PRINTED: 10/10/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION (2) A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345240	B. WING _			09/16/2016	
NAME OF PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COL	•		
WADDEN UILLE A DEDCONAL	ADE		864 US HWY 158 BUSINESS WEST			
WARREN HILLS A PERSONAL (ARE		WARRENTON, NC 27589			
PREFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
physical restraints i	AINTS e right to be free from any mposed for purposes of nience, and not required to	F 2	21		10/11/16	
by: Based on observar interviews and reco have a medical just tray for 2 of 7 reside (Resident #87, Res The findings include 1. Resident #87 wa 5/16/14. Diagnoses Accident, Chronic k and Muscle Weakn The most recent Qu (MDS) Assessment Resident #87 as co Interview for Menta #87 had no behavior person assistance with wal hallway and extens toileting. He had ra one side of his upp on both sides of his #87 was frequently bladder, his balanc history of falls. Res having a trunk restr in the chair or out of The Care Area Ass	ed: s admitted to the facility on included Cerebrovascular Gidney Disease, Osteoarthritis ess. uarterly Minimum Data Set dated 6/29/16 assessed gnitively intact with a Brief I Status score of 13. Resident ors, required extensive two with bed mobility and ed limited one person king in his room and the ive one person assistance with nge of motion limitations on er extremities and limitations I lower extremities. Resident incontinent of bowel and e was unsteady and he had a ident #87 was assessed as aint that was used daily when		The statements made on this Correction are not an admiss not constitute an agreement alleged deficiencies. To rema compliance with all Federal a Regulations the facility has ta take the actions set forth in the Correction. The Plan of Corrections the facility's allegated compliance such that all allegate deficiencies cited have been corrected by the date or date. F221 RIGHT TO BE FREI PHYSICAL RESTRIANTS. Corrective Action: Resident #87. Resident #87. Resident #87 was physically No injuries, or marks or bruis noted at that time. The care prompleted a device evaluation the device on 10/5/2016. The be screened by therapy to sealternative seating arrangement made. Therapy screened the 10/6/2016 and decided to dis of lap tray. Additionally on 10 care plan team evaluated the lap tray. The team decided to	assessed. es were colan team on related to patient will be if eents can be expatient on accontinue use 1/6/2016 the expatient of the expatient on accontinue use 1/6/2016 the expatient on the expatient on the expatient on the expatient on accontinue use 1/6/2016 the expatient of the expatient on the expatient on the expatient on accontinue use 1/6/2016 the expatient of the expatient on the expatient of the expatient of the expatient on the expatient of the expat		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/07/2016

Electronically Signed

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			09	/16/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				80	64 US HWY 158 BUSINESS WEST			
WARREN	HILLS A PERSONAL (CARE		V	VARRENTON, NC 27589			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE	
F 221	Continued From pa	age 1	f F	221				
		#87 used a trunk restraint			the use of the lap tray after therapy			
		nning decision box was			recommendation. Lap tray discontinu	ed		
	checked.	g decicion box nac			on 10/6/2016 as a result of the screen			
		updated 7/12/16, revealed a			after care plan team review of			
		sk for falls. Interventions			recommendations. New interventions	are		
	included lap tray to	wheelchair when out of bed			to toilet resident upon rising, before ar	ıd		
	due to unsteady ga	it, attempting unassisted			after meals and at bedtime. Resident			
		rs and safety awareness.			wheelchair cushion changed.			
		t listed in the care plan as a			Resident #137			
	problem/focus.				Therapy screened the patient on			
		raint Evaluations, dated			9/15/2016. Lap tray was discontinued			
		5/16 and 7/12/16 documented			after therapy screen. The team update	:d		
		for restraint use as multiple			her care plan with new intervention to			
		ry. The Summary Evaluation esident #87 did have at one			place resident at nursing station while on wheelchair and offer Activities.	up		
		(often referred to as a lap			on wheelchair and oner Activities.			
		emove it, get up unassisted			Identification of other residents who m	av		
		I with a laceration the lap tray			be involved with this practice:	۵,		
	was initiated.	a laceration and lap tray			All residents have the potential to be			
		sician 's order, dated 10/8/15			affected by this alleged deficient practi	ce.		
		ntinuing the TLC cushion to the			On 10/4/2016 to 10/6/2016 the nurse			
	wheelchair due to ι	unsteady gait and ambulating			managers completed device evaluatio	n		
	unassisted. A lap t	ray to the wheelchair was			forms on all current residents. This wa	as		
		mpting to ambulate without			accomplished by going into every			
		or safety awareness.			resident's room and determining what			
		ent Report dated 3/6/16			type of side rails, hi low or other poten	-		
		ent #87 attempted to transfer			restraining devices were being used.			
		nout asking for assistance			included bed rails, hi-low mattresses,			
	_	ap tray. He had a fall. The ncluded encouraging the			chairs, and other cushions that might to considered restraints. Once a device			
		assistance when he needed to			was determined to be attached or			
		and asking maintenance to			adjacent to the resident's body it was			
	-	e sure it latched/strapped in			evaluated by the nurse to identify if it			
	place.				restricted the patients freedom of			
					movement or normal access to the			
	Review of the Incid	ent Report dated 4/8/16			patient's body. Devices that were			
		ent #87 removed his lap tray			considered a restraint were then revie	wed		
	and attempted to to	oilet self. He was found on the			for medical necessity by the evaluating	3		
	floor near the hathr	nom The root cause was			nurse If the device was identified as	2		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			09/16/2016	
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				86	64 US HWY 158 BUSINESS WEST		
WARREN	HILLS A PERSONAL CA	.RE		W	/ARRENTON, NC 27589		
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F 221	go to the bathroom. part, was to ensure be in resident reach. On 9/14/16 at 11:40A observed sitting in his the lap tray in place. behind the wheelchawere noted to be loos attempt to remove the could do so. On 9/14/16 at 2:50Ph in his wheelchair with seat belt was fastened On 9/15/16 at 10:24A observed sitting in his in place. The seat be wheelchair. The seat firmly. On 9/15/2016 at 11:5 observed sitting in his the lap tray and buback. On 09/15/2016 at 3:4 observed in his wheel attached. The seat be wheelchair hanging le lower portion of the wheelchair hanging le lower portion of the wheelchair and had a lap tra awareness. She state injuries and this was ask for help.	s lap tray and attempting to The intervention listed, in uckle for the lap tray was not at M, Resident #87 was swheelchair in his room with The seat belt was latched in seat. The seat belt straps se. The resident made no e device when asked if he at M, Resident #87 was sitting in the lap tray attached. The ed behind the wheelchair. AM, Resident #87 was swheelchair with the lap tray elt was latched behind the toelt was not tightened. 3AM, Resident #87 was swheelchair in his room with The seat belt was attached lockled behind the wheelchair with the lap tray lelt was attached lockled behind the wheelchair with the lap tray lelt was attached behind the bosely, draping towards the wheelchair back.	F	221	restraint and not medically indicated a reduction plan was established by the care planning team. This review was completed by 10/6/2016. As of 10/6/20 all patients have been evaluated and a restraining devices without medical necessity have been discontinued or hactive reduction plans with specified tir frames to accomplish the reduction. A result of this review, 7 patients had changes in bedrail utilization, 3 residenhave Restraints with a medical necess and will be reviewed weekly. 34 patie that utilize either Geri chairs, hi low mattresses or other devices are being screened by therapy as the first step of their restraint reduction plan. The care plan team will review each resident on restraint reduction plan on the weekly 0 meeting. Systemic Changes: On 10/4/2016, the QA Nurse Consultar in-serviced all nurses managers (unit managers, MDS, SDC and DON) on restraints. Topics included: Many devices can be a restraint for patient. For something to be a restraint depends on why and how we use it. Was typically think of a restraint being a ves restraint or wrist restraints but restraint can be anything that limits a patient's ability to move. The official definition of a physical restraint is according to the State Operation Manual is was reviewed with staff. Emphasis was put on the fact the bedrails, hi-low mattresses and Geri chairs can be considered restraints.	ave me s a a sts ity nts fe the QA ant, or a ant it We st s	

