STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS NURSING CENTER	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility to clarify an order for 1 of 1 residents with Conjunctivitis (Resident #52). The findings included: Resident #52 was admitted to the facility on 12/29/15 and re-admitted on 12/23/16 with diagnoses including Atrial Fibrillation and Hypertension. She was given the diagnosis of Bacterial Conjunctivitis on 7/26/17. Review of the Physician's orders on the eMAR (electronic Medication Administration Record) dated 7/26/17 documented an order for Tobrex (antibiotic) Solution 0.3% to instill two drops into the left eye three times daily for Conjunctivitis until 8/2/17. Review of the eMAR for July 2017 documented an order for Tobrex Solution 0.3% to instill two drops in left eye three times daily for conjunctivitis until 8/2/17. The eMAR documented on 7/26 at 9PM the #3 (meaning absent from home), on 7/27-7/30 at 9AM, 2PM and 9PM the #9 (meaning see nursing note) and on 7/31/17 at 9AM and 2PM the #2 (meaning refusal) and 7/31/17 at 9PM as given. On 8/1/17 the medication was	F 281	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take 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 indicated. F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Corrective Action: Resident #.52 Physician was notified on (8/23/2017). The physician did not want to initiate any further treatment. Resident representative notified on (8/24/2017). Identification of other residents who may be involved with this practice: All residents with a diagnosis of Conjunctivitis have the potential to be affected by the alleged practice. On 9/5/2017 to 9/7/2017 2017 a chart audit	9/12/17

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

Electronically Signed | 09/08/2017

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F 281	Continued From page 1 documented as not available for the 9AM and 2PM dose but was given at 9PM. On 8/2/17 the medication was given all three doses. The medication was not administered after 8/2/17. Review of the nursing notes from 7/27/17 through 7/30/17 documented the medication was not in the facility and the facility was waiting for the pharmacy to deliver. There was not a nursing note for 7/31/17. The nursing note dated 8/1/17 documented the medication was not in the facility until the evening. During a review of the July 2017 eMAR and interview with Nurse #1 on 8/23/17 at 3:40PM she stated the resident's medication started on 8/1/17 at 9PM and the nurse should have seen that more doses were needed after 8/2/17 and clarified the order with the physician to continue the medication. During an interview with the Director of Nursing on 8/23/17 at 4:13PM she stated the medication should have been given as ordered and the doctor should have been notified to clarify the need to continue the Tobrex after 8/2/17.	F 281	was initiated for all current residents with Conjunctivitis in the facilities to ensure that all physician orders were followed and initiated. The audit was also initiated to ensure that all orders for the diagnosis of Conjunctivitis were followed and initiated as ordered by the physician .The chart audit was completed by the Nurse Management Team (Director of Nursing, Unit Manager and Support Nurse). All physician orders for diagnosis of Conjunctivitis were followed and initiated as ordered. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) and the interdisplinary care planning team on the fact that the services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to notify physician, follow and initiate Physician orders. If resident refuses to follow physician orders, documentation of refusal will be indicated in the Electronic Medication Administration. Physician and Resident representative will be notified. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers orders are located at each nurse's station. If you are unable to reach the attending physician or the physician on call, call the	

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F 281	Continued From page 2	F 281	facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response 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 (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who 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 Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 residents' charts with diagnosis of conjunctivitis physician orders to ensure that physician orders were followed, initiated as ordered. 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 brought to the Director of Nursing or	

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F 281	Continued From page 3	F 281	Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Committee meeting which is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _September 12th, 2017_____	
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means	F 328		9/12/17

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F 328	Continued From page 4 receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to properly store respiratory equipment for 3 of 3 residents with CPAP (Continuous Positive Airway Pressure) and nebulizers. (Resident #3, #81and #149). The findings included:	F 328	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of	

