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
	345551	A. BUILDING ______ B. WING ______	02/07/2014

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 323 SS=D	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 and interviews the facility failed to secure used oxygen cylinder bottles in 1 of 68 occupied resident rooms (Room 605) and 1 of 2 storage areas (oxygen storage room between rooms 401 and 403). The findings include: 1) A review of the facility's policies and procedures, "Oxygen Administration Safety and Storage" dated January 2009 and revised 05/2013 reads in part: Paragraph entitled - Safety - Item #3: Do not fasten an oxygen tank to a patient/resident's bed. Tanks in use must either be installed on a stable, wheeled dolly or on an oxygen tank stand. Paragraph entitled - Storage - Item #1: Assure that oxygen tanks kept in storage rooms are either chained to the wall or installed on a stable, wheeled dolly or floor stand. On 02/03/14 a tour of the facility was conducted. At 10:43 a.m. an observation was made of resident room 605. During the room observation the bathroom/shower was also observed.	F 323	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirement. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. F323 Immediate Correction Safety item #1 and item #3, oxygen tanks, were placed in appropriate stable, wheeled dolly or an oxygen tank stand. Identification of others with potential to be affected:	2/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/19/2014

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 Observed in the bathroom's shower stall in front of and next to a wheelchair and wooden room chair (1/2 in and ½ out of the shower stall) was a used medium metal oxygen cylinder. The oxygen cylinder was not secured to any wall and not in any type of stand, dolly, or rack to support it and was found to be easily tipped over by anyone entering the bathroom and accidently touching the bottle. 02/03/14 at 12:27 p.m. a second observation of room 605's bathroom was conducted. The oxygen cylinder was again observed standing ½ in and ½ out of the shower stall in front of and next to a wheelchair and wooden room chair without any support. There was no means of support to keep the oxygen bottle from tipping over if accidently bumped. On 02/03/2014 at 3:38 p.m. an interview was conducted with resident #93 in room 605A who was sitting in her wheelchair next to her bed. The resident was asked how long the oxygen bottle had been in her bathroom. The resident could not state how long the bottle had been in the bathroom. After the interview a third observation of the resident ' s bathroom was conducted. The oxygen cylinder bottle was again observed standing ½ in and ½ out of the shower stall in front of and next to a wheelchair and wooden room chair without any means of support to keep it from falling on a resident, visitor, or staff member if accidently moved. During the observation a female nursing assistant entered the room and assisted resident #93 with her wheelchair into the bath room for toileting assistance. On 02/04/14 at 3:55 p.m. a fourth observation of	F 323	100% audit of all Oxygen tanks was conducted and completed throughout the facility on 2-5-14 by the Maintenance Director, Housekeeping Director and Director of Health Services. This audit comprised of all residents on oxygen tanks and the proper securing of said device in an appropriate stable, wheeled dolly or on an oxygen tank stand, as well as all oxygen tanks being stored in storage rooms are properly secured either by being chained to the wall or installed on a stable, wheeled dolly or floor stand. No other tanks were identified during this audit. Systemic Changes/Measures Administrator, Director of Health Services, Unit Managers, and all Department Managers initiated in-service education on 2-5-14 with all staff on all shifts to stress the importance of safety related to proper securing of oxygen tanks when in use or stored by being installed in a carrier even during transportation. All staff will be educated by 2-19-14. Any staff not educated by 2-19-14, will not be allowed to work until educated on the proper storage of oxygen tanks. This process will be added on orientation process for our new staff moving forward. The Root Cause Analysis was completed by Dr. Jackson on Feb.5, 2014 thru Feb. 7, 2014.	