Facility ID: 923530

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AND DUAN OF CORRECTION IN IMPER-		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345240	B. WING			09/	16/2016
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				86	64 US HWY 158 BUSINESS WEST		
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F 221	Continued From page	a 3	F	221			
		she stated Resident #87 had		1	Device evaluation forms must be		
		eness. She further stated if			completed on all patients on admission	,	
		to use the bathroom he			readmission, every 6 months and with	١,	
		y, " take this off ", referring			significant changes. Additionally any t	ime	
	to the lap tray.	y, take the on , retering			a resident has fall where a device was		
		vith Resident #87 on 9/14/16			utilized the device must be evaluated t	0	
		I he did not remove the tray			ensure that the device does not pose		
		move it when he needed to			hazard to the patient. A device evaluate		
	use the toilet.				form should be completed to documen		
	During a follow up interview with Resident #87 on				this review in the medical record. The		
	9/14/16 at 2:50PM he	e stated he could not remove			device evaluations should look at all		
	his tray.				devices that the patient uses that may		
					meet the definition of a restraint listed		
	_	vith Nurse #3 on 09/15/2016			above. If the device is considered a		
		that Resident #87 usually			restraint then the medical necessity of	the	
	hollered out when he				device is reviewed. If the device is		
		d he was toileted every two			medically necessary then the		
		s in between. She stated the			interdisciplinary care plan team should review the device to try and reduce or		
	_	h a TLC cushion but he so the facility began using a			eliminate the use of the restraint.		
		seat belt in the back of the			Reduction plans should be reviewed e	verv	
		ed she believed he could			week during the daily clinical meeting		
		ir and remove the tray.			ensure that the restraint is being reduce		
	Todon bonnia ano ona	in and remove the tray.			This must continue until the restraint is		
	During an observation	n and interview on			discontinued.		
		with Nurse #3 and Resident					
	#87 the nurse asked	the resident to remove his			On 10/4/2016 the nurse managers beg	jan	
	lap tray. Resident #87	7 was sitting in his			in-servicing all current nursing staff (R	N,	
	wheelchair in his roor	m. Resident #87 stated that			LPN, NA both full time, part time and F	RN	
	he could not remove	the seat belt. Resident #87			regarding the use of devices and side		
	I .	the lap tray because he			rails. The Director of Nursing will		
	couldn't get up to use	the bathroom.			ensure that any employee who has no		
					received this training by 10/11/2016 w		
	_	vith the Director of Nursing			not be allowed to work until the training	•	
		7PM she stated Resident			completed. This in-service included the	9	
		TLC cushion and he would			following topics:		
	I .	and fall. The facility then			There are lots of reason why we		
		lap tray. She stated the			should not use a restraint. Studies ha		
	iacility attempted to re	emove the lap tray and the			shown that restraints do not prevent fa	IIS	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
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F 221	Continued From pag	e 4	F 2	21			
	resident would fall. Shitting his head, the helmet, but the resid throw it across the rothe lap tray was put further stated that the chair at one time and resident was able to loosening the belt aruntil the seat belt late the facility had now I back of the wheelchanot reach the latch. During an interview one of the control of the wheel of the latch.	She stated after falling and facility attempted to use a ent would remove it and foom. She stated it was then back on his wheelchair. She is eseat belt was higher on the dighter; however, the wiggle his elbows on the tray and moving the tray sideways on the was reachable. She stated owered the seat belt on the fair where the resident could with the Administrator on she stated it was her a medical justification for the		and can actually cause harm to This harm can include fracture injuries, or even death by strate The survey guidelines that regnursing facilities also include that protect the resident's right being restrained. Restraints can include a prestraint or chemical restraint (medications). For something restraint it depends on why arruse it. We typically think of a being a vest restraint or wrist but restraints can be anything patient's ability to move. The definition of a physical restrain reviewed during the inservice. If a patient uses one of the we need to ensure that the definator the patient. If you in the survey of the survey of the patient. If you in the survey of the sur	es, skin ngulation. gulate skilled regulations t against physical I to be a nd how we restraint restraints that limits a official nt was lose devices evice is not a notice the		
	6/6/16 and had a dia accident with hemipl diabetic retinopathy. The Admission Minir Assessment dated 6 had moderate cognit behaviors. The MDS required the extension for transfers and extractivities of daily living The Care Area Asset Loss dated 6/17/16 reslowly and some day The CAA for Activitied dated 6/17/16 noted total assistance and	num Data Set (MDS) /13/16 revealed the resident ive impairment and no revealed the resident /e assistance of 2 persons ensive to total assistance for		patient throwing their legs over gerichair, notify the charge nurse manager. The charge nurse ensure that the nurse manager will need a device or side rail evaluation that the device is still medicall or they will need to make efforcemove the device. The survey manual says: may not be used for staff converted to the device or ensured the made at the device or ensured the made at the resident needs care, restraints may be used for periods to permit medical treat proceed unless the facility has indicating that the resident has made a valid refusal of the tree question. If a resident's unant violent or aggressive behavior	rese se should er is notified. to complete n to ensure ly necessary rts to Restraints venience. s emergency for brief ttment to s a notice s previously eatment in icipated		

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X DENTIFICATION NUMBER: (X DILLDING		(X3) DATE SURVEY COMPLETED		
		345240	B. WING _		09/16/2016
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, Z	·
				864 US HWY 158 BUSINESS WE	
WARREN	HILLS A PERSONAL	CARE		WARRENTON, NC 27589	
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION (X5)
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F 221	Continued From p	age 5	F 2	221	
	noted the resident	required up to total assist with		him/her or others in imn	ninent danger, the
	transfers and wou	ld fluctuate between 1-2 staff		resident does not have	the right to refuse
	members for trans	sfers and had a history of falls		the use of restraints.	
	with poor vision.			As you can see the	ere are very few
		ician 's order dated 7/3/16 for a		situations where restrain	nts should be
		eel chair due to attempting to		used.	
		assistance and poor safety		In general when de	
	awareness.	s updated on 7/3/16 that read:		who is agitated there ar steps you can follow to	
		chair due to attempting to		agitation. They include	-
		assistance and multiple falls.		provide reassurance, pr	<u> </u>
		ided to ensure correct		modify the environment	· · · · · · · · · · · · · · · · · · ·
		oper body alignment while		for the patient and chec	
		to report to nurse any episodes		ensuring your approach	-
		the chair when in use.		reassuring.	
	On 9/13/16 at 2:5	5PM, Resident #137 was		Each patient is union	que and
	observed sitting in	her room in a wheelchair with		interventions to minimiz	e the risk of falling
		ested on the arms of the		may range from offering	
		t of the resident and secured		playing music or a TV p	-
	1	rapped around the back of the		may like. The patient's	-
		the straps were hooked		include interventions that	
		dent was observed to rest her		to try to calm the patien	
		able and her eyes were closed.		should also be notified s	
		8 PM, Nurse #5 stated in an		interventions can be explan interventions do no	- I
		reason the resident had the lap the resident was blind and		agitation is more severe	
	1	out assistance and fall.		interventions listed in th	
		4 AM the Director of Nursing		work and the physician	-
		n interview they put a tray on		additional directions, the	· · · · · · · · · · · · · · · · · · ·
	, ,	eelchair and the resident would		or nurse manager on ca	-
		up and fall so they put a tray on		Anytime a patient is	
	_	at fastened in the back of the		get up unassisted or if t	
	wheelchair so she	could not remove it.		get out of a Geri chair u	nassisted or
		6 PM an interview was		throwing their legs over	
		e Administrator and the MDS		one supervision must be	•
		MDS Coordinator stated in		Staffing should be realled	
	_	ey identified restraints as a		patients until additional	
		written a plan of correction that		called in to cover the or	
	was still in progres	ss and not complete.		supervision. Your charg	ge nurse should

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 221	interview the residen The Nurse stated the would get up and wa stated the tray table	e 6 PM, Nurse #4 stated in an it had a lap tray for safety. e resident was blind and inder around. The Nurse was removed today and they the hall so they could watch	F 2		d DON ts this criteria rdinating the trators and ted at the supervision e patient is urance team entions are The QA team elete a device ration is to document in the assist in fall ude any colster as in use. It is safety for be used in raints can be Physician rypically in as a sheet with device is it. If you are t who is trying refer to the minimize the c contact the ervision may t safety. ease contact sor for		
				the standard orientation trair required in-service refresher	ning and in the		

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F 221	Continued From page			all employees and will be review Quality Assurance Process to with change has been sustained Monitoring: To ensure compliance, Administ Director of Nursing or designeer monitor this issue using the QA tool. Facility will monitor compliate reviewing 5 residents each week have any devices. They will ensure to identify if it restricts the freedom of movement or normate to the patient's body. They will devices which are considered a have a medical necessity. If a considered is identified as a restraint and is medically indicated, they will ensure the reduction plan is established care planning team. This will be weekly basis for 4 weeks then a months by the Support Nurse Manager, or designee. Reports presented to the weekly QA Conthe Administrator or designee to corrective action initiated as ap Any immediate concerns will be the Director of Nursing or Admin for appropriate action. Compliate monitored and ongoing auditing reviewed at the Weekly Quality Meeting. Weekly QA Committee is attended by Administrator, Din Nursing, MDS Coordinator, Uni Support Nurse, Therapy, HIM, Manager, Wound Nurse. Date of Compliance: 10/11/201	verify that d. strator or e will A survey siance by ek that sure that ed by the e patients al access ensure that device that s not nsure that ed by the e done on monthly for e, Unit s will be ommittee by o assure opropriate. e brought to inistrator ince will be g program of Life e meeting irector of it Manager, Dietary	10/11/16	
F 279	483.20(d), 483.20(k)	(I) DEVELOP	F 2	279		10/11/16	

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F 279 SS=D	Continued From page		F 2	79			
	A facility must use the to develop, review are comprehensive plan. The facility must develop plan for each resident objectives and timetal medical, nursing, and needs that are identifiassessment. The care plan must of the furnished to attain the particulation of the furnished to attain the possible process of the second of the furnished to attain the furnished t	e results of the assessment of revise the resident's of care. elop a comprehensive care of that includes measurable obles to meet a resident's domental and psychosocial fied in the comprehensive elescribe the services that are pain or maintain the resident's hysical, mental, and fing as required under evices that would otherwise elescribe of rights under e right to refuse treatment					
	by: Based on staff interviolating facility failed to devel sampled residents (Forestraints and failed to find 1 resident (Reside antidepressant medical) The findings included 1. Resident #87 was 5/16/14. Diagnoses in	cation. d: admitted to the facility on necluded Cerebrovascular dney Disease, Osteoarthritis		The statements made on this Correction are not an admissing not constitute an agreement walleged deficiencies. To remai compliance with all Federal ar Regulations the facility has tal take the actions set forth in the Correction. The Plan of Corrections titutes the facility's allegated compliance such that all allegate deficiencies cited have been corrected by the date or dates	on to and do vith the in in nd State ken or will is Plan of ection tion of ed or will be		

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CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				JIVID INC	. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345240	B. WING _			09/	16/2016
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
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WARREN	HILLS A PERSONAL CA	IKE		W	ARRENTON, NC 27589		
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F 279	Continued From page	a 0	F 2	270			
1 213			Γ 2	279	F070 DEVELOR		
		ssment (CAAs) Summary			F279 DEVELOP		
		ed in the area of restraints 7 used a trunk restraint			COMPREHENSIVE CARE PLANS Corrective Action:		
	daily.	or used a tidlik restrailit			Resident #87:		
		rterly Minimum Data Set			Resident Care plan was reviewed and		
		lated 6/29/16 assessed			updated.		
		nitively intact with a Brief			Resident #126		
	_	Status score of 13. Resident			Resident Care plan was reviewed and		
	#87 was assessed as	s having a trunk restraint that			updated		
	was used daily when	in the chair or out of bed.			Identification of other residents who ma	y	
	I .	sessed as having two falls			be involved with this practice:		
	without injury and two				All residents have the potential to be		
	· ·	odated 7/12/16, revealed a			affected by the alleged practice. All		
	·	for falls. Interventions			comprehensive assessments (most		
		heelchair when out of bed			recent) within the last 6 months were		
	1	attempting unassisted			reviewed: a review of each Care Area		
		and safety awareness,			Assessment (CAA) for each respective	,,,,	
	remove lap tray to an	of the lap tray every shift,			comprehensive assessment was review to ensure that each Care Area	/eu	
		d and use the FWW (front			Assessment triggered that had a Care		
		and 2nd shifts daily and for			Plan Consideration checked "YES" has	а	
		ery two hours. Restraints			care plan addressed with interventions		
	were not listed in the				place. This was done by 10/7/2016 by t		
	problem/focus.	•			QA Nurse Consultant.		
	During an interview w	vith the Occupational			Systemic Changes:		
	Therapist on 09/16/20	016 10:12 AM she stated			On 10/5/2016 The RN MDS Coordinato	r	
		s at his baseline and he			and any other Interdisciplinary team		
		d and support his weight and			member that participates in the MDS		
	he no longer ambulat	ted with the rolling walker.			assessment process was in serviced		
					/educated by the QA Nurse Consultant.		
	_	vith the Director of Nursing			The education focused on Facilities use	•	
		M she stated that the facility			the findings from the comprehensive	4	
	plan as an interventic	estraint under the fall care			assessment to develop an individualize care plan to meet each resident's needs		
	Resident #87 was no				(42 CFR 483.20(b)). The Facility uses the		
	program.	iongor on a tollotting			CAAs in identifying and clarifying areas		
	program.				concern that are triggered based on how		
	During an interview w	vith the Administrator on			specific MDS items are coded on the		

