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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	06/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to investigate the cause of 2 of 7 falls for 1 (Resident #274) of 3 sampled residents who experienced falls; the facility failed to put new interventions into place to prevent falls for 1 (Resident #274) of 3 sampled residents who experienced falls, and the facility failed to implement falls interventions to prevent falls for 1 (Resident #274) of 3 sampled residents who experienced falls. Findings included: Resident #274 was admitted to the facility on 4/23/13 for a hip fracture with repair as a result of a fall. The resident ' s other diagnoses included dementia and hypertension. Review of the resident ' s Admission Minimum Data Set of 4/30/13 revealed the resident was rarely/never understood by others, had long and short term memory deficits, and moderately impaired/poor daily decision making skills. The resident was assessed as having required extensive assistance of two or more person	F 323	**323** **This Plan of correction is respectfully submitted as evidence of our allegation of compliance. This plan of correction is not an admission that the deficiency actually existed or that we are in agreement with the deficiencies cited. It is however our expression of a desire to comply and correct any deficiency cited.** **Corrective action for the affected resident:** Resident # 274 was assessed by the Director of Health Services and Assistant Director of Health Services to include evaluation of the root cause for the fall to include incontinence considerations, interventions put into place as a result of the fall and care plans updated to reflect changes.	7/17/13 7/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darryl Taylor — TITLE: Administrator — (X6) DATE: 7/11/13

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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F 323	Continued From page 1 physical assistance for bed mobility and transfers. The resident was documented to have required extensive assistance of one person for locomotion on and off the unit, dressing, and toileting. A facility admission "Scored Fall Risk Assessment" of 4/23/13 indicated the resident was at high risk for falls. Resident #274 ' s Admission Minimum Data Set of 4/30/13 indicated the resident had short and long term memory deficits and had moderately impaired decision making skills. The assessment revealed the resident required extensive assistance of 2 or more persons for bed mobility and transfer. The resident was documented as not having walked during the assessment period. The resident was documented as always incontinent of bowel and bladder and was not on a toileting program. Balance was assessed as not able to stabilize without human assistance when transferring from surface to surface. Review of the resident ' s Care plan of 5/10/13 revealed a problem identified as: Resident has potential for injury related to falls, 4/24/13; Fall-Resident sent to ER (emergency room) and returned (bruise area noted to thigh and nose); 5/1/13 Fall in day room - no injury; 5/2/13 Fall - Resident fell in hall way on face - abrasions to face and nose, abrasions to thumb and nail bed; 5/9/13 Fall - found on knees on floor, stated she was praying; Fall 5/11/13 slid from chair to floor in Day Room; Fall 5/19/13 Fell getting out of bed, no injuries noted; Fall 5/20/13 fell 5/19/13 abrasion/bruise; and Fall 6/3/13 Fell at Doctors office appointment.	F 323	**Corrective Action for those residents with the potential to be affected by the deficient practice:** The DHS, ADHS or their designee has audited 100% of the incident reports for falls to include a root cause analysis and residents care plans from June 19, 2013 to current. Changes made to address each residents specific needs were then updated to care plans for each specific fall with appropriate interventions. The Clinical Competency Coordinator has educated the nursing staff on appropriate fall risk assessments, facility event investigation form for root cause analysis, pain assessment, effective interventions to be put into place to prevent falls and updates to care plans as needed. 100% compliance of this training will be obtained.	7/17/13

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F 323	Continued From page 2 Interventions on the care plan for the prevention of falls included: 4/24/13 mats to the floor at bedside while resident is in bed. On 5/9/13, bed alarm place to the bed while resident is in bed. Maintain proper shoes size with non-skid soles when available. Keep bed in low position at all times. Keep call light within reach while in bed. Keep pathways clear and free of obstacles. Therapy to evaluate and treat as indicated. Maintain safety with transfers. Assist with toileting needs routinely or as needed. On 5/11/13, Body alarms placed, assist with toileting routinely, assist and encourage fluids routinely, provided routine snacks. On 5/19/13, Ensure bed alarm is working. 1) Review of facility accident/incident reports revealed the resident fell on 4/24/13 at 6 PM. The reported indicated Resident #274 fell out of a wheelchair face down in the day room (located across from the Supportive Care Unit nurses desk). The documented immediate intervention was listed as: Transferred to hospital for evaluation (resident had a laceration on her forehead). The investigation follow-up revealed the interventions that were put into place were: mats on the floor beside the bed and a bed alarm. Resident will be checked frequently. Restraint free alarm at all times. An interview was conducted with the Director of Nursing (DON) on 6/18/13 at 3:16 PM. The DON reported residents ' falls were reviewed the next day by the Interdisciplinary Team and any necessary interventions were put in place. The DON stated when Resident #274 returned from	F 323	**Systematic Changes to Prevent Deficient Practice:** Education was added to the general orientation for new nursing hires to include appropriate fall risk assessments, facility event investigation form for root cause analysis, pain assessment, effective interventions to be put into place to prevent falls and updates to care plans as needed. The DHS, ADHS or their designee will review all occurrences of falls during morning clinical meeting to ensure appropriate fall risk assessments, facility event investigation form for root cause analysis, pain assessment, effective interventions to be put into place to prevent falls and updates to care plans as needed. The DHS, ADHS or their designee will audit fall risk assessments, facility event investigation form for root cause analysis, pain assessment, effective interventions to be put into place to	7/17/13

