STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 04/16/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Health Service Regulation, Nursing Home Licensure and Certification Section, conducted a complaint investigation from 4/8/13 through 4/9/13. An extended survey was done on 4/15/13 and 4/16/13. Immediate Jeopardy was identified at CFR 483.25. The Immediate Jeopardy began on 3/28/13 and was removed on 4/16/13 at 6:51 PM when the facility provided a credible allegation of compliance.The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective.	F 000	This plan of correction constitutes a written allegation of compliance, preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on this statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law	
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, Emergency Medical Services (EMS) interview and hospital staff interviews the facility failed to provide the correct Resident's demographic, history, and advanced directive information, for full code status, to allow a medical team to use every possible measure to sustain life for 1 of 4 residents (Resident #1) reviewed for acute care	F 309	F 309 **IMMEDIATE CORRECTIVE ACTION** Resident #1 is no longer in the facility **METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED** Advance directive audits were completed for all residents on 4/15/13 by the Assistant Director of Health Services. Senior Care Partner, Clinical competency Coordinator and Unit managers. Moving forward, advance directive audits will be completed for all new admissions, re-admissions and then quarterly for all residents by Senior Care Partner quarterly, using advance directives audit tool.	4/23/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	5/2/2013

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.

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UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	6935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 309	Continued From page 1 transfer to the hospital. Immediate Jeopardy began on 03/28/13 at 7:00 AM when facility staff provided the Emergency Medical Services team, the Face Sheet, Medication Administration Record (MAR), recent lab reports, and Do Not Resuscitate (DNR) order, from the clinical record of the wrong resident (Resident #2) during Resident #1 ' s acute episode of respiratory distress and transport to the hospital. Immediate jeopardy was removed on 04/16/13 at 6:51 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective. Findings included: Resident#1 was admitted to the facility on 3/21/2013 with diagnoses including acute and chronic respiratory failure, acute and chronic exacerbation of chronic obstructive pulmonary disease (COPD), upper extremity deep venous thrombosis (DVT), abdominal aortic aneurysm (AAA), and pulmonary hypertension. A record review revealed a 2 page document for Advance Directives. On page 1 which was titled Advance Directives Checklist, the Power of Attorney had checked ' I have not executed an advance directive, and do not wish to discuss advance directives further at this time ' and signed the page. On page 2 titled, Consent Form for " Do not Resuscitate " Order the Power of Attorney had signed the area that read Full Code; a term for	F 309	**SYSTEMIC CHANGES** Director of Health Services, Assistant Director of Health Services, Clinical Competency Coordinator, Unit managers and Shift Supervisor completed in-service education sessions on 4/22/2013, for all licensed nurses on all shifts to stress the importance of ensuring correct information is sent with the resident at the time of transfer. This includes a copy of; Resident's face sheet, Resident Transfer Form, Medication Administration Records, Diagnosis List/Sheet, Do Not Resuscitate (Golden Rod Form), Advance Directives, Physician Communication tool, and Bed hold documentation. Charge nurse will cross check/double check Medical records sent to the hospital with another staff witness; using the "acute care transfer & release of medical records acknowledgment form" this form identifies documents sent with the EMS to the ED at the time of transfer. Acute care transfer & release of medical records acknowledgment form will be maintained in the resident medical records. Staff will be made aware of advanced Directives located under the advance directive tab in a resident medical record and by way of the Medication Administration Record and the CNA care guides.	

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F 309	Continued From page 2 when a medical team uses every possible measure to sustain life, dated 3/21/13. The Minimum Data Set discharge assessment dated 03/24/2013 indicated Resident #1 was cognitively intact. Review of the clinical record revealed that on 3/24/2013 he was transferred to a Hospital after a 911 call for an episode of coughing, shortness of breath, and wheezing. The clinical record indicated he returned to the facility on 3/25/2013. There were no changes made to Resident#1 ' s Advance Directive Order. On 3/28/2013 a second 911 call was made for breathing problems and EMS was dispatched to the facility. Review of nurse note from 3/28/13 revealed at 7:00 AM the resident was in his room yelling for help. The nurse ' s note indicated that upon exam Resident #1 ' s skin was clammy and the resident was gasping for air. Vital signs readings included an oxygen saturation of 64% so a respiratory treatment was initiated. A recheck of the oxygen saturation increased the oxygen saturation value to 80%. The note said the resident lost consciousness and EMS was called. The note also said an order was received to send the resident to the hospital. An interview was conducted on 4/9/2013 2:15 PM with Nurse#1, the Resident's primary nurse on 3/28/2013. Nurse#1 said he was called to the Resident's room by the nurse aid. When Nurse #1 approached the Resident's room, he could hear the resident calling for help. Nurse#1 assessed the resident, recognized his trouble breathing and provided a breathing treatment.	F 309	**MONITORING PROCESS** Director of Health Services, Assistant Director of health Services and/or unit managers will review clinical records for hospital transfers to ensure that the "Acute care transfer & release of medical records acknowledgment form" is utilized appropriately monthly x 3 months then quarterly thereafter. Utilization of Acute care transfer & release of medical records acknowledgment form will be tracked monthly and discussed in our QAPI process. Additional action planning will be implemented by the QAPI committee as necessary	