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F 328	Continued From page 5 1. Resident #3 was admitted to the facility on 1/30/03 and re-admitted on 6/1/17 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Pleurisy. Review of the most recent Quarterly Minimum Data Set Assessment dated 4/25/17 identified Resident #3 as cognitively intact with a Brief Interview for Mental Status score of 15. Review of the Physician's order dated 6/2/17 read Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 unit inhale orally via nebulizer every 6 hours for COPD. Review of the August eMedication Administration Record (eMAR) documented Resident #3 received her inhalation treatments twice daily at 9am and 5pm. During an observation on 8/22/17 at 11:21am Resident #3 was up in her wheelchair. Resident #3 had a nebulizer unit and tubing and uncovered mask lying on her bed. During an observation on 8/22/17 at 3:05pm the nebulizer unit and uncovered mask were lying on the bed. During an observation on 8/23/17 at 8:48am the nebulizer unit and uncovered mask were lying on the bed. During an observation on 8/23/17 2:25pm the nebulizer unit and uncovered mask were lying on the bed. During an interview with Nurse #2 on 8/23/17 at	F 328	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. F328 TREATMENT/CARE FOR SPECIAL NEEDS Corrective Action: Resident #149 Respiratory equipment; CPAP (Continuous Positive Airway Pressure) equipment was properly stored. Resident #81 Respiratory equipment; Nebulizer equipment was properly stored. Resident#3 Respiratory equipment; Nebulizer equipment was properly stored. Identification of other residents who may be involved with this practice: All residents with Respiratory equipment have the potential to be affected by the alleged practice. On 9/5/2017 to 9/7/2017 2017 a chart audit and observation was initiated for all current residents with Respiratory equipment in the facility to ensure that all respiratory equipment was stored properly. The chart audit and observation of the Respiratory equipment was completed by the Nurse Management Team (Director of Nursing, Unit Manager and Support Nurse). All Respiratory equipment was stored properly. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time,	

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F 328	Continued From page 6 4:20pm she stated all of the CPAP and nebulizer mask should be stored in plastic bags. During an observation on 8/24/17 at 8:15am the nebulizer unit and uncovered mask were lying on the bed. 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. 2. Resident #81 was admitted to the facility on 4/17/17 and re-admitted 4/21/17 with diagnoses including Chronic Obstructive Pulmonary Disease. 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. Review of the Physician's order dated 8/16/17 documented an order for DuoNeb Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 mg/ml inhale orally via nebulizer every 4 hours as needed for cough and wheeze. During an observation on 8/22/17 at 2:40pm Resident #81 had a nebulizer unit and mask lying on the bed uncovered. Resident #81 stated she had a treatment earlier in the day. During an observation on 8/23/17 at 8:51am the nebulizer unit and uncovered mask were lying on the bed.	F 328	part time, and PRN) and the interdisplinary care planning team on the fact that Respiratory equipment should be stored properly. Nebulizer equipment's should be cleaned routinely. Nebulizer equipment; tubing and Mask should be changed weekly and labeled. Nebulizer equipment tubing and mask should be stored in plastic bags when not in use. Humidifier bottles on Oxygen concentrator machines are to be changed according to the manufactures specifications. Oxygen tubing is to be labeled and dated and changed weekly according to the facility schedule. Oxygen tubing and Masks should be stored in plastic bags if not in use. CPAP equipment; Masks should be stored in plastic bags if not in use. This in service was completed by September 12th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who 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 Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing and observing 5 residents with respiratory equipment to ensure that the equipment is stored	

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F 328	Continued From page 7 During an observation on 8/23/2017 2:25pm the nebulizer unit and uncovered mask were lying on the bed. During an interview with Nurse #2 on 8/23/17 at 4:20pm she stated all of the CPAP and nebulizer mask should be stored in plastic bags. During an observation on 8/24/17 at 8:14am the nebulizer unit and uncovered mask were lying on the bed. 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. 3. Resident #149 was admitted to facility on 7/17/17 with a diagnosis of Sleep Apnea. Review of the Admission Minimum Data Set Assessment (MDS) dated 7/23/17 identified Resident #149 as cognitively intact with a Brief Interview for Mental Status score of 15. Review of Admission MDS Section O identified Resident #149 as using a CPAP machine. Review of Physician order dated 7/17/17 documented the CPAP home unit 9CMH-2- with 2LFLO2 apply at evening for sleep apnea and remove every morning. During an observation on 8/22/17 at 1:30pm the CPAP mask was lying uncovered on nightstand.	F 328	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 brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting and the monthly QA Committee meeting which is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _September 12th, 2017_____	

