STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 08/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST - ACUTE CARE OF DURHAM	**3100 ERWIN 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 A complaint survey was conducted on 8/4-8/5/14 (NC 99414 & NC 99318).	F 000		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the medication error rate was 5% or below by not following the doctor's orders. There were 2 errors of 27 opportunities for error resulting in a 7.4% error rate. The findings included: 1. Resident # 7 had s doctor's order dated 1/4/14 for Humalog insulin 25 units subcutaneous (SQ) three times a day with meals (9:00 AM-1:00 P and 6:00 PM) for diabetes mellitus. He had also an order for Humalog insulin according to the sliding scale On 8/4/14 at 5:05 PM, Nurse #1 was observed during the medication pass. Nurse #1 was observed to prepare 25 units of Humalog and then checked the blood sugar of Resident #7. The blood sugar was 250, an additional 2 units of Humalog was added to the syringe (with 25 units). Nurse #1 was observed to administer the Humalog 27 units via SQ to the right upper quadrant.	F 332	F332 Free of Medication Error Rate of 5% or greater. 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 conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	8/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/12/2014

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 332	Continued From page 1 On 8/5/14 at 1:35 PM, nurse supervisor #1 was interviewed. She stated that the expectation was to administer the medication with meals if the order was to be given with meals. The dinner trays were served on the hall between 5:30 and 6:00 PM. She added that Resident #7 was served closed to 6:00 PM because he ate in his room. On 8/5/14 at 3:30 PM, Nurse #1 was interviewed. She acknowledged that she administered the insulin before dinner time and should have been given with meals. 2. Resident #8 had a doctor's order to discontinue the pepcid (antacid) on 8/4/14 at 11:00 AM. On 8/4/14 at 5:20 PM, Nurse #1 was observed during the medication pass. She was observed to prepare and to administer the medications to Resident #8 including pepcid 20 milligrams (mgs) 1 tab by mouth. On 8/5/14 at 3:30 PM, Nurse #1 was interviewed. She did not give an explanation as to why she administered the pepcid on 8/4/14.	F 332	Corrective action for those residents to have been affected. Resident #7 was provided insulin with meals and/or snacks. Resident #8 Pepcid was removed from medication packets. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 8/12/14 six medication administration observations were initiated by the Director of Health Services, Unit Coordinators, Nurse Managers and Senior Nurse Consultant for insulin dependent residents who receive insulin with their meals. In addition to the above medication observations, an additional ten complete medication pass observations, including insulin administration with meals were completed. On 8/12/14 Medication cart audits	

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F 332	Continued From page 2	F 332	were completed by the Director of Health Services, Unit Manager, Unit Coordinators and Senior Nurse Consultant to identify and/or remove discontinued medications from the cart. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. On 8/12/14 the Director of Health Services and the RN Managers began education for all licensed nurses including weekend and PRN staff on administration of insulin with meals and identification of discontinued medications from the medication packets. This education was provided with face to face demonstration on the facilities protocol on how to write	

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F 332	Continued From page 3	F 332	a discontinuation order for a medication and how to identify such orders on the individual medication packets. Of the forty licensed nurses on staff, thirty four have completed the education. The remaining six PRN (as needed) nurses will complete their education prior to working the medication cart. Education on administering insulin with meals and discontinuing medication per order for new hire nurses has been added to orientation. At least 10 licensed nurses monthly (four day shift, four evening shift, and two midnight shift to include weekend staff). Will have med-ication pass observation including	

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F 332	Continued From page 4	F 332	insulin administration with meals. Completed by the Director of Health Services, Senior Nurse Consultant, Nurse Managers, and/or Pharmacy Consultant monthly for three months. Physician orders will be correlated with the medication packets daily times seven days, weekly times four weeks and monthly times three months by the Director of Health Services, Nurse Managers, Unit Coordinators, and MDS Nurse to ensure discontinued medications are documented accordingly. Facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.	

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F 332	Continued From page 5	F 332	The Director of Health Services will present the findings of the medication pass observations, including insulin administration with meals and the the physician orders audit related to dis-continued medications to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained.	