PRINTED: 09/25/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _		08	C / 24/2017	
NAME OF PE	ROVIDER OR SUPPLIER		' I	STREET ADDRESS, CITY, STATE, ZIP CODE	,	-	
WARREN	HILLS NURSING CENTE	D		864 US HWY 158 BUSINESS WEST			
WAINILIN	THEEO NONOING CENTE	· ·		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 281 SS=D	PROFESSIONAL STA		F 2	81		9/12/17	
	(b)(3) Comprehensive	e Care Plans					
	-	d or arranged by the facility, mprehensive care plan,					
	by:	is not met as evidenced					
		ew and staff interviews, the der for 1 of 1 residents with ent #52).		The statements made on this Pla Correction are not an admission to not constitute an agreement with talleged deficiencies. To remain in	and do		
	The findings included	:		compliance with all Federal and S Regulations the facility has taken			
	Resident #52 was add	mitted to the facility on		take the actions set forth in this Pl			
	12/29/15 and re-admi	tted on 12/23/16 with		Correction. The Plan of Correction	n		
	diagnoses including A			constitutes the facility's allegation	of		
	Hypertension. She w Bacterial Conjunctiviti	as given the diagnosis of is on 7/26/17.		compliance such that all alleged deficiencies cited have been or wi corrected by the date or dates ind			
	Review of the Physici	an's orders on the eMAR		land and a date of dates mu			
	(electronic Medication dated 7/26/17 document	n Administration Record) ented an order for Tobrex .3% to instill two drops into		F281 SERVICES PROVIDED PROFESSIONAL STANDARDS	MEET		
	•	es daily for Conjunctivitis		Corrective Action: Resident #.52			
				Physician was notified on (8/23/20			
		for July 2017 documented		The physician did not want to initia	-		
		olution 0.3% to instill two		further treatment. Resident repres	entative		
		e times daily for conjunctivitis		notified on (8/24/2017).			
		R documented on 7/26 at		Identification of other residents wh	no may		
		absent from home), on		be involved with this practice:			
		M and 9PM the #9 (meaning		All residents with a diagnosis of	, ho		
		d on 7/31/17 at 9AM and		Conjunctivitis have the potential to			
		refusal) and 7/31/17 at /17 the medication was		affected by the alleged practice. C 9/5/2017 to 9/7/2017 2017 a chart			
ARODATORY I		SUPPLIER REPRESENTATIVE'S SIGNATURE	:	TITLE	. addit	(X6) DATE	

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

Electronically Signed

09/08/2017

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			08/2	24/2017	
	ROVIDER OR SUPPLIER HILLS NURSING CENTE	r R		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 PREFIX TAG				(X5) COMPLETION DATE	
F 281	2PM dose but was giver medication was giver medication was not at Review of the nursing 7/30/17 documented the facility and the far pharmacy to deliver. note for 7/31/17. The documented the medication are review of the interview with Nurse stated the resident's at 9PM and the nurse more doses were need clarified the order with the medication.	vailable for the 9AM and ven at 9PM. On 8/2/17 the nall three doses. The dministered after 8/2/17. g notes from 7/27/17 through the medication was not in cility was waiting for the There was not a nursing enursing note dated 8/1/17 ication was not in the facility e July 2017 eMAR and #1 on 8/23/17 at 3:40PM she medication started on 8/1/17 e should have seen that eded after 8/2/17 and have the physician to continue	F2	was initiated for a Conjunctivitis in that all physician and initiated. The to ensure that all of Conjunctivitis winitiated as ordered chart audit was confunctivitis was conjunctivitis were as ordered. Systemic Change Director of Nursin serviced all Nurse part time, and PR interdisplinary call fact that the serviced that the serviced comprehensive call conjunctivity, as comprehensive call conjunctivities were as ordered.	all current residents whe facilities to ensure orders were followed audit was also initiate orders for the diagnost were followed and ed by the physician .Tompleted by the Nursum (Director of Nursing Support Nurse). All for diagnosis of refollowed and initiate es: ag and /or Designee in es (RNs, LPNs, full ting RN) and the re planning team on the ces provided or arrandoutlined by the are plan, must meet	ed sis he e g, ed		
	should have been giv	I she stated the medication as ordered and the een notified to clarify the Tobrex after 8/2/17.		Nurses (RNs, LPI and PRN) were a that it is the nurse physician, follow orders. If resident physician orders, refusal will be ind Medication Admir Resident represe Physician should and 7 days a ween to change due to week. Physician are located at each are unable to reach	dards of quality. All Ns, full time, part time also educated on the file's responsibility to not and initiate Physician to refuses to follow documentation of licated in the Electron instration. Physician and antative will be notified be called 24 hours a each. This process does not time or day of the phone numbers order the attending only sician on call, call	act tify ic nd day s		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345240	B. WING_			C 08/2	4/2017
	ROVIDER OR SUPPLIER HILLS NURSING CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589			4/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIA CIENCY)	I	(X5) COMPLETION DATE