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F 323	Continued From page 3 the hospital after the fall on 4/24/13, the team put interventions in place to keep her from falling out of the bed. Staff present reported the resident stood up from the wheelchair and teetered on her feet and fell onto her face. The DON stated there was no new intervention to prevent falls from the wheelchair. 2) Resident #274 experienced a fall on 5/1/13 at 3:35 PM. Documentation in the fall report revealed the resident was in a wheelchair in the hallway on the 500 hall and was by the nurse's side during a medication pass. The resident got up from the wheelchair and fell face down. The reported indicated Resident #274 frequently got up/stood up from the wheelchair or bed, so the resident was on one-on-one observation by staff nurse and the nursing assistant (NA). The resident ' s chair alarm was on and working at time of the fall. The fall resulted in an abrasion from an old wound on the bridge of the nose, a left thumb abrasion and half of the fingernail was removed. Immediate actions taken were documented as: assessed for injury and two staff helped resident up from floor, given pain medication, and vital signs were taken. Review of the Investigation follow-up revealed: PT eval (Physical Therapy evaluation) for proper chair for positioning and was given a new specialized chair. An interview was conducted with the Assistant Director of Nursing (ADON) on 6/18/13 at 2:25 PM The ADON stated they just didn't know why the resident kept trying to get out of the chair, so they tried a different chair, just drawing straws to see what would work.	F 323	prevent falls and updates to care plans once weekly at falls risk committee meeting and results will be documented. **How will corrective action be monitored?** The audits completed by the DHS, ADHS or their designee from the falls risk committee meeting will be brought to the QAPI committee by the DHS or ADHS monthly for 3 months for review and appropriate actions as needed. If at that time substantial compliance is maintained the audit results will then be reported quarterly for 3 quarters for review and appropriate actions as needed. If at that time substantial compliance is maintained the reporting will end. The QAPI committee meets monthly, all administrative staff attend and the Medical Director attends at least quarterly.	7/17/13

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F 323	Continued From page 4 3) Review of a fall report of 5/9/13 at 3 PM indicated Resident #274 was found on both knees beside the bed with hands in a praying position. The resident stated that she was praying. Immediate interventions were documented as: placed tab alarm on the resident as well as a bed alarm that was already in place. The follow-up investigation revealed: a re-evaluation from therapy for a self release seat belt. An interview with the ADON on 6/18/13 at 2:30 PM revealed the nurse could not say whether the resident was in the chair or in the bed before she was found on her knees. The ADON stated that according to the nurse note and fall report, she was unaware of whether the alarms sounded or not, and the notes didn't indicate the bed alarm worked or not, just that they put it back on An interview with the DON on 6/18/13 at 3:24 PM, the DON stated the resident was in her wheelchair at the time before being found on the floor on her knees. The DON stated there was no documentation that could help to know how the resident got from the wheelchair to her knees to pray, that any of the alarms were functioning at the time of the fall. 4) A fall report for Resident #274 revealed the resident experienced a fall of 5/11/13 at 8:20 PM. Documentation in the report revealed the nurse was made aware by an NA and another nurse that the resident slid from her recliner (specialized chair) in the day room. The resident was found in sitting position. The note indicated a personal body alarm was still attached to the resident and	F 323		

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was alarming. Immediate interventions were documented as: the resident was toileted, offered fluids and snacks, and given Tylenol for comfort. The investigation follow up revealed: the resident ' s body alarm was put back into place, the resident was toileted, and provided fluids and snacks.

An interview with the ADON on 6/18/13 at 2:35 PM revealed they didn't know why the resident fell other than the resident slid. The ADON reported the fall could have been because the resident wanted to go to the bathroom, or just slid.

An interview was conducted on 6/18/13 at 3:30 PM with the DON. After review of the resident ' s fall of 5/11/13, the DON reported the immediate interventions were part of the ongoing interventions that had already been implemented and no new interventions were initiated.

5) Review of a fall report of 5/19/13 at 3 AM, indicated the resident fell after getting out of bed without calling for assistance. The resident was noted on the floor by the NA responding to her bed alarm going off. Immediate interventions were documented as: assessed to rule out injuries. The follow-up investigation revealed interventions documented as: floor mats for beside bed, ensure bed alarm is working appropriately.

An interview was conducted with the ADON on 6/18/13 at 2:40 PM. The ADON stated the alarm was working at the time of the fall, so the new intervention of ensuring the alarm was working appropriately was not a new, effective intervention. Regarding the plan to provide floor

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F 323	Continued From page 6 mats as a new intervention, the ADON stated she didn't know if the floor mats were down on the floor at the time of the fall since they were an intervention from a fall of 4/24/13. An interview was conducted with the DON on 6/18/13 at 3:32 PM, The DON stated new interventions put in place were to put a fall matt on each side of the bed, but wouldn't keep her from falling, but would help to prevent the resident from getting hurt. During an interview with DON on 6/18/13 at 3:35 PM, the DON stated she didn't have interviews from staff present on shift when the resident fell to know what the resident was doing prior to the fall to determine the resident's need to get up. As far as the investigation into the resident's falls, the alarms aren't preventing falls, because she still falls. An observation of the resident's room with the DON revealed no floor mats were present in the resident's room. The DON reported the fall mats must not have been transferred with the resident when she was moved from another unit. but expected all of the resident's belongings, including the floor mats, were transferred with her when she moved onto the unit. An interview was conducted with NA #1 on 6/18/13 at 4:15 PM. The NA stated it was her first time to have cared for the resident. The NA stated she asked the other NA about how to care for the resident and also referred to the care guide in the resident's closet. The NA was unaware the resident's bed was to be in a low position at all times and was also unaware the	F 323		

