SEP 1 3 2012

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 08/22/2012

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

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F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the responsible party for 1	F 157	Warren Hills Nursing Center acknowledges and proposes this plan of corrections to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Warren Hills Nursing Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, Warren Hills reserves the right to refute any deficiency on this statement of deficiencies through Informal Dispute Resolution, Formal Appeal and or Administrative or Legal Procedures. F157 Warren Hills shall continue to ensure that the doctor and responsible party are notified of any significant change in residents. Resident #2 responsible party, the resident, and the medical doctor were notified of her stage III decubitus on her sacral area. All in-house residents, their responsible party, and medical doctors were notified of decubitus, skin tears, etc. Also discussed treatments with them in detail to see if they had any questions we could help them with. Also, Resident # 3's responsible party was notified of his treatment for his UTI. All in-house residents to include, Resident #2 and #3 were notified of antibiotic use for UTI's along with their responsible party	9/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Danny W Moore	ADMINISTRATOR	9-14-12

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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F 157	Continued From page 1 of 3 sampled residents (Resident # 2) after a pressure ulcer was detected, then worsened and for 1 of 3 sampled residents (Resident # 3) who was placed on anti-biotics after developing an urinary tract infection. The findings include: 1. Resident #2 was admitted to the facility on 3/26/12 then readmitted on 8/16/12 with the following cumulative diagnoses: Methicillin-resistant Staphylococcus aureus (MRSA) urinary tract infection, type II diabetes, hypertension, enterobacter cloacae urinary tract infection, sacral and ischial tuberosity stage III ulcer, cerebrovascular accident and altered mental status. She was admitted to the hospital for evaluation and treatment on 6/25/12-6/27/12 as well as 8/13/12-8/16/12. On the quarterly Minimum Data Set (MDS) 7/11/12 she was assessed as being cognitively intact. Resident #2 needed extensive assistance for bed mobility, transfers and had limitations with her upper and lower body range of motion. The medical chart was reviewed and revealed a Nursing Admission Assessment, 6/27/12, completed by Nurse #1 that stated that had developed a stage II sacral decubitus, measuring 0.8 centimeters (CM) x 0.6cm. A Decubitus/Pressure Area Monitor sheet, 6/28/12 noted that the sacral decubitus had a dark red area, with no signs or symptoms of infection. It was staged at II. On 7/4/12, the sheet reflected that the ulcer remained 0.8cm x 0.6 cm had advanced to a stage III and now required a	F 157	and medical doctor whom ordered the antibiotics for treatment. A monitor sheet for charge nurses on the halls and one for the supervisors of the building were put into effect to be returned to me weekly for review. A Quality Assurance Tool and 24 hr. Quality Assurance Monitoring Tool shall be used to monitor for UTI, decubitus, and any significant changes in residents. Rounds are to be made daily by supervisors, charge nurses, and/or designees to look for significant changes and report immediately to the Director of Nursing. Nurses staff inserviced on calling Responsible Party, Medical Doctor, and documenting any significant changes observed in the chart (ie: decubitus change in stages, antibiotic use for UTI's, falls, skin tears, and etc). daily. The Quality Assurance Committee to include the Medical Doctor shall review the audit tool results weekly X 4 months, then monthly X 1 year.	

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F 167	Continued From page 2 wet-dry dressing schedule. On 7/11/12, the area had increased in size to 2.0 cm x 1.1 cm. Pink tissue was observed with no signs or symptoms of infection. On 7/18/12, the sacrum was noted to be at stage III with the diameter measuring 2.6cm x3.0 cm. On 7/25/12 the sacrum remained at stage III, at 2.6cm x 2.6cm with a scant amount of yellow slough. The shape of the wound was noted to be irregular. On 8/1/12, the sacrum area measured at 2cm x 1.5cm with pink irregular edges with no drainage noted. On 8/8/12, the sacrum was 5cm x 6cm with odor, blood draining and had a red center with a white center, noted Nurse #1. The Facility ' s Interim/Standing Orders Procedure was reviewed. It stated under Decubitus Ulcers to call the Medical Doctor and Family. The Progress Notes were reviewed from 6/24/12 to 8/13/12 and did not document any communication from the facility to the responsible party (RP) that Resident #2 had a pressure ulcer and that it increased in size and advanced from a stage II to stage III once treatment began. The Staff Development Coordinator was interviewed on 8/22/12 at 9:50 am. She stated that her expectation for the nurses is for them to notify the nurse supervisor when a resident had a change in condition so that the doctor can be contacted. She stated that the family should be notified of any changes. On 8/22/12 at 11:27 pm, the nurse supervisor	F311	Warren Hills shall continue to ensure that residents receive treatment/services to improve/maintain their ADL functions. Resident #4 was screened and treated as needed for anything that can help her maintain as much independence in her ADL functions. Nursing Staff and Therapy Department shall observe all in-house residents that may need treatment to maintain/improve their function with ADL's, etc. Nursing and therapy staff shall use therapy form as a tool to help identify in-house residents/admissions that may need therapy services to improve/maintain their ADL functions. We shall notify the Medical Doctors of needs and obtain orders for therapy to treat as needed to maintain/help residents to reach their potential in ADL's and etc. Nursing and/or therapy staff shall notify responsible party of Physician's orders for any therapy services being started. A Quality Assurance Assessment tool shall be used to assess results of notification of responsible parties by charge nurses, therapy staff, and/or designee. The Quality Assurance Committee to include the Medical Director shall review the audit tool results weekly X 4 months then monthly X 1 year.	9/14/12

