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

PRINTED: 03/08/2013 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 345252 01/25/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD RD **WARSAW HEALTH & REHABILITATION CENTER WARSAW, NC 28398** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 This 2567 was amended on 03/08/13 because F242- The Administrator has the survey team deleted F241G as a result of done rounds to each resident new information provided by the facility. F 242 483.15(b) SELF-DETERMINATION - RIGHT TO F 242 room and has interviewed each MAKE CHOICES SS=D individual resident to see what The resident has the right to choose activities, their ideal room temperature schedules, and health care consistent with his or would be. The Administrator her interests, assessments, and plans of care; has adjusted each thermostat interact with members of the community both inside and outside the facility; and make choices to account for each residents about aspects of his or her life in the facility that temperature choice. The are significant to the resident. **Director of Nursing has** inserviced all staff on Self-This REQUIREMENT is not met as evidenced Determination and the ability of bv: Based on resident and staff interviews, the each resident to make their facility failed to allow a resident to choose the own choices for their room temperature in their room for two of two residents (Resident #5, resident #83). temperatures on the dates of 01/24/2013 to 01/29/2013. Findings included: The DON or her designee will 1. Record review indicated Resident #83 was interview two residents per admitted to the facility on 10/25/2012. week for three weeks, then one Review of the resident's Minimum Data Set per week for two weeks to (MDS) dated 12/29/2012 indicated the resident ensure that each resident is had no cognitive impairment. able to make their own choices, In an interview with the resident on 1/23/2013 at and that they are happy with 10:40 AM, the resident reported facility staff came in the room all the time and turned the heat off if their room temperatures. The they thought it was too hot. The resident did not give specific staff names or particular shifts and indicated it occurred op-all shifts with different IREGTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE TITLE LABORATO

Any definiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other salequards 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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SS=D	staff. The resident furion many occasions shout they turned it off a 2. Record review indicadmitted to the facility Review of the resident (MDS) dated 10/12/20 had no cognitive impa In an interview with the at 10:45 AM, the resident further reported and was done by man In an interview with the on 1/23/2013 at 3:45 Ftemperature in a resident fesident's choice. 483.25 PROVIDE CAFHIGHEST WELL BEIN Each resident must record the necessary or maintain the highest mental, and psychosociac accordance with the coand plan of care.	ther revealed she told staff ne liked it warm in her room, nyway. cated Resident #5 was on 10/30/2003. It's Minimum Data Set 112 indicated the resident irment. Resident #5 on 1/23/2013 ent reported facility staff the time" and turned the stit was too hot. The end it happened on all shifts y staff. Director of Nursing (DON) PM, the DON indicated the ent's room should be the RE/SERVICES FOR IG Deive and the facility must care and services to attain it practicable physical,	F3	09	results of the resident interviews will be brought to the QA committee for review and interventions will be put into place as needed. F309- The residents mentione were monitored for signs and symptoms of bleeding immediately, as well as all dialysis residents. All dialysis residents were palpated for thrill and auscultated for bruit immediately. There were no	7 777 777 18 18 18 18 18 18 18 18 18 18 18 18 18	2/2/13	

