DEPARTMENT OF HEALTH AND HUMAN SERVICES

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2011

PRINTED: 11/16/2011 FORM APPROVED OMB NO. 0938-0391

		MEDICAID SERVICES				ONID INC	<u>). 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIP	LE CONSTRUCTION Y Y XUII	(X3) DATE SU	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUIL	.DING	r ' <u> /_</u>	COMPLET	
		1 / Car	B. WIN	Ω	MOV NOV		С
		345551	D. WIN	·		₹ <u>₹ 20</u> 41/0	2/2011
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	- 17	1
IINIHEAI	TH POST-ACUTE CARE	- CAROLINA POINT		59	935 MOUNT SINAI ROAD		
VIIIILAL	III COI-ACOIL CARL	- CAROLINA POINT		D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309 SS=J	provide the necessar or maintain the highe mental, and psychoso	NG eceive and the facility must y care and services to attain st practicable physical,	F			and does not by the ed or the th on the correction use of	
	This REQUIREMENT is not met as evidenced by:  Based on family, EMT, staff interviews, and record review, the facility failed to assess change in condition timely and intervene for 1 of 1 (Resident #1) sampled residents experiencing hypothermia. The facility failed to ensure a functioning heating unit in the room of Resident #1 (room 107).  Immediate jeopardy began on 10/22/11. The facility was notified of immediate jeopardy on 10/31/11 at 3:59 pm. Immediate jeopardy was removed at 11/2/11 at 4:50 pm when the facility provided a credible allegation of compliance. The facility remained out of compliance at scope/severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and implement monitoring.  Findings include:  Resident #1 was admitted to the facility on 9/30/11. His diagnoses included pneumonia, rib fractures, dementia, anemia, blindness and insomnia. Resident #1 resided in room 107.			Personal section and the section of	is prepared and submitted solely because of requirements under state and federal law.  F309  A. The facility began in-servicing all staff, on 11/1/11, on hypothermia and on what to do when a heating unit is unplugged for any reason.  B. The Clinical Competency Coordinator, began in-servicing a staff, on 11/1/11, on hypothermia including signs and symptoms of hypothermia which include cold extremities, confusion, lethargy, and shivering. Treatments for hypothermia to include remove person from environment, communicate with the resident if room is at desired temperature, apply blankets and cover head, warm fluids to drink, monitor vital signs, complete a skin assessment to assess extremities and call 911 if indicated. All staff will be in-serviced by 11/2/11.  Staff that has not had the hypothermia in-service will not be permitted to work until in-service is completed.  The Clinical Competency Coordinator began in-servicing all		11-18-11

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R1U011

Facility ID: 20090049

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			RVEY ED
		345551	B. WING		All and Physical Control of Andrew		C 2/2011
	ROVIDER OR SUPPLIER TH POST-ACUTE CARE	- CAROLINA POINT		593	ET ADDRESS, CITY, STATE, ZIP CODE 5 MOUNT SINAI ROAD RHAM, NC 27705	1 170	2,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	·	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	impairment. He was required extensive as mobility. He used a vithe facility.  His 10/7/11 care plan awareness secondary history of falls, muscle difficulty walking and approaches: "assist member for all ambuf wearing tennis shoes resident 's condition supervision/assistance resident uses a wheel mobility."  His 10/7/11 care plan effects and/or advers drug use secondary the evidenced by daily us approaches "monito ongoing basis, admin hold medication if resident."  His temperature range 10/21/11. No temper 10/20/11. From 10/13 temperature ranged for Weather.com indicate temperature high was	on minimum data set d he had severe cognitive non-ambulatory and sistance with transfers and wheelchair for locomotion in  for "poor safety y to diagnosis of dementia, e weakness, unsteady gait, blindness" had t resident with one staff ation, resident prefers , monitor for changes in that may warrant increased the and notify the physician, Ichair for long distance  for "potential for side e reaction to psychotropic to diagnosis of dementia as the of Risperdal "had or mood/behavior on an ister medication as ordered, ident is lethargic and notify  ed from 96.9 and 97.4 on ature was documented for 3/11 to 10/19/11 his daily from 96.4 to 98.1 degrees.	F3	309	with the heating unit (i.e. rothe cover from the unit, play with knobs, kicking at the unit, observed the behavior the remove the resident immer and the following will be preformed: a behavior screcompleted and screen forw to the Social Worker, the new supervisor notified for apprintervention, corrected with unit. Behavioral screens with reviewed by the Social Ser Director for placement on the behavioral management points and point in the unit needs to be unpleduled. In service also included with the unit needs to be unpleduled, move resident to a differoom, and notifying the Maintenance Director and Administrator and/or Director Health services). All staff win-serviced by 11/2/11. Stathas not had the heating unservice will not be permitted work until in-service is complicated by added to our general orient conducting behavior screens on 11/1/11, to identify the behaviors that interfere with functional capacity and managuality of life, on all resident assess the potential behavior such as removing the Any residents with identified behavior such as removing the sidents with identified the sidents with identified the sidents with identified the sidents with identifi	aying units ). If staff y are to diately een varded nursing ropriate n the ill be roices the rogram. nat to do lugged o the fferent the tor of vill be uff that nits in- d to npleted. when a vill be tation. or ral ntify h the ximum nts to ior of units. d	