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F 328	Continued From page 8 During an observation on 8/22/17 at 3:10pm the CPAP mask was lying uncovered on the nightstand. During an interview with the resident on 8/22/17 at 3:25pm she stated the mask was always on the nightstand. She said at one time she thought there was a bag covering it. During an observations on 8/23/17 at 10:15am the CPAP mask was uncovered lying on the bed. Resident #149 was up in her wheelchair. During an observation on 8/23/2017 2:24pm the CPAP mask was uncovered lying on the bed. During an interview with Nurse #2 on 8/23/17 at 4:20pm she stated all of the CPAP and nebulizer mask should be stored in plastic bags. During an observations on 8/24/17 8:13 am the CPAP mask was uncovered lying on the nightstand. 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.	F 328		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		9/12/17

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F 425	Continued From page 9 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to implement procedures for the acquisition of a medication to meet the need of a resident for 1 of 1 resident with a diagnosis of Conjunctivitis (resident #52). The findings included: Resident #52 was admitted to the facility on 12/29/15 and re-admitted on 12/23/16 with diagnoses including Atrial Fibrillation and Hypertension. She was given the diagnosis of Bacterial Conjunctivitis on 7/26/17. Review of the Physician's orders dated 7/26/17 documented an order for Tobrex Solution 0.3%, instill two drops into the left eye three times daily for Conjunctivitis until 8/2/17. Review of the eMAR for July 2017 documented an order for Tobrex Solution 0.3%, instill 2 drops in the left eye three times daily for conjunctivitis until 8/2/17. The eMAR documented on 7/26/17 a "#3" (#3 correlated with the code at the bottom of the eMAR absent from home.) On 7/27/17 through 7/30/17 a "#9" (#9 correlated with the code at the bottom of the eMAR see nursing note.) On 7/31/17 the eMAR documented refusal. The August 2017 eMAR indicated on 8/1/17 the	F 425	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take 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 indicated. F425 PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH Corrective Action: Resident #.5 Physician was notified on (8/23/2017). The physician did not want to initiate any treatment. Resident representative notified on (8/24/2017). Identification of other residents who may be involved with this practice: All residents with a diagnosis of Bacterial Conjunctivitis have the potential to be affected by the alleged practice. On 9/5/2017 to 9/7/2017 2017 a chart audit was initiated for all current residents with Conjunctivitis in the facilities to ensure that all physician orders were followed	

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F 425	Continued From page 10 medication was not available for the 9:00 AM and 2:00 PM dose but was given at 9:00 PM. On 8/2/17 the medication was documented as refused at 9:00 AM and 2:00 PM and given at 9:00 PM. The medication was not given after 8/2/17. Resident #52 was given 4 doses out of 21 potential opportunities to receive the Tobrex eye drops. Review of the Nursing Notes from 7/27/17 through 8/1/17 documented the medication was not in the facility and the facility was waiting pharmacy delivery. Review of a fax from Resident's #52's physician's office dated 8/24/17 read Resident #52 had left eye conjunctivitis that appeared to be bacterial. The fax documented that no culture was ordered so she was placed on Tobrex eye drops on 7/26/17. Observations of Resident #52 were made on 8/24/17 at 9:01 AM. She was wearing glasses. Her eyes were closed. Observations were made on 8/24/17 at 1:28 PM with the Director of Nursing and Hall Nurse of the medication cart and the medications to be returned to pharmacy box in the medication room. There was no Tobrex located. During an interview with Nurse #1 on 8/23/17 at 3:40 PM she stated she could not find an order in the computer and there was not a hard copy of the order in the chart for Tobrex. She stated someone took off an order because our pharmacy documented the order on the eMAR. She stated the facility had a problem with getting the ordered medications they needed at times.	F 425	and initiated. The audit was also initiated to ensure that all orders for the diagnosis of Conjunctivitis were followed and initiated as ordered by the physician .The chart audit was completed by the Nurse Management Team (Director of Nursing, Unit Manager and Support Nurse). All physician orders for diagnosis of Conjunctivitis were followed and initiated as ordered. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, 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 biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Medication and related products are received from the provider pharmacy on a timely basis. Medication orders are transmitted to the pharmacy. New medications except for emergency or “stat” medications are orders as follows: if needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery within (4) hours. Timely delivery of new orders is required so that medication administration	