09/16/2016 2:23 PM she stated it would be her

MDS. The process focuses on evaluating

	TEMENT OF DEFICIENCIES I PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		345240	B. WING		09)/16/2016
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F 279	Continued From page	e 10	F 2	79		
		re plan be developed to s the focus and be updated		these triggered care areas us CAAs, but does not provide eon how to select pertinent integrate planning. Interventions individualized and based on a	xact detail erventions for nust be	
	facility on 4/17/15 and	s originally admitted to the d was readmitted on 6/1/15 ding Anxiety Disorders, ession.		effective problem solving and making approaches to all of the information available for each Care Area Triggers (CATs) ide	decision ne resident. entify	
	revealed Psychotropi further review due to antidepressant medic	#126's Care Area ry (CAA) dated 3/31/16 ic Drug Use triggered for the resident receiving an cation. Resident #126's CAA fied a care plan would be		conditions that may require fu evaluation because they may impact on specific issues and conditions, or the risk of issue conditions for the resident. Ea item must be assessed furthe the use of the CAA process to	have an /or es and/or ach triggered r through	
	According to Resider Quarterly Minimum E 6/15/16, Resident #1 assistance in most ar living, except in the a independently and shassistance with walki another in her room. Interview for Mental S which meant she had The MDS also specificantidepressant medicidays.	ea of Psychotropic Drug Use. Int #126's most recent Potata Set (MDS) dated 26 required extensive reas of activities of daily Irea of eating, she fed herself		care plan decision making, but may not represent a condition or will be addressed in the call significance and causes of an trigger may vary for different r in different situations for the stresident. Different CATs may be common causes, or various it associated with several CATs connected. CATs provide a "flag" for the lift members, indicating that the tricare area needs to be assess completely prior to making cat decisions. Further assessment triggered care area may ident risk factors, and complications	at it may or that should re plan. The y given residents or ame have ems may be DT triggered re planning at of a ify causes,	
	dated 9/12/16, revea medication was not of Review of Resident # Physician's orders re	led antidepressant		with the care area condition. To care then addresses these fact the goal of promoting the residuing highest practicable level of full improvement where possible maintenance and prevention of	The plan of ctors with dent's nctioning: (1) or (2)	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
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F 279	night. Further review Physician's orders re orders to receive Lex During an interview 0 Corporate MDS Coor Coordinator revealed plan for antidepressa #126. The Corporate nurses were docume on the Medication Addaily. During an interview on Nursing Assistant (Not the nurse if Resident behaviors. She revea about Resident # 126 nursing assistants and	cation) at bedtime every of Resident #126's vealed the resident had apro nightly since 11/24/15. 9/15/2016 at 3:10 PM, the dinator and the facility MDS they could not find the care nt medication for Resident MDS Coordinator stated nting any visible side effects ministration Record (MAR) on 09/16/2016 at 11:41 AM, A) #3 stated she informed	F 2'	declines. The CAA process may help the I Identify and address associated and effects; Determine whether a multiple triggered conditions are Identify a need to obtain addition medical, functional, psychosocial financial, or other information ab resident's condition that may be from sources such as the resident's family or other responsarty, the attending physician, distaff, rehabilitative staff, or that relaboratory and diagnostic tests; whether and how a triggered cor actually affects the resident's fur quality of life, or whether the resident's fur quality of life, or whether the resident's fur quality of life, or whether the resident's situation with a health care pract (e.g., attending physician, medicine).	causes and how related; ial I, out a obtained nt, the sible rect care equires Identify idition iction and dent is at s itioner		
	what to look for in ref Resident #126's med During an interview of Director of Nursing (E #126 should have a C medication use or it of together with other is Pharmacist monitored medications and Nurs nurses know about be medication. During an interview of Administrator revealed assessment specified antidepressant medical	erence to side effects of ications. n 9/16/16 at 1:29 PM, the DON) revealed Resident Care Plan for antidepressant could have been combined sues. She stated the d Resident # 126's sing Assistants let the ehaviors and side effects of n 09/16/2016 at 3:20 PM the diff the resident's CAA If the use of an		director, or nurse practitioner), to identify links among causes and causes and consequences, and pertinent tests, consultations, an interventions; Determine whether esident could potentially benefit rehabilitative interventions; Begin develop an individualized care processed and times meet a resident's medical, function mental and psychosocial needs identified through the compreher assessment. Good assessment is the starting good clinical problem solving and making and ultimately for the cresound care plan. The CAAs proving the control of the care plan in the care plan in the care plan in the care plan.	o try to between to identify d r a from n to lan with ables to onal, as nsive point for d decision eation of a ride a link		

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	Continued From pa	age 12 in for the use of this medication.	F 2	care plan should be revised ongoing basis to reflect char resident and the care that th receiving (see.42 CFR 483.2 Comprehensive Care Plans). The RN coordinator is require and date the Care Area Asse (CAA) Summary after all trig have been reviewed to certiful of the comprehensive asses Completion Date, V0200B2) have 7 days after completing assessment to develop or resident's care plan. Facilities the date at V0200B2 to dete date at V0200C2 by which the must be completed (V0200E). The 7-day requirement for comodification of the care plan Admission, SCSA, SCPA, an RAI assessments. A new canot need to be developed af SCSA, SCPA, or Annual rea	on an nges in the le resident is 20(k),). red to sign essment gered CAAs fy completion is ment (CAAs in Facilities go the RAI evise the less should use ermine the less care plan (B2 + 7 days). Completion or applies to the lend/or Annual are plan does fiter each is sessment.		
				Instead, the nursing home mexisting care plan using the latest comprehensive asses. Facilities should also evalua appropriateness of the care times including after Quarter assessments, modifying as a The Director of Nursing or Rewill review comprehensive at to ensure that a comprehensis completed for each reside requirements as listed above Any issues will be reported to for Nursing or Administrator fraction. During the daily Clinical Meeting assessments as listed above the comprehension of the comprehension of the comprehension.	results of the sment. Ite the plan at all rly needed. IN Designee assessments sive care plan ent per the RAI e. to the Director for appropriate		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
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WARREN	HILLS A PERSONAL CA	ARE		864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589		
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F 279			F 2	through Friday), the RN MDS Coor Designee will review assessme reference dates for OBRA assess. The Daily Clinical Meeting is atterthe Director of Nursing, Unit Mana MDS Coordinators, Support Nurs Therapy, HIM, Dietary Manager, Worker, The Administrator and ot needed. Monitoring: To ensure compliance, the Direct Nursing or Designee will conduct using the QA Tool. Five residents comprehensive OBRA assessment be reviewed weekly for 4 weeks, monthly for three months. The ite reviewed on the QA Care plan To include: CAAs triggered reviewed plan considerations reviewed, Comprehensive care plan for antipsychotic medication and rest is completed, Identified issues will reported immediately to the Direct Nursing or Administrator for approaction. Compliance will be monited ongoing auditing program reviewed weekly QA Meeting. The weekly Meeting is attended by the Direct Nursing, MDS Coordinator, Unit Meeting is Administrator. Date of Compliance: 10/11/2016	ent ments. nded by agers, e, Social hers as or of a review nts will and then ms ol will , Care raint use I be tor of opriate red and ed at the QA or of Manager,	10/11/16
F 280 SS=D	PARTICIPATE PLAN	NING CARE-REVISE CP right, unless adjudged	F 2	50		10/11/16

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F 280	participate in planning changes in care and A comprehensive case within 7 days after the comprehensive associated interdisciplinary tear physician, a register for the resident, and disciplines as determined, to the extent professional, the resident, the resident in planning the resident in planning the resident in planning the participation of the planning the planni	the laws of the State, to ng care and treatment or treatment. re plan must be developed	F2	80			
	by: Based on record redication facility failed to revise sampled residents (If the findings include Resident #87 was as 5/16/14. Diagnoses Accident, Chronic Kiand Muscle Weakner The most recent Qu (MDS) Assessment Resident #87 as cogniterview for Mental #87 was assessed as was used daily when the resident was as without injury and two	d: dmitted to the facility on included Cerebrovascular dney Disease, Osteoarthritis ss. arterly Minimum Data Set dated 6/29/16 assessed initively intact with a Brief Status score of 13. Resident is having a trunk restraint that in the chair or out of bed. sessed as having two falls		Correction and not constitute alleged deficition compliance with Regulations to take the action Correction. To constitutes the compliance is deficiencies of corrected by the F280		and do e te will n of f be ated.	