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F 323	Continued From page 7 resident required fall mats on each side of the bed when the resident was in the bed. An interview with the DON on 6/18/13 at 4:20 PM, the DON stated the resident's care guide was not updated with interventions as they occurred and expected it was updated with each new intervention, as well as the care plan. The DON stated fall mats did not prevent falls and expected new interventions be put into place for each fall. The weekly QA meetings included discussion of new interventions for this resident and new interventions were missed and expected all of the resident's fall interventions would be carried over with a move to another room.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide 1 of 2 sampled residents (Resident #114), reviewed for nutrition concerns, with a nutritional supplement ordered by the physician as a weight loss intervention.	F 325	**F325** **Corrective action for the affected resident:** Resident # 114 was given the ordered supplement and supporting documentation changed to reflect correct order for correct supplement by corresponding entry to the SNO system. **Corrective Action for those residents with the potential to be affected by the deficient practice:** A 100% resident audit was completed	7/17/13 7/17/13

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F 325	Continued From page 8 Findings included: Resident #114 was admitted to the facility on 05/22/13. The resident's documented diagnoses included hypertension, dyslipidemia, advanced Parkinson's disease, and right hip fracture. A 05/23/13 physician's order began the resident on a standard 2.0 supplement 120 cubic centimeters (cc) three times daily (TID). Facility weight records documented the resident weighed 120.6 pounds on 05/27/13. Resident #114's 05/29/13 Admission Minimum Data Set (MDS) documented the resident had short and long term memory impairment, was moderately impaired in decision making, coughed or choked during meals, required extensive assistance by a staff member with eating, and had not experienced significant weight loss or weight gain. Facility weight records documented the resident weighed 114.2 pounds on 06/04/13. On 06/04/13 "Nutrition Risk: receiving mechanically altered diet, fed by staff and /or family/sitter" was identified as a problem in the resident's care plan. Interventions to this care plan included "Diet as ordered." During a 06/05/13 assessment by the facility's registered dietitian (RD) she recommended adding a health shake TID between meals to help prevent further weight loss for Resident #114. A 06/05/13 physician's order initiated the	F 325	on all residents in the facility to ensure that all dietary supplements have an appropriate order and communication given to dietary to ensure the correct orders are in place for the dietary SNO system which records and provides therapeutic diet information to the dietary staff to ensure the correct diets are supplied to residents. **Systematic Changes to Prevent Deficient Practice:** Nurse that failed to notify dietary has been given 1:1 education on the correct procedure to ensure therapeutic diet orders are forwarded to dietary. The Clinical Competency Coordinator has educated all the nurse's in the facility on how to communicate to dietary when new orders are written. 100% completion of this training has	7/17/13

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F 325	Continued From page 9 provision of the health hakes with Resident #114's meals. Facility weight records documented the resident weighed 112 pounds on 06/07/13, 112.2 pounds on 06/10/13, and 109.6 pounds on 06/12/13. At 8:38 AM on 06/18/13 Resident #114 was eating breakfast in her room. There was no health shake on her tray, and review of the resident's tray slip revealed there was no documentation that the resident was to receive a shake with her breakfast meal. At 12:26 PM on 06/18/13 Resident #114 was eating lunch in her room. There was no health shake on her tray, and review of the resident's tray slip revealed there was no documentation that the resident was to receive a shake with her lunch meal. A visitor in the resident's room reported the resident had recently lost weight, and the resident liked ice cream and ice cream products. At 12:48 PM on 06/18/13 the facility's food service director stated the provision of nutritional supplements from dietary was identified as a problem in the April 2013 Performance Improvement (PI) meeting. He reported the problem was still being addressed by the PI committee. Review of PI documentation revealed two total facility audits of nutritional supplements were conducted, the last completed on 05/22/13. During these audits physician orders for nutritional supplements were compared to resident tray slips. On 06/03/13 a summary of	F 325	accomplished. Clinical Competency Coordinator will In-service all new hires in orientation on correct procedures to be followed. The RD/CDM or designee will attend the daily clinical meeting five times a week. During this clinical meeting, the team will review all physician orders written since the last clinical meeting (24 or 72 hours on Monday) to ensure the orders were communicated properly to the dietary department. The RD/CDM or designee will ensure that all new orders are placed in the SNO system to ensure therapeutic diets are provided to residents as ordered.	