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

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345551	B. WIN	G_	**************************************		C 2/2011
	ROVIDER OR SUPPLIER TH POST-ACUTE CARE	CAROLINA POINT	<b>T</b>	5	REET ADDRESS, CITY, STATE, ZIP CODE 935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	maintained at 73 degr rooms was individually he did not routinely chindividual resident rooms was individually he did not routinely chindividual resident rooms. During an interview, on Nurse #1 (evening nu stated Resident #1 was Nurse #1 stated he wo stand from his wheelor #1 was kept at nursing provide close supervisions. On 10/28/11 at 7:30 at for 10/20/11) stated R and was blind. Nurse would be agitated and attempt to get out of he Resident #1 's speech understand.  During an interview, of family member of Resident was not working at family member stated unit not working was not wooccasions.  On 10/27/11 at 4:17 pt 10/21/11) stated Resident	in/22/11 the high with a low of 44.  In, the Maintenance corridor temperatures were ees. The heat in individual y controlled. MD #1 stated eck the temperatures in ms.  In 10/27/11 at 4:24 pm, rese 10/19/11 and 10/21/11) as blind and confused. Evaluation until 8-10 pm to be station until 8-10 pm to sion.  In, Nurse #2 (evening nurse esident #1 had dementia #2 stated Resident #1 reach with his hand and is wheelchair. He stated in was difficult to in 10/27/11 at 1:33 pm, a dident #1 stated room 107	F.	309	from heating unit, tampering the knobs, or attempting to the unit will be placed on the behavioral management pro and monitored weekly by the interdisciplinary team.  Interventions, one on one ac placing resident in common when behaviors are observed check unit when resident is tampering with unit to ensur proper function, will be put in for any identified behaviors communicated to the direct staff via Behavior Managen Communication sheet that is placed in front of the CNA Acare plan. Behavior screens be completed on all residen 11/2/11. As a result of the behavioral screen, 2 out of residents (these residents at the same room) were identificated in the same room) were identificated in the behavioral management program, interventions were place, communication added the ADL Care plans book as plan was updated. These residents will be revieweekly by the interdisciplinate team. The Clinical Compete Coordinator, began in-servicion 10/24/11, nursing staff (licensed and unlicensed) of acute change of condition including indication and assochange of condition, who to change of condition to, and documentation of change of condition to, and documentation of change of condition to, and	unplug egram, eg	