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F 280	to Resident #87 having transitioning, unstead fall and he used a true. The care plan, last up problem/focus of risk included lap tray to we due to unsteady gait, ambulation/transfers check the placement remove lap tray to an assistance as needed wheel walker) on 1st prompted toileting ev During an interview were Therapist on 09/16/20 that Resident #87 was could no longer standing an interview were no longer ambulated. During an interview were on 9/16/16 at 1:20 Pt #87 was no longer or During an interview were 09/16/2016 2:23 PM	ed in the area of falls related ong balance problems during by gait, having at least one nk restraint daily. Indated 7/12/16, revealed a for falls. Interventions wheelchair when out of bed attempting unassisted and safety awareness, of the lap tray every shift, inbulate resident with dand use the FWW (front and 2nd shifts daily and for ery two hours. With the Occupational one of 10:12 AM she stated is at his baseline and he dand support his weight and sted with the rolling walker.	F	280	Resident Care plan was reviewed and updated. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All comprehensive assessments (most recent) within the last 6 months were reviewed: a review of each Care Area Assessment (CAA) for each respective comprehensive assessment was review to ensure that each Care Area Assessment triggered that had a Care Plan Consideration checked "YES" has care plan addressed with interventions place. This was done by 10/7/2016 by QA Nurse consultant. Systemic Changes: On 10/5/2016 The RN MDS Coordinate and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the QA nurse consultant. The education focused on 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. A comprehensive care plan must be developed within 7 days after a 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 participati	ved a in the	

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F 280	Continued From pa	age 16	F 2	of the resident, the resident's resident's legal representative periodically reviewed and reviteam of qualified persons after assessment. Facilities use the findings from comprehensive assessment to individualized care plan to me resident's needs (42 CFR 483 Facility uses the CAAs in ider clarifying areas of concern that triggered based on how specifiems are coded on the MDS. process focuses on evaluating triggered care areas using the does not provide exact detail select pertinent interventions planning. Interventions must be individualized and based on a effective problem solving and making approaches to all of the information available for each Care Area Triggers (CATs) ide conditions that may require fure evaluation because they may impact on specific issues and conditions, or the risk of issue conditions for the resident. Earliem must be assessed furthed the use of the CAA process to care plan decision making, but may not represent a condition or will be addressed in the call significance and causes of an trigger may vary for different resident. Different CATs may common causes, or various it associated with several CATs	e; and ised by a ser each on the co develop a set each (3.20(b)). The stiffic MDS (5.20) The g these e CAAs, but on how to for care be applying decision he are resident. Sentify urther a have an allow of the contify urther of the contife of the continuous	an he d ut	

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F 280	Continued From p	age 17	F 2	connected. CATs provide a "flag" for the members, indicating that the care area needs to be asses completely prior to making of decisions. Further assessm triggered care area may ide risk factors, and complication with the care area condition care then addresses these the goal of promoting the rehighest practicable level of the improvement where possible maintenance and prevention declines. The CAA process may help Identify and address associand effects; Determine whe multiple triggered conditions Identify a need to obtain addredical, functional, psychost financial, or other information resident's condition that material from sources such as the reparty, the attending physicial staff, rehabilitative staff, or the laboratory and diagnostic tewhether and how a triggered actually affects the resident's quality of life, or whether the particular risk of developing conditions; Review the resisting interest of the particular risk of developing conditions; Review the resisting interest of the particular risk of developing conditions; Review the resisting interest of the particular risk of developing conditions; Review the resisting interest of the particular risk of developing conditions; Review the resisting conditions; Review the resisting identify links among causes causes and consequences, pertinent tests, consultation	e triggered ssed more care planning ent of a ntify causes, ons associated . The plan of factors with sident's functioning: (1) e or (2) n of avoidable the IDT: ated causes ther and how is are related; ditional social, on about a y be obtained esident, the sponsible an, direct care that requires ests; Identify d condition is function and e resident is at the dent's practitioner nedical er), to try to and between and to identify		

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F 280	Continued From pa	age 18	F 28	interventions; Determine whet resident could potentially benerehabilitative interventions; Bedevelop an individualized care measurable objectives and time meet a resident's medical, fundential and psychosocial need identified through the comprehassessment. Good assessment is the starting good clinical problem solving a making and ultimately for the esound care plan. The CAAs problems of the esound care plan and care plan and care plan should be revised or ongoing basis to reflect chang resident and the care that the receiving (see.42 CFR 483.20 Comprehensive Care Plans). The RN coordinator is require and date the Care Area Asses (CAA) Summary after all trigge have been reviewed to certify of the comprehensive assessment completion Date, V0200B2). I have 7 days after completing assessment to develop or reviresident's care plan. Facilities the date at V0200B2 to determ date at V0200C2 by which the must be completed (V0200B2 The 7-day requirement for cormodification of the care plan and Admission, SCSA, SCPA, and RAI assessments. A new care not need to be developed after SCSA, SCPA, or Annual reass Instead, the nursing home mand existing care plan using the resident and the resident and the resisting care plan using the resident and the resident and the care plan and the	efit from legin to legin to legin to legin to legin with metables to nctional, ds as hensive ling point for and decision creation of provide a linit lanning. The lanning of lanning	r on a k e

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F 280	Continued From page	ge 19	F2	latest comprehensive ass Facilities should also eva appropriateness of the catimes including after Qual assessments, modifying a The Director of Nursing of will review comprehensive to ensure that a comprehensive to ensure that a comprehensive completed for each restriction. During the daily Clinical Methody Friday, the RN Mor Designee will review a reference dates for OBRATHE Daily Clinical Meeting the Director of Nursing, UMDS Coordinators, Supp Therapy, HIM, Dietary May Worker, The Administrator needed. Monitoring: To ensure compliance, the Nursing or Designee will using the QA Tool. Five recomprehensive OBRA as be reviewed weekly for 4 monthly for three months reviewed on the QA Care include: CAAs triggered replan considerations reviewed completed, Identified is reported immediately to the Nursing or Administrator is completed, Identified is reported immediately to the Nursing or Administrator of the RAMINISTRATE.	luate the are plan at all rterly as needed. or RN Designee e assessments ensive care plan sident per the RAI dove. ed to the Director or for appropriate of the conduct assessment of the conduct are view esidents essessments will weeks, and then are plan Tool will reviewed, Care wed, in for and restraint use issues will be the Director of conduct as essues will be the Director of conduct as essues will be the Director of conduct are view esidents.		

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F 280 F 323 SS=D	as is possible; and ea	ACCIDENT ISION/DEVICES	F 28	action. Compliance will be monitored ongoing auditing program reviewed weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Mar Support Nurse, Therapy, HIM, Dieta Manager, and the Administrator. Date of Compliance: 10/11/2017	at the of nager,
	by: Based on observation interviews, the facility restraint for 2 of 7 restraints (Resident # The findings included 1. Resident #87 was 5/16/14. Diagnoses in Accident, Chronic Kid and Muscle Weaknes The most recent Quark (MDS) Assessment of Resident #87 as cogniterview for Mental \$ #87 was assessed as was used daily when	d: admitted to the facility on ncluded Cerebrovascular dney Disease, Osteoarthritis		The statements made on this Plan of Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Stat Regulations the facility has taken or take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated the set of t	and do e te will of pe ated.

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				CIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345240	B. WING _			09/	16/2016
NAME OF P	ROVIDER OR SUPPLIER			S	FREET ADDRESS, CITY, STATE, ZIP CODE		
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F 323	Continued From page	e 21	F:	323			
		ed in the area of restraints	, ,		Resident #87		
		7 used a trunk restraint			Resident #87 was physically assessed		
	daily.	discu a trunk restraint			No injuries, or marks or bruises were		
	, -	odated 7/12/16, revealed a			noted at that time. The care plan team		
		for falls. Interventions			completed a device evaluation related	to	
		heelchair when out of bed			the device on 10/5/2016. The patient wi		
		attempting unassisted			be screened by therapy to see if		
	, , ,	and safety awareness,			alternative seating arrangements can be	e	
		of the lap tray every shift,			made. Therapy screened the patient o		
	remove lap tray to an				10/6/2016 and decided to discontinue	use	
	assistance as needed	d and use the FWW (front			of lap tray. Additionally on 10/6/2016 th	ne	
	wheel walker) on 1st	and 2nd shifts daily and for			care plan team evaluated the use of the	е	
	prompted toileting ev	ery two hours. Restraints			lap tray. The team decided to disconting	nue	
	were not listed in the	care plan as a			the use of the lap tray after therapy		
	problem/focus.				recommendation. Lap tray discontinue		
		ian 's order, dated 10/8/15			on 10/6/2016 as a result of the screen	and	
		nuing the TLC cushion			after care plan team review of		
		o as a lap buddy) to the			recommendations. New interventions		
		steady gait and ambulating			to toilet resident upon rising, before and	a	
	•	y to the wheelchair was			after meals and at bedtime. Resident		
	assistance and poor	pting to ambulate without			wheelchair cushion changed.		
		nt Report dated 3/6/16			Resident #137 Therapy screened the		
		it #87 attempted to transfer			patient on 9/15/2016. Lap tray was discontinued after therapy screen. The		
		ut asking for assistance			team updated her care plan with new		
		tray. He had a fall. The			intervention to place resident at nursing	נ	
		luded encouraging the			station while up on wheelchair and offe	-	
		sistance when he needed to			Activities.		
		nd asking maintenance to					
	•	sure it latched/strapped in			Identification of other residents who ma	ay	
	place.	• •			be involved with this practice:	-	
					All residents have the potential to be		
	Review of the Incider	nt Report dated 4/8/16			affected by the alleged practice. All		
		it #87 removed his lap tray			resident with devices were assessed b	y	
	and attempted to toile	et self. He was found on the			the Director of Nursing or Unit support		
	floor near the bathroo	om. The root cause was			nurse or MDS Coordinators from		
		s lap tray and attempting to			10/4/2016 to 10/6/2016 to ensure that t	the	
		The intervention listed, in			devices used were applied correctly an	ıd	
	part, was to ensure b	uckle for the lap tray was not			functioning properly.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		TE SURVEY MPLETED
		345240	B. WING	· · · · · · · · · · · · · · · · · · ·	0	9/16/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				864 US HWY 158 BUSINESS WEST		
WARREN	HILLS A PERSONAL CA	.RE		WARRENTON, NC 27589		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 22	F 32	3		
	in resident reach. On 9/14/16 at 11:40A observed sitting in his the lap tray in place. behind the wheelcha were noted to be loos attempt to remove the could do so. On 9/14/16 at 2:50Pl in his wheelchair with seat belt was fastened on 9/15/16 at 10:24A observed sitting in his in place. The seat be wheelchair. The seat firmly. On 9/15/2016 at 11:50 observed sitting in his the lap tray in place. to the lap tray and buback. On 09/15/2016 at 3:40 observed in his wheelchair hanging leath of the wheelchair hand a lap tray and had a lap tray and had a lap tray awareness. She state injuries and this was ask for help.	aM, Resident #87 was a wheelchair in his room with The seat belt was latched in seat. The seat belt straps se. The resident made no e device when asked if he and the lap tray attached. The seat belt was sitting in the lap tray attached. The seat behind the wheelchair. AM, Resident #87 was as wheelchair with the lap tray selt was latched behind the seat belt was not tightened. AM, Resident #87 was as wheelchair in his room with The seat belt was attached lockled behind the wheelchair with the lap tray selt was attached behind the wheelchair with the lap tray selt was attached behind the cosely, draping towards the wheelchair back. With Nurse #2 on 9/14/16 at esident #87 was at risk for any because of safety ed he had had falls with just a reminder for him to		Systemic Changes: Director of Nursing and /or Desserviced all staff (full time, part PRN) to inform that the facility ensure that the resident enviror remains as free of accident haz possible; and each resident recadequate supervision and assist devices to prevent accidents. A device is not functioning proper take the device out of order and work order for the maintenance Staff will also notify the Director or designee for a replacement alternative intervention if needs staff member (full time, part time PRN) who did not receive in-settraining will not be allowed to we training is completed. This information training and in the reconstruction of Nursing or designeed Monitoring: To ensure compliance, Administ Director of Nursing or designeed monitor this issue using the QA tool. Facility will monitor completing safety checklists on used by 5 residents to ensure the devices are correctly applied and functioning properly. This will be weekly basis for 4 weeks then the 3 months by the Support Nurses	time, and must nument cards as is serives stance any time a rely staff will dill out a director. It of nursing or an ed. Any he, and ervice fork until remation andard equired for all dill by the verify that directors as survey ance by a devices that the ed one on monthly for e, Unit	
	9/14/16 at 11:20AM s	with Nursing Assistant #2 on she stated Resident #87 had reness. She further stated if		Manager, or designee. Reports presented to the weekly QA Co	s will be ommittee by	

ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	B. WING		09/16/2016
	ARE	:	864 US HWY 158 BUSINESS WEST	
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esident needed d call out and se lap tray. In an interview B PM she stated red out when he com. She stated out when he com. She stated and sometime by started out when the come are the could rever the tray. In an observation of the wheeler of the wheeler out we he could rever the tray. In an observation of the wheeler of the could rever the tray. In an observation of the wheeler of the could not removed the did not like the could not removed the did not like the could not the could not the could not the tray attempted to the could fall. So the could fall. So the could fall. So the could fall out back on his did that the seat	with Nurse #3 on 09/15/2016 d that Resident #87 usually e needed to use the ed he was toileted every two es in between. She stated the ith a the TLC cushion but remove it and so the facility ay which had a seat belt in elchair. She stated she each behind the chair and on and interview on I with Nurse #3 and Resident d the resident to remove his B7 was sitting in his om. Resident #87 stated that e the seat belt. Resident #87 e the lap tray because he see the bathroom. with the Director of Nursing I6 at 2:57 PM she stated ally had a TLC tray and he ay and fall. The facility then d lap tray. She stated the remove the tray and the She stated it was then the lap wheelchair. She further belt was higher on the chair	F 323	<u> </u>	e brought to inistrator ance will be g program / of Life ee meeting Director of it Manager, Dietary
TI FOR THE TOUR OF THE TANK TO COUNTRY	summary s (EACH DEFICIEN REGULATORY OF inued From pagesident needed d call out and selap tray. Ing an interview 8 PM she state red out when heroom. She state s and sometime ty started out w dent #87 would in using a lap tr back of the whee ved he could re ove the tray. Ing an observation solution of the well cover the tray. Ing an observation solution of the whee ved he could re ove the tray. Ing an observation solution of the whee ved he could re ove the tray. Ing an observation solution of the whee ved he could re ove the tray. Ing an interview N) on 09/15/201 d remove the tray of the word of the	A PERSONAL CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) inued From page 23 esident needed to use the bathroom he d call out and say, " take this off ", referring e lap tray. ng an interview with Nurse #3 on 09/15/2016 8 PM she stated that Resident #87 usually red out when he needed to use the room. She stated he was toileted every two s and sometimes in between. She stated the ty started out with a the TLC cushion but dent #87 would remove it and so the facility an using a lap tray which had a seat belt in tack of the wheelchair. She stated she ved he could reach behind the chair and ove the tray. Ing an observation and interview on 5/2016 3:41 PM with Nurse #3 and Resident the nurse asked the resident to remove his ray. Resident #87 was sitting in his elchair in his room. Resident #87 stated that build not remove the seat belt. Resident #87 and he did not like the lap tray because he dn't get up to use the bathroom. Ing an interview with the Director of Nursing N) on 09/15/2016 at 2:57 PM she stated dent #87 originally had a TLC tray and he d remove the tray and fall. The facility then an using the hard lap tray. She stated the ty attempted to remove the tray and the lent would fall. She stated it was then the lap put back on his wheelchair. She further dd that the seat belt was higher on the chair	A PERSONAL CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) inued From page 23 esident needed to use the bathroom he d call out and say, " take this off " , referring e lap tray. ng an interview with Nurse #3 on 09/15/2016 B PM she stated that Resident #87 usually red out when he needed to use the room. She stated he was toileted every two s and sometimes in between. She stated the ty started out with a the TLC cushion but dent #87 would remove it and so the facility un using a lap tray which had a seat belt in eack of the wheelchair. She stated she ved he could reach behind the chair and ove the tray. In ga no observation and interview on 6/2016 3:41 PM with Nurse #3 and Resident the nurse asked the resident to remove his ray. Resident #87 was sitting in his elchair in his room. Resident #87 stated that build not remove the seat belt. Resident #87 In the did not like the lap tray because he din't get up to use the bathroom. Ing an interview with the Director of Nursing N) on 09/15/2016 at 2:57 PM she stated dent #87 originally had a TLC tray and he d remove the tray and fall. The facility then an using the hard lap tray. She stated the ty attempted to remove the tray and the ent would fall. She stated it was then the lap put back on his wheelchair. She further dd that the seat belt was higher on the chair	R OR SUPPLIER A PERSONAL CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) inued From page 23 esident needed to use the bathroom he do call out and say, "take this off", referring a lap tray. ga an interview with Nurse #3 on 09/15/2016 B PM she stated that Resident #87 usually red out when he needed to use the room. She stated he was toileted every two sand sometimes in between. She stated the ty started out with a the TLC cushion but dent #87 would remove it and so the facility an using a lap tray which had a seat belt in ack of the wheelchair. She stated she ved he could reach behind the chair and over the tray. Ing an observation and interview on 5/2016 3:41 PM with Nurse #3 and Resident the nurse asked the resident #87 stated that build not remove the seat belt. Resident #87 of he did not like the lap tray because he don't get up to use the bathroom. Ing an interview with the Director of Nursing N) on 09/15/2016 at 2:57 PM she stated dent #87 originally had a TLC tray and he deformed the tray and fall. The facility then an using the hard lap tray. She stated the ty attempted to remove the tray and the lent would fall. She stated it was then the lap put back on his wheelchair. She further

1 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·			(X3) DATE SURVEY COMPLETED	
		345240	B. WING			09/16/2016	
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F 323	DON on 09/16/2016 was observed sitting The seat belt was lo the wheelchair back pull the tray forward approximate gap of resident's chest and stated if we move the in the back of the whole wheele a potential hazard where it was correct During an interview 09/16/2016 2:23 PM	on and interview with the at 1:55 PM Resident #87 in his wheelchair in the hall. osely hanging in the back of The DON was observed to and there was an inches between the the tray. The DON then the belt up where it should be neelchair and tighten the belt, move the tray back and forth the latch and undo the belt. realized that the gap could dand tightened the belt	F 3:	23			
	6/6/16 and had a dia accident with hemipl diabetic retinopathy. The Admission Minir Assessment dated 6 had moderate cognit behaviors. The MDS required the extension for transfers and extactivities of daily livin The Care Area Asse	num Data Set (MDS) i/13/16 revealed the resident tive impairment and no brevealed the resident ive assistance of 2 persons ensive to total assistance for					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345240	B. WING	·		9/16/2016	
	ROVIDER OR SUPPLIER HILLS A PERSONAL CA	ARE	•	STREET ADDRESS, CITY, STATE, ZIP COI 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589	•		
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F 323	The CAA for Activitie dated 6/17/16 noted total assistance and staff members. The Conoted the resident retransfers and would imembers for transfer with poor vision. There was a physicial lap tray to the wheel ambulate without assawareness. The Care Plan was used following: Lap tray to attempting to ambulate multiple falls. Interve correct positioning with while device in use a episodes of sliding do On 9/13/16 at 2:55Pl observed sitting in he a tray table that reste wheelchair in front of wrapped around the where the straps were the tray table. The reference the tray table secure the tray table secure the tray table was notable was leaning do resting her arms on to forward. On 9/15/16 at 10:25 wheelchair and tray table.	rs were better than others. Is of Daily Living (ADLs) Ithe resident required up to would fluctuate between 1-2 CAA for Falls dated 6/17/16 quired up to total assist with fluctuate between 1-2 staff Is and had a history of falls In 's order dated 7/3/16 for a chair due to attempting to sistance and poor safety Indated on 7/3/16 with the wheelchair due to Ithe without assistance and Intions included to ensure Ith proper body alignment Ind to report to nurse any Indian in the chair when in use. In Resident #137 was Ither resident with straps that back of the wheelchair Ither ensured to rest Ither than the stable Ither than the stable Ither than the stable Ither than than than than than than than than	F 32				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _		09/	/16/2016	
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F 323	table was not applied asked the Director of the wheelchair with the stated it looked like the were not long enough tray table and would device. On 9/15/16 at 2:33 Fobserved sitting in the Conserved sitting in the Conserv	d correctly. The Administrator f Nursing (DON) to look at he tray table and the DON he arms of the wheelchair h to support the front of the have therapy evaluate the PM, Resident #137 was he hall without the tray table. PM, Nurse #4 stated the tray hoday and they were keeping	F3	23			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 323	front of the plastic grobolt that attached the the tray table on each rear groove was miss to separate from the gront of the tray table. On 9/16/16 at 11:09 A conducted with NA #5 Resident #137 on 9/1 had not worked with tuntil 9/14/16 and 9/15 she saw the tray table thought there was a pwhere the table fit over the NA stated she did anyone.	back of the plastic groove to side. The bolt on the left ing and caused the table top grooved section causing the to lean downward M an interview was who was assigned to 4-15/16. The NA stated she he resident for about a week 1/16. The NA stated when the leaning on 9/14-15/16 she lece missing on the bottom or the arm of the wheelchair. If not report the problem to	F 323		10/11/16
SS=D	This REQUIREMENT by: Based on observation interviews, the facility medication error rate evidenced by 2 errors resulting in a medicat of 5 residents observe (Resident #82 and Reincluded: 1. Resident #82 was a 6/11/16 and had a dia obstructive pulmonary	is not met as evidenced is not met as evidenced in, record review and staff failed to be free of a greater than 5% as out of 26 opportunities ion error rate of 7.6% for 2 and during medication pass esident #74). The findings admitted to the facility on gnosis of chronic		The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or witake the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicate	II :