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(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 425	Continued From page 11 During an interview with the Director of Nursing on 8/24/17 at 8:30 AM she stated she could not find the original physician order but someone had to have seen it to put the order in for pharmacy. She stated the nurse or medication aide takes the order from the physician and sends the order to the pharmacy. She stated she had a call in to the doctor to see if he and his nurse made rounds and what paperwork they had. During an interview with the facility pharmacy on 8/24/17 at 12:45 PM a representative stated the facility received the order for Tobrex on 7/27/17 from the facility and that same night sent the order to the backup pharmacy, located in the facility's town, and the facility was to go pick up the medication. During an interview on 8/24/17 at 12:54 PM with the local back up pharmacy the pharmacist stated that a prescription came through from the facility pharmacy on 7/27/17 for Tobrex for Resident #52. The pharmacist stated they did not have the Tobrex in stock. She stated the protocol was to call the facility pharmacy and then the facility pharmacy was to call the facility and let them know they needed to get in touch with the physician to order a different medication or cancel this order. She stated the facility pharmacy was notified. She further stated no one came to pick up Tobrex because we could not fill the order. During a follow up interview on 8/24/17 at 1:19 PM with the facility pharmacy the representative stated that they never sent any Tobrex to the facility. During an interview with the Administrator on	F 425	is not delayed. The emergency kit is used when the resident needs a medication prior to pharmacy delivery. If the required information is unavailable from the provider pharmacy the pharmacy will determine the appropriate method for obtaining it. Attending physicians are informed regarding the availability of medications in the facility. Emergency pharmaceutical service is available on a 24 hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order form the provider pharmacy. Telephone /fax numbers for emergency pharmacy services are posted at nursing station. When an emergency or "stat" order is received, the nurse will: follow the procedures for order documentation, determines that the order is a true emergency, i.e., cannot be delayed until the scheduled pharmacy delivery. The nurse ascertains whether the ordered medication is contained in the emergency kit by referring to the list of contents posted on the box in the medication room. If the medication is not available, the nurse calls/faxes the pharmacy, using the afterhours emergency number if necessary. The provider pharmacy supplies emergency or "stat" medications according to the provider pharmacy agreement. Emergency drugs, antibiotics, and infusion products are stored together. Medications are not borrowed from other residents except in extreme emergency. The ordered medication is obtained either from the emergency box or from the	

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F 425	Continued From page 12 8/24/17 at 1:15 PM she stated that she was unaware that the backup pharmacy did not have the medication because she did not receive any emails related to this as she is typically copied on all emails related to the pharmacy. She stated she would expect the medication be available to be given as ordered.	F 425	provider pharmacy. The provider pharmacy is called if an emergency arises requiring immediate pharmacist consultation about appropriateness of therapy, drug information, etc. If the required information is unavailable from the provider pharmacy the pharmacy will determine the appropriate method for obtaining it. The emergency supply is maintained at a designated area, along with a list of supply contents as follows: Emergency non-parenteral medications are kept at (with other emergency medications), in locked room or secure location. Antibiotic starter doses are kept with other emergency medications, in a portable container/in a locked room or secure location. Emergency infusion therapy kits are kept /with other emergency medications, in portable container in a locked room or secure location. Refrigerated emergency supplies are kept in a portable container. When an emergency or starter dose of a medication is needed, the nurse removes the required medication from the emergency box. As soon as possible, the nurse records the medication use the Emergency box Usage Form and (faxes the pharmacy for replacement of the dose). Use of the emergency medication is noted on the resident's medication administration record (MAR). If replacing used medications, the replacement doses are added to the kit within (72 hours) of opening. Kits opened during the weekend or on holidays are faxed to the pharmacy immediately. The kits are inventoried by the Director of Nursing at least (every	

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F 425	Continued From page 13	F 425	thirty (30) days) for completeness and expiration dating of the contents. The date of inventory is noted on the outside of the kit. The Provider Pharmacy is responsible for establishing the list of medications to be maintained in the emergency supply, in compliance with any directives from state law regarding controlled substances emergency supply. Attending physicians are informed regarding the availability of emergency medications in the facility. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers orders are located at each nurse's station. If you 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 response 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 (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who 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 Assurance Process to verify that the change has been sustained.	

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F 425	Continued From page 14	F 425	Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 residents' charts with diagnosis of conjunctivitis physician orders to ensure that physician orders were followed, initiated as ordered. 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 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 brought to the Director of Nursing or Administrator for appropriate action. Compliance will be 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 Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _September 12th, 2017_____	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		9/12/17

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F 428	Continued From page 15	F 428		

(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, 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.

