee break room failed to activate an audible or a visual signal. 42 CFR 483.70 (a)	K 061	1. The tamper alarms on the sprinkler riser valves located in the employee break room was replaced by s new valves on 11/29/12 by BFPE. 2. Any new construction or renovations will be inspected to ensure that it functions properly. 3. The tamper alarms on the sprinkler riser valves will be checked on a quarterly basis during preventive maintenance checks by BFPE. 4. Preventive Maintenance logs will be reviewed quarterly during our Performance Improvement Committee by the Maintenance Director for suggestions and recommendations for change and improvements.	11/29/12

CP