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER HILLS A PERSONAL CA	\RE	•	86	TREET ADDRESS, CITY, STATE, ZIP CODE 64 US HWY 158 BUSINESS WEST /ARRENTON, NC 27589		
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F 332	twice a day. On 9/14/16 at 3:46 P to administer 2 inhala Resident #82. Symbi medication and used manufacturer 's paci gave instructions to h mouth with water afte to prevent a fungal ir instruct the resident f Symbicort was admin On 9/14/16 at 3:50 P interview that she ha they were supposed their mouth after the had not been told to On 9/16/16 at 3:09 P in an interview she w follow the manufactu administering the me 2. Resident #74 was 12/9/10 and had a di Review of the clinica 's order dated 8/29/ 0.4-0.3%, instill 1 dro day for dry eyes. On 9/15/16 at 8:37 A to prepare and admin Resident #74. The no Systane eye drops. On 9/15/16 at 9:00 A overlooked the Systa #74 and administerer resident. On 9/16/16 the Admi	M, Nurse #6 was observed ations of Symbicort to cort contains a corticosteroid to treat COPD. The kage insert for Symbicort nave the patient rinse the er the inhalation of Symbicort affection. The Nurse did not to rinse her mouth after the histered. M Nurse #6 stated in an d worked at a place where to have the resident rinse use of Symbicort but she do it at this facility. M, the Administrator stated rould expect the nurse to rer's instructions for dication. admitted to the hospital on agnosis of Dry Eyes. I record revealed a physician le for Systane Ultra Solution op in both eyes four times a M, Nurse #5 was observed hister medications to curse did not administer the M, Nurse #5 stated she are eye drops for Resident did the eye drops to the	F	332	F332 FREE OF MEDICATION ERR RATES OF 5% OR MORE Corrective Action: Resident #82 Medications administered as ordered. Manufacturer's instructions followed. Resident #74 Medications administered as ordered. Identification of other residents who make involved with this practice: All residents have the potential to be affected by the alleged practice. Audits were done by the Director of Nursing be 10/6/2016 checking the Medication Administration records ensuring that all medication were administered as prescribed. Audits were done by Direct of Nursing by 10/6/2016 to ensure that oral inhalations medication are administered and also following manufacturer's instructions. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, fitime, part time, and PRN) that the facili must ensure that it is free of medication error rates of five percent or greater. Medications are administered as prescribed in accordance with good nursing principles and practices and or by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorize by state laws and regulations to prepar	ay y l or all ull ty n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			9/16/2016	
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F 332	Continued From p	age 29	F3	medications. Prior to admin medication and dosage sch resident's MAR is compare medication label. If the laber different and the container indicating a change in direct is any other reason to quest dosage or directions, the ploorders are checked for the schedule. Medications are accordance with written or attending physician. If a dosexcessive considering their and condition, or a medicat seems to be unrelated to the current diagnosis or conditicalls the provider pharmacy clarification prior to the admitten medication. If necessar pharmacy contacts the phy clarification. This interaction pharmacy and the resulting clarification are documente nursing notes and elsewher medical record as appropria. Medications are administer they are prepared. Medication is the administers the dose. Hand should be performed before administration of topical, opparenteral, enteral, rectal, a medications. The resident in observed after administration that the dose was completed only a partial dose is ingest noted on the MAR, and activation and control in the individual appropriate. The individual	dedule on the d with the el and MAR are is not flagged ctions or if there tion the hysician's correct dosage administered in ders of the se seems resident's age ion order re resident's on, the nurse of for hinistration of y, the provider sician for hy with the order d in the re person who I hygiene re and after other hygiene re the hygiene r		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345240	B. WING_		09/	16/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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WARKEN	HILLS A PERSONAL CA	KE		WARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(X5) COMPLETION DATE
F 332	Continued From page	÷ 30	F	administers the medication dose recornithe administration on the resident's MA directly after the medication is given. As the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without firs recording the administration of any medications. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Signal will be found on master signature sheet a dose of regularly scheduled medication is withheld, refused, or given at other the scheduled time (for example, the resident is not in the facility at scheduled dose time, or a starter dose of antibiotine needed), (the space provided on the frof the MAR for that dosage administratis initialed and circled. An explanatory note is on the reverse side of the recorprovided for PRN documentation). If (to consecutive doses) of a vital medication are withheld or refused, the physician in notified. When administering Oral Inhalation medications, determine that an adequation amount of medication is remaining in the aerosol canister. Remove the cap and hold the inhaler upright. Shake the inhalativity that the resident to tilt his/her head back slightly, stand or sit up as straigh possible, and breathe out through mountlace inhaler into mouth. Instruct resident into mouth. Instruct residen	t e er ic ture tt. If on han ed c is ont ed wo in s ate ene aler.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			09/16/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE		
WARREN	HILLS A PERSONAL CA	DE		864 US HWY 158 BUSINESS WEST	Г		
WARREN	HILLS A PERSONAL CA	.NE		WARRENTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIAT		
F 332	Continued From page	e 31	F3	to inhale slowly as you de canister to release the me Breathe in and out normal minute, keeping inhaler in mouth. Have resident rins and spit out the rinse wat the inhaler mouthpiece. Very This in service was comp 10/11/2016. Any nursing service was comp 10/11/2016. Any nursing service was comp 10/11/2016. Any nursing service in-see not be allowed to work under completed. This informati integrated into the standal training and in the require refresher courses for all ewill be reviewed by the Querocess to verify that the been sustained. Monitoring: To ensure compliance, Administration compliance, Administration record on a compliance of the standard training and in the require refresher courses for all ewill be reviewed by the Querocess to verify that the been sustained. Monitoring: To ensure compliance, Administration could the sissue using the tool. Facility will monitor of auditing 5 residents med Administration record on a consure that medications as as prescribed. The audit of the success for 4 weeks then medications weekly to ensure manufacturer's instruction followed. This will be done basis for 4 weeks then medications for 4 weeks then medication of the weekly of the Administrator or designee. Represented to the weekly of the Administrator or designer corrective action initiated Any immediate concerns	edication. ally for one (1) in place in the se his/her mout ier. Rinse and o Wash your hand bleted by staff member int time, and PR rvice training w intil training is ion has been and orientation ed in-service employees and iuality Assurance change has dministrator or designee will he QA survey compliance by lication a weekly basis are administere will also review tions medicatio that the ins are being ie on weekly onthly for 3 urse, Unit deports will be QA Committee ignee to assure as appropriate	dry ds. N) rill to ed r 5 n by	