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen

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F 428	Continued From page 16 review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews and pharmacy consultant interview the pharmacy consultant failed to identify that a resident had not received an antibiotic medication as ordered, resulting in 17 missed doses for 1 of 1 resident with a diagnosis of Conjunctivitis (resident #52). Resident #52 was admitted to the facility on 12/29/15 and re-admitted on 12/23/16 with diagnoses including Atrial Fibrillation and Hypertension. She was given the diagnosis of Bacterial Conjunctivitis on 7/26/17. Review of the Physician's orders dated 7/26/17 documented an order for Tobrex Solution 0.3%, instill two drops into the left eye three times daily for Conjunctivitis until 8/2/17. Review of the eMAR for July 2017 documented an order dated 8/26/17for Tobrex Solution 0.3% instill 2 drops in the left eye three times daily for conjunctivitis until 8/2/17. Resident #52's July 2017 eMAR documented for 7/26/17 a "#3" (#3 was correlated with the code at the bottom of the eMAR which indicated the resident was "absent from home.") For 7/27/17 through 7/30/17 a "#9" was documented. (#9 was correlated with the code at the bottom of the eMAR to see nursing note). On 7/31/17 the eMAR documented refusal. On 8/1/17 the	F 428	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take 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 indicated. F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON Corrective Action: Resident #.52 Physician was notified on (8-23-17). The physician did not want the Tobrex reordered. Resident representative notified on (8-24-17). Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 9/5/2017 to 9/7/2017 2017 a chart audit was initiated for all current residents to ensure that a drug regimen of each resident had been reviewed at least once a month by a licensed pharmacist. The audit also ensured that any irregularities	

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F 428	Continued From page 17 medication was not available for the 9:00 AM and 2:00 PM dose but was given at 9:00 PM. On 8/2/17 the medication was documented as refused at 9:00 AM and 2:00 PM and given at 9:00 PM. The medication was not given after 8/2/17. Resident #52 was given 4 doses out of 21 potential opportunities to receive the Tobrex. Review of the Nursing Notes from 7/27/17 through 8/1/17 documented the medication was not in the facility and the facility was waiting pharmacy delivery. Review of the facility progress note type: Pharmacy dated 8/15/17 documented Resident #52 had a medication review. Vitals were reviewed. Labs were reviewed. Consults were reviewed. Medication changes were reviewed. Psychiatric medications were reviewed and "rec: RN." There were no recommendations found in the medical record. Review of a fax from Resident's #52's physician's office dated 8/24/17 read Resident #52 had left eye conjunctivitis that appeared to be bacterial. The fax documented that no culture was ordered so she was placed on Tobrex eye drops on 7/26/17. Observations were made on 8/24/17 at 1:28 PM with the Director of Nursing and Hall Nurse of the medication cart and the medications to be returned to pharmacy box in the medication room. There was no Tobrex located. During an interview with Nurse #1 on 8/23/17 at 3:40 PM she stated she could not find an order in the computer and there was not a hard copy of the order in the chart for Tobrex. She stated	F 428	reported by the pharmacist have been reported to the attending physician and the facility's medical director and director of nursing, and these reports have been acted upon. The chart audit was completed by the Administrator and Nurse Management Team (Director of Nursing, Unit Manager and Support Nurse). All residents have had a drug regimen reviewed at least once monthly by a licensed pharmacist and all reports have been reported to the attending physician and the facility's medical director and director of nursing, and these reports have been acted upon. Systemic Changes: The Administrator in serviced the pharmacist consultant on the fact that the; the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 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: Anti-psychotic; Anti-depressant; Anti-anxiety; and Hypnotic. 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. Irregularities include, but are not limited to, any drug that meets the criteria for an unnecessary drug. 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	

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F 428	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 she could see the resident had refused the eye medication twice on 8/2/17. During an interview with the facility pharmacy on 8/24/17 at 12:45 PM the representative stated they received the order for Tobrex on 7/27/17 from the facility and that same night sent the order to the backup pharmacy, located in the facility's town, and the facility was to go pick up the medication. During an interview on 8/24/17 at 12:54 PM with the local back up pharmacy the pharmacist stated that a prescription came through from the facility pharmacy on 7/27/17 for Tobrex for Resident #52. The pharmacist stated the backup pharmacy did not have the Tobrex eye drops in stock. She stated when the medication was not available, the protocol was to call the facility pharmacy and then the facility pharmacy was to call the facility to let them know they needed to get in touch with the physician to order a different medication or cancel this order. She stated the facility pharmacy was notified. She further stated no one came to pick	F 428	medical director and director of nursing and lists, at minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. 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. The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This in service was completed by September 12th 2017. Any facility pharmacist consultant who 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 Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 residents' charts to ensure that the drug regimen of each resident has been reviewed at least	