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F 325	Continued From page 10 audit findings was presented to the director of nursing (DON). On 06/13/13 nursing staff was in-serviced about the procedure to follow to ensure the dietary department was made aware of orders for nutritional supplements. Weekly audits were done comparing random tray slips against the food/beverages/supplements on resident trays. However, no audits were being conducted to make sure nurses who took new orders for nutritional supplements were actually completing a Change of Diet form (the notification tool making dietary aware of the new orders). Review of Resident #114's medical record revealed no copies of the Change of Diet form placing the resident on health shakes with meals were present. At 1:12 PM on 06/18/13 the RD stated Resident #114's family reported she had a good appetite and ate well prior to the hospitalization which led to her current nursing home admission. However, while in the hospital the family commented about all the resident ate was candy and ice cream. According to the RD, the resident was a slow eater and required feeding assistance. She stated on 06/05/13 she approached the family about the possibility of beginning an appetite stimulant. When the family declined, the RD reported she wrote an order for health shakes at meals instead. At 3:18 PM on 06/18/13 Nurse #1 and at 9:50 AM on 06/19/13 Nurse #2 stated nurses who took orders for nutritional supplements were responsible for completing a Change of Diet form. They reported the yellow copy of the form was taken to dietary, and the white copy was placed in	F 325	**How will corrective action be monitored:** The 5 days a week audit completed by the CDM/RD or designee will review the daily audits and results reported to the QAPI committee monthly for review and appropriate actions as needed. When substantial compliance is obtained then the review will be changed to quarterly for three quarters. If at that time substantial compliance is maintained then the 5 day per week audit will be discontinued. The QAPI committee meets monthly, includes all administrative staff and the Medical Director attends at least quarterly.	7/17/13

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F 325	Continued From page 11 the resident's chart. They commented it was dietary's responsibility to enter the supplement information into the computer so that it would print out on resident tray slips.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff and pharmacist interviews and record review the facility failed to get risk/benefit statements for duplicate therapy	F 329	**F329** **Corrective action for the affected residents:** DHS and or ADHS reviewed resident #32 on antipsychotics with no dosage reduction or no documented behaviors that would require the use of an antipsychotic. Gradual dose reductions were written to reduce the use of the antipsychotic. DHS and or ADHS reviewed resident #171 on antipsychotics with no dosage reduction or no documented behaviors that would require the use of an antipsychotic. Gradual dose reductions were written to reduce the use of the antipsychotic.	7/17/13

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	345538	A. BUILDING _____ B. WING _____	06/19/2013

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

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F 329	Continued From page 12 (Residents #144, #236 and 95);failed to obtain a physician ordered repeat laboratory evaluation (resident #144); and failed to prevent the use of antipsychotic agents in residents with dementia for Residents # 32 and #171 for five of ten sampled resident reviewed for unnecessary medications, (Resident #32, #95, #144, #171, and #236.) Findings included: 1. Resident #32 was admitted to the facility on 04/09/08 with cumulative diagnoses of end stage dementia, degenerative joint disease and gout. Record review of the resident ' s physician order sheet revealed two orders for Seroquel (quetiapine); " Quetiapine 25 mg (milligram) one halftab (12.5 mg) by mouth every evening (5 PM) and Quetiapine 25 mg by mouth at bedtime written 10/04/12. " The resident has been on this medication for over 8 months with no gradual dose reduction. Lexi-comps Geriatric Dosage Handbook, 17th edition stated that Quetiapine was an atypical antipsychotic agent used in the treatment of schizophrenia and bipolar disease. There is a black box warning (the strongest warning that the Food and Drug Administration issues) " Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo (inert comparison). Quetiapine is not approved for the treatment of dementia-related psychosis. " Record review of the physician ' s order sheets for June 2013 revealed the resident is on a	F 329	Results of those reductions showed behaviors returned that resulted in use of the antipsychotic in the first place. A benefit risk analysis was provided by physician. DHS and or ADHS reviewed resident #144 who was receiving duplicate med therapy without supporting documentation. A risk benefit analysis was completed by physician demonstrating the need for this duplicate med therapy. DHS and or ADHS reviewed resident #95 who was receiving duplicate med therapy without supporting documentation. A benefit risk analysis was completed by physician	

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F 329	Continued From page 13 pureed diet with thickened liquids indicating problems swallowing. Record review reveals she is less than 100 pounds. Observation of the resident #32 in the common area of the facility on 06/18/13 at 11:30 AM revealed her sleeping in her chair. She did not arouse to voice command. Observation of the resident #32 on 06/19/13 at lunchtime in the main dining room with the consultant pharmacist reveals the resident is being fed by a nursing assistant. She is barely awake and the nursing assistant stated she is pocketing food. The pharmacist and nursing assistant do not know of any behaviors and record review of the physician ' s order sheet reveals that no behaviors are chosen from the preprinted list. Observation of resident #32 with a corporate nurse back in the common area after lunch revealed she was attended by her husband. She did not acknowledge voice commands, was staring straight ahead, and was drooling. In an interview with the consultant pharmacist on 06/19/13 at 10 AM, she was asked to provide documentation of a gradual dose reduction request and the reason (behaviors) that would necessitate an antipsychotic in a resident with dementia. At 2 PM, she provided a review written that day that described the pocketing of the food, current weight under 100 pounds and a request for a gradual dose reduction. No behaviors for this resident were established that would require an antipsychotic. 2. Resident #171 was admitted to the facility on	F 329	demonstrating the need for this duplicate med therapy. DHS and or ADHS reviewed resident #144 who was admitted to the facility needing periodic laboratory evaluation for thyroid levels. Lab was ordered and appropriate interventions taken. DHS and or ADHS reviewed resident #236 who was receiving duplicate med therapy without supporting documentation. A benefit risk analysis was completed by physician demonstrating the need for this duplicate med therapy.	

