STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	C 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS A PERSONAL CARE	**864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589**

(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 No deficiencies were cited as a result of the complaint investigation survey of 11/6/14. Event ID# WS7411.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to develop a care plan for fall risk for 1 of 4 residents assessed for falls, Resident # 93. The findings include: Resident # 93 was admitted to the facility on 12/14/2011, with diagnoses to include Alzheimer '	F 279	Warren Hills Nursing Center acknowledges and proposes this plan of corrections to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provision s of quality care of residents. The Plan of Corrections is	12/4/14

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

Electronically Signed | 11/27/2014

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F 279	Continued From page 1 s dementia, hypertension, and depression. The most recent comprehensive Minimum Data Set (MDS) assessment dated 8/28/14, indicated the resident had impaired short term and long term memory, and severely impaired cognitive skills. The assessment also indicated she had fluctuating inattention and wandering 1 to 3 days per week. She was assessed as needing supervision for dressing, toilet use, personal hygiene, and walking in corridor; and extensive assistance for bathing. The Resident ' s Care Area Assessment (CAA) worksheet, dated 9/4/2014, documented the resident was at risk for falls, based on her physical performance limitations, neuromuscular functions, and cognitive status. Documentation on the CAA included a note under care plan considerations that stated will proceed with plan of care with approaches under an at risk for falls problem. A review of Resident #93 ' s care plan, dated 9/11/2014 revealed no plan of care documentation for risk of falls, or falls. A review of nurse ' s notes on the Residents medical record documented that on 10/11/14 at 4:40 AM, Resident #93 had a fall in her room, which resulted in a fractured left forearm. A Fall Scene Investigation Report dated 10/11/2014 stated that the Resident used the bedside commode, and was attempting to get back into bed and fell. A cup of water was found spilled on the floor by the Resident. A cause of the fall could not be determined, but it was believe it was due to slipping on the water. A review of the Fall Scene Investigation Report described the initial intervention to prevent future falls: " Ask for assistance and use call light. " On 11/3/2014 at 10:45 AM an observation and interview was conducted with Resident #93. The	F 279	submitted as written allegation of compliance. Warren Hills Nursing Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, Warren Hills reserves the right to refute any deficiency on this statement of deficiencies through Informal Dispute Resolution, Formal appeal and or Administrative or Legal Procedures. The facility shall develop, review and revise the resident's Comprehensive Plan of Care for updates. (Falls interventions 1. Non-skid socks, 2. Arm and leg protectors, 3. Bed and Chair Alarms, 4. Helmets, 5. One side of bed against the wall, 6. Half-rails to define the parameters of the bed) Resident #93 and all in house resident's plan of care have been updated with interventions for falls by Care Plan Nurses 11/13/2014. The Care Plan Care Area Assessment have been audited by Resident Plan of Care Nurses 11/17/2014 for all triggered areas i.e.(bathing, dressing, mobility, mood, behavior, falls, pain, cognitive, communication, urinary, activities, nutritional status, feeding tube, dehydration/fluid maintenance, dental, pressure ulcer, physical restraints, return to community referral)that stated shall proceed to care plan and any areas addressed with a care plan 11/17/2014. All care plans have been updated for resident #93(11/7/2014) and all other in house residents have been updated with fall interventions (1. Non-skid socks, 2. Arm and leg protectors, 3. Bed and Chair	