F 281	Continued From page	æ 2	F2	facility medical director of contacting the prima attending physician or does not provide an ap or does not call back we then the nurse is to cor immediately for further. This in service was cor September 12th, 2017. LPNs, full time, part time member of the interdistion did not receive in-service be allowed to work unticompleted. This inform integrated into the stantarining and in the requirefresher courses for a will be reviewed by the Process to verify that the been sustained. Monitoring: To ensure compliance, or designee will monitor the QA survey tool. The compliance by reviewire charts with diagnosis of physician orders to ensure orders were followed, in this will be done on we weeks then monthly for Director of Nursing, Su Manager, or designee. presented to the weekl meeting by the Administ to assure corrective accompropriate. Any imme be brought to the Director.	ry physician. If to medical director oppropriate responsithin 30 minutes near the DON instructions. Impleted by Any Nurse (RN ne, and PRN) and ciplinary team whose training is nation has been adard orientation hired in-service. If employees and Quality Assurance change has a proper this issue using the facility will moning 5 residents of conjunctivitis sure that physician itiated as ordered eekly basis for 4 or 3 months by the proof Nurse, United the proof of the proo	se s, d no ot l ce ing g itor an ed. et t	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345240	B. WING			C
	ROVIDER OR SUPPLIER HILLS NURSING CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589	1 0	8/24/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 281	Continued From page	. 3	F 28	Administrator for appropriate ac Compliance will be monitored a ongoing auditing program review monthly QA Committee meeting attended by the Administrator, I Nursing, MDS Coordinator, Unit Support Nurse, Therapy, HIM, I Manager, Social Services. Date of Compliance: _September 12th, 2017	nd wed at the g which is Director of t Manager,	
F 328 SS=D	(b)(2) Foot care. To e proper treatment and and good foot health, (i) Provide foot care a with professional stant to prevent complication medical condition(s) a (ii) If necessary, assist appointments with a carranging for transport appointments (f) Colostomy, ureter The facility must ensure require colostomy, ure services, receive such professional standard comprehensive persont the resident's goals a	nsure that residents receive care to maintain mobility the facility must: Ind treatment, in accordance dards of practice, including ons from the resident's and It the resident in making qualified person, and tation to and from such Distomy, or ileostomy care. Irre that residents who eterostomy, or ileostomy in care consistent with sof practice, the n-centered care plan, and	F 32	28		9/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			C // 24/2017	
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIF 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589	CODE	72472017	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 328	to prevent compincluding but not lindiarrhea, vomiting, abnormalities, and (h) Parenteral Fluid administered consistandards of practic physician orders, the person-centered cargoals and preference (i) Respiratory care and tracheal suction that a resident who including tracheost suctioning, is provide professional standards comprehensive per residents' goals and this subpart. (j) Prostheses. The resident who has a and assistance, constandards of practic person-centered care and preferences, to prosthetic device. This REQUIREMED by: Based on record reinterviews the facility respiratory equipmed CPAP (Continuous	priate treatment and services lications of enteral feeding nited to aspiration pneumonia, dehydration, metabolic nasal-pharyngeal ulcers. Is. Parenteral fluids must be stent with professional ce and in accordance with ne comprehensive ure plan, and the resident's ces. Including tracheostomy care ning. The facility must ensure needs respiratory care, comy care and tracheal ded such care, consistent with ards of practice, the son-centered care plan, the dipreferences, and 483.65 of effectility must ensure that a prosthesis is provided care nesistent with professional ce, the comprehensive ure plan, the residents' goals of wear and be able to use the NT is not met as evidenced eview, observations and the failed to properly store cent for 3 of 3 residents with Positive Airway Pressure) and int #3, #81and #149).	F3	The statements made or Correction are not an adr not constitute an agreem alleged deficiencies. To recompliance with all Feder Regulations the facility hat take the actions set forth	mission to and do ent with the emain in ral and State as taken or will		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345240	B. WING _				C 24/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	24/2017	
				86	64 US HWY 158 BUSINESS WEST			
WARREN	HILLS NURSING CENTE	R			/ARRENTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 328	Continued From page 1. Resident #3 was a	F 3	328	Correction. The Plan of Correction constitutes the facility's allegation of				
	1/30/03 and re-admittincluding Chronic Ob (COPD) and Pleurisy			compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated	d.			
	Review of the most re Data Set Assessmen Resident #3 as cogni Interview for Mental S			F328 TREATMENT/CARE FOR SPECIAL NEEDS Corrective Action: Resident #149				
	Ipratropium-Albuterol	ian's order dated 6/2/17 read Solution 0.5-2.5 (3) orally via nebulizer every 6			Respiratory equipment; CPAP (Continuous Positive Airway Pressure) equipment was properly stored. Resident #81 Respiratory equipment; Nebulizer			
	Review of the August eMedication Administration Record (eMAR) documented Resident #3 received her inhalation treatments twice daily at 9am and 5pm.				equipment was properly stored. Resident#3 Respiratory equipment; Nebulizer equipment was properly stored. Identification of other residents who ma	av		
	Resident #3 was up i	n on 8/22/17 at 11:21am n her wheelchair. Resident nit and tubing and uncovered d.			be involved with this practice: All residents with Respiratory equipmentave the potential to be affected by the alleged practice. On 9/5/2017 to 9/7/202017 a chart audit and observation was	nt : :17		
	nebulizer unit and un the bed.	n on 8/22/17 at 3:05pm the covered mask were lying on			initiated for all current residents with Respiratory equipment in the facility to ensure that all respiratory equipment w stored properly. The chart audit and	as .		