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F 329	Continued From page 14 11/18/09 with cumulative diagnoses of chronic subdural hematoma, hypertension and dementia. The resident was 89 years old. Record review of the physician ' s order sheets for June 2013 revealed an order for Resident #171 for Risperdal (risperidone) solution at 1 mg (milligram) per ml (milliliter) stock strength, to give 0.5 ml by mouth twice daily (Delusions) (put in liquid beverage) and was written 04/02/12. The resident has been on this dosage for over one year without a gradual dose reduction. Lexi-Comps Geriatric Dosage Handbook, 17th edition stated Risperdal is an atypical antipsychotic agent used in the treatment of schizophrenia and bipolar disorders. A black box warning (the strongest warning the Food and Drug Administration issues) stated "[U.S. Boxed Warning] Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death, compared to placebo (inert comparator). Observation of the resident #171 on 06/18/13 at 11:45 AM revealed the resident was asleep in bed. Observation of resident #171 at lunchtime, revealed the resident being fed by a sitter. When asked if the resident got agitated or displayed behaviors, the sitter stated that she reached for your arm or hand but was very frail and did no damage. Observation of the resident #171 on 06/19/13 in the presence of the corporate nurse revealed the resident in bed with a different sitter. When	F 329	**Corrective Action for those residents with the potential to be affected by the deficient practice:** DHS, ADHS or their designee will complete a 100% audit of all residents in the facility that were receiving duplicate med therapies for psychoactive medications will be completed. DHS, ADHS or their designee will ensure that needed actions will be taken to address the administration of these meds to include dosage reductions where possible or risk benefit analysis to substantiate the need of the meds. DHS, ADHS or their designee will complete a 100% audit of all residents in the facility that were receiving antipsychotics with a diagnosis of dementia.	7/17/13

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F 329	Continued From page 15 asked if the resident was aggressive, she stated that if the resident became agitated, she let her calm down and then gave care. Review of the physician ' s order sheet did not indicate any specific behaviors that would necessitate an antipsychotic. In an interview with the consultant pharmacist on 06/19/13 at 10 AM, she was asked to provide documentation of a gradual dose reduction request and the reason (behaviors) that would necessitate an antipsychotic in a resident with dementia. At 2 PM, she provided a review written that day that described the trouble with swallowing, current weight under 91.6 pounds and that fact that documentation in the nurses notes revealed that the resident was more "rigid" than usual. A request for a gradual dose reduction was written that day, on 06/19/13. No behaviors for this resident were established that would require an antipsychotic. 3. Resident #144 was admitted to the facility on 05/10/13 with cumulative diagnoses of hypertension, seizure disorder, depression, ataxia (unsteady gait) and altered mental status. Record review of the physician ' s order sheet for June 2013 revealed orders for: Lexapro 20 mg in the AM, Remeron 7.5 mg at bedtime, and Desyrel 50mg at bedtime [all antidepressants], Klonopin 0.25 mg twice daily [sedative hypnotic) and Ativan 0.5 mg used daily in the evening [antianxiety agents both in the benzodiazepine class] and Provigil 100 mg twice a day [a stimulant].	F 329	DHS, ADHS or their designee will ensure that needed actions will be taken to address the administration of these meds to residents with a diagnosis of dementia to include reviews as often as needed but at least quarterly to determine appropriate therapy and actions.. DHS, ADHS or their designee will complete a 100% audit of all laboratory results in the facility for current residents to ensure that no other lab sheets that the attending physicians, NP's and PA's had reviewed did not contain a written note indicating a desire for additional lab tests to be obtained without writing a physicians order which is the correct process.	

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F 329	Continued From page 16 Lexi-comps Geriatric Dosage Handbook stated that Remeron, Desyrel, Klonopin and Ativan all have sedation as a side effect. In the monograph for Provigil it stated that this drug can increase the effect of selective serotonin inhibitors (Lexapro, Desyrel) In an interview with the consultant pharmacist on 06/19/13 at 10 AM, she was asked to provide documentation for the use of 3 antidepressants, two sedating benzodiazepines and a stimulant medication. The pharmacist produced a review regarding the use of Provigil with the presence of chronic anxiety, but her review dated 06/14/13 did not include a review for duplicate therapy. She did get a decrease in one of the antianxiety agents (Klonopin). 4. Resident #95 was admitted to the facility on 05/23/13 with cumulative diagnoses of hypertension, dementia and hypothyroidism. Record review of the physician ' s orders for June 2013 revealed that the resident was on two antidepressants; Zoloft 150 mg and Desyrel 75 mg. Both agents are listed as selected serotonin reuptake inhibitors. She also received Zyprexa 2.5 mg twice daily [an antipsychotic] for a diagnosis of dementia. The resident was 89 years old. Observation of the resident on 06/18/13 and 06/19/13 at the lunch meal revealed she was asleep in her chair for 30 minutes before the meal was served. When the meal was served, she was encouraged to eat by a nursing assistant. Review of nursing notes on her admission dates	F 329	**Systematic Changes to Prevent Deficient Practice:** The Clinical Competency Coordinator has presented to Pharmacist consultant, Medical Director, other attending physicians, Nurse Practitioners, Physician Assistants and Gero Psychiatrist with copies of the new CMS Change titled The National Partnership to improve Dementia Care in Nursing Homes; Interim Changes to Appendix PP in the State Operations Manual (SOM) for F309 – Quality of Care and F329 –Unnecessary Drugs. This includes but is not limited to duplicate med therapies for psychoactive medications, dosage reductions for residents with dementia on antipsychotics and or a risk benefit analysis when appropriate. A signature sheet to acknowledge receipt and understanding was provided.	7/17/13