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resident's cor #65) upon ret findings included the findings includ	e facility dition for urn from ded: licy title was revure" the essure a dalpate from dialydoctor) if resident disease was code minimum titively in coded as received as and reputation of the resident disease was listed as received as received as received as received as received as received as resident disease was listed and reputation of the resident disease and reputation of the resident disease as a received as received	failed to monitor a are 2 of 2 residents (#32 and a dialysis treatment. The dialysis dated as riewed. Under the section following was listed: "2. and pulse upon return from or thrill and auscultate bruit risis and document. Notify foruit and thrill are absent. Its condition and dialysis and dialysis. The diagnoses that included pertension, anemia and se requiring dialysis. The do not the most recent and date as the dated 04/26/12 tact. In addition, the arequiring extensive (activities of daily living) eiving dialysis. The care plan dated roblem "H/O (history of) of the modialysis." The ent will have no so hemodialysis." Under sted "monitor shunt for out to MD as needed." If record did not reveal any ity was monitoring the	F	309	signs and symptoms of bleeding and thrill and bruit were present for each dialysis resident. The Director of Nursing has inserviced all Nurses on the new policy for dialysis residents on the dates of 01/24/2013 to 01/29/2013. Documentation for receiving a resident back from dialysis will be communicated on the new dialysis communication form. This form includes checking for thrill and bruit, vital signs, signs and symptoms of bleeding, and condition of shunt site. On non-dialysis days, thrill and bruit, and signs and symptoms of bleeding will be documented on the MAR. If signs and symptoms of bleeding are present then medical attention will be provided STAT. If thrill or bruit are absent then the attending MD will be notified	s s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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F 309	resident's shunt upon During an interview w (DON) on 01/23/13 at would expect that the when she returns fron include checking the s resident's vital signs respirations)." When documented the DON have any place for it a dialysis communicatio on." A review of the fc Communication Record documentation of posi During an interview wi at 10:20 AM it was rev the only thing they do They don't look at my pressure." During an interview wi 8:00 AM it was reveal pressure when she co all I would do. A revie not reveal any docume resident's blood press dialysis. 2. Resident #65 was a 08/17/12 with cumulat left cerebral hemorrha and end stage renal d The resident was code annual MDS dated 08.	return from the dialysis. ith the Director of Nursing 4:20 PM it was revealed "I resident is checked on the dialysis. This would shunt and taking the (blood pressure, pulse, asked where this would be stated "I guess we don't to this time. We do have a in sheet that we document form titled "Dialysis rd" did not reveal any to dialysis monitoring. ith the resident on 01/24/13 wealed "when I come back is give me my medication. arm or take my blood ith Nurse #1 on 01/25/13 at ed "I might check the blood mes back but that would be we of the medical record didentation to indicate that the ure had been taken post admitted to the facility on ive diagnoses that included ge with left side hemiplegia isease requiring dialysis.	F	309	immediately. The DON will conduct audits on two resident per weeks and one resident per week for three weeks to ensure that this monitoring and documentation and communication with the MD is occurring. All findings will be reported to the QA	ee				

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F 309	was coded as requiring A review of the resident 12/05/12 revealed a Freceiving dialysis." Unlisted "protect/monitor A review of the medical were no vital signs do January and there was nurse notes to indicate the resident upon returning an interview with (DON) on 01/23/13 at would expect that the when she returns from include checking the seriodent's vital signs of respirations)." When a documented the DON have any place for it a dialysis communication on." A review of the formunication Record documentation of postions of the postion of the postion of the postion of postions an interview with at 10:20 AM it was reviewed.	sistance with his ADLs and g hemodialysis. Int's care plan updated broblem "care of resident inder the Approaches was access site -lt. (left) arm." In record revealed that there cumented for the month of is no documentation in the enthat the facility monitored in from dialysis. If the Director of Nursing 4:20 PM it was revealed "I resident is checked on in the dialysis. This would shunt and taking the stated "I guess we don't it this time. We do have a in sheet that we document orm titled "Dialysis" did not reveal any	F	309	DEFICIENCY)		
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PRINTED: 02/25/2013 PEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FORMEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 345262 02/21/2013 HAVE OF PROVIDER DE SUPPLIER STREET ADDRESS, CITY, STAYE, ZIP CODE 214 LANEFIELD RD WARSAW HEALTH'S REHABILITATION CENTER WAR9AW, NC 28398 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (K4) ID PREFIX (ZK) NOTELIAMO (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG TAG DEFICIENCY Continued From page 1 periodically. 19.7.6, 4.8.12, NFPA 13, NFPA K 062 K 062 K062—The sprinkler head in room 25, 9,7 64 has been cleaned and now is able to operate as it was designed. The sprinkler heads in the main This STANDARD is not met as evidenced by: Bases on the observations and staff interviews on 2/2/1/2013 the following Life Safety item was observed as noncompliant, specific findings nurse's station have been reviewed by Simplex-Grinnell and the technician has stated that the include sprinkler heads are compatible 1. The standard sprinkler head in room 64 had paint on the heat element of the sprinkler. without replacing the existing one, (see attached letter from Technician). The maintenance 2. The sprinkler heads instelled at the main nurses station were a mix of a quick response head and a standard fused head, all sprinkler heads in a smoke compartment are required to department has been inserviced on the importance of sprinkler head functioning and cleaning. The be of little same type so that the sprinkler system in that space can work in unison. Actual NFPA Standard: NFPA 13,5-3,1.5.2 administrator will make weekly rounds for one month then monthly thereafter to ensure that 42 CFR 483.70 (b) compliance with sprinkler head functioning is continued. The findings will be brought to the QA committee for review and changes will be initiated as needed. (N CMS-2587(02-99) Privious Versions Obsolete if continuation sheet Page 2 of 2 Event ID: F6FM21 Facility ID: 923122