	nebulizer unit and un the bed.	n on 8/23/17 at 8:48am the covered mask were lying on			observation of the Respiratory equipmed was completed by the Nurse Managem Team (Director of Nursing, Unit Managem and Support Nurse). All Respiratory	nent		
		n on 8/23/17 2:25pm the covered mask were lying on			equipment was stored properly. Systemic Changes: Director of Nursing and /or Designee in	1		
	During an interview w	vith Nurse #2 on 8/23/17 at			serviced all Nurses (RNs, LPNs, full tin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		345240	B. WING			C / 24/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	72-7/2017	
				864 US HWY 158 BUSINESS WEST			
WARREN	HILLS NURSING CENTE	iR .		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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 328	Continued From page	e 6	F 32	8			
	4:20pm she stated al mask should be store	I of the CPAP and nebulizer ed in plastic bags.		part time, and PRN) and the interdisplinary care planning team fact that Respiratory equipment sh	ould be		
		n on 8/24/17 at 8:15am the covered mask were lying on		stored properly. Nebulizer equipme should be cleaned routinely. Nebul equipment; tubing and Mask shoul changed weekly and labeled. Nebu	lizer d be		
	During an interview with the Director of Nursing on 8/24/17 at 8:13am she stated it was expected that the mask be covered in a plastic bag when not in use.			equipment tubing and mask should stored in plastic bags when not in the Humidifier bottles on Oxygen concomachines are to be changed according to the manufactures specifications. Outling is to be labeled and dated a changed weekly according to the fischedule. Oxygen tubing and Masi	use. entrator rding to exygen acility		
		admitted to the facility on ted 4/21/17 with diagnoses structive Pulmonary		should be stored in plastic bags if use. CPAP equipment; Masks show stored in plastic bags if not in use. This in service was completed by September 12th, 2017. Any Nurse	not in uld be		
	Review of the most recent Admission Minimum Data Set Assessment dated 4/28/17 identified Resident #81 as cognitively intact with a Brief Interview for Mental Status score of 15.			LPNs, full time, part time, and PRN member of the interdisciplinary tea did not receive in-service training whe allowed to work until training is completed. This information has be	l) and m who vill not		
	documented an order 0.5-2.5 (3) MG/3ML (ian's order dated 8/16/17 r for DuoNeb Solution Ipratropium-Albuterol) 3 a nebulizer every 4 hours as d wheeze.		integrated into the standard oriental training and in the required in-serv refresher courses for all employees will be reviewed by the Quality Ass Process to verify that the change had been sustained.	ice s and surance		
	Resident #81 had a r on the bed uncovered had a treatment earlied During an observation	n on 8/23/17 at 8:51am the		Monitoring: To ensure compliance, Director of or designee will monitor this issue the QA survey tool. The facility will compliance by reviewing and obse	using monitor		
	nebulizer unit and un the bed.	covered mask were lying on		residents with respiratory equipme			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			l	C 24/2017
NAME OF P	ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	24/2017
				86	64 US HWY 158 BUSINESS WEST		
WARREN	HILLS NURSING CENTE	R		W	ARRENTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 328	nebulizer unit and un the bed. During an interview w 4:20pm she stated al mask should be store. During an observation nebulizer unit and un the bed. During an interview won 8/24/17 at 8:13am	n on 8/23/2017 2:25pm the covered mask were lying on with Nurse #2 on 8/23/17 at I of the CPAP and nebulizer	F3	3328	properly. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly Quality of Life meeting by the 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 program reviewed at the Weekly Quality of Life Meeting and the monthly QA Committed meeting which is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager	e. nt to be m	
	Review of the Admiss Assessment (MDS) of Resident #149 as cogniterview for Mental Street Review of Admission Resident #149 as using Review of Physician documented the CPA 2LFLO2 apply at everemove every morning an observation	sion Minimum Data Set lated 7/23/17 identified gnitively intact with a Brief Status score of 15. MDS Section O identified ng a CPAP machine. order dated 7/17/17 P home unit 9CMH-2- with ning for sleep apnea and			Social Services. Date of Compliance: _September 12th 2017	•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345240	B. WING				24/2017
	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589	1 06/	24/2017
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 328		n on 8/22/17 at 3:10pm the	F	328			
	CPAP mask was lying nightstand.	g uncovered on the					
	at 3:25pm she stated	vith the resident on 8/22/17 the mask was always on said at one time she thought bring it.					
		ns on 8/23/17 at 10:15am uncovered lying on the bed. p in her wheelchair.					
	_	n on 8/23/2017 2:24pm the overed lying on the bed.					
		vith Nurse #2 on 8/23/17 at I of the CPAP and nebulizer and in plastic bags.					
	During an observation CPAP mask was unconightstand.	ns on 8/24/17 8:13 am the overed lying on the					
	on 8/24/17 at 8:13am	with the Director of Nursing she stated it was expected ered in a plastic bag when					
F 425 SS=D	483.45(a)(b)(1) PHAF ACCURATE PROCE	RMACEUTICAL SVC - DURES, RPH	F.	425			9/12/17
	that assure the accurdispensing, and admi	cility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and ne needs of each resident.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		، ا	c	
		345240	B. WING			1	24/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2-112011	
				8	64 US HWY 158 BUSINESS WEST			
WARREN	HILLS NURSING CENTE	ER		v	VARRENTON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 425	Continued From page	⊇ Q	F	425				
		ion. The facility must		725				
	` '	services of a licensed						
	pharmacist who	Services of a floorised						
	F							
	(1) Provides consulta	tion on all aspects of the						
	· · · · · · · · · · · · · · · · · · ·	y services in the facility;						
	· ·	is not met as evidenced						
	by:				T			
	interviews the facility	iew, observations and staff			The statements made on this Plan of	l do		
	1	equisition of a medication to			Correction are not an admission to and not constitute an agreement with the	uo		
		esident for 1 of 1 resident			alleged deficiencies. To remain in			
		onjunctivitis (resident #52).			compliance with all Federal and State			
	The state of the				Regulations the facility has taken or wi	II.		
	The findings included	l:			take the actions set forth in this Plan of	;		
					Correction. The Plan of Correction			
		mitted to the facility on			constitutes the facility's allegation of			
		itted on 12/23/16 with			compliance such that all alleged			
	diagnoses including A				deficiencies cited have been or will be	-I		
	Bacterial Conjunctivit	as given the diagnosis of			corrected by the date or dates indicate	J.		