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F 329	Continued From page 17 revealed she was transferred to the locked unit because she was screaming at staff. In an interview with the consultant pharmacist on 06/19/13 at 10 AM, she was asked to provide documentation for the risk/benefit of using two agents in the same class which could potentially increase the side effects of the medications. She produced a pharmacy review dated 06/14/13 which stated the resident had no indication for the use of the antipsychotic but did not address the duplicate therapy of two antidepressants. This review was written during the survey on 06/19/13. 5. Resident #144 was admitted to the facility on 05/10/13 with cumulative diagnoses of hypertension, seizure disorder, depression, ataxia (unsteady gait) and altered mental status. Review of the physician's order sheets for June 2013 revealed that the resident was on Synthroid for hypothyroidism. This medication required periodic laboratory evaluation to ensure proper dosing. The test for monitoring is a TSH (thyroid stimulating hormone, normal values for normal adult range are 4-10 mcg/dL (micrograms per deciliter. A TSH was done on 05/13/13 and reported 05/14/13 at 10.90 which is " H " (high) The nurse practitioner noted on the lab report: " on Levothyroxine, given recent illness recheck in 1 month.". Review of the laboratory section did not reveal the recheck.	F 329	100% compliance will be obtained by the Clinical Competency Coordinator. Clinical Competency Coordinator has presented to Pharmacist consultant a copy of the new CMS Change titled The National Partnership to improve Dementia Care in Nursing Homes; Interim Changes to Appendix PP in the State Operations Manual (SOM) for F309 – Quality of Care and F329 –Unnecessary Drugs. This includes but is not limited to required monthly reviews and consultant pharmacist communication to physicians on evaluations for duplicate med therapies in the psychoactive medications and antipsychotic reduction requests for residents with a diagnosis of dementia and or the need for a risk benefit analysis when appropriate. A signature sheet to acknowledge receipt and understanding was provided.	

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F 329	Continued From page 18 In an interview with the consultant pharmacist on 06/19/13 at 10 AM, she was asked if the recheck was done. At 2:30 PM on 06/19/13, the consultant pharmacist stated that the order was never formally transcribed but it would be done that day. 6. Resident #236 was admitted to the facility on 12/28/12 with cumulative diagnoses of senile dementia, cerebral vascular accident and coronary artery disease. Review of the physician's order sheet for June 2013 revealed the resident was on two antidepressants of the same class [SSRI-selective serotonin reuptake inhibitors]; Zoloft 50 mg (milligram) in the morning and Desyrel 75 mg at bedtime. In an interview with the consultant pharmacist on 06/19/13 at 10 AM, she was asked to provide documentation of a risk/benefit statement for two medications of the same class. Review of the pharmacist and psychiatrist notes did not reveal a risk benefit statement.	F 329	100% compliance will be achieved for this training by the Clinical Competency Coordinator. Clinical Competency Coordinator has presented to Medical Director, other Attending Physicians, Physician Assistants and Nurse Practitioners with educational material covering proper procedure to follow when requesting labs and follow up labs to include that all requests must be submitted by a written physician order. A signature sheet to acknowledge receipt and understanding was provided. 100% compliance will be achieved for this training by Clinical Competency Coordinator.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**371** **Corrective action for the affected Resident:** All residents had the potential to be affected by the deficient practice: Dietary staff will ensure Tea canisters are covered at all times.	7/17/13

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F 371	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to cover tea canisters to help protect from contamination by flies found in the kitchen, failed to air dry tray pans before stacking them in storage, failed to de-stain kitchenware, and failed to post open dates on food items and dispose of outdated leftovers in storage. Findings included: 1. During initial tour of the kitchen, which began at 7:48 AM on 06/17/13, the tea canister which contained freshly brewed tea was uncovered. There were at least eight flies in the kitchen. During food preparation observation from 2:00 PM through 2:58 PM on 06/19/13 the tea canister which contained freshly brewed tea was uncovered. There were at least eight flies in the kitchen. At 8:47 AM on 06/19/13 the food service manager (FSM) stated during the summer months when flies were in the kitchen it was important to keep food and beverages covered. He reported if insects landed on food items which were not going to be subjected to heat to kill bacteria there was the potential residents could get sick. The FSM also commented if food items were left uncovered for too long, nesting and breeding of insects could become a problem. At 3:27 PM on 06/19/13 dietary employee #1 stated all food items should be covered unless they were being served from the steam table or	F 371	Dietary staff will ensure all pans are air dried prior to stacking them in storage. CDM conducted a review of all Kitchenware in the facility and ensured de staining was completed for all items with stains. Dietary staff will ensure to de stain kitchenware as needed. Dietary staff will post open dates on item when opened. Dietary staff will ensure all prepared food will have a posted prepared date and are disposed of after 3 days from preparation date. Facility has and maintains a pest control program to eliminate pests. Facility ordered additional pest control treatments to address pests. Facility has ordered four additional fly lights which will be mounted in kitchen and surrounding areas. Dietary staff were provided in service education on labeling food products when opened, documenting the prepared	