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F 279	Continued From page 2 Resident was fully dressed lying in bed on top of her blankets, with an orange cast on her left forearm. The Resident stated that she fell while getting out of bed and broke her arm. The Resident ' s call light was observed to be hooked to itself on the wall. The resident stated that she didn ' t use that thing and didn ' t want it on her bed. She stated that she will get up and get what she needs. An interview was conducted on 11/6/2014 at 8:55 AM with Nursing Assistants #4 and #5. NA #4 stated that the Resident did have a fall and the staff checked her vital signs and monitored her after her fall. NA #4 and #5 did not know of a care plan developed for Resident #93 to prevent falls. An interview was conducted on 11/6/2014 at 9:10 AM with Nurse #2. The nurse stated that the resident didn ' t like to use her call light and she was independent with her walking, so she would just go and get the nurse when she wanted something. The nurse stated that the interventions put in place after her fall were to check her cast and her fingers and make sure the cast wasn ' t too tight, and to check her vital signs. The nurse stated she wasn ' t aware of any other intervention to prevent falls. On 11/6/2014 at 12:10 PM an interview was conducted with Minimum Data Set (MDS) Nurse #1. The MDS nurse stated that when a fall happened, the hall nurse would initiate interventions. When the nursing supervisor received the incident report of the fall, she would send a copy of it to the MDS nurse, and a fall care plan would be implemented or updated. This process to implement a care plan could take 3 or 4 days. The MDS nurse was unable to find a plan of care for Resident #93 ' s fall risk or fall prevention. The MDS nurse stated that she had	F 279	alarms, 4. Helmets, 5. One side of bed against the wall, 6 Half rails to define the parameter of the bed) (11/13/2014). The falls care plan for each in-house resident to include resident #93 were placed in a book on each hall. Nursing staff (nurses and certified nursing assistant) were in-serviced by Staff Development Nurse on 11/10/2014 about the safety interventions in place on resident's care plan that are in the falls care plan book i.e. 1. Non-skid socks, 2. Arm and Leg protectors, 3. Bed and Chair Alarms, 4. Helmets, 5. One side of bed against the wall, 6. Half-rails to define the parameters of the bed. Express the important of using the falls care plan book on their assigned hall to maintain resident safety. Nursing staff (nurses/certified nursing assistant are to read the resident's plan of care for falls in the book to know what each resident has in place to meet their need for safety. Charge nurse on each hall shall and get certified nursing assistants to sign on assignment sheet on each hall daily x 2 weeks and weekly, that they have read the falls care plan on their assigned residents. The Staff Developer shall in-service during orientation, for newly hired nursing staff nurses/certified nursing assistants about the resident's fall book, why we use it, where it is located, how to let the charge nurse know you read it, what type of interventions are used for each resident in the facility i.e. 1. Non-skid socks, 2. Arm and leg protectors, 3. Bed and chair alarms, 4. Helmets, 5. One side of bed	

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F 279	Continued From page 3 written a note on the residents CAA to proceed with a plan of care for fall risk, but she had not developed a fall risk care plan. On 11/6/2014 at 2:21 PM, an interview was conducted with the director of nursing (DON). The DON stated that there was not a facility program for fall prevention. The facility conducted fall prevention individually by resident. The DON stated that they had tried a bed alarm and a chair alarm for this resident, but she had refused them, and she did not know what other interventions could be put into place.	F 279	against the wall, 6. Half-rails to define the parameter of the bed. The Interterm Care Plans for new admission for fall risk have interventions put in place (non-skid socks, helmet, Half rails, bed against the wall, on admission. The Charge Nurse on each hall shall complete this on the weekend and the care plan nurses of the facility shall complete the interterm care plan Monday through Friday. A Quality Audit Tool shall be used by care plan nurses in the facility to be assured that falls interventions (non-skid socks, helmets, bed and chair alarms, one side of bed against the wall, are in place for staff to assess easily. The Quality Audit Tool shall contain date completed, medical record number, was interterm care plan done on admission, falls assessment done admission, above interventions put in place on admission and readmission if applicable, initials of person completing it, any changes done placed in comment section of Quality Audit Tool. The Medical Director and Director of Nursing shall review the audit results monthly x 3 months then Quarterly times one year. The Quarterly Assurance Committee (Medical Director, Administrator, Director of Nursing, Dietary Manager, Care Plan Nurses, Activity Personnel, Certified Nursing Assistant (when applicable) shall review and revised during monthly meeting or before if deem necessary.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		12/4/14

