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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING ______ B. WING ______	01/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW HEALTH & REHABILITATION CENTER	214 LANEFIELD RD WARSAW, NC 28398

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This 2567 was amended on 03/08/13 because the survey team deleted F241G as a result of new information provided by the facility.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to allow a resident to choose the temperature in their room for two of two residents (Resident #5, resident #83). Findings included: 1. Record review indicated Resident #83 was admitted to the facility on 10/25/2012. Review of the resident's Minimum Data Set (MDS) dated 12/29/2012 indicated the resident had no cognitive impairment. In an interview with the resident on 1/23/2013 at 10:40 AM, the resident reported facility staff came in the room all the time and turned the heat off if they thought it was too hot. The resident did not give specific staff names or particular shifts and indicated it occurred on all shifts with different	F 242	F242- The Administrator has done rounds to each resident room and has interviewed each individual resident to see what their ideal room temperature would be. The Administrator has adjusted each thermostat to account for each residents temperature choice. The Director of Nursing has inserviced all staff on Self-Determination and the ability of each resident to make their own choices for their room temperatures on the dates of 01/24/2013 to 01/29/2013. The DON or her designee will interview two residents per week for three weeks, then one per week for two weeks to ensure that each resident is able to make their own choices, and that they are happy with their room temperatures. The	2/2/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin R. Dixon, NHA
TITLE: Administrator
(X6) DATE: 03/10/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

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F 242	Continued From page 1 staff. The resident further revealed she told staff on many occasions she liked it warm in her room, but they turned it off anyway. 2. Record review indicated Resident #5 was admitted to the facility on 10/30/2003. Review of the resident's Minimum Data Set (MDS) dated 10/12/2012 indicated the resident had no cognitive impairment. In an interview with the Resident #5 on 1/23/2013 at 10:45 AM, the resident reported facility staff came in the room "all the time" and turned the heat off if they thought it was too hot. The resident further reported it happened on all shifts and was done by many staff. In an interview with the Director of Nursing (DON) on 1/23/2013 at 3:45 PM, the DON indicated the temperature in a resident's room should be the resident's choice.	F 242	results of the resident interviews will be brought to the QA committee for review and interventions will be put into place as needed.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident	F 309	F309- The residents mentioned were monitored for signs and symptoms of bleeding immediately, as well as all dialysis residents. All dialysis residents were palpated for thrill and auscultated for bruit immediately. There were no	2/2/13

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F 309	Continued From page 2 interviews, the facility failed to monitor a resident's condition for 2 of 2 residents (#32 and #65) upon return from a dialysis treatment. The findings included: The facility policy titled "Care of Dialysis" dated as revised 01/99 was reviewed. Under the section titled "Procedure" the following was listed: "2. Take blood pressure and pulse upon return from dialysis. 4. Palpate for thrill and auscultate bruit upon return from dialysis and document. Notify MD (medical doctor) if bruit and thrill are absent. 6. Document residents condition and interventions." 1. Resident #32 was admitted to the facility on 04/19/12 with cumulative diagnoses that included renal failure, lupus, hypertension, anemia and end stage renal disease requiring dialysis. The resident was coded on the most recent annual MDS (minimum data set) dated 04/26/12 as being cognitively intact. In addition, the resident was coded as requiring extensive assistance with ADLs (activities of daily living) and was coded as receiving dialysis. A review of the resident's care plan dated 11/05/12 revealed a problem " H/O (history of) incontinent episodes R/T (related to) ESRD (end stage renal disease) with hemodialysis." The Goals included " resident will have no complications related to hemodialysis." Under the approaches was listed " monitor shunt for complications and report to MD as needed." A review of the medical record did not reveal any indication that the facility was monitoring the	F 309	signs and symptoms of bleeding and thrill and bruit were present for each dialysis resident. The Director of Nursing has inserviced all Nurses on the new policy for dialysis residents on the dates of 01/24/2013 to 01/29/2013. Documentation for receiving a resident back from dialysis will be communicated on the new dialysis communication form. This form includes checking for thrill and bruit, vital signs, signs and symptoms of bleeding, and condition of shunt site. On non-dialysis days, thrill and bruit, and signs and symptoms of bleeding will be documented on the MAR. If signs and symptoms of bleeding are present then medical attention will be provided STAT. If thrill or bruit are absent then the attending MD will be notified	