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F 371	Continued From page 20 still being prepared or assembled. She commented insects such as flies could spread bacteria which might make residents sick. 2. During initial tour of the kitchen, which began at 7:48 AM on 06/17/13, 8 of 11 tray pans stacked in storage were wet. Dietary staff reported these tray pans were placed in storage the night before because they had not run any through their three-compartment sink system so far that morning. During an inspection of kitchenware, which began at 10:25 AM on 06/19/13, 1 of 10 tray pans stacked in storage was wet. At 8:47 AM on 06/19/13 the food service manager (FSM) stated all kitchenware was to be air dried before being placed in storage. He reported moisture trapped between tray pans could lead to bacterial formation. According to the FSM, a new employee still in orientation failed to air dry the tray pans before stacking them in storage on the evening of 06/16/13. However, he commented while in orientation the dietary employee providing training was supposed to check behind the new employee to make sure he/she did not make any mistakes. At 3:27 PM on 06/19/13 dietary employee #1 stated all dietary staff were trained to make sure kitchenware was dry and free of food particles before stacking it in storage. 3. During an inspection of kitchenware, which began at 10:25 AM on 06/19/13, 10 of 24 green plastic coffee mugs had dark brown residue in them. In addition, 7 of 7 sectional plates had dark	F 371	date on the food product, removing the food product from use 3 days after prepared date, covering food products immediately after preparation, de staining kitchenware as needed, keeping lids on tea canisters except when being serviced and storage of kitchenware only after they have been completely air dried. 100% compliance of this training will be completed. **Corrective Action for those residents with the potential to be affected by the deficient practice:** Same response as corrective action taken for affected residents as all residents had the potential to be affected by the deficient practice. **Systematic Changes to Prevent Deficient Practice:** The CDM/Clinical Competency Coordinator Or their designee will ensure newly hired nutritional service employees will be educated	

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F 371	Continued From page 21 brown stains in all compartments. At 8:47 AM on 06/19/13 the food service manager (FSM) stated kitchenware prone to staining was supposed to be placed in a de-staining solution weekly. At 3:27 PM on 06/19/13 dietary employee #1 stated she de-stained kitchenware as soon as she noticed residue or staining problems. She commented the facility used a commercial product to remove stains from kitchenware. 4. During initial tour of the kitchen, which began at 7:48 AM on 06/17/13, there were gallon containers of heavy duty mayonnaise and Catalina dressing which had been opened and stored in the walk-in refrigerator which did not have open dates on them. In addition, in the walk-in refrigerator there were leftover enriched soup dated 06/12/13, ground and regular sausage dated 06/09/13, and cooked pork loin with a date which was unreadable. In the walk-in freezer bags of skinless chicken breast, breaded chicken breast, and frozen roll dough, which had been opened, did not have open dates posted on them. In the dry storage room a 2-pound/10-ounce container of old fashioned oats and a 56-ounce bag of cornbread stuffing which had been opened did not have open dates on them. During a follow-up inspection of storage areas, beginning at 8:18 AM on 06/19/13, an opened 35-ounce bag of corn flakes cereal was found in the dry storage room without an open date on it. At 8:47 AM on 06/19/13 the food service manager	F 371	during general orientation regarding labeling food products when opened, documenting the prepared date on the food product, removing the food product from use 3 days after prepared date, covering food products immediately after preparation, de staining kitchenware as needed, keeping lids on tea canisters except when being serviced and storage of kitchenware only after they have been completely air dried. The CDM and or designee will conduct a walk through of the dietary department daily to ensure labeling food products when opened, documenting the prepared date on the food product, removing the food product from use 3 days after prepared date, covering food products immediately after preparation, de staining kitchenware as needed, keeping lids on tea canisters except when being serviced and storage of kitchenware	

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F 371	Continued From page 22 (FSM) stated the dietary manager (DM) monitored all storage areas every morning to make sure open dates were posted on opened food items and leftovers were disposed of within three days of being placed in refrigerated storage. He also reported all staff entering storage areas and the PM supervisor should be monitoring the dating of opened food items and disposal of leftovers in storage areas. According to the FSM, all opened food items should have open dates posted on them, and all leftovers should have dates on them reflecting when they were placed in storage. At 3:27 PM on 06/19/13 dietary employee #1 stated all employees entering storage areas were supposed to check to make sure opened food items were dated and refrigerated leftovers were disposed of after two days. She reported the FSM and PM supervisor checked behind staff daily to make sure this monitoring was getting done.	F 371	only after they have been completely air dried. **How will corrective action be monitored?** CDM or designee will conduct department audits 6 times per week for 30 days. Audits will be conducted during AM and PM shifts. If substantial compliance is obtained in the 30 days audits will drop to once per week for 90 days. Audits will be conducted on random shifts at random times. If substantial compliance is maintained the audits will be discontinued. Findings of audits will be documented on audit tools and reported to QAPI committee by CDM or RD monthly. Findings will be reviewed and appropriate actions taken to address findings. QAPI committee meets monthly, all administrative staff attend and the Medical Director attends at lest quarterly.	

