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 _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW HEALTH & REHABILITATION CENTER	**214 LANEFIELD ROAD 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 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		7/18/18

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

Electronically Signed | 07/13/2018

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F 842	Continued From page 1 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide accurate documentation and clarification to previous documentation of what happened when a resident was left outside the facility unattended by staff, for 1 of 1 residents reviewed for providing supervision to prevent accidents. (Resident #1). The findings included: Resident #1 was originally admitted to the facility	F 842	Resident discharged to home on 5/25/2018. In-service all licensed nurses on accuracy of documentation in electronic record to include procedure for clarification of previously written nurses note by 7/18/2018. All nurses notes will be reviewed by Director of Nursing or designee weekly for	

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F 842	Continued From page 2 on 5/5/18 with diagnoses including Diabetes Mellitus II, Hyperlipidemia, Smoker, Chronic pain, Chronic Kidney Disease, Hypertension, Cognitive Communication Deficit, Restless/Agitation and Age Related Physical Debility. The Administrator of the facility accessed an inactive file in electronic records, which was not previously accessible and revealed on 5/20/18 an original note was written regarding an incident with Resident #1 being left unattended outside of the facility. Another note was re-written in the active file in electronic records and was dated 5/22/18 and referred to an incident on 2/20/18 in error instead of 5/20/18. Review of Staff Nurse #1's original nurse's note on 5/20/18 read in part, "the resident was noted to be outside without assistance and was walking by the edge of the road. SN ran to get resident and assisted resident back inside. The resident refused several times and stated "I am going home." Talked with resident for a few minutes and explained to him that he is here for therapy and this is where he is staying until therapy is completed. Resident still confused and disoriented and stated I'm not going back in there. Nursing Assistant brought wheelchair out to where nurse was standing with resident and resident sat down. At this time nurse and nursing assistant assisted resident back into facility." The note was written by Staff Nurse #1, note inactivated on 5/22/18 at 5:09 PM and inactivated by Staff Nurse #1. Review of Staff Nurse #1's rewritten nurse's note on 5/22/18 at 5:12 PM, read in part, "Charting for 2/20/18, Resident outside with family on porch,	F 842	4 weeks, then bimonthly for 4 weeks, then monthly for four weeks. Results of the audits will be reviewed by Quality Assurance Committee for continued improvement.	

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F 842	Continued From page 3	F 842		

writer went to another room to assist another resident, upon exiting this room another resident's family member informed writer that resident was attempting to walk around outside unattended. Writer goes outside and finds resident unattended walking around. Resident assisted back into building without difficulty. Resident noted to be extremely confused at this time; upon entry back into building resident watched carefully."

During an interview on 6/19/18 at 3:20 PM, Staff Nurse #1, revealed Resident #1 was outside, but her original note was written incorrectly. She said it was another resident that told her Resident #1 was out by the roadside mailbox. She said Resident #1 was never that far or anywhere near the road.

During an interview on 6/21/18 at 11:05 AM, the Administrator reported that Resident #1 was admitted to the facility on 5/5/18 and he was discharged home on 5/25/18. She said Staff Nurse #1 had 24 hours to change the original note and she told Staff Nurse #1 to be objective and write what actually occurred. She said the note should have been an accurate reflection of what Staff Nurse#1 saw. She said she asked Staff Nurse #1 to be specific and detailed in the note that she wrote.

During an interview on 6/21/18 at 5:01 PM, the Administrator revealed Staff Nurse #1, documented on 5/20/18. She revealed she reviewed the note written by Staff Nurse #1 and told her to write another note. She revealed Staff Nurse #1 deleted the original note and rewrote the note. She said Staff Nurse #1 modified the original note on that date. The Administrator

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F 842	Continued From page 4 stated it was a clarification order and the computer system does not strike over, instead the original note was placed in the inactivate file. She explained since the original note was inactive she could not print the note. The Administrator said she told Staff Nurse #1 to put accurate information in the note. She explained that Staff Nurse #1 wrote what someone told her. She emphasized that Staff Nurse #1 wrote another note to clarify what she saw.	F 842		