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F 281	Continued From page 4 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to draw blood for lab work for 1 of 1 residents reviewed that had labs ordered, Resident # 44. The findings included: Resident #44 was admitted to the facility on 5/15/2014. Her diagnoses included dementia, Parkinson's disease, congestive heart failure, and hypertension. The labs ordered on admission were complete blood count (CBC) every 6 months; and blood, urea, nitrogen (BUN), creatinine and electrolytes every 3 months. Lab results present in the medical records were dated 5/19/2014, and included results for CBC, BUN, creatinine, and electrolytes. No lab results were present in the medical record for August, when the BUN, creatinine and electrolytes were due to be repeated. A copy of a lab sheet in the medical record documented that CBC, BUN, creatinine and electrolytes were due to be drawn on 11/10/2014. On 11/5/2014 at 4:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the August results could be on the computer, and not in the medical record. The DON could find no lab results in the computer or medical record. On 11/6/2014 at 2:32 PM an interview was conducted with the DON and Nurse #2. The DON stated that she transcribed the lab orders from the medical record and put them on a 3 x 5	F 281	The facility shall draw blood for lab work/urine for urinalysis and culture and sensitivity as ordered by physician for all in house residents and resident #44. Resident #44 labs were drawn on 11/6/2014. An audit of labs that include: room numbers, resident name, labs ordered by physician order sheets in the chart, date audit completed (11/17/2014) by Register Nurse Supervisor on 7 to 3 shift. The Register Nurse on 7-3 shift is responsible for doing the audit monthly x6 months then every 3 months. The Registered Nurse Supervisor on 7-3 shall use the pharmacy monthly report to double check with charts for accuracy. Any discrepancies shall be called to physician and order clarification written for Omnicare Pharmacy for corrections to be done on the physician's order sheet. New admission and all in-house residents, to include resident #44 has a lab card. The lab card shall include: resident's name, social security number, Medicare number, Medicaid number, date of birth, physician's name, and labs that the physician ordered and the frequency they are to be done. This lab card is done on admission/or day after by the Registered Nurse on 7-3 shift. The Director of Nursing shall do the lab card if the 7-3	

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F 281	Continued From page 5 index card. The index card was completed with the name of labs to be drawn, how often they were to be drawn, and dates they were due. Then Nurse #2 took the August index cards out of the box and wrote out lab requests for laboratory personnel to complete when they came into the facility. The index card containing Resident # 44's information was marked that it was completed, but no lab request was found to support that. The laboratory facility was called by the DON, and the facility stated that they had no record of a request for August for that resident. Nurse #2 stated that she marked that she had completed the task, but she had not completed it. Nurse #2 thought that she must have been distracted from the task when she was attempting to complete the lab request for Resident #44.	F 281	Registered Nurse is off. Registered Nurse, 7-3 Supervisor, was in-serviced by the Director of Nursing (11/7/2014) on the process of being sure physician's order for labs has been done as ordered and on lab card for accurately. A Quality Audit Tool that includes (name, social security number, date of birth, Medicare number, Medicaid number, physician name, labs ordered, frequency, shall be done monthly x 6 months then every 3 months by Register Nurse Supervisor 7-3 shift. The Quality Assurance Committee, to include the Medical Director and Director of Nursing, shall review the audit tool results monthly x 3 months then Quarterly x 1 year. The Quality Assurance Committee, Medical Director, Administrator, Director of Nursing shall review and revise as needed.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility	F 371	The facility shall maintain sanitary	12/4/14