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		345551	B. WIN	G			C 2/2011
	ROVIDER OR SUPPLIER TH POST-ACUTE CARE -	CAROLINA POINT		5	REET ADDRESS, CITY, STATE, ZIP CODE 935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	was placed in bed at a During an interview, on Nurse #4 (night nurse stated Resident #1 had unit off the wall in room the date. Nurse #4 stated for all the time she indicated she routinely Resident #1 was at the night of 10/21/11 from indicated Resident #1 station so staff could on 10/28/11 at 8:30 a 10/20/11 and 10/21/11 not sleep at night. Re and agitated. On 10/2 Resident #1 in his who station. Resident #1 was place NA#2 stated the heater #1 stated Resident #1 cover off the heating up the specific date. NA #1 did attempt to pull it unit was unplugged be During an interview, on #3 (day NA for 10/22/11 restless and agitated a indicated Resident #1	the floor. She stated see and required ed. She stated Resident #1 f0:00 pm.  In 10/28/11 at 8:09 am, for 10/20/11 and 10/21/11) d attempted to pull heating in 107. She did not recall ated the heating unit was cared for him. Nurse #4 v cared for Resident #1. e nursing station on the 2 am until 4 am. Nurse #4 was placed at nursing observe him directly.  Im, NA #2 (night NA for b) stated Resident #1 did sident #1 would be restless f1/11 at 1:00 am she placed belchair by the nursing vas wearing a tee shirt, pair of non-skid socks. fd back in bed at 3:30 am. fr was not plugged in. NA had attempted to pull the nit. NA #1 did not know #2 stated when Resident freating unit cover off, the ficause if was a fire hazard.  In 10/28/11 at 12:17 pm, NA 1) stated Resident #1 was at 6:30 am. NA #3 would routinely have NA #3 stated shé got the	F	309	condition. All staff will be in services by 11/2/11. Staff the not had the change in acute condition in-service will not permitted to work until in-secompleted. The Social Sen Director will review findings the behavioral screens with Administrator and/or Director Health services in the daily interdisciplinary team meeting. Monitoring of the Behavioral and behavioral management powill be conducted by the Director Health Services and/or Administrator. Health Services and/or Administrator. Findings of the monitoring will be corrected at the time of discovery by the Director of Health Services and/or Administrator. Findings of the monitoring will brought forth to the facilities in Performance Improvement Committee for patterns, trends further interventions will be developed as necessary to ensu continued compliance.	hat has e be be ervice is vices from the or of ings. screens lans ctor of istrator onthly liance f ealth l be nonthly and	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345651	B. WING				C 11/02/2011	
	ROVIDER OR SUPPLIER TH POST-ACUTE CARE -			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINA! ROAD DURHAM, NC 27705		1170.	2/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 309	Resident was wearing flannel sweater. Resinursing station in his whe was sleepy and war #3 stated she called hecause she could not NA #3 thought that so Resident #1 due to his assisted in getting him.  On 10/28/11 at 12:48 10/22/11) stated she as Resident #1 in bed. As shoes off and found his placed on his bedsprecover him.  During an interview, on Nurse #3 (day shift nurse ponded to Resident #1 was lethat she was unable to obte (device measures oxystated she was unable to make tympanic (ear) temper did not put any oxyger stated Resident #1 har #3 stated she did not phim. Nurse #3 stated #5 in assessing Resident #1 is room at 9:45 am stated Resident #1 har were dangling off the belankets covering him.	g sweat pants, tee shirt and dent was placed at the wheelchair. After breakfast as placed back in bed. NA Jurse #3 to the room at get a BP on Resident #1. mething was wrong with a sleepiness. NA #4 h back in bed.  pm, NA #4 (day NA for assisted NA #3 to get IA #4 stated she took his is feet were cold. He was ad and two blankets to in 10/28/11 at 12:28 pm, rse on 10/22/11) stated she to #1 's room at 9:30 am. rgic and Nurse #3 stated ain a BP or pulse oximetry gen in the blood). Nurse #3 to obtain an oral or ature. Nurse #3 stated she in on Resident #1. Nurse #3 d 2-3 blankets on. Nurse but any more blankets on she was assisted by Nurse ent #1.	F3	09				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345551	B. WING			C 2/2011
	ROVIDER OR SUPPLIER	- CAROLINA POINT	599	ET ADDRESS, CITY, STATE, ZIP CODE 35 MOUNT SINA! ROAD JRHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	blowing cold air. Nurse the unit. Nurse #5 sta of 44 but she was una #5 stated she did not Resident #1 until EMS.  During an interview, or Nurse #6 (day supervhad been called to Reference #5. Nurse #6 stated from the end to the end	Nurse #5 stated she eat mode but the unit kept se #5 stated she unplugged ated Resident #1 had a HR able to obtain a BP. Nurse put any other blankets on Garrived.  In 10/28/11 at 12:59 pm, isor on 10/22/11) stated she esident #1 's room by Nurse Resident #1 was lethargic tated she was able to obtain Nurse #6 indicated the en or plugged in. Nurse #6 ce any more blankets on 6 stated she was not in the ed.  In nursing note stated "The extresident as he did not ent into the resident 's in his back. Resident was Myself and the other nurse ent. I noticed his feet were was at the head of the bed We took resident vitals and	F 309			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345551	B. WIN	ıG		1	C 2/2011
	ROVIDER OR SUPPLIER	CAROLINA POINT		59	EET ADDRESS, CITY, STATE, ZIP CODE 135 MOUNT SINAI ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE