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F 309	Continued From page 3 Resident#1's pulse oximtery reading was low, the breathing treatment did not improve the resident ' s condition, and the resident was in and out of consciousness so 911 was called. Nurse#1 reported having made copies of the medical record in a centralized copy room and handing them to EMS transport. He spoke to the EMS team about Resident#1's recent hospitalization on 3/24/2013 and provided the EMS team with the discharge summary from 3/25/2013. Nurse#1 reported that during his chart completion he realized the chart sent with the EMS team was incorrect, at the same time the hospital was calling for identity clarification of the resident that was sent to the hospital. Nurse#1 stated that he clarified over the phone with the hospital staff that Resident#1 was the correct resident, that Resident#1 was a full code, and to provide services if needed. Nurse#1 announced he would be at the hospital in 15 minutes with the correct papers and to retrieve the do not resuscitate (DNR) paper belonging to Resident #2. When asked, Nurse#1 indicated that prior to the incident he was unaware of the Resident#1's code status/advance directives. Record review of EMS transport log on 3/28/2013 revealed the EMS team was dispatched at 6:46 AM, arrived at the nursing home at 6:58 AM, left the facility at 7:35 AM, and arrived at the hospital at 7:42 AM. EMS record log documented the following: 6:59 AM, skin cool and pale with excessive moisture; lungs sound normal; capillary refill absent; blood pressure 90/60; pulse 90bpm (beats per min) weak and regular; respirations 36 per minute and labored; and a normal heart rhythm with some premature beats.	F 309		

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F 309	Continued From page 4 7:14 AM reported an absent blood pressure; pulse 172bpm; respirations 34 per minute and labored; and a fast abnormal heart rhythm. 7:25 AM reported an absent blood pressure; pulse 166bpm; respirations 35 per minute and shallow; and a fast abnormal heart rhythm. 7:35 AM reported an absent blood pressure; pulse 114bpm weak and irregular; respirations 32 per minute shallow and irregular; and a change in the abnormal heart rhythm. 7:39 AM reported an absent blood pressure; pulse 44bpm weak and regular; respirations 4 per minute to absent; and a slow abnormal heart rhythm. 7:42 AM reported an absent blood pressure; pulse 40bpm weak and regular; respirations 13 per minute with EMS assisted ventilation; and a slow abnormal heart rhythm. The EMS trip log indicated that Resident#1 experienced multiple changes in condition during transport and the changes were treated with continuous high flow Oxygen; intravenous fluids (IVF); multiple electrocardiograms (EKG) a test to check the hearts electrical activity; Adenosine (a medication to treat irregular heartbeats); continuous positive airway pressure (CPAP); a nasal airway to support breathing efforts; and finally the EMS team member#1 assisted Resident# 1's with his breathing by providing breaths. EMS team member#1's narrative notes revealed Resident#1 was sitting in a wheelchair with nasal cannula at 3 liters per minute. Resident#1 was in obvious respiratory distress with an increased work of breathing, abdominal retractions, eyes wide open, not blinking, and only making sounds	F 309		

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when asked his name. The facility staff reported Resident# 1 was just in the hospital for the respiratory problems but the staff was unsure of the diagnosis. EMS team member#1 also reported staff said they were unsure of his specific information such as demographics, diagnosis, medications, and allergies and they would give EMS the paperwork. Resident#1 was agitated and pulled at the oxygen mask. Residen#1 stated he felt a little better after the medications. Resident#1 stated "hurry up lets go." During transport Resident#1's Glasgow Coma Scale (GCS) decreased. (GCS is a tool for recording the conscious state of a person). The notes stated Resident#1's breathing had become "agonal" (an inadequate pattern of breathing associated with extreme distress).