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F 371	Continued From page 6 failed to maintain sanitary conditions and ensure proper storage by 1) not providing a barrier between ready to eat foods and staff hands and 2) not removing dented cans from the ready to use food storage rotation. The findings included: 1) On 11/4/14 at 12:33pm nurse #4 was observed to hold a roll in her bare hands and place butter on it. She then touched the resident on the shoulder while talking to him. Next, while at the same table, she assisted another resident with removing his utensils from the paper bag. She was observed to grasp the bowel end of that resident's spoon with her thumb and index finger. She did not wash her hands prior to assisting the second resident seated at the same table. She again touched the second resident on the shoulder while talking to him. An interview was conducted on 11/4/14 at 12:50 with nurse #4. She stated she was not aware that she touched the bread with her bare hands and she stated she did not know how she would hold the bread unless she wore gloves. She stated she should not have touched the bread with her bare hands. She added she was not aware she had touched the residents. On 11/5/14 at 11:55am in an interview with the Food Service Director she stated ready to eat food should not be touched with bare hands. She stated a napkin could be used to hold the bread while buttering it. 2) On 11/3/14 at 8:00am 3 dented cans were observed on the can rack in the food service storage room. There were 2 dented cans labeled as tomato sauce and one dented can labeled as black-eye peas. During an interview with dietary aide 1 on 11/3/14 at 8:03am he stated he was responsible for putting away the food items when they were delivered.	F 371	conditions and ensure proper storage, preparation , distribution and serving of food under sanitary conditions. All nursing staff to include nurse #4, have been re in-serviced on properly handling of food and utensil, by Staff Developer Nurse on 11/13/2014 for proper handling of food, utensils, cups rims (use of deli-paper, napkins, to butter bread, put jelly on bread, to open lid on cups, remove fork, spoon and knife on handle ends, for all in house residents and any admission. Staff shall use deli-papers, napkins and utensil covers to open bread and utensils items while preparing meal tray for resident's to maintain sanitary conditions. Hand sanitizer shall be placed in dining rooms for use of staff as needed to maintain sanitary condition (i.e. between residents). Staff also informed may leave dining area to wash hands as needed, and shall wash hands in resident's room. An Audit Tool to include: date, monitor dining area by nurse assigned to dining area (main and 600 hall dining area) shall be used by nurses in dining area and on halls to audit sanitary practices in dining area daily x 2 months then monthly x 12 months to include; if food, bread, cups, utensils touched yes/no, initials of who did the monitoring, hand sanitizer in dining area yes/no, hand sanitizer used yes/no, touching of other residents yes/no, initials of who did the monitoring. If it occurs to take to the Staff Developer Nurse for 1:1 in-service on proper technique of handling food, (not touching bread, food, cup rim, open of utensil using covers not to touch eating part of utensils. If same nursing	

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F 371	Continued From page 7 During an interview with the Food Service Director on 11/3/14 she stated the dented cans should be kept in the outside storage building. She revealed she was aware that dented cans were not usable and should not be stored in the rack with the cans ready to be used.	F 371	staff member continues to improperly handle food/utensil, cup rim, touching of other residents, they shall be reprimanded by the Director of Nursing. (May include suspension or termination of employment) daily x 2 months then monthly x 12 months. The Quality Assurance Committee, to include the Medical Director, Administrator, Dietary Manager, Care Plan Nurse, Activity Personnel, Certified Nursing Assistant, and Director of Nursing, shall review the Audit tool results weekly x 3 months, then monthly x 1 year. The Quality Assurance Committee shall review and revise as needed. The facility shall ensure proper storage of food under sanitary conditions. Dietary staff were in-serviced on removal of dented cans from the can rack in the food storage area and placed in the outside storage building by Register Dietitian on 11/10/2014. The Dietary Manager, Assistant Dietary Manager, head cook shall audit daily using an audit tool that has the date checked, if dented on the can rack yes/no, dented cans removed yes/no, initial of who checked/removed them and that they were place outside in the storage building. The Register Dietitian shall check twice a month during his visits for dented cans on the can rack. He shall report to the Dietary Manager, Assistant Dietary Manager any of his findings. The Dietary Manager shall in-service dietary staff involved. If staff member repeats offense they may be suspended and/or terminated.	

