STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLAUD Identification Number:

346538

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
12/11/2012

NAME OF PROVIDER OR SUPPLIER
UNIHEALTH POST-ACUTE CARE-RALEIGH

STREET ADDRESS, CITY, STATE, ZIP CODE
2420 LAKE WHEELER ROAD
RALEIGH, NC 27603

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X4) ID PREFIX TAG
F 280

SS=D

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on observation, resident and staff interviews and medical record reviews the facility failed to update a care plan after Resident #3 fell and received injury. This was evident for 1 of 3 residents reviewed for care plan updates.

(Resident #3)

Findings include:
According to the minimum data set (MDS) dated 11/19/12 Resident # 3 had moderately impaired cognition; she required extensive assistance for ADLs, fall history prior to admission with a left femur fracture. Resident # 3 wore a straight leg brace. Right leg had 2 surgeries.

Corrective action to ensure that the right to participate in planning Care-revise CP. The Care Plan and Individual Care Guide were updated during the Survey to reflect the intervention for the identified resident.

Corrective action for those with Potential to be affected. All residents With falls, will have their Care Plan individual and care guide reviewed & updated to ensure interventions have been addressed.

LABORATORIES DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE

ADMINISTRATOR

1/4/13

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 patient. (See Instructions.) Except for nursing homes, the findings stated above are discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continue program participation.

FORM CMS-2587(02-99) Previous Versions Obsolete Event ID: SX1891 Facility ID: 590702

If continuation sheet Page 1 of 3
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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 1
brace to her left leg.
Review of the incident report dated 10/28/12
revealed resident fell attempting to get out of bed
without calling for assistance. She was assessed
and had no apparent injury. The interventions
following this incident were to place resident bed
in the lowest position and remind her to call for
assistance.

Review of the physician’s note dated 10/29/12
revealed in part: “pt fell 10/27/12 and
complained of increased pain to left leg. X-rays
done showed positive acute fracture of distal
femur fracture. Examined pt increased swelling,
increased tenderness, decreased ROM (range of
motion) distal Left fracture.”

Review of Admission Interim Care Plan dated
9/17/12 revealed: resident at risk for falls. The
interventions included: call bell within reach, cue
for safety awareness, assist for toileting and
transfers when necessary.

Review of the resident’s individual care guide
located on the resident’s closet door dated
9/27/11. (This is used by the staff to provide the
individual care for each resident.) The care plan
revealed no intervention for bed in the lowest
position.

An interview on 12/11/12 at 1:00 PM with nursing
assistant (NA) who cared for Resident #3
revealed the staff followed the care plan on the
resident’s closet door for care of each resident.
He indicated there was no intervention for bed in
the lowest position on the care plan.

An interview on 12/11/12 at 1:15 PM with the

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PROVIDER’S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Systemic Changes to Prevent Deficient Practice. Any new incidents of falls will
have Care Plans and Care Guides
updated to reflect interventions.
DHS and ADHS or designee will
review and ensure all interventions
for falls are updated on care plans and
care guidelines. Interventions for falls
to be discussed at A.M. clinical
meeting with MDS and clinical
staff.

How Corrective Action will be
Monitored. 100% of nurses will
Be in serviced on updating care
Plans and care guides for falls.

(x5) COMPLETION DATE
1-6-13
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director of nursing (DON) revealed after the resident sustained the fall on 10/27/12 there was a meeting with the administrative staff (including minimum data set nurse (MDS nurse), administrator, DON, assistant director of nursing (ADON) and social worker) and the intervention of placing her bed in the lowest position was to be added to her care plan. The MDS nurse should have added this to the care plan and the NA care guide located on each resident’s closet door. The DON acknowledged there were no updates on the resident’s care plan. An interview with the MDS Nurse on 12/11/12 at 2:00 PM revealed she was unaware an updated needed to be added to the care plan.  

| F 280 | 100% audit of all residents with Falls will be done immediately to  

Ensure interventions in care plan and Care Guide are updated. Will be monitored 5 times a week for 3 weeks and then 1 time a week For 3 weeks until substantial Compliance is achieved and then  

As indicated by PI committee that includes all administrative staff. The Medical Director attends quarterly.