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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW NURSING AND REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/18/2025 through 03/21/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HA1H11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/18/2025 through 03/21/2025. Event ID# HA1H11. The following intake was investigated: NC00228189. 1 of the 1 complaint allegation resulted in deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		4/4/25

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

Electronically Signed | 04/02/2025

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 565	Continued From page 1 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to act upon grievances that were reported by the Resident Council, resolve repeat grievances, and to communicate the facility's efforts to address grievances voiced during Resident Council meetings for 6 of 6 consecutive months: October 2024, November 2024, December 2024, January 2025, February 2025 and March 2025. The findings included: A review of the Resident Council minutes completed by the Activities Director dated 10/10/24 revealed it was attended by Residents #20, #14, #21, #30, #3, #61, #48, #32, #38, #23 and #39. The following grievances were expressed: the need to provide locks for the nightstands, a better verbal response to patients in need from the nursing assistants, a timelier response to call lights, and bed baths were not	F 565	1. Immediately transcribed concerns from group meeting on 3/20/2025 onto grievance forms and initiated the grievance resolution process. Grievances addressed included: Sta¿ refusing to care for resident, snacks Unavailable at Night, and Night Shift Sta¿ being loud while doing rounds. 2. To identify other residents at risk of this deficient practice, concerns from the resident council meeting from the prior 6 months were transcribed as active grievances to ensure adequate resolution. Grievances initiated include: the need to provide locks on nightstands, a better verbal response to residents from NAs, timely response to call lights, bed baths not being completed, ice not passed on Saturday and Sundays, no snacks available at night, coverage for sta¿ when	

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F 565	Continued From page 2	F 565		

being completed.

A review of the Resident Council minutes completed by the Activities Director dated 11/14/24 indicated it was attended by Residents #34, #21, #61, #3, #38, #56, #48, #32, #58, and #20. There was no indication in the 11/14/24 minutes that the grievances voiced during the 10/10/24 Resident Council meeting were addressed. The following grievances were expressed: ice was not passed on Saturdays or Sundays, and no snacks were available at night.

A review of the Resident Council minutes completed by the Activities Director dated 12/5/24 revealed it was attended by Residents #30, #14, #10, #48, #6, #23, #38, #56, #32, #39, #61, #58, #19, and #27. The minutes indicated there had been no improvement in the prior months' grievances. The following grievances were expressed: coverage for when staff took breaks, not receiving showers only bed baths, the need of a better showerhead in back, having healthy snacks for the snack cart, ice was not passed on Saturdays or Sundays (repeat grievance from the previous month's meeting), no snacks available at night (repeat grievance from the previous month's meeting), more activities geared towards men, better salads, more bacon and breaded fish on the menu, staff was forgetting to pick up food trays after meals.

A review of the Resident Council minutes completed by the Activities Director dated 1/9/25 indicated it was attended by Residents #48, #14, #10, #21, #20, #51, #12, #30, #39, #38, #23, #6, #32, and #56. The minutes indicated there was no improvement regarding the snack cart or ice being passed on Saturdays and Sundays. The on break, showers not being given-only bed baths, need for a better shower head in the back shower room, healthier snacks on the snack cart, more activities geared towards men, better salads available with more bacon and breaded fish on the menus, sta¿ forgetting to pick up trays after meals, bed control replacement for room 52-B, television remote replacement for beds 66 and 7, sta¿ not setting up residents to eat breakfast, sta¿ not getting residents up when requested, no cleaning after housekeeping sta¿ left for the day, more salad toppings, sta¿ need to be quieter at night time. Each item to be addressed by the facility and the resident council to be notified of results.

3. Activities Director and Administrator educated on the grievance process for resident Council concerns including transcribing each concern as a