PRINTED: 07/17/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING 01 - MAIN BUILDING B. WING	AUG 06 2013 CONSTRUCTION 07/17/2013

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

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K018 Door to rooms 102 and 109 will be repaired to remove gap at top of door to resist passage of smoke. Smoke resistant weather stripping has been ordered and as soon as it arrives will be installed to address concern. See attached.	9/20/13
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 8:30 am onward, the following items were noncompliance; specific findings include: residents room doors 102 and 109 had a gap at top of door preventing door to resist passage of smoke. 42 CFR 483.70(a)	K 018	All doors in facility were checked for gaps that would not resist passage of smoke at the time of the survey with the Life Safety Inspector and the two identified doors were the only doors with a gap that would not resist passage of smoke. The Director of Environmental Services will perform an audit to check at least 50% of all doors in the facility monthly to ensure none have developed gaps that would not resist the passage of smoke.	7/17/13 8/8/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour	K 029	The Director of Environmental Services will report monthly to the QAPI committee on findings	8/8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darrell Taylor — TITLE: Administrator — (X6) DATE: 8/6/13

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING 01 - MAIN BUILDING B. WING	07/17/2013

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

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K 029	Continued From page 1 fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 8:30 am onward, the following items were noncompliance; specific findings include: clean linen door from laundry would not close and latch. Also dry storage room door in kitchen not closing and latching. CFR 483.70(a)	K 029	and this information will be reviewed to see if any additional actions are necessary. K029 Door to Laundry Room and Dry Storage Room in kitchen that would not close and latch properly will be repaired. Parts have been ordered that will secure the doors to the frames and adjust them so that they will close and latch properly. See attached.	9/20/13
K 038 SS=E	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. 18.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 8:30 am onward, the following items were noncompliance; specific findings include: cooler and freezer door release knob could not be located if power was lost in facility. 42 CFR 483.70(a)	K 038	All doors in facility were checked at the time of the survey with the Life Safety Surveyor to ensure they closed and latched properly. No additional doors were found that were not closing and latching properly. The Director of Environmental Services will perform an audit to check at least 50% of all doors in the facility monthly to ensure none do not close and latch properly.	7/17/13 8/8/13

The Director of Environmental Services will report monthly to the QAPI committee on findings and this information will be reviewed to see if any additional actions are necessary.	8/8/13
K038	
The walk in cooler and freezer Doors will have glow in the dark safety latches will be installed so that in the event of a power outage the exit handles from the walk in cooler and freezer will be visible to staff inside of the walk in cooler or freezer. These parts have been ordered.	9/20/13
There are no other doors in the facility with this requirement to be addressed. See attached.	7/17/13
There is no monitoring necessary to ensure this deficient practice reoccurs as this is a one time fix.	
The initial findings of the deficiency and subsequent repairs will be reported to the QAPI committee and thereafter no additional monitoring or reporting will be necessary.	8/8/13

FACILITY REQUEST FOR WAIVER OR VARIANCE

TO BE COMPLETED BY STATE AGENCY

☒ Life Safety Code (405.1134a)

☐ 7-Day R.N. Requirement

☐ Medical Director (405.1911b)

☐ Physical Environment

☐ Patient Room Size (405.1134c)

☐ Beds Per Room (405.1134e)

1. Name of Facility UNHEALTH POST - ACUTE CARE - RALEIGH

Address 2420 LAKE WHEELER RD, RALEIGH, NC 27603

2. Type Facility: SNF

3. Vendor No. _____

Program: XVIII/XIX ☒ XIX ☐

Provider No. 345538

4. Date of Survey: Life Safety Code 07/17/2013

General GW

5. Expiration Date of Current Agreement:

6. State Agency recommendation: ☒ Approved ☒ Waiver/Variance Previously Approved

☐ Not Approved

7. Reason for Recommendation: SCHEDULING A CONTRACTOR TO INSTALL (K-18, 29, 38 TAGS.) MATERIALS.

8. Period for which Waiver/Variance is Recommended: 09/20/2013

9. 8/12/13
Date

10. _____
Authorizing Signature of State Agency

TO BE COMPLETED BY REGIONAL OFFICE

11. Waivers/Variance Approved

(a)
(b)
(c)
(d)

12. Waivers/Variance Not Approved

(a)
(b)
(c)
(d)

3. _____
Program Reviewer Signature

_____
Date

4. _____
Discipline Reviewer Signature

_____
Date

5. _____
Authorizing Signature
Acting Director, Survey & Certification

_____
Date

North Carolina Department Of

Human Services Regulations

Construction Section

2705 Mail Service Center, Raleigh NC 27699

Mr. Gordon Washburn

During our inspection at Uni Health Post Acute Care Raleigh, formally known as Oaks of Carolina on 7/17/2013 I would like to request a waiver for a extension on the following tags- K 018, K 029, K038 these are all three findings during our inspection. Due to scheduling a outside contractor for these three tags I am asking the waiver for the extension to 9/20/2013.

Dean Bascone

Uni Health Post Acute Care Raleigh

2420 Lake Wheeler Rd

919-755-5600 Main 919-518-3142 Cell