

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345538	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 8/29/2013
NAME OF PROVIDER OR SUPPLIER UNIHHEALTH POST-ACUTE CARE-RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the residents status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and family interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the discharge outcome for one of one resident, Resident # 1. Findings included:</p> <p>Resident # 1 was admitted to the facility on 05/03/13 with diagnoses including heart failure, hypertension, diabetes mellitus, depression, asthma, chronic pulmonary lung disease.</p> <p>Review of the Skilled Daily Nurses Note dated 05/20/13 at 5:45 AM revealed the resident became short of breath, that the supervisor contacted the physician, and that the physician gave an order to discharge the resident to the local emergency room. The same note signed by Nurse # 2 revealed the resident was transported to the emergency room at 6:20 AM by Emergency Medical Service (EMS.)</p> <p>An interview with Resident # 1's responsible party (RP) was conducted on 08/30/13 at 9:24 AM. The RP stated Resident # 1's physician contacted her at approximately 5:30 AM on 05/20/13 to inform her that Resident # 1 was being transported to the local emergency room. The RP further stated Resident # 1 remained in the hospital until 06/15/13.</p> <p>The Minimum Data Set (MDS) dated 05/31/13 indicated that Resident #1 had a scheduled discharge to a private home instead of another facility. The MDS Assessment Administration was signed as completed on</p>		

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345538	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/29/2013
----------------------------------------------------------------------------------------------------------------------	---------------------------------	--------------------------------------------------------------	----------------------------------------------

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------------	-----------------------------------

F 278	<p>Continued From Page 1</p> <p>05/31/13 by two MDS Coordinators, # 1 and # 2.</p> <p>During an interview conducted with the MDS Director on 08/29/13 at 4:45 PM, she stated the Minimum Data Set information regarding the discharge outcome for Resident # 1 was an error.</p> <p>In an interview with the MDS Director and the Director of Health Services on 08/29/13 at 5:20 PM, both parties acknowledged there was an error regarding the discharge outcome for Resident # 1.</p>
--------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------