F 309	70/40, HR was 88 we rectal temperature was The EMS report state stated that she had con and patient 's heater stated that when they blowing cold air. Facilitis was her first day show long the heat in poff. Room temperature approximately 40-50 condicated that EMS stated the roof heating unit was not confused to facility for EMT #1 stated the roof heating unit was not confused 's skin was cold and was 85.1. EMT #1 stated that EMS stated she was we felt cold to her. She shypotensive, confused 's skin was cold and was 85.1. EMT #1 stated that EMS stated she was we felt cold to her. She shypotensive, confused 's skin was cold and con the state of	Resident #1 's BP was ak and irregular and his is 85.1 degrees Fahrenheit. It is 85.1 degrees Facility staff person cold unplugged. Facility staff plugged it in the found it lity staff person stated that and that she was not sure patient 's room had been are noted to be degrees." The report aff instructed staff to get rapped the patient in other.  In the end of the patient in the end when they arrived. EMT aring a jacket and the room tated Resident #1 was in a gracket and agitated. Resident #1 dry. The rectal temperature at a staff was instructed to be not Resident #1.  In the end of the problem. Check and found to be hypotensive the to obtain a temperature, The ER note indicated a grees with a BP of 90/51. and slightly pale.	F	309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345551	B. WiN			I	C 02/2011
	ROVIDER OR SUPPLIER	- CAROLINA POINT		5935	T ADDRESS, CITY, STATE, ZIP CODE 5 MOUNT SINA! ROAD RHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	primary diagnosis was exposure. Secondar cardiogenic versus seartery disease. Reside to the facility under comeasures were put in hospitalization due to The clinical record independent of the facility on 10/26/1 On 10/28/11 at 1:30 pon 10/22/11 staff notion of Resident #1. The active the unit unplugged are cover. The Mode know properly. The heating 10/22/11.  During an interview, of Maintenance Director (after the incident with call that the heating unworking. MD #1 state off. The unit was unput unned on the mode know the fixed. MD #1 state off. The unit was unput unned on the mode know the fixed. MD #1 state off. The unit was unput unned on the mode know the fixed. MD #1 state off. The unit was unput unned on the mode know the fixed. MD #1 state off. The unit was unput unned on the mode know the fixed. MD #1 state off. The unit was unput unned on the mode know the fixed. MD #1 state off. The unit was unput unned on the mode know the fixed was unput to explain to keep Resident #1 was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was unable to explain to keep Resident #1 was arrested to the fixed was arreste	as hypothermia due to ry diagnoses were shock, eptic, dementia and coronary dent #1 was discharged back comfort care. Comfort n place during his o hypothermia.  dicated Resident #1 died in	F	309			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		345551	B. WING_	<del></del>	1	C	
	ROVIDER OR SUPPLIER TH POST-ACUTE CARE	***************************************	s	TREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705	1 1170	2/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 309	Jeopardy on 10/31/1 provided a credible a 11/2/11 at 4:50 pm. stated:  After the notice of the facility started in-service hypothermia and on wounit is unplugged for The Clinical Comin-servicing all staff, of including signs and swhich include cold exhergy, and shiverin hypothermia to include environment, community or the community of the color of the complete a sking extremities and call 9 be in-serviced by 11/2 the hypothermia in-service is they observe a reside heating unit (i.e. remorplaying with knobs, king unplugging the unit). behavior they are to reimmediately and the fabehavior screen corforwarded to the Socia supervisor notified for	s notified of Immediate 1 at 3:59 pm. The facility Illegation of compliance on The allegation of compliance  immediate jeopardy the ricing all staff, on 11/1/11, on what to do when a heating any reason. Inpetency Coordinator, began on 11/1/11, on hypothermia tymptoms of	F 30	9			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345551	B. WIN			l .	C 2/2011
	ROVIDER OR SUPPLIER	CAROLINA POINT	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 1935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 309	corrected with the unit be reviewed by the So placement on the beh program. In-service the unit needs to be unit needs to the bed, moreom, and notifying the and the Administrator services). All staff will Staff that has not had will not be permitted to completed. In-servicin heating unit is unpluggeneral orientation. The Social Services Dehavioral screens on behavioral screens on behaviors that interfer capacity and maximum residents to assess the tampering with the heavith identified behavior from heating unit, tampeting to unplug the behavioral management weekly by the interdiscontinuous or esident in common and observed, check unit with unit to ensure proplace for any identified communicated to the communicated to the communicated in front of the Behavior screens will be residents by 11/2/11. As a result of the behavior the services in the services in the services will be residents by 11/2/11.	t. Behavioral screens will broial Services Director for avioral management also included what to do if inplugged (i.e. apply extra nove resident to a different ne Maintenance Director and/or Director of Health I be in-serviced by 11/2/11. Ithe heating units in-service to work until in-service is no on what to do when a gred will be added to our director began conducting 11/1/11, to identify the with the functional in quality of life, on all the potential behavior of atting units. Any residents or such as removing cover pering with the knobs, or the unit will be placed on the sent program, and monitored ciplinary team. One activity, placing the east when behaviors are when resident is tampering per function, will be put in the behaviors and direct care staff via the CNA ADL care plan. The completed on all serviced in the same room)	F	309			