Due to the event an EMS internal report was written by EMS team member#1. The internal report included, "Code 3 transport to (hospital). During transport pt (patient) condition deteriorated rapidly until pt (patient) had only agonal respirations and weak central pulses. Due to DNR, I chose to support pt respiratory efforts with [a tube in the nose to protect the airway] and [a mask placed over the nose and mouth to force oxygen in to the lungs] instead of placing an advanced airway (a tube inserted into the lungs that allowes a paramedic to have control of the airway). I also did not have my partner pull over and call for additional assistance as we would not be performing cardio pulmonary resucitation (CPR)." The report also included, " Upon further review it was found that a total of three pts (patients ') information had been given to us by (the facility). The majority of paperwork belonged to (Resident #2) including the DNR, DNR

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acknowledgement form, MAR 's (Medication Administration Record), and demographics sheet. Several pages of labs belonged to a female (Resident#3) and the discharge summary from (other hospital) belonging to (Resident# 1). Several minutes of confusion went by as the pt ' s identity was attempted to be acertained. Finally (hospital nurse) found pt wallet in pants pocket (with) photo ID. Pt then firmly identified as (Resident #1). "

During an interview on 4/15/2013 at 3:27 PM EMS team member#1 revealed when directed to Resident#1's room she found the man slumped in chair, unable to speak, with no radial pulse; she was unable to obtained vital signs. EMS team member#1 asked the facility staff about medications, allergies, and coumadin and the staff provided a do not resucitate order (DNR). Another staff member reported Resident#1 recent history and a previous admission for the same condition and provided a copy of that hospital discharge. At approximately 7:30 the resident was loaded into the ambulance. EMS team member #1 said, " He (Resident #1) said ' I ' m fixing to go out ' and I told him I'd take care of him. " EMS team member #1 said Resident#1, " looked terrified. " EMS team member #1 also said, " In the truck his heart rate turned to 20-30bpm which is bradicardic (very slow heart rate). His lungs went from clear to a fluid filled sound so I provided a CPAP. His breathing was so slow and then it stopped all together. At the time knowing he had a DNR I could not intubate. I chose a nasal airway. " The EMS team member reported she assisted with his breathing the whole way to the hospital. She recalled at 7:40 am he stopped breathing adequately and she

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took over breathing efforts for about 3 minutes. When asked about the difference in care with a person who was full code, EMS team member#1 said, "Yes, I would have placed a more advanced airway" She indicated she would have been able to monitor his carbon dioxide level, respiratory rate and had definitive control of his airway. She added that if she had known of his history of blood clots, and diabetes she would have handled the patient differently. She said, if she had the differential diagnoses, "I would have been on higher alert with my path of treatment." EMS team member #1 said the EMS team would have spent much less time at the facility because there was, "a greater likelihood of a pulmonary embolus rather than just an exacerbation of COPD." EMS team member#1 then described the events in the Emergency Room (ER). She reported the ER physician was at Resident#1 ' s bedside and was looking through the stack of paperwork and discovered the Resident #2 ' s February Medication Administration Record (MAR) had the DNR rescinded but the DNR on hand was dated March 4th 2013. EMS team member#1 said the emergency room team started CPR but still did not place an advance airway. She indicated it was the ER physician who first recognized that some of the documents belonged to other residents. EMS team member#1 stated, " There were at least 30 sheets of paper, 25 for one person, 2 or 3 for a female (Resident#3) and we were still under the asumption that the person on the bed was the man with the DNR. " About that time the charting nurse discovered the man's wallet and correctly identified him by his picture identification. EMS team member#1 stated, "The DNR was not his, the face sheet was not his, the MAR was not his. " EMS team member#1

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reported she announced the resident ' s name provided in the paperwork at the facility several times and no one said anything.

The Hospital records from 3/28/2013 revealed an initial diagnosis of respiratory arrest. Respiratory Arrest is a term used to indicate the stop of breathing and if not reversed will lead to Cardiac Arrest. The physician summary indicated that immediatelly after arrival the patient had lost pulses and there was an initial confusion over the identity of the patient from the facility and the code status. The report stated the patient arrived with a DNR form from a different person. The patients condition was such that it required the doctors full attention. The ER provided an advanced air way and performed CPR on the patient. Advanced medical equipment and medications were used to maintain Resident#1 ' s life. After discussion with the family the decision was made to withdraw care. Resident #1 expired at 5:55 PM.