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F 428	Continued From page 19 up Tobrex because they could not fill the order. During a follow up interview on 8/24/17 at 1:19 PM with the facility pharmacist representative they stated they never sent any Tobrex to the facility. During an interview with the Administrator on 8/24/17 at 1:15PM she stated it would her expectation that the pharmacy consultant would make the facility aware if a resident had not received a medication as ordered.	F 428	once a month by a licensed pharmacist. 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 brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality of life meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _September 12th 2017_____	
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all portions of the call	F 463	The statements made on this Plan of Correction are not an admission to and do	9/12/17

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F 463	Continued From page 20 light system were functioning properly, revealing call lights located beside beds and outside, above the door for rooms 203 and 213 would not turn on for 2 out of 2 resident rooms located on 1 out of 5 halls. On 8/22/17 at 10:57 AM it was observed that the call light located beside the bed and outside, above the door to room 203 did not turn on when the call light button was pressed for resident # 97 located in 203-B bed. On 8/22/17 at 11:03 AM it was observed that the call light located beside the bed and outside, above the door to room 213 did not turn on when the call light button was pressed for resident # 111 located in 213-B bed. In an interview on 8/23/17 at 11:05 AM Resident # 111 stated that his call light did not work, so he waited until he saw someone on the hall and then he would yell out to them. On 8/23/17 at 11:15 AM it was observed that the call light located beside the bed and outside, above the door to room 213 did not turn on when the call light button was pressed for resident # 111 located in 213-B bed. On 8/23/17 at 11:20 AM it was observed that the call light located beside the bed and outside, above the door to room 203 did not turn on when the call light button was pressed for resident # 97 located in 203-B bed. On 8/23/16 at 1:05 PM the Director of Nursing stated that the maintenance man checks the call lights monthly before a new resident is admitted to a room. The DON stated that staff were up	F 463	not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take 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 indicated. F463 RESIDENT CALL SYSTEM-ROOMS/TOILET/BATH Corrective Action: No residents identified. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 9/5/2017 to 9/7/2017 2017 the Maintenance director observed all portions of the call light system to ensure that they were functioning properly, revealing call lights located beside beds and outside above the door for all rooms. All portions of the call light system were observed to functioning properly. Systemic Changes: The Administrator in serviced the Maintenance Director on the fact that the; the facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area . All portions of the call light system have to be functioning properly, revealing	

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F 463	Continued From page 21 and down the halls all day and available to help residents. She revealed that Resident # 111 was able to use his call light. Beginning at 2:01 PM on 8/23/17 the assistant maintenance man was accompanied for a tour of the 200 hall and the call lights for rooms 203 and 213 were checked for functioning. When the call light buttons were pressed for beds 203-b and 213-b, the light located beside the bed and outside the room, above the door did not turn on. On 8/23/17 at 2:05 PM the assistant maintenance man stated that if the call lights did not light up it usually meant there was a short in the call light cord. He indicated that there was a process for staff to fill out work orders and give to maintenance to complete the repairs. He stated that he would replace the call light cords immediately. On 8/23/17 at 2:10 PM the MDS nurse revealed that Resident # 97 was alert and able to ring her call light. On 8/23/17 at 3:35 PM the Maintenance Director stated that there was a check list for new admits that maintenance followed to make sure a room is in order for new admissions. He revealed if maintenance were in a room working or making repairs they would check the call light to make sure it was working, but call lights were not checked on any regular basis.	F 463	call lights located beside beds and outside above the door for the rooms. This in service was completed by September 12, 2017. Any facility maintenance director who 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 Assurance Process to verify that the change has been sustained monthly. Monitoring: To ensure compliance, Administrator or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by observing 5 residents call lights to ensure that the call light system is functioning properly , revealing call lights located beside beds and outside above the door for the rooms. 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 brought to the Director of Nursing or Administrator for appropriate action. Compliance will be 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 Manager, Support Nurse, Therapy, HIM, Dietary	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 22	F 463	Manager, Social Services. Date of Compliance: _September 12th, 2017_____	