	Bacterial Conjunctivit	15 011 7/20/17.			F425 PHARMACEUTICAL			
	Review of the Physic	ian's orders dated 7/26/17			SVC-ACCURATE PROCEDURES, RP	Н		
		r for Tobrex Solution 0.3%,						
	instill two drops into t	he left eye three times daily			Corrective Action:			
	for Conjunctivitis until	l 8/2/17.			Resident #.5			
					Physician was notified on (8/23/2017).			
		for July 2017 documented			The physician did not want to initiate a	าง		
		olution 0.3%, instill 2 drops			treatment. Resident representative			
	until 8/2/17.	mes daily for conjunctivitis			notified on (8/24/2017). Identification of other residents who may			
	until 0/2/17.				be involved with this practice:	1 y		
	The eMAR document	ted on 7/26/17 a "#3" (#3			All residents with a diagnosis of Bacter	ial		
		ode at the bottom of the			Conjunctivitis have the potential to be			
		ome.) On 7/27/17 through			affected by the alleged practice. On			
		rrelated with the code at the			9/5/2017 to 9/7/2017 2017 a chart aud	t		
	bottom of the eMAR	see nursing note.) On			was initiated for all current residents w	th		
		cumented refusal. The			Conjunctivitis in the facilities to ensure			
	August 2017 eMAR in	ndicated on 8/1/17 the			that all physician orders were followed			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345240	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	343240	D: WillO		TREET ADDRESS, CITY, STATE, ZIP CODE	08/	24/2017	
NAME OF PI	ROVIDER OR SUPPLIER				, , ,			
WARREN	HILLS NURSING CENTI	ER			64 US HWY 158 BUSINESS WEST			
				VV	/ARRENTON, NC 27589		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 425	Continued From pag		F4	425				
	2:00 PM dose but wa 8/2/17 the medication refused at 9:00 AM a 9:00 PM. The medica 8/2/17. Resident #52	available for the 9:00 AM and as given at 9:00 PM. On an was documented as and 2:00 PM and given at ation was not given after awas given 4 doses out of 21 as to receive the Tobrex eye			and initiated. The audit was also initiate to ensure that all orders for the diagnos of Conjunctivitis were followed and initiated as ordered by the physician .T chart audit was completed by the Nurs Management Team (Director of Nursin Unit Manager and Support Nurse). All physician orders for diagnosis of Conjunctivitis were followed and initiate	he e g,		
	through 8/1/17 docur	ng Notes from 7/27/17 mented the medication was the facility was waiting			as ordered. Systemic Changes: Director of Nursing and /or Designee ir serviced all Nurses (RNs, LPNs, full tin	1		
	office dated 8/24/17 eye conjunctivitis tha The fax documented	Resident's #52's physician's read Resident #52 had left it appeared to be bacterial. that no culture was ordered in Tobrex eye drops on			part time, and PRN) and the interdisplinary care planning team on the fact that the facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological	he		
		ident #52 were made on She was wearing glasses. d.			to meet the needs of each resident. The facility must employ or obtain the serving of a licensed pharmacist who provides consultation on all aspects of the	ces		
	with the Director of N medication cart and	nade on 8/24/17 at 1:28 PM lursing and Hall Nurse of the the medications to be y box in the medication Tobrex located.			provision of pharmacy services in the facility. Medication and related product are received from the provider pharma on a timely basis. Medication orders ar transmitted to the pharmacy. New medications except for emergency or	су		
	3:40 PM she stated sthe computer and the the order in the chart someone took off an pharmacy document. She stated the facility	with Nurse #1 on 8/23/17 at she could not find an order in ere was not a hard copy of for Tobrex. She stated order because our ed the order on the eMAR. y had a problem with getting ons they needed at times.			"stat" medications except for emergency or "stat" medications are orders as follows needed before the next regular delivery phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for promy delivery and request delivery within (4) hours. Timely delivery of new orders is required so that medication administrations.	y, ot		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245240	B. WING			С	
		345240	I B. WING			8/24/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
WARREN	HILLS NURSING CENTE	R		864 US HWY 158 BUSINESS WEST			
***************************************				WARRENTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425	Continued From pag	e 11	F 42	 -5			
F 425	During an interview on 8/24/17 at 8:30 Al find the original phys to have seen it to put She stated the nurse order from the physic the pharmacy. She s doctor to see if he an and what paperwork During an interview of 8/24/17 at 12:45 PM facility received the offrom the facility and to order to the backup offacility's town, and the medication. During an interview of the local back up phat that a prescription capharmacy on 7/27/17. The pharmacist state Tobrex in stock. She call the facility pharm pharmacy was to call know they needed to physician to order a of this order. She stated notified. She further sup Tobrex because we During a follow up into the seen in the property of the state of the pharmacy of the state of the physician to order and the physician the physicia	with the Director of Nursing M she stated she could not ician order but someone had the order in for pharmacy. or medication aide takes the cian and sends the order to tated she had a call in to the d his nurse made rounds they had. with the facility pharmacy on a representative stated the order for Tobrex on 7/27/17 hat same night sent the oharmacy, located in the e facility was to go pick up on 8/24/17 at 12:54 PM with armacy the pharmacist stated me through from the facility of for Tobrex for Resident #52. In the facility and let them	F 42	is not delayed. The emergency when the resident needs a may prior to pharmacy delivery. If the information is unavailable from provider pharmacy the pharm determine the appropriate me obtaining it. Attending physicial informed regarding the availal medications in the facility. Empharmaceutical service is ava 24 hour basis. Emergency neemedication are met by using the approved emergency medication by special order form the pipharmacy. Telephone /fax nure emergency pharmacy service at nursing station. When an element of the procedures for order documentation, determines the is a true emergency, i.e., candelayed until the scheduled pledelivery. The nurse ascertains the ordered medication is con emergency kit by referring to the contents posted on the box in medication room. If the medica available, the nurse calls/faxe pharmacy, using the afterhous emergency number if necessal provider pharmacy supplies element of the stat medications according the provider pharmacy agreement Emergency drugs, antibiotics, infusion products are stored to	edication the required on the accy will thod for ans are collity of ergency ilable on a eds for the facility's ion supply rovider mbers for as are posted mergency or arse will: at the order not be narmacy s whether tained in the the list of the ation is not s the ary. The mergency or o the t. and		