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345240	B. WING _			09/	16/2016
	ROVIDER OR SUPPLIER HILLS A PERSONAL CA	RE		86	TREET ADDRESS, CITY, STATE, ZIP CODE 64 US HWY 158 BUSINESS WEST VARRENTON, NC 27589		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 332 F 371 SS=E	Continued From page 483.35(i) FOOD PRO	CURE,		3332	the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing progra reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manage Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 10/11/2016	be im ng of	10/11/16
	considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food ons					
	by: Based on observation interviews the facility equipment clean and prevent cross contains the tray steam table usteam tables observed Review of the Sanitations revision date Policy: Equipment, we	n, record review and staff failed to maintain kitchen in a sanitary condition to ination by failing to clean under shelf for one of one d. The findings included: ion, Manual Cleaning & ry Equipment and Work of 9/11. Reads as follow: "ork stations and all food t be cleaned and sanitized.			F371 SS=E Corrective Action for Resident Affected No specific resident is identified. Corrective Action for Resident Potentia Affected All residents residing in the facility have potential to be affected. The facility is maintain kitchen equipment in a sanita condition to prevent cross contamination	e to ry	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		345240	B. WING		09/	09/16/2016	
	ROVIDER OR SUPPLIER HILLS A PERSONAL CA	RE		STREET ADDRESS, CITY, STATE, ZIP CODE 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 371	equipment before cle soil from under and a Review of the cleaning to 9/17/16 under AM as "Steamtable, toas walk-In cooler, floor, in check label and date cleaning list was initial indicating the steamtathat date. During an observation 5 well steam table was underside of the steam to be covered with date A second observation 5½ foot underside of observed to be covern particles. During a third observation 5½ foot underside of observed to be covern particles. During a third observation 5½ foot underside was observed to be covern particles. In an interview with the 9/16/16 at 10:12 AM and PM dietary aide of they should also cleas shelf. On 9/16/16 at 10:18 Athat the steam table is every day, but that she we follow the cleaning so	aning. *Remove food and round the equipment. " g list for the week of 9/11/16 Aide 2 listed cleaning duties ster, cook refrigerator, meal carts, meal cards, all foods items. " The alled on Sunday 9/11/16 Able had been cleaned on on 9/14/16 at 11:26 AM the alled sobserved. The 5 ½ foot on 1/15/16 at 9:17 AM the the steam table shelf was ed with dark dried food ation on 9/16/16 at 10:12 AM the of the steam table shelf overed with dark dried food ation on 9/16/16 at 10:12 AM the of the steam table shelf overed with dark dried food at the steam table wells in the underside of the steam table wells in the underside of the steam table shelf overed with dark dried food the Food Service Manager on she stated that when the AM clean the steam table wells in the underside of the steam table wells in the dietary staff stated thelf should be cleaned the just did not get to it today. The Administrator on 9/16/16 ould expect dietary staff to	F3	Cleaning schedules are to be followed and completed cleaning assignments be monitored to ensure satisfactory completion. Compliance will be monitored by Die Management. Systemic Changes Thorough cleaning of the steam table area including under the steam table was completed _9-15-16 An audit will be put in place to monitor cleaning the steam table area. Staff was in-serviced by the Dietary Manager on10-7-16 regarding completion of all cleaning assignments. Quality Assurance The Dietary Services Director will money this issue using the Dietary QA Audit This will be done 3 days per week for three months or until resolved by QC committee. Reports will be given to be weekly QOL/QA committee and Corrective Action initiated as appropring QALIC Committee. This regularly scheduled weekly meeting attended by The Administrator, Director Nursing, Dietary Services Director, andMDS The Medical Director will review during the Quarte QA Meeting.	will ary shelf it tool g of L/QA he sate.	10/11/16	
SS=D	PROPERLY	2 S, WAD, IOE WINE! OOE		~~~		13/11/10	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			09	/16/2016
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
WADDEN	HILLS A PERSONAL C	ADE		86	64 US HWY 158 BUSINESS WEST		
WARREN	HILLS A PERSONAL O	ANE		W	ARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 372	Continued From pag		F3	372			
	properly.	pose of garbage and refuse					
	This REQUIREMEN	T is not met as evidenced					
	Based on observati	ons, record review and staff			F372 SS=D		
	interviews the facility	y failed to maintain the area			Corrective Action for Resident Affected	t	
	dumpsters observed				No specific resident is identified.		
	The findings include				Corrective Action for Resident Potentia	ally	
		ation, Disposal of Garbage			Affected		
		ist revised on 9/11, reads as			All regidents regiding in the facility has		
	Refuse.	, Disposal of Garbage &			All residents residing in the facility have potential to be affected. The facility is		
		h receptacles should be kept			dispose of garbage & refuse properly.	10	
		with their drain plugs in			Compliance will be monitored by Dieta	ırv &	
		rea is to be kept clean at all			Facility Maintenance Management.	,	
	During an observation	on of the dumpster on 9/16/16			Systemic Changes		
		lastic bag of trash and one			The Dumpster area was cleaned of all		
		ere observed on the ground			trash on9-14-16		
	beside the dumpster				audit tool will be put in place to monito	r	
		on on 9/16/16 at 9:42 AM			the cleanliness of the area.		
		stic bag of trash and one ere observed on the ground			Quality Assurance		
	beside the dumpster				The Dietary Services Director &		
	-	e dumpster was conducted			Maintenance Director will monitor this		
		ce Manager on 9/16/16 at			issue using the Dietary QA Audit Tool.		
		lastic bag of trash and one			This will be done 3 days per week for		
	disposable glove we	ere observed on the ground			three months or until resolved by QOL	/QA	
	beside the dumpster				committee. Reports will be given to the	е	
		AM the Food Service			weekly QOL/QA committee and		
	_	she had checked the			Corrective Action initiated as appropria	ate.	
		that morning and another			The QOL/QA committee is the main		
		their trash on the ground.			Quality Assurance Committee. This		
		PM the Administrator stated			regularly scheduled weekly meeting is		
	the dumpster.	ct all staff to pick up around			attended by The Administrator, Director, Nursing, Dietary Services Director,	וט וע	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345240	B. WING	 	09/16/2016
	ROVIDER OR SUPPLIER HILLS A PERSONAL CA	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 372	Continued From pag	e 35	F 37	andMaintenance The Medical Director will review during Quarterly QA Meeting.	
F 441 SS=D	483.65 INFECTION (SPREAD, LINENS	CONTROL, PREVENT	F 44	11	10/11/16
	Infection Control Pro safe, sanitary and co to help prevent the d of disease and infect (a) Infection Control The facility must esta Program under which (1) Investigates, contin the facility; (2) Decides what pro should be applied to (3) Maintains a recoractions related to infection (b) Preventing Sprea (1) When the Infection determines that a residue of the province of the prevention of	Program ablish an Infection Control it - trols, and prevents infections acedures, such as isolation, an individual resident; and d of incidents and corrective ections. d of Infection on Control Program sident needs isolation to			
	isolate the resident. (2) The facility must promunicable diseated from direct contact will train (3) The facility must phands after each direct hand washing is indicated professional practice.	require staff to wash their ect resident contact for which cated by accepted			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345240	B. WING		09/16/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	7 00/10/2010
WARREN	HILLS A PERSONAL	CARE		864 US HWY 158 BUSINESS WEST	
WANKEN	TILLO A F LIGORAL	CARL		WARRENTON, NC 27589	
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 441	Continued From p transport linens so infection.	age 36 as to prevent the spread of	F 44	11	
	by: Based on observer facility nurse failed residents for 3 of 9 medication pass (1 and Resident #8). The facility policy 1/2010 listed the paread of germs a section Alcohol Based Hat contact with reside with resident. "1 a On 9/15/16 at observed to prepare #74. The nurse way pill from each of 3 used her fingers to pack and place in During the observed to the pill got into the was observed to a Resident #74. b. The nurse exite to apply a brace to Resident #8 who whall near the medic. The nurse was medication cart to	ation and staff interviews, a at to sanitize her hands between a residents observed during a Resident #74, Resident #141. The findings included: atitled Handwashing dated burpose was to prevent the nd cross-contamination. The ased Handrubs read: " Use nd Rubs: Before having direct ent. After having direct contact when the search as observed to punch out one blister pack punch cards and or remove each pill from the a plastic medication cup. The nurse ation, the Nurse stated she had and to use her fingers to ensure medication cup. The nurse administer the medications to did the room and was observed to the right foot and leg of was sitting in a wheelchair in the cation cart. Observed to return to the prepare medications for the nurse was observed to punch		The statements made on this Plan Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Sta Regulations the facility has taken or take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility's allegation or compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indic F441 INFECTION CONTROL, PRE SPREAD, LINENS Corrective Action: Resident # 74 Medication was administered as ordered maintaining standard precautions during medical administration. Resident #141 Medication was administered as ordered maintaining standard precautions during medical administration. Resident #8 Medication was administration.	and do e ate r will n of f be ated. EVENT g ation g ation istered Nurses Med

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	DATE SURVEY COMPLETED
		345240	B. WING _			09/16/2016
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
WARREN	HILLS A PERSONAL C	CARE		864 US HWY 158 BUSINESS WEST		
				WARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	pack and place in a medication pass, th hands or use a han residents. On 9/15/16 at 9:20 interview that she w wash her hands and drawer of the medic hand sanitizer to sa On 9/16/16 at 3:08 in an interview it wo	remove each pill from the plastic cup. During the le nurse did not wash her d sanitizer between the 3 AM, Nurse #5 stated in an was nervous and forgot to d was observed to open a cation cart and used a bottle of	F	of infection during medication administration. To ALWAYS standard precautions during administration and to alway hands when resident contact Identification of other reside be involved with this practice. All residents have the potent affected by the alleged pract of Nursing observed Medical Administration Passes on NLPN and Med Techs) All residents administration. Systemic Changes: Director of Nursing and /or I serviced all Nurses staff and (RN, LPN and Med Techs: fitime, and PRN) about infect preventing spread of infection medication administration. The facility must establish a an infection Control Program provide a safe, sanitary and environment and to help predevelopment and transmiss and infection.(a) Infection Corgram The facility must enfection Control Program ut (1) Investigates, controls, and infections in the facility;(2) Exprocedures, such as isolation applied to an individual residual transmiss and infections in the facility and the procedures, such as isolation applied to an individual residual resi	maintain g medication s wash their ct is made. ents who may se: ntial to be ctice. Director ation lurses (RN, sidents is ordered utions during Designee in d Med Techs full time, part tion control, on during and maintain m designed to d comfortable event the sion of disease control establish an inder which it - ind prevents Decides what on, should be dent; and(3) ents and o infections.(b) ion(1) When im determines	

PREFIX (EACH DEFICIE		` IDENTIFICATION NUMBED: ` ´		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			09/16/2016	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DDE I	03/10/2010	
				864 US HWY 158 BUSINESS WEST			
WARREN	HILLS A PERSONAL	CARE		WARRENTON, NC 27589			
PREFIX	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From p	age 38	F4	the spread of infection, the sisolate the resident.(2) The prohibit employees with a condisease or infected skin less direct contact with residents if direct contact will transmit (3) The facility must require their hands after each direct contact for which hand wash indicated by accepted profe practice.(c) Linens Personn handle, store, process and linens so as to prevent the sinfection. Medications are administered they are prepared. Medicati pre-poured. The person who dose for administration is the administers the dose. Hand should be performed before administration of topical, op parenteral, enteral, rectal, a medications. Always observe Standard P during any medication admin Wash hands if resident cont Standard Precautions should all procedures involving bloop potentially infectious body flointments and drops should separate containers labeled resident's name. Liquid and medications should be kept in the medication carts. No used for treatments such as should be kept in the medication the treatment cart. Any medication the treatment cart. Any medication the treatment of a resident was the treatment of a resident to the treatment of the treatment of a resident to the treatment of the t	facility must ommunicable ons from sortheir food, the disease. staff to wash tresident hing is ssional el must transport spread of ed at the time ons are not oprepares the e person who hygiene and after hthalmic, otic, nd vaginal electric is made. It is made. It is made with od or other uids. It is deserted be kept in the with the PO ed separately medications is creams ation cart. In the ion used for		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG	1 ' '	(X3) DATE SURVEY COMPLETED	
		345240	B. WING		09/	16/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WADDEN	IIII I C A DEDCOMAL CA	D.F.		864 US HWY 158 BUSINESS WEST			
WARREN	HILLS A PERSONAL CA	KE		WARRENTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE .	(X5) COMPLETION DATE	
F 441	Continued From page	÷ 39	F	isolation precautions should be stored separately from other resident's treatr supplies and should be locked to prevunauthorized access. Medication cart shall be cleaned when visibly soiled. I and utensils shall be handled in a sar manner. Unused medication cups shakept covered or inverted. Sharps containers on medication carts shall be affixed or secured to prevent spillage. When administering oral medications never touch pills or tablets with bare hands. If blister pack medications are prepared by pharmacy, punch the medication directly into a medication for dispensing. If tablets are in a bottle then pour the medication into the lid at then transfer ordered dose into the medication cup. Clean any spilled liquing medication immediately. When administering eye drops, Alway wear gloves. Wash hands after administration. Ensure that eye medication dispensers/containers do touch the resident's eyes. If eye secretions are present, cleanse the liquit with saline. Always wipe from the innecanthus outward. Always use separat tissue wipes or cotton balls for each eto prevent cross contamination. When administering injections, Alway wear gloves. Wash hands after administration. Use sterile technique when preparing the medication for injection. Cleanse the site with an antiseptic prior to administration of the injection. Dispose of the sharp in an appropriate container immediately following administration. Monitor the	nent ent s cood itary II be e cup s not r e eye		

	NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3)		(X3) DATE SURVEY COMPLETED			
		345240	B. WING _			09/16/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
WARREN	HILLS A PERSONAL CA	RE		864 US HWY 158 BUSINESS WEST		
***************************************				WARRENTON, NC 27589		
(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 C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIAT	
F 441	Continued From page	e 40	F 4	injection site for sign and syninfection. When administering medical syringe, the syringe should be one resident only. Syringe should be changed at least every 24 he shall be rinsed thoroughly, shall be ready for next use. This in services were complested to feel ready for next use. This in services were complested to feel ready for next use. This in services were complested to feel ready for next use. This in services were complested to feel ready for next use. This in services were complested to feel ready for next use. This in services were complested to feel ready for next use. This in services were complested to feel ready for next use. This in services were complested to feel ready for next use. This in services were complested to feel ready for the sustained to the standard training and in the required in refresher courses for all empty will be reviewed by the Qual Process to verify that the change in the sustained. Monitoring: To ensure compliance, Director designee will monitor this the QA survey tool. Facility we compliance by observing 5 compliance by observing 5 compliance by observing 5 compliance by observing 5 compliance and ministration part of the part of the standard precautions are maduring medication administration administration administration administration and the support Nurse, Unit Mardesignee. Reports will be put the weekly QA Committee by the weekly QA Commi	tions via be used for hall be ours. Syring deparated an use and or in a plastic eding pole eted on aff member me, and PR be training w training is a has been orientation ange has ctor of nursin issue using will monitor different asses done during any sure that aintained ation and tha at contact is a weekly bas a r 3 months b hager, or resented to	nd c (N) rill ce ng by at sis

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		PLE CONSTRUCTION (X3		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			09/	16/2016	
	ROVIDER OR SUPPLIER HILLS A PERSONAL CA	RE		86	REET ADDRESS, CITY, STATE, ZIP CODE 4 US HWY 158 BUSINESS WEST ARRENTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 441	assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activiti develops and implem action to correct ident. A State or the Secret disclosure of the reco except insofar as succompliance of such co requirements of this secret.	in a quality assessment and consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify which quality assessment ites are necessary; and ents appropriate plans of itified quality deficiencies. Tary may not require reds of such committee to the committee with the		5520	Administrator or designee to assure corrective action initiated as appropriate Any immediate concerns will be brough the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing progra reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meetir is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manag Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 10/11/2016.	be m ng f	10/11/16	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345240	B. WING _			9/16/2016
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD	•	0.10.2010
WADDEN	LULI C A DEDOONAL	CARE		864 US HWY 158 BUSINESS WEST		
WARREN	HILLS A PERSONAL	CARE		WARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 520	Continued From pa and correct quality a basis for sanction	deficiencies will not be used as	F 5	20		
	by: Based on record r facility's Quality A Failed to maintain effective monitoring comprehensive can to ensure complian had a pattern of tw first which was orig a recertification surve originally cited in C recertification surve recertification surve the facility during to show a pattern of the an effective Quality The findings include This tag was cross 1. F279 -Based of interviews the facility for 1 of 7 sampled reviewed for restrat care plan for 1 of 1 an antidepressant During the recertifithe facility failed to dialysis and failed to dialysis and failed to 1 resident reviewed 2. F221 - Based 2. F221 - Based 2. F221 - Based 2. F221 - Based 3. F321 - Based 4. F321 - Based 4. F321 - Based 5. F321 - Based 6. F321 - Based 7. F321 - Based 8. F321 - Based 9. F321 - Based	ey, and the current ey. The continued failure of wo federal surveys of record he facility 's inability to sustain of Assurance program. ed: referenced to: on record review and staff ty failed to develop a care plan residents (Resident # 87) ints and failed to develop a resident (Resident #123) on medication. cation survey of October 2015 develop a care plan for estriction for 1 of 1 resident on to care plan a restraint for 1 of		The statements made on this Correction are not an admissi not constitute an agreement walleged deficiencies. To remai compliance with all Federal and Regulations the facility has tatake the actions set forth in the Correction. The Plan of Corrections to the facility's allegated compliance such that all allegate deficiencies cited have been corrected by the date or dates. F520 QAA COMMITTEE-MEMBERS/MEQUARTERLY/PLANS Corrective Action: Cross reference Tag F520 to Resident #87, Resident #126 Resident #87 and #126. Resident #87 and #126. Resident #87, Resident #137 Resident #87, Resident #137 Resident #87, Resident #137 Resident #87. Resident #137 Resident #87 was physically and injuries, or marks or bruise noted at that time. The care prompleted a device evaluation the device on 10/5/2016. The bescreened by therapy to sea alternative seating arrangementade. Therapy screened the 10/6/2016 and decided to discontinuation.	on to and do with the in in in and State ken or will is Plan of ection ation of ed or will be is indicated. EET Tag F279 dents Care ated. Tag F221 assessed. es were lan team in related to patient will e if ents can be a patient on	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345240	B. WING			09/	16/2016
	ROVIDER OR SUPPLIER HILLS A PERSONAL CA	RE	·	STREET ADDRESS, CITY, STATE, ZIP CODE 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	a lap tray for 2 of 7 restraints (Resident #During the recertificate the facility failed to have a lap buddy restraint to assess for the less resident reviewed for During an interview wo (DON) on 9/16/16 at Quality Assurance (Quality Assurance (Quality Assurance (Quality Assurance and the charts and care the last survey and all the deficiencies that where was unaware that removed during meal that the facility had all	cal justification for the use of esidents reviewed with 187, Resident #137). Ition survey of October 2015 ave a medical justification for for 1 of 1 resident and failed restrictive device for 1 of 1 restraint use. With the Director of Nursing 1:40pm she stated the 1A) Performance tree met monthly and any bring a problem to the QA ted. The DON indicated that the plans were reviewed after 1 corrections were made for were cited. She stated that the trestraints needed to be 1 times. She further stated ways listed restraint use or falls as an intervention.	F		of lap tray. Additionally on 10/6/2016 the care plan team evaluated the use of the lap tray. The team decided to discontinute use of the lap tray after therapy recommendation. Lap tray discontinue on 10/6/2016 as a result of the screen after care plan team review of recommendations. New interventions at to toilet resident upon rising, before and after meals and at bedtime. Resident wheelchair cushion changed. Resident #137 Therapy screened the patient on 9/15/2016. Lap tray was discontinued after therapy screen. The team updated her care plan with new intervention to place resident at nursing station while to on wheelchair and offer Activities. Identification of other residents who make involved with this practice: All residents have the potential to be affected by the alleged practice. Cross Reference Tag F520 to Tag F279 All residents have the potential to be affected by the alleged practice. All comprehensive assessments (most recent) within the last 6 months were reviewed: a review of each Care Area Assessment (CAA) for each respective comprehensive assessment was review to ensure that each Care Area Assessment triggered that had a Care Plan Consideration checked "YES" has care plan addressed with interventions place. This was done by 10/7/2016 by 10 QA Nurse Consultant. Cross Reference Tag F520 to Tag F222 All residents have the potential to be	e nue ed and are d d up eved e a in the	

PREFIX (EACH DEFICIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _		0.0	0/16/2016	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		710/2010	
				864 US HWY 158 BUSINESS WEST			
WARREN	HILLS A PERSONAL	CARE		WARRENTON, NC 27589			
PRÉFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From p	age 44	F5	affected by this alleged defice On 10/4/2016 to 10/6/2016 in managers completed devices forms on all current resident accomplished by going into resident's room and determitype of side rails, hi low or orestraining devices were beincluded bed rails, hi-low managers completed bed rails, hi-low managers completed bed rails, hi-low managers and other cushions the considered restraints. Once was determined to be attact adjacent to the resident's beding evaluated by the nurse to independent of the patients freed of movement or normal access patient's body. Devices the considered a restraint were for medical necessity by the nurse. If the device was idea restraint and not medically in reduction plan was established care planning team. This recompleted by 10/6/2016. As all patients have been evaluated restraining devices without result of this review, 7 patients changes in bedrail utilization have Restraints with a medinand will be reviewed weekly that utilize either Geri chairs mattresses or other devices screened by therapy as the their restraint reduction plan plan team will review each restraint reduction plan on the re	the nurse e evaluation ts. This was every ining what other potentially ing used. This attresses, Geri that might be the a device the a device the the reviewed to the the reviewed the revi		

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345240	B. WING		09	/16/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WARREN	HILLS A PERSONAL CA	RE		864 US HWY 158 BUSINESS WEST			
				WARRENTON, NC 27589			
(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	
F 520	Continued From page	e 45	F 52	meeting. Systemic Changes: Director of Nursing and /or Designe serviced all nursing staff (RNs, LPN Medication Aides, CNAs full time, p time, and PRN) that: Cross reference Tag F520 to Tag F Resident #87, Resident #126. Cross Reference Tag F520 to Tag F Resident #87, Resident #137 A facility must maintain a quality assessment and assurance commit consisting of them director of nursir services; a physician designated by facility; and at least 3 other membe the facility's staff. The quality asses and assurance committee meets at quarterly to identify issues with resp which quality assessment and assurance activities are necessary; and develor and implements appropriate plans action to correct identified quality deficiencies. A State or the Secreta not require disclosure of the record such committee except insofar as so disclosure is related to the compliant such committee with the requirement this section. Good faith attempts by committee to identify and correct quality deficiencies will not be used as a bis sanctions. This in service was completed by 10/5/2016.Any Quality assessment assurance committee team member time, part time, and PRN) who did receive in-service training will not be allowed to work until training is committee team derivation has been integrated the standard orientation training and	Is, art 279 5221 ttee ag the rs of sment least oect to irance ops of uch acc of athe uality asis for and r (full not e apleted. ed into		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345240	B. WING		09/	16/2016
	ROVIDER OR SUPPLIER HILLS A PERSONAL CA	RE	:	STREET ADDRESS, CITY, STATE, ZIP CODE 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	446	F 520	required in-service refresher courses for all employees and will be reviewed by Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator of Director of Nursing will monitor this issusing the QA survey tool. Facility will monitor compliance of QA for F 279 ar F279. This will be done on weekly bas for 4 weeks then monthly for 3 months the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriat Any immediate concerns will be broughthe Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing programeviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting attended by Administrator, Director of Nursing, MDS Coordinator, Unit Managuer, Wound Nurse. Date of Compliance: 10/11/2016	the at rue nd is by te. ht to r be am ng	