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F 323	Continued From page 2 room 605's bathroom was conducted. The oxygen cylinder bottle was again observed standing ½ in and ½ out of the shower stall in front of and next to a wheelchair and wooden room chair without any means of support (chained to the wall, in a wheeled dolly, stand, or rack). On 02/05/14 at 7:20 a.m. a fifth observation of room 605's bathroom was conducted. The resident was up dressed and seated in her wheelchair next to her bed. The oxygen cylinder bottle was again observed standing ½ in and ½ out of the shower stall without any means of support to keep it from falling over if bumped. The resident was again asked how long the oxygen bottle had been in the bathroom. The resident still could not state how long the oxygen bottle had been in her bathroom. After the observation a male nursing assistant entered the room and indicated he was back to take her to the bathroom (for toileting assistance). The male nursing assistant was observed to wheel resident #93, seated in her wheelchair, into the bathroom. On 02/05/14 at 9:20 a.m. an interview and observation of room 605's bathroom/shower was conducted with the facility's Director of Nursing (DON). The observation revealed the previously observed oxygen cylinder bottle still standing ½ in and ½ out of the shower stall in front of and next to a wheelchair and wooden room chair without any means of support to keep it from falling. The DON indicated the oxygen bottle was used and was not being supported by any means as it should have been per the facility's policies and procedures. The DON indicated the metal oxygen bottle was not being supported and could fall over and injure on any resident, visitor, and/or	F 323	Monitoring Process Department Managers and clinical staff who conduct compliance rounds will monitor the securing of oxygen tanks in use by residents daily, Monday through Friday, and the weekend Supervisor and/or weekend clinical manager on duty will monitor on Saturday and Sunday. The Central Supply Clerk will monitor storage areas for the proper securing of oxygen tanks Monday through Friday, and the weekend supervisor and/or weekend clinical manager on duty will monitor on Saturday and Sunday. The Administrator or Director of Health Service will monitor compliance weekly x 3 months then monthly afterwards, unless recommended otherwise by the Quality Assurance Performance Improvement Committee. Additional action planning will be implemented by the Quality Assurance Performance Improvement Committee as necessary.	

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staff member who may accidently bump it. The DON indicated the oxygen bottle should have been in a dolly or stand. The back of the wheelchair located in the resident's shower was also observed. The wheelchair had no device to support or store the oxygen cylinder. The DON indicated that when an oxygen cylinder bottle was used it was supposed to be removed from the resident's room and placed in the oxygen storage room on the 400 hall in one of the dollies, racks, or stands. The DON indicated it was his expectation that all staff secured the facility's oxygen cylinder bottles according to the facility's policies and procedures to prevent accidents.

An interview was conducted with the DON on 02/07/2014 at 4:30 p.m. The DON indicated that the facility's QA&A team had identified a problem with oxygen tanks not being stored on a secured rack during a tour of the facility on 01/14/2014. The DON stated that this was an identified issue that prompted an immediate corrective action plan that included monitoring to be done by unit managers/coordinators Monday through Friday and by the weekend supervisors on the weekends. The DON indicated that he and the Assistant Director of Nursing (ADON) would monitor compliance weekly for three weeks and then monthly afterward with a target correction date of 02/15/2014. When asked if he could produce documentation that would indicate the monitoring had been initiated according to the QA&A plan, the DON indicated that there was no documentation available and the monitoring was a work in progress with the completion date of 02/15/2014.

A review of the information provided by the DON during the interview was conducted. The

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information indicated the facility initiated the immediate corrective action plan on 01/14/2014 after identifying the quality deficiency during a tour of the facility. A calculation of 21 days (3 weeks) was made per the DON' s interview which indicated the facility completed the initial 3 weeks of monitoring by the unit managers, coordinators, weekend supervisors, ADON, and DON on 02/04/2014. Per the DON's interview there was no documentation or other means the facility could provide to show the facility actually monitored the identified quality deficiency during or after the initial 3 weeks of monitoring was completed. A review of the facility's Action Plan indicated the facility was to monitor for unsecured oxygen bottles weekly for three months then monthly for three months. A review of the observation dates between 02/03-05/2014 (during and after the initial 3 weeks of monitoring) indicated by the DON's interview the facility took no action to monitor or correct the identified quality deficiency, implement changes in monitoring the quality deficiency, or make needed revisions to the action plan to ensure the quality deficiency was corrected prior to or during the survey.

On 02/07/2014 at 5:00 p.m. an interview was conducted via phone with the facility's oxygen supplier (Life Gas) at the insistence of the DON. The supplier indicated that any used oxygen cylinder bottle would not cause any harm if it was knocked over however, all oxygen tanks whether empty or full should be secured. The supplier did not indicate the risk of possible injury due to a falling tank or skin tear injury if the tank fell on a resident, visitor, or staff member.