	stated that they neve facility.	r sent any Tobrex to the		Medications are not borrowed residents except in extreme e The ordered medication is obt from the emergency box or fro	from other mergency. cained either		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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		345240	B. WING _			08/24/2017
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		_		864 US HWY 158 BUSINESS WEST		
WARREN H	IILLS NURSING CENTE	.R		WARRENTON, NC 27589		
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	Continued From page		F 4		lor	
	unaware that the back the medication becau emails related to this all emails related to the	ne stated that she was kup pharmacy did not have use she did not receive any as she is typically copied on the pharmacy. She stated medication be available to		provider pharmacy. The provider pharmacy is called if an emerging requiring immediate pharmacists consultation about appropriate therapy, drug information, etc. required information is unavailed the provider pharmacy the pharmacy the pharmacy the pharmacy the pharmacy the pharmacy the pharmacy at a designated are with a list of supply contents as Emergency non-parenteral meare kept at (with other emergency medications), in locked room or location. Antibiotic starter dose with other emergency medications portable container/in a locked is secure location. Emergency in therapy kits are kept /with other emergency medications, in portable container in a locked room or slocation. Refrigerated emerger are kept in a portable container emergency or starter dose of a is needed, the nurse removes required medication from the ebox. As soon as possible, the records the medication use the Emergency box Usage Form a the pharmacy for replacement dose). Use of the emergency mis noted on the resident's medications, the replacement dose). Use of the emergency mis noted on the resident's medications, the replacement dose). When the emergency medications, the replacement dose is noted on the resident's medications, the replacement dose). Use of the emergency mis noted on the resident's medications, the replacement dose). When the emergency mis noted on the resident's medications, the replacement dose). The kits opened during the or on holidays are faxed to the immediately. The kits are invertigated in the immediately. The kits are invertigated in the parmacy is noted to the kit within (72 lopening. Kits opened during the or on holidays are faxed to the immediately. The kits are invertigated in the parmacy is noted to the kit within (72 lopening. Kits opened during the or on holidays are faxed to the immediately. The kits are invertigated in the parmacy is noted to the kit within (72 lopening. Kits opened during the or on holidays are faxed to the immediately.	gency arisest set set set set set set set set set	ies an ion y s an ges and cy

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
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		345240	B. WING _		08/2	24/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARREN	HILLS NURSING CENTE	R		864 US HWY 158 BUSINESS WEST		
				WARRENTON, NC 27589		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 425	Continued From page	e 13	F	thirty (30) days) for completeness and expiration dating of the contents. The dof inventory is noted on the outside of tkit. The Provider Pharmacy is responsite for establishing the list of medications the maintained in the emergency supply compliance with any directives from stallaw regarding controlled substances emergency supply. Attending physician are informed regarding the availability emergency medications in the facility. Physician should be called 24 hours as and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers order are located at each nurse's station. If y are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate responding or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by September 12th, 2017. Any Nurse (RN LPNs, full time, part time, and PRN) and member of the interdisciplinary team will did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assuran Process to verify that the change has been sustained.	he ble o o /, in ate as of day s s ou he es the hse d ho ot	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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WADDEN	0	-		86	64 US HWY 158 BUSINESS WEST		
WARREN	HILLS NURSING CENTE	К		W	ARRENTON, NC 27589		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	Continued From page	: 14	F	125	Monitoring: To ensure compliance, Director of Nursor designee will monitor this issue usin the QA survey tool. The facility will mor compliance by reviewing 5 residents' charts with diagnosis of conjunctivitis physician orders to ensure that physician orders were followed, initiated as order This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Un Manager, or designee. Reports will be presented to the weekly Quality of Life meeting and monthly QA Committee meeting which is attended by the 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 program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manages, MDS Coordinator, Unit Manages, Social Services.	g nittor an ed. e it be m	
F 428 SS=D	483.45(c)(1)(3)-(5) DF REPORT IRREGULA	RUG REGIMEN REVIEW, R, ACT ON	F4	128	Date of Compliance: _September 12th		9/12/17
	c) Drug Regimen Rev	riew					
		of each resident must be e a month by a licensed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ER		864 US HWY 158 BUSINESS WEST		00/24/2017		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE		
Continued From pag	ge 15	F 42	8				
brain activities asso- and behavior. Thes limited to, drugs in the (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.	ciated with mental processes e drugs include, but are not ne following categories:						
(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.							
drug that meets the	criteria set forth in paragraph						
during this review m separate, written rep attending physician director and director minimum, the reside	ust be documented on a port that is sent to the and the facility's medical of nursing and lists, at a ent's name, the relevant drug,						
resident's medical re irregularity has been action has been take be no change in the physician should do the resident's medic	ecord that the identified n reviewed and what, if any, en to address it. If there is to medication, the attending cument his or her rationale in al record.						