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F 371	Continued From page 8	F 371	The Quality Assurance Committee to include the Medical Director, Administrator, Directory of Nursing, Dietary Manager, Care Plan Nurse, Activity Personnel and Certified Nursing Assistant, shall review the audit tool results weekly x 3 months then monthly x 1 year. The Quality Assurance Committee, shall review and revise as needed.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		12/4/14

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F 441	Continued From page 9 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to keep the treatment cart free of cross contamination during 1 of 2 wound care observations (Resident # 70). Findings included: The facility ' s infection control book, dated March 2013, indicated on 8, that there was no restriction on taking a treatment cart into a resident's room, as long as nursing staff did not contaminate the cart while in the room by going back and forth to the cart with contaminated hands. Nurse # 1 was observed completing wound care for Resident # 70 on 11/5/14 at 10:55 AM. The nurse took the treatment cart and treatment book into the resident's room. After removing the dressing, Nurse # 1 opened a bottle of normal saline that was sitting on top of the treatment cart. She opened a drawer on the treatment cart and removed a transparent film used to measure the size of the wound. Nurse # 1 then washed her hands and donned clean gloves. The clean dressing was applied to the wound. Nurse # 1	F 441	The facility shall maintain an Infection Control Program designee to provide a safe sanitary, comfortable environment and to help prevent the development and transmission of disease. All nurses, to include nurse #1, were in-serviced on 11/10/2014 by Staff Developer, on cross contamination. Register Nurses (Supervisors 7-3, 3-11, 11-7 Shift, Director of Nursing shall use Audit tool to include: date, room number, medical record, treatment cart out of room, supplies gathered, hand washing between donning and doffing of gloves, dressing observed without cross contamination, initials of whom observed and comments began on 11/10/2014. Register Nurses Supervisor 7-3, 3-11, 11-7 shall also daily, while making rounds monitor for cross contamination, i.e. washing of hands while donning and doffing gloves, when gloves removed wash hands before touching treatment cart each time, putting barrier down for clean dressing to lie on. Also informed	

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WARREN HILLS A PERSONAL CARE	**864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589**

(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 441	Continued From page 10 then opened the treatment cart and removed a cotton swab used to measure the depth of the wound. After completion of wound measurements, Nurse # 1 opened a drawer on the treatment cart to remove tape that would be used to secure the dressing material. After removing a marker from her pocket, she dated the tape and covered the dressing material with the tape. An interview was held with Nurse # 1 on 11/05/14 at 1:28 PM. She stated she was allowed to take the treatment cart in the resident ' s room as long as it did not touch anything. Nurse # 1 stated taking the treatment cart into a room had never been an issue and she was used to carrying the cart into the resident ' s room. Nurse # 1 stated hands were to be washed after removing gloves; adding she was unaware she had not washed her hands each time gloves were removed and prior to touching items on top of the treatment cart or opening drawers on the treatment cart. An interview was held with Staff Development Coordinator/Infection Control Nurse (SDC/IC) on 11/5/14 at 1:38 PM. The SDC/IC nurse stated that normally the treatment carts were left outside, but they could be taken into the room as long as there was no contamination of the cart. The IC nurse stated that if the nurse did not wash her hands after removing gloves and touched things inside or on top of the treatment cart; that was considered cross contamination.	F 441	that no treatment carts are to go in any resident's room. Nurses in-serviced that anytime you remove gloves, touch the treatment cart, items around you, in house and new admitted residents, to include resident #70, you are to wash you hands. Registered Nurses shall use audit tool and monitor cross contamination i.e. treatment cart out of room, supplies gathered, hand washing between donning and doffing of gloves, dressing observed without cross contamination. Dressing changes to be monitor weekly x 3 months then bi-weekly x 12 months. The Quality Assurance Committee, to include the Medical Director, Administrator, Director of Nursing, Dietary Manager, Care Plan Nurse, Activity Personnel, and Certified Nursing Assistant shall review the audit tool results monthly x 3 months, then quarterly x 1 year. The Quality Assurance Committee shall review and revise as needed.	