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F 323	Continued From page 5 2) A review of the facility's policies and procedures, "Oxygen Administration Safety and Storage" dated January 2009 and revised 05/2013 reads in part: Paragraph entitled - Safety - Item #3: Do not fasten an oxygen tank to a patient/resident's bed. Tanks in use must either be installed on a stable, wheeled dolly or on an oxygen tank stand. Paragraph entitled - Storage - Item #1: Assure that oxygen tanks kept in storage rooms are either chained to the wall or installed on a stable, wheeled dolly or floor stand. On 02/03/14 at 11:07 a.m. a tour of the facility was being conducted. During the tour an observation of the oxygen supply room on the 400 hall (between resident rooms 401 and 403) was conducted. The door was observed to be unlocked and accessible to any resident, visitor, or staff member opening the door. The observations revealed several racks of differing size oxygen tanks, both full and used, comingled together making it difficult to identify used from unused oxygen cylinders. When entering the room three used medium oxygen cylinder tanks were observed standing to the left of the open door without any means of support (chain to wall, dolly, stand, or rack etc.) and could be easily tipped over by anyone entering the room. On 02/03/14 at 12:35 p.m. a second observation of the 400 hall's oxygen storage room was conducted. The three empty oxygen tanks were observed to still be standing unsecured on the floor without any support (chain to wall, dolly, stand, or rack etc.).	F 323		

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On 02/03/2014 at 3:45 p.m. a third observation of the 400 hall's oxygen storage room was conducted. The three empty oxygen tanks were observed to still be standing unsecured on the floor without any support (chain to wall, dolly, stand, or rack etc.).

On 02/04/14 at 4:05 p.m. a fourth observation of the oxygen storage room on the 400 hall was made. The door remained unlocked and accessible to any resident, visitor, or staff member opening the door. The three empty oxygen tanks were observed to still be free standing on the floor without any support (stand, rack etc.) to the left side of the door when entering the room.

On 02/05/14 at 9:15 a.m. an observation and interview with the facility's Director of Nursing (DON) was conducted of the 400 hall's oxygen storage room. The door was observed to still be unlocked and accessible to any resident, visitor, or staff member opening the door. To the left side of the door when entering the room the three previously observed used oxygen cylinder bottles were observed to still be unsupported by any chain, dolly, stand, or rack and could be easily tipped over by anyone entering the room. The DON indicated the three oxygen cylinder bottles should have been supported so they would not fall and possibly injure someone. The DON indicated it was his expectation that all staff secured the facility's oxygen cylinder bottles according to the facility's policies and procedures to prevent accidents.

An interview was conducted with the DON on 02/07/2014 at 4:30 p.m. The DON indicated that the facility's QA&A team had identified a problem

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F 323	Continued From page 7 with oxygen tanks not being stored on a secured rack during a tour of the facility on 01/14/2014. The DON stated that this was an identified issue that prompted an immediate corrective action plan that included monitoring to be done by unit managers/coordinators Monday through Friday and by the weekend supervisors on the weekends. The DON indicated that he and the Assistant Director of Nursing (ADON) would monitor compliance weekly for three weeks and then monthly afterward with a target correction date of 02/15/2014. When asked if he could produce documentation that would indicate the monitoring had been initiated according to the QA&A plan, the DON indicated that there was no documentation available and the monitoring was a work in progress with the completion date of 02/15/2014. A review of the information provided by the DON during the interview was conducted. The information indicated the facility initiated the immediate corrective action plan on 01/14/2014 after identifying the quality deficiency during a tour of the facility. A calculation of 21 days (3 weeks) was made per the DON' s interview which indicated the facility completed the initial 3 weeks of monitoring by the unit managers, coordinators, weekend supervisors, ADON, and DON on 02/04/2014. Per the DON's interview there was no documentation or other means the facility could provide to show the facility actually monitored the identified quality deficiency during or after the initial 3 weeks of monitoring was completed. A review of the facility's Action Plan indicated the facility was to monitor for unsecured oxygen bottles weekly for three months then monthly for three months. A review of the observation dates between 02/03-05/2014 (during	F 323		

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F 323	Continued From page 8 and after the initial 3 weeks of monitoring) indicated by the DON's interview the facility took no action to monitor or correct the identified quality deficiency, implement changes in monitoring the quality deficiency, or make needed revisions to the action plan to ensure the quality deficiency was corrected prior to or during the survey. On 02/07/2014 at 5:00 p.m. an interview was conducted via phone with the facility's oxygen supplier (Life Gas) at the insistence of the DON. The supplier indicated that any used oxygen cylinder bottle would not cause any harm if it was knocked over however, all oxygen tanks whether empty or full should be secured. The supplier did not indicate the risk of possible injury due to a falling tank or skin tear injury if the tank fell on a resident, visitor, or staff member.	F 323		