PROVIDENCE OF STRUCTION DEPARTMENT OF STRUCTURE STRUCTURE DEPARTMENT OF STRUCTURE STRUCTURE  NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST-ACUTE CARE - CAROLINA POINT  STREET ADDRESS, CITY, STATE, 2P CODE SEAS MOUNT SIMA ROAD DURHAMI, NC 27265  CONTINUED FOR THE STRUCTURE STATE OF STRUCTURE STRUCTURE STRUCTURE STRUCTURE STATE STA	· · · · · · · · · · · · · · · · · · ·	<u></u>	<u>,</u>					NO. Jabo-Jabi
MANE OF PROVIDER OR SUPPLIER  UNINEALTH POST-ACUTE CARE - CAROLINA POINT  O(4) ID PRETEX TAD STANDARY STATEMENT OF DESICIENCIES (E-CAROLINA POINT SIMA ROAD DURHAM, N. C. 27705  O(4) ID PRETEX TAO  CONTINUED FROM THE PROPERTY TAO  F 309  Continued From page 10 heating unit. These residents were placed on the behavioral management program, interventions were put in place, communication added to the ADL Care plans book and care plan was updated. These residents will be reviewed weekly by the interdisciplinary team.  The Clinical Competency Coordinator, began in-servicing, on 10/24/11, nursing staff (ilensed and unlicensed) on acute change of condition including indication and assessing change of condition, who to report thenge of condition to, and documentation of change of condition inservices will not be permitted to work until in-service is completed.  The Social Services Director will review findings from the behavioral screens with the Administrator and/or Director of Health services in the daily interdisciplinary team meetings from the behavioral screens with the Administrator and/or Director of Health services in the daily interdisciplinary team meetings in the daily interdi				- 1				
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT  OC-01 D  SUMMARY STATEMENT OF DEFICIENCIES  TAB  FOR SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FILL  RESULATORY OR LSC DIENTIFYING INFORMATION)  F 309  Continued From page 10  heating unit. These residents were placed on the behavioral management program, interventions were put in place, communication added to the ADL Care plans book and care plan was updated. These residents will be reviewed weekly by the interdisciplinary team and sassessing change of condition, and documentation of change of condition to, and documentation of change of condition to, and documentation of change of condition to, and added to the permitted to work until inservice is completed.  The Social Services Director will review findings from the behavioral screens with the Administrator and/or Director of Health services in the daily interdisciplinary team meetings.  The credible allegation was verified 11/2/11 at 6:00 pm, as evidenced by staff interviews on identifying hypothermia, interventions to treat hypothermia, change in condition, and documentation of change in condition, and reporting of malfunctioning heating units. Staff interviews included identifying residents with potential for tampering with heating units and response to behavior.  Review of behavioral screening sheet was completed on each resident. Two residents were identified and placed in behavioral management program.			345551	B. WIN	IG		1	
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT    C49 ID   PRETIX   CLASH DETICIENT STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION   PRETIX   PROVIDER'S PLAN OF CORRECTION   PROVIDER   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN	NAME OF	PROVIDER OR SUPPLIER			erne	ET ADDRESS SITU OTATE TIP SODE		TO ELECT !
CASID PREFERX TAGE SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY BUST SER PRECEDED BY FULL TAGE (EACH CONTRECT PLAN OF CORRECTION SHOULD BE CROSS REFERENCES OF THE APPROPRIATE DEFICIENCY)  F 309  Continued From page 10 heating unit. Those residents were placed on the behavioral management program, interventions were put in place, communication added to the ADL Care plans book and care plan was updated. These residents will be reviewed weekly by the interdisciplinary team.  