On 4/16/2013 at 8:00 AM an interview was conducted with attending physician in the Emergency Room. The physician said EMS brought in the resident identification and DNR " and we were not too aggressive because of golden ticket (DNR form). " The ER physician looked through the papers and saw several different names, she saw a rescinded DNR, and she recognized the Face Sheet identified the patient as Caucasian and the patient in the ER was African American. The physician added that there were lab results with a female name. The physician stated that she called out the names of Resident#2 and Resident#3 and as staff undressed the patient a nurse found a wallet with

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F 309	Continued From page 9 the identification of Resident#1. The physician said the hospital placed a call to Resident #1's next of kin. She added that the family of Resident#1 identified him as a full code and said "help him as much as you can." During an interview on 04/15/2013 at 12:06 PM the Director of Nursing (DON) stated, "This was not a systemic failure. It was an honest mistake. "The DON added," I did go back and see if we have ever had any concern of wrong records being sent. " He indicated that out of 58 hospital transfers since January 1, 2013 the paperwork was correct for 57 of those residents. Resident #1 was the only error. He also indicated non-mandatory in-services about hospital transfer records were initiated on 03/26/2013. The DON also said, "The nurse did everything possible after the hospital called." On 04/15/2013 at 5:31 PM the Administrator said that when this incident was reviewed they, "felt this was and isolated incident and decided not to take it to QA (the Quality Assurance Committee). " During an interview on 4/16/2013 11:39 AM, Nurse#2 revealed that EMS was already in the facility when he arrived to work. Nurse #2 said EMS asked what Resident#1's other diagnosis were and, "I went to the chart and copied the discharge summary." Nurse #2 added, "He (Resident#1) kept saying ' I need to go (to the hospital). I'm short of breath 'over and over." The resident was passing in and out of consciousness. Review of Hospital medical records revealed	F 309		

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F 309	Continued From page 10 Resident #1 died on 3/28/2013 at 5:55 PM. Diagnosis of: 1) Respiratory Arrest, 2) Cardiac Arrest, 3) Atrial Fibrillation with Rapid Ventricular Rate, and 4) Pulmonary Embolism. On 4/16/2013 5:46 PM the Director of Nursing revealed his expectations would be that two staff members would cross check the transfer papers for correct identification so the correct information would go out. On 4/16/2013 5:47 PM the Administrator revealed that he would expect his staff to have the accurate information and for it to be verified. On 04/15/2013 at 5:40 PM, the Administrator was notified of the Immediate Jeopardy. Credible Allegation of Compliance IMMEDIATE CORRECTIVE ACTION Named resident is no longer in the facility METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED Advance directive audits were completed for all residents on 4/15/13 by the Assistant Director of Health Services. Senior Care Partner, Clinical competency Coordinator and Unit managers. Moving forward, advance directive audits will be completed for all new admissions, re-admissions and then quarterly for all residents by Senior Care Partner quarterly, using advance directives audit tool. SYSTEMIC CHANGES · Director of Health Services, Assistant Director of Health Services, Clinical Competency	F 309		

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F 309	Continued From page 11 Coordinator, Unit managers and Shift Supervisor initiated in-service education session on 4/15/2013, with licensed nurses on all shifts to stress the importance of ensuring correct information is sent with the resident at the time of transfer. This includes a copy of; Resident ' s face sheet, Resident Transfer Form, Medication Administration Records, Diagnosis List/Sheet, Do Not Resuscitate (Golden Rod Form), Advance Directives, Physician Communication tool, and Bed hold documentation. · As of 4/16/2013, 34 nurses out of 52 licensed nurses have been educated on acute care transfer & release of medical records acknowledgement form. Licensed nurses will be educated before their next working shift. · Charge nurse will cross check/double check Medical records sent to the hospital with another staff witness; using the " acute care transfer & release of medical records acknowledgment form " this form identifies documents sent with the EMS to the ED at the time of transfer. · Acute care transfer & release of medical records acknowledgment form will be maintained in the resident medical records. · Staff will be made aware of advanced Directives located under the advance directive tab in a resident medical record and by way of the Medication Administration Record and the CNA care guides. MONITORING PROCESS · Director of Health Services, Assistant Director of health Services and/or unit managers will review clinical records for hospital transfers to ensure that the " Acute care transfer & release of medical records acknowledgment form " is utilized appropriately monthly x 3 months then	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 quarterly thereafter. · Utilization of Acute care transfer & release of medical records acknowledgment form will be tracked monthly and discussed in our QAPI process. · Additional action planning will be implemented by the QAPI committee as necessary Alleged Date of Compliance 4/23/13 Immediate jeopardy was abated on 04/16/2013 at 6:51 PM when interviews with nursing staff confirmed they had received in-service training on advance directives which included full code status or DNR for residents. The nursing staff were able to explain the use of the transfer packet and all forms to be sent with a resident going to the hospital. Nurses also said the contents of the transfer packet were to be checked by two facility staff to ensure only correct resident information was included. Record reviews were done to verify Advance Directives were available in the records of current residents. Administrative staff provided copies of inservices conducted and attendance records. Advance Directive audits were completed for all residents. Another resident, who was transfered out for an acute episode on 4/16/13, was reviewed and the new facility policy had been implemented. The Acute Care Transfer Checklist tool was reviewed as well as the tracking tool for Utilization of Acute Care transfer form.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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