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY O	ROVIDER OR SUPPLIER HILLS NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	ROVIDER OR SUPPLIER HILLS NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-apsychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	ROVIDER OR SUPPLIER ### STREET ADDRESS, CITY, STATE, ZIP CODI ### CACH CORRECTIVE ADDRESS ### STATE, ZIP CODI ### STREET ADDRESS, CITY, STATE, ZIP CODI ### CACH CORRECTIVE ADDRESS ### STANE, CACH CODI ### CACH CORRECTIVE ADDRESS ### CACH CORRECTIVE ADDRESS ### STANE, CACH CODI ### CACH CORRECTIVE ADDRESS ### CACH CORRECTIVE AD	ROVIDER OR SUPPLIER HILLS NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 864 US HWY 158 BUSINESS WEST WARRENTON, NC. 27589 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY PULL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 Continued From page 15 Continued From page 15 (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-andety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345240	B. WING			۰,	C 3/24/2017
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	3/24/2017
					US HWY 158 BUSINESS WEST		
WARREN	HILLS NURSING CEN	TER			RRENTON, NC 27589		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 428	Continued From pa	age 16	F4	128			
1	review that include	, but are not limited to, time					
	frames for the diffe	rent steps in the process and					
	steps the pharmaci	ist must take when he or she					
		arity that requires urgent action					
	to protect the resid						
		NT is not met as evidenced					
	by:				The statements were do not this Diese of		
	Based on record re			The statements made on this Plan of Correction are not an admission to and	4 40		
		rmacy consultant interview the nt failed to identify that a			not constitute an agreement with the	1 UO	
		ceived an antibiotic medication			alleged deficiencies. To remain in		
		ng in 17 missed doses for 1 of			compliance with all Federal and State		
		agnosis of Conjunctivitis			Regulations the facility has taken or wi	ill	
	(resident #52).	,			take the actions set forth in this Plan o		
					Correction. The Plan of Correction		
		admitted to the facility on			constitutes the facility's allegation of		
		Imitted on 12/23/16 with			compliance such that all alleged		
		g Atrial Fibrillation and			deficiencies cited have been or will be		
	Hypertension. She Bacterial Conjuncti	e was given the diagnosis of vitis on 7/26/17.			corrected by the date or dates indicate	d.	
					F428 DRUG REGIMEN REVIEW,		
	_	sician's orders dated 7/26/17			REPORT IRREGULAR, ACT ON		
		der for Tobrex Solution 0.3%,			0 " 1"		
		o the left eye three times daily			Corrective Action:		
	for Conjunctivitis ur	Mill 8/2/17.			Resident #.52 Physician was notified on (8-23-17). T	'ho	
	Review of the eMA	R for July 2017 documented			physician did not want the Tobrex	HE	
		6/17for Tobrex Solution 0.3%			reordered. Resident representative		
	instill 2 drops in the left eye three time				notified on (8-24-17).		
	conjunctivitis until 8				Identification of other residents who man	av	
					be involved with this practice:	•	
	Resident #52's July 2017 eMAR docum				All residents have the potential to be		
	,	was correlated with the code at			affected by the alleged practice. On		
		MAR which indicated the			9/5/2017 to 9/7/2017 2017 a chart aud		
		ent from home.") For 7/27/17			was initiated for all current residents to)	
		'#9" was documented. (#9			ensure that a drug regimen of each		
		the code at the bottom of the			resident had been reviewed at least or		
		ng note). On 7/31/17 the			a month by a licensed pharmacist. The		
	i eiviak aocumented	d refusal. On 8/1/17 the	1		audit also ensured that any irregularitie	38	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
			7 56.25		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Reported by the pharmacist have been reported to the attending physician and the facility's medical director and direct of nursing, and these reports have been reported by the Administrator and Nursing and the Administrator and Nursing and Support Nurse). All residents have had a drug regimen reviewed at least once monthly by a ficensed pharmacist and all reports have been reported to the attending physician and the facility's medical director and director of nursing, and these reports	С		
		345240	B. WING _				24/2017	
NAME OF P	ROVIDER OR SUPPLIER	-1	<u>'</u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
				86	64 US HWY 158 BUSINESS WEST			
WARREN	HILLS NURSING CEN	TER		V	ARRENTON, NC 27589			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
F 428	Continued From pa	nge 17	F4	128				
	medication was not	t available for the 9:00 AM and			reported by the pharmacist have been			
	2:00 PM dose but v	vas given at 9:00 PM. On			reported to the attending physician and	j		
	8/2/17 the medicati	on was documented as			the facility's medical director and direct	.or		
	refused at 9:00 AM	and 2:00 PM and given at			of nursing, and these reports have bee	n		
	refused at 9:00 AM and 2:00 PM and given at 9:00 PM. The medication was not given after				acted upon. The chart audit was			
		52 was given 4 doses out of 21						
	potential opportunit	ties to receive the Tobrex.				Э,		
	D : 60 N							
		ing Notes from 7/27/17			,			
	_	umented the medication was				,		
	pharmacy delivery.	nd the facility was waiting						
	priarriacy delivery.					an		
	Review of the facili	ty progress note type:						
		15/17 documented Resident			have been acted upon.			