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F 309	Continued From page 3 resident's shunt upon return from the dialysis. During an interview with the Director of Nursing (DON) on 01/23/13 at 4:20 PM it was revealed " I would expect that the resident is checked on when she returns from the dialysis. This would include checking the shunt and taking the resident's vital signs (blood pressure, pulse, respirations)." When asked where this would be documented the DON stated " I guess we don't have any place for it at this time. We do have a dialysis communication sheet that we document on." A review of the form titled "Dialysis Communication Record" did not reveal any documentation of post dialysis monitoring. During an interview with the resident on 01/24/13 at 10:20 AM it was revealed " when I come back the only thing they do is give me my medication. They don't look at my arm or take my blood pressure." During an interview with Nurse #1 on 01/25/13 at 8:00 AM it was revealed " I might check the blood pressure when she comes back but that would be all I would do. A review of the medical record did not reveal any documentation to indicate that the resident's blood pressure had been taken post dialysis. 2. Resident #65 was admitted to the facility on 08/17/12 with cumulative diagnoses that included left cerebral hemorrhage with left side hemiplegia and end stage renal disease requiring dialysis. The resident was coded on the most recent annual MDS dated 08/23/12 as being cognitively intact. In addition, the resident was coded as	F 309	immediately. The DON will conduct audits on two residents per week for two weeks and one resident per week for three weeks to ensure that this monitoring and documentation, and communication with the MD is occurring. All findings will be reported to the QA	

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F 309	Continued From page 4 requiring extensive assistance with his ADLs and was coded as requiring hemodialysis. A review of the resident's care plan updated 12/05/12 revealed a Problem "care of resident receiving dialysis." Under the Approaches was listed "protect/monitor access site -lt. (left) arm." A review of the medical record revealed that there were no vital signs documented for the month of January and there was no documentation in the nurse notes to indicate that the facility monitored the resident upon return from dialysis. During an interview with the Director of Nursing (DON) on 01/23/13 at 4:20 PM it was revealed " I would expect that the resident is checked on when she returns from the dialysis. This would include checking the shunt and taking the resident's vital signs (blood pressure, pulse, respirations)." When asked where this would be documented the DON stated " I guess we don't have any place for it at this time. We do have a dialysis communication sheet that we document on." A review of the form titled "Dialysis Communication Record" did not reveal any documentation of post dialysis monitoring. During an interview with the resident on 01/24/13 at 10:20 AM it was revealed " when I come back, the only thing they do is give me my medication. They don't look at my arm or take my blood pressure." During an interview with Nurse #1 on 01/25/13 at 8:00 AM it was revealed " I might check the blood pressure when he comes back but that would be all I would do. A review of the medical record did	F 309		

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F 309	Continued From page 5 not reveal any documentation to indicate that the resident's blood pressure had been taken post dialysis.	F 309		

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	345262	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type V protected construction utilizing Delayed Egress Special locking arrangements, and is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	K038--The delayed egress door at the exit of the EBC has been repaired by Carolina Phone and Alarm, and now functions as required. The mag lock mechanism needed to be adjusted. The administrator has inserviced the maintenance department on proper functioning of all exit doors and the delayed egress requirements. The administrator will make rounds to the exits once per week for one month then monthly thereafter. The findings will be brought to the QA committee for review and interventions as needed.	3/5/13
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 2/21/2013 the following Life Safety item was observed as noncompliant, specific findings include: The delayed egress door at the exit for the secured unit at EBC did not activate the irreversible process at the door. NOTE: The door at that location did release with activation of the fire alarm system. CFR#: 42 CFR 483.70 (a)	K 038		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062		

MAR 12 2013
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin L. Dixon, NHA
TITLE: Administrator
(X6) DATE: 3/12/2013

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.

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K 062	Continued From page 1 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 2/21/2013 the following Life Safety item was observed as noncompliant, specific findings include: 1. The standard sprinkler head in room 64 had paint on the heat element of the sprinkler. 2. The sprinkler heads installed at the main nurses station were a mix of a quick response head and a standard fused head, all sprinkler heads in a smoke compartment are required to be of the same type so that the sprinkler system in that space can work in unison. Actual NFPA Standard: NFPA 13,5-3.1.5.2 CFR#: 42 CFR 483.70 (a)	K 062	K062—The sprinkler head in room 64 has been cleaned and now is able to operate as it was designed. The sprinkler heads in the main nurse's station have been reviewed by Simplex-Grinnell and the technician has stated that the sprinkler heads are compatible without replacing the existing one, **(see attached letter from Technician)**. The maintenance department has been inserviced on the importance of sprinkler head functioning and cleaning. The administrator will make weekly rounds for one month then monthly thereafter to ensure that compliance with sprinkler head functioning is continued. The findings will be brought to the QA committee for review and changes will be initiated as needed.	3/10/13