The Clinical Competency Coordinator, began in-servicing, on 10/24/11, nursing staff (licensed and unilicensed) on acute change of condition 10, and documentation of change of condition 1, and documentation of change of condition and sassessing change of condition of change of condition in-service will not be permitted to work until In-service is completed.  The Social Services Director will review findings from the behavioral screens with the Administrator and/or Director of Health services in the daily interdisciplinary team meetings.  The credible allegation was verified 11/2/11 at 5:00 pm, as evidenced by staff interviews on identifying hypothermia, interventions to treat hypothermia, change in condition, and documentation of change in condition, and documentation of change in condition and reporting of malfunctioning heating units. Staff interviews included identifying residents with potential for tampering with heating units and response to behavior.  Review of behavioral screening sheet was completed on each resident. Two residents were identified and placed in behavioral management program.	UNIHEA	LTH POST-ACUTE CARE	- CAROLINA POINT	,	,			
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heating unit. These residents were placed on the behavioral management program, interventions were put in place, communication added to the ADL Care plans book and care plan was updated. These residents will be reviewed weekly by the interdisciplinary team.  The Clinical Competency Coordinator, began in-servicing, on 10/24/11, nursing staff (licensed and unlicensed) on acute change of condition including indication and assessing change of condition including indication and assessing change of condition including indication and assessing change of condition will be in-services by 11/2/11. Staff that has not had the change in acute condition in-service will not be permitted to work until in-service is completed.  The Social Services Director will review findings from the behavioral screens with the Administrator and/or Director of Health services in the daily interdisciplinary team meetings.  The credible allegation was verified 11/2/11 at 5:00 pm, as evidenced by staff interviews on identifying hypothermia, interventions to treat hypothermia, change in condition, and cocumentation of change in condition and reporting of malfunctioning heating units. Staff interviews included identifying residents with potential for tampering with heating units and response to behavior.  Review of behavioral screening sheet was completed on each resident. Two residents were identified and placed in behavioral management program.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	IULD BE	COMPLETION
Review of in-service records for hypothermia and air/heating units indicated nursing and		heating unit. These rebehavioral management were put in place, con ADL Care plans book These residents will be interdisciplinary team. The Clinical Competer in-servicing, on 10/24/and unlicensed) on accincluding indication and condition, who to repose and documentation of staff will be in-services not had the change in will not be permitted to completed. The Social Services Diffrom the behavioral scr Administrator and/or Diffrom the daily interdiscipling. The credible allegation 5:00 pm, as evidenced identifying hypothermia hypothermia, change in documentation of change reporting of malfunction interviews included identifying hypothermia change in documental for tampering of response to behavior.  Review of behavioral sociompleted on each residientified and placed in program.	esidents were placed on the ent program, interventions in munication added to the and care plan was updated, a reviewed weekly by the ency Coordinator, began 11, nursing staff (licensed ute change of condition do assessing change of condition do assessing change of condition. All by 11/2/11. Staff that has acute condition in-service work until in-service is rector will review findings the ens with the encountered are the ency team meetings.  I was verified 11/2/11 at by staff interviews on an interventions to treat condition, and the incondition and the incondition and the incondition and the ency team meeting with the ency team of the ency tea	F	309			

TATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED  A BUILDING (X3) DATE SURVEY COMPLETED	
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345551 B. WING	11
NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST-ACUTE CARE - CAROLINA POINT  STREET ADDRESS, CITY, STATE, ZIP CODE  5935 MOUNT SINAI ROAD  DURHAM, NC 27705	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (COM	(X5) MPLETION DATE
F 309 Continued From page 11 maintenance and housekeeping staff were inserviced on identifying risk of hypothermia, treatment of hypothermia and reporting maintenance concerns for heating/air units.  F 456 SS=J OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on family, EMS and staff interviews and record review, the facility failed to ensure 1 of 89 resident heating units was functioning properly (room 107) resulting in Resident #1 becoming hypothermic.  Immediate jeopardy began on 10/22/11. The facility was notified of immediate jeopardy was removed at 11/2/11 at 4:50 pm when the facility provided a credible allegation of compliance. The facility remained out of compliance. The facility remained out of compliance at scope/severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and implement monitoring.  Findings are:  During an interview, on 10/27/11 at 1:33 pm, a family member of Resident #1 stated room 107 felt cold when he visited on 10/21/11 in the afternoon. The family member of Resident #1 stated the heating unit was not working and was unplugged. The	18/11

Facility ID: 20090049

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ATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Γ, '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
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NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE				
UNIHEAL	TH POST-ACUTE CARE	CAROLINA POINT		1	935 MOUNT SINAI ROAD				
				DURHAM, NC 27705					
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	family member stated unit not working was a 2 occasions.  On 10/27/11 at 4:49 p Director (MD)#1 state were maintained at 73 individual rooms was #1 stated he did not rotemperatures in individues not routinely cherooms.  During an interview, on Nurse #4 (night nurse stated Resident #1 ha unit off the wall in room the date. Nurse #4 stateft off all the time she  On 10/28/11 at 8:30 at 10/20/11 and 10/21/11 plugged in room 107. had attempted to pull the unit. NA #1 did not know the specific off Resident #1 did attempoff, the unit was unplughazard.  On 10/28/11 at 8:57 arourse on 10/22/11) statenplugged in room 107 plugged it in, put in hear	concerns about the heating reported to nursing staff on the Maintenance of the corridor temperatures of degrees. The heat in individually controlled. MD butinely check the dual resident rooms. He can 10/28/11 at 8:09 am, for 10/20/11 and 10/21/11) of attempted to pull heating in 107. She did not recall ated the heating unit was cared for him.  In NA #2 (night NA for ) stated the heater was not NA #1 stated Resident #1 he cover off the heating ow the specific date. NA ent #1 did attempt to pull heating unit. NA #1 did late. NA #2 stated when of to pull heating unit cover toged because if was a fire	F	456	proper functioning, to incluproper functioning of the sithe unit distributes warm a air, the filters are clean, and the units are plugged into outlets. Audit will be conducted. Maintenance Director and/week-end supervisor. Any identified will be corrected immediately including the temperature of room at the discovery and temperature the issues is corrected. We orders and Maintenance locurrently part of general orientation.  D. Results from the monitoring reviewed with the Administ and /or Director of Health Services. Monitoring of the maintenance logs accuracy verified during preventive maintenance completed by Maintenance Director per plentified areas will be corrimmediately and the Admin and/or Director of Health Sewill be notified of any inaccibetween the identified items the maintenance logs. The findings of the maintenance monitoring will be brought for the facilities Performance Improvement Committee for patterns and trends, and fur interventions will be developnecessary to ensure continucompliance.	witches, and cool of that the licted by for issues time of after ork gs are will be rator will be rolicy, ected istrator ervices uracies and erth to red as			