	•	on review. Vitals were			·			
	reviewed. Labs we	re reviewed. Consults were			Systemic Changes:			
	reviewed. Medication	on changes were reviewed.			The Administrator in serviced the			
	-	tions were reviewed and "rec:			pharmacist consultant on the fact that t			
	RN." There were no	o recommendations found in			the drug regimen of each resident mus			
	the medical record.				be reviewed at least once a month by			
		D 4 #50			licensed pharmacist. A psychotropic dr	ug		
		m Resident's #52's physician's			is any drug that affects brain activities			
		7 read Resident #52 had left			associated with mental processes and	not		
	l	nat appeared to be bacterial. ed that no culture was ordered			behavior. These drugs include, but are limited to, drugs in the following	TIOL		
		on Tobrex eye drops on			categories: Anti-psychotic;			
	7/26/17.	on robiox eye drope on			Anti-depressant; Anti-anxiety; and			
					Hypnotic. The pharmacist must report	any		
	Observations were	made on 8/24/17 at 1:28 PM			irregularities to the attending physician	•		
	with the Director of Nursing and Hall Nurse of the medication cart and the medications to be				and the facility's medical director and	ĺ		
					director of nursing, and these reports	ĺ		
		cy box in the medication			must be acted upon. Irregularities inclu			
	room. There was r	no Tobrex located.			but are not limited to, any drug that me			
					the criteria for an unnecessary drug. A	าy		
		with Nurse #1 on 8/23/17 at			irregularities noted by the pharmacist			
		d she could not find an order in			during this review must be documented			
		here was not a hard copy of			on a separate, written report that is ser			
	une order in the Cha	art for Tobrex. She stated	1		the attending physician and the facility'	o	1	

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NAME OF PROVIDER OR SUPPLIER WARREN HILLS NURSING CENTER WARRENTON, NO. 27589 FOUND SUMMARY STATISHEST OF DEFICIENCIES WARRENTON, NO. 27599 FOUND SUMMARY STATISHEST OF DEFICIENCIES WARRENTON, NO. 27599 FOUND SUMMARY STATISHEST OF DEFICIENCIES WARRENTON, NO. 27599 FOUNDERS FLAVOR OR LOCAL DEPARTMENT OF DEFICIENCIES WARRENTON, NO. 27599 FOUNDERS FLAVOR OR LOCAL DEPARTMENT OF DEFICIENCIES WARRENTON, NO. 27599 FOUNDERS FLAVOR OR SHOULD BE CARDS REFERENCED TO THE APPROPRIATE DEFICIENCY) FALS Continued From page 18 Someone took off an order because the pharmacy documented the order on the eMAR. She stated the facility had a problem with getting the ordered medications they needed at times. During an interview with Pharmacy Consultant on 8/24/17 at 10:05 AM she stated that she did a medication review on 8/15/17 and did not document any information related to the Tobrex. She stated she would not have mentioned this as she could not see the nursing notes or any order if the medication was discontinued. She stated she would have left this up to the nursing staff to contact the physician. During the interview the pharmacist stated this up to the nursing staff to contact the physician. During the interview the pharmacist stated she could see the resident had refused the eye medication twice on 8/24/17 at 12:45 PM the representative stated they received the order for Tobrex on 7/27/17 from the facility pharmacy on 8/24/17 at 12:45 PM with the local back up pharmacy to pharmacy is the pharmacist stated that a prescription came through from the facility pharmacy on 7/27/17 for Tobrex for Resident 8/2. The pharmacist stated that a prescription came through from the facility pharmacy or 1/27/17 for Tobrex for Resident 8/2. The pharmacist stated that a prescription came through from the facility pharmacy on 8/24/17 for Tobrex for Resident 8/2. The pharmacist stated that a prescription came through from the facility pharmacy on 7/27/17 for Tobrex for Resident 8/2. The pharmacist stated that a prescription came through	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
MARREN HILLS NURSING CENTER CAN INDIVIDUAL STATEMENT OF DEPOSITIONS AND FOR SECOND STATES AND PROPERTY OF THE PROPERTY OF T									
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stated when the medication was not available, the protocol was to call the facility pharmacy and then Monitoring: To ensure compliance, Administrator or					the change has been sustain	ned.			
protocol was to call the facility pharmacy and then To ensure compliance, Administrator or					Maniforina				
					_	iniatratar ==			
the facility pharmacy was to call the facility to let them know they peopled to get in touch with the					_	-			
them know they needed to get in touch with the physician to order a different medication or cancel QA survey tool. The facility will monitor compliance by reviewing 5 residents'									
this order. She stated the facility pharmacy was charts to ensure that the drug regimen of		' '							
notified. She further stated no one came to pick each resident has been reviewed at least			* ·						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345240	B. WING _			C 08/24/2017
	ROVIDER OR SUPPLIER HILLS NURSING CENTE	R			S, CITY, STATE, ZIP CODE BUSINESS WEST NC 27589	00/2 1/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 428	During a follow up int PM with the facility ph they stated they never facility. During an interview w 8/24/17 at 1:15PM sh expectation that the p	erview on 8/24/17 at 1:19 narmacist representative r sent any Tobrex to the with the Administrator on e stated it would her sharmacy consultant would re if a resident had not	F4	once a more This will be weeks ther Director of Manager, of presented meeting by to assure of appropriate be brought Administra Complianc ongoing au Weekly Qu Quality of I Administra Coordinate Nurse, The Social Serv		eee will r the
F 463 SS=D	ROOMS/TOILET/BAT (g) Resident Call Sys The facility must be a residents to call for st communication syste directly to a staff men work area - (2) Toilet and bathing This REQUIREMENT by: Based on observatio	tem dequately equipped to allow aff assistance through a m which relays the call hber or to a centralized staff	F 4	201763 The stater	ments made on this Plan of are not an admission to and	9/12/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		C		
		345240	B. WING			1	08/24/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2-7/2017	
				80	64 US HWY 158 BUSINESS WEST			
WARREN	HILLS NURSING CENTE	ER .			VARRENTON, NC 27589			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 463	Continued From page	e 20	F.	463				
	light system were fun	ctioning properly, revealing			not constitute an agreement with the			
		side beds and outside, above			alleged deficiencies. To remain in			
	the door for rooms 20	3 and 213 would not turn on			compliance with all Federal and State			
	for 2 out of 2 resident	rooms located on 1 out of 5			Regulations the facility has taken or wi	il		
	halls.				take the actions set forth in this Plan of	;		
					Correction. The Plan of Correction			
	On 8/22/17 at 10:57	AM it was observed that the			constitutes the facility's allegation of			
	call light located besi-	de the bed and outside,			compliance such that all alleged			
	above the door to roo	m 203 did not turn on when			deficiencies cited have been or will be			
	the call light button w located in 203-B bed.	as pressed for resident # 97			corrected by the date or dates indicate	d.		