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F 157	Continued From page 3 was interviewed. She stated whenever there are major changes in a resident ' s condition (example skin tears, bruises, falls and pressure sores (stages III and IV), the doctor and RP should be notified. On 8/22/12 at 1:08 pm, Nurse # 1 was interviewed. She worked with Resident #2 often and stated that family members would visit almost daily. She stated that the relatives of Resident #2 are given verbal updates of any changes in her conditions due the frequency of their visits. She shared that expectation would be to call the RP for any changes and any acute condition changes. The Director of Nursing was interviewed on 8/22/12 at 3:40 pm. She stated that the nurses are encouraged to document pressure ulcers at the onset and if it worsens; stating the RP should be informed. She stated that this information should be placed on the chart. Nurse #2 was interviewed on 8/22/12 at 3:55pm. She reviewed the Nursing Admission Form that she completed on 6/27/12. She stated that she cannot recall why she did not contact family when Resident #2 returned from the hospital with a pressure ulcer. 2. Resident # 3 was admitted to the facility on 10/14/98, and then re-admitted on 12/7/10 with the following cumulative diagnoses: history of urinary tract infections, quadriplegia, cerebral palsy, seizure disorder and diabetes mellitus type II. On the quarterly MDS, 6/27/12, it was noted that	F 157		

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F 157	Continued From page 4 he had no memory problem and had modified independence for daily decision making. He was totally dependent on staff for transfers and toilet use. Resident #3 was identified as being always incontinent and did not have a catheter. It was noted that during the review period, he had been treated for pneumonia and an urinary tract infection (UTI). A review of the medical records contained standing orders, dated 12/7/10 that instructed nursing to obtain an urine dip when UTI symptoms (confusion, fever, frequent/painful/bloody urination) appeared. A telephone order, 6/8/12 recorded " obtain urine dip, send for C & S (urine culture and sensitivity). " A copy of the lab results, from a collection on 6/8/12 with the results updated on 6/10/12 were in the chart and found Resident #3 to have a urinary tract infection. A hand written note on the lab results stated that the MD was notified, with telephone orders received and written on the MAR (medication administration record) on 6/10/12 at 5:10 pm. A telephone order, written on 6/10/12 prescribed Amoxicillin, an anti-biotic at 875mg, twice a day for 7 days for a UTI. The nurse ' s notes reflect, daily administration of the anti-biotic until 6/18/12, however there is no documentation that the RP for Resident # 3 was notified for the change in his condition. The Staff Development Coordinator was interviewed on 8/22/12 at 9:50 am. She stated that her expectation for the nurses is for them to notify the nurse supervisor when a resident had a	F 157		

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F 157	Continued From page 5 change in condition so that the doctor can be contacted. She stated that the family should be notified of any changes. On 8/22/12 at 11:27 pm, the nurse supervisor was interviewed. She stated whenever there are major changes in a resident ' s condition (example skin tears, bruises, falls and pressure sores (stages III and IV), the doctor and RP should be notified. The Director of Nursing was interviewed on 8/22/12 at 5:50 pm regarding her expectation of notifying the RP for changes in condition. She stated that their practice was to notify the RP for skin tears, falls, trips to the emergency room, decrease in appetites and fluids and for significant weight loss. She stated that they do not call for every fever unless it last more then 24 hours nor if anti-biotics are given for infections. She stated that many family members visit the residents often, so if they see them during a visit they will inform them, but don ' t call for these conditions normally.	F 157		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide adaptive equipment to facilitate eating for 1 of 3 sampled residents (Resident #4) with noticed hand shakes	F 311		

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F 311	Continued From page 6 when attempted to eat independently. Findings included: Resident #4 was admitted into the facility on 7/28/11. Cumulative diagnoses included Dementia, Paralysis Agitans and Degenerative Joint Disease. The annual Minimum Data set (MDS) completed on 8/2/12 indicated Resident #4 mental status was severely impaired. The MDS indicated Resident #4 usually made self understood with clear speech. Eating was indicated as occurred only once or twice with one person physical assists during the 7 day look back period; for the MDS assessment completed on 8/2/12 and 5/17/12. Occupational therapy and restorative nursing program was not indicated. A previous quarterly MDS assessment completed on 2/23/12 eating was indicated as independent with setup only. The care plan dated 8/16/12 as an approach read "Provide limited assistance with meals daily. Offer more assistance as needed; consult skilled occupational therapist as needed - decline in activity of daily living (ADL) function." A review of the occupational therapy progress notes revealed no occupational therapy screening or evaluation since admission into the facility on 7/28/11. On 8/22/12 at 1:40 pm, Resident #4 held a regular spoon with noticed hand shakes to both hands. Resident #4 had difficulties in bringing the food to her mouth to eat with a steady hand control. In an interview on 8/22/12 at 4:45 pm, the Occupational Therapist (OT) stated there had	F 311		

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F 311	Continued From page 7 been no received orders for referrals or screening for Resident #4 since admission. The OT elaborated that a weighted eating utensil was helpful in assisting with better hand control when eating; for one who exhibited shakes or tremors of the hands, and was capable of grasping and bringing food items to his/her mouth. In an interview on 8/22/12 at 5:30 pm, the Director of Nursing stated she could not provide supportive documentation after review of Resident #4 record that any trials to promote independence with support devices for eating had been attempted; nor could she provide any documented occupational therapy referrals or screening since admission into the facility.	F 311		