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NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST-ACUTE CARE - CAROLINA POINT				5	REET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705		
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F 456	Continued From page 13  The EMS report stated "Facility staff person stated that she had come in to find the room cold		F	456			
	stated that when they blowing cold air. Fac this was her first day how long the heat in poff. Room temperaturapproximately 40-50 of 11/1/11 at 11:00 a	degrees. " m, EMT #1 stated EMS	The second secon				
THE PARTY OF THE P	responded to facility for Resident #1 at 10:30 am.  EMT #1 stated the room felt cold. She stated the heating unit was not on when they arrived. EMT #1 stated she was wearing a jacket and the room felt cold to her.						7
	on 10/22/11 staff notifi of Resident #1. The a check the heater in ro			***************************************			
	the incident with Resident that the heating unit in MD #1 stated no piece unit was unplugged. Von the mode knob was	#1 stated on 10/22/11 (after lent #1) he received a call room 107 was not working. s of the unit were off. The When the unit was turned stuck and had to be fixed. er occasions he had to put unit. MD #1 could not					

*ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST-ACUTE CARE - CAROLINA POINT				REET ADDRESS, CITY, STATE, ZIP CODE 1935 MOUNT SINAI ROAD DURHAM, NC 27705	1		
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F 456	Continued From page  The administrator was Jeopardy on 10/31/11 provided a credible al 11/2/11 at 4:50 pm. T stated:  When the facility was 10/22/11, that the resi was hypothermic the I conducted a 100% au ensure proper function Maintenance Director working and use of maintenance log begathe work orders and mpart of general orienta On October 22, 2011 completed a 100% authe building. The resurom 107 not working 110 had a loose contracovering over the contaying on top of the un (unit is not open at cur unit (noisy and needs knob, room 612 needs left side filter, room 60 room 604 loose knob, warm air(unit was fixed different knob. The ide been corrected as of 1 After the notice of the interest in the state of the interest in the stat	s notified of Immediate at 3:59 pm. The facility legation of compliance on the allegation of compliance  notified by EMS, on dent, residing in room 107, Maintenance Director dit of the 89 heating units to ning. In-servicing by the on reporting units not aintenance work orders and in for all staff. Completing naintenance logs is currently tion. Maintenance Director dit of the 89 heating units in alts revealed the following: (was changed out), room of knob, room 118 the rol knobs was removed and it, room 211 not working rent time), room 307 old cleaning), room 315 loose cleaning, room 610 needs loose lid to controls, room 601 not blowing ly, and room 501 had entified concerns have		DEFICIENCY)	PRIATE	DATE	
	units on 10/31/11 and ensure proper function as follows: room 115 c	finished on 11/1/11 to ing of the unit. Results are			1		

TATEMENT OF DEFICIENCIES JD PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA JD PLAN OF CORRECTION  345651  NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST-ACUTE CARE - CAROLINA POINT  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		A. BUII B. WIN ID PREFI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  5936 MOUNT SINAI ROAD  DURHAM, NC 27705  ID PROVIDER'S PLAN OF CO  PREFIX (EACH CORRECTIVE ACTION  TAG CROSS-REFERENCED TO THE  DEFICIENCY)		ORRECTION (X5) IN SHOULD BE COMPLETION E APPROPRIATE DATE		
	TH POST-ACUTE CARE - CAROLINA POINT  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IL.	456			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/16/2011 FORM APPROVED

TATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	PLE CONSTRUCTION G	(X3) DATE S COMPLE			
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NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST-ACUTE CARE - CAROLINA POINT				STREET ADDRESS, CITY, STATE, ZIP CODE 6935 MOUNT SINAI ROAD DURHAM, NC 27705					
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F 456		e 16 Inctioning control knob.	E	456					
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