					F463 RESIDENT CALL			
	On 8/22/17 at 11:03 /	AM it was observed that the			SYSTEM-ROOMS/TOILET/BATH			
	call light located besi	de the bed and outside,						
	above the door to roo	om 213 did not turn on when			Corrective Action:			
	the call light button w	as pressed for resident #			No residents identified.			
	111 located in 213-B	bed.			Identification of other residents who ma	ay		
					be involved with this practice:			
		23/17 at 11:05 AM Resident #			All residents have the potential to be			
	111 stated that his ca	Il light did not work, so he			affected by the alleged practice. On			
		omeone on the hall and then			9/5/2017 to 9/7/2017 2017 the			
	he would yell out to the	nem.			Maintenance director observed all			
					portions of the call light system to ensu	re		
		AM it was observed that the			that they were functioning properly,			
	call light located besi	de the bed and outside,			revealing call lights located beside bed	S		
		om 213 did not turn on when			and outside above the door for all roon			
	_	as pressed for resident #			All portions of the call light system were	3		
	111 located in 213-B	bed.			observed to functioning properly.			
	On 8/23/17 at 11:20 /	AM it was observed that the			Systemic Changes:			
	call light located besi	de the bed and outside,			The Administrator in serviced the			
	_	om 203 did not turn on when			Maintenance Director on the fact that the	ne;		
	the call light button w	as pressed for resident # 97			the facility must be adequately equippe	: d		
	located in 203-B bed.				to allow residents to call for staff			
					assistance through a communication			
	On 8/23/16 at 1:05 P	M the Director of Nursing			system which relays the call directly to	а		
	stated that the mainte	enance man checks the call			staff member or to a centralized staff w	ork		
	lights monthly before	a new resident is admitted			area . All portions of the call light syste	m		
	,	stated that staff were up			have to be functioning properly, revealing			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345240	B. WING _				24/2017
NAME OF P	ROVIDER OR SUPPLIER	1 1 1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	24/2017
TO WILL OF TH	TO VIDER OR GOLF EIER				, , ,		
WARREN	HILLS NURSING CENTE	R			64 US HWY 158 BUSINESS WEST		
				W	/ARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 463	Continued From page	e 21	F 4	163			
		I day and available to help ed that Resident # 111 was ht.			call lights located beside beds and outs above the door for the rooms. This in service was completed by	side	
	_				September 12, 2017. Any facility		
		on 8/23/17 the assistant as accompanied for a tour of			maintenance director who did not recein-service training will not be allowed to		
		call lights for rooms 203 and			work until training is completed. This	•	
		functioning. When the call			information has been integrated into th	e	
		essed for beds 203-b and			standard orientation training and in the		
		ed beside the bed and			required in-service refresher courses for		
	_	ove the door did not turn on.			all employees and will be reviewed by	the	
	O 0/00/47 -+ 0.05 D	NA 41			Quality Assurance Process to verify the		
		M the assistant maintenance			the change has been sustained month	у.	
		call lights did not light up it			Manitorina		
	· ·	vas a short in the call light			Monitoring: To ensure compliance, Administrator o	_	
	staff to fill out work or	at there was a process for			designee will monitor this issue using t		
		plete the repairs. He stated			QA survey tool. The facility will monitor		
	that he would replace				compliance by observing 5 residents of		
	immediately.	the can light coluc			lights to ensure that the call light system		
					functioning properly, revealing call ligh		
	On 8/23/17 at 2:10 P	M the MDS nurse revealed			located beside beds and outside above		
	that Resident # 97 wa	as alert and able to ring her			the door for the rooms. This will be do		
	call light.	J			on weekly basis for 4 weeks then mont	hly	
					for 3 months by the Director of Nursing	,	
	On 8/23/17 at 3:35 Pl	M the Maintenance Director			Support Nurse, Unit Manager, or		
	stated that there was	a check list for new admits			designee. Reports will be presented to)	
	that maintenance follo	owed to make sure a room			the weekly Quality of life meeting by th	е	
		missions. He revealed if			Administrator or designee to assure		
		a room working or making			corrective action initiated as appropriat		
		eck the call light to make			Any immediate concerns will be brough		
	_	out call lights were not			the Director of Nursing or Administrator		
	checked on any regul	lar basis.			for appropriate action. Compliance will		
					monitored and ongoing auditing progra	m	
					reviewed at the Weekly Quality of Life		
					Meeting. Weekly QA Committee meeting		
					is attended by Administrator, Director of		
					Nursing, MDS Coordinator, Unit Manag	jer,	
					Support Nurse, Therapy, HIM, Dietary		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ADED		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED	
		345240	B. WING		C 08/24/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/24/2017		
				864 US HWY 158 BUSINESS WEST			
WARREN	HILLS NURSING CENTE	R		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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	ON	
F 463	Continued From page	. 22	F 46	Manager, Social Services. Date of Compliance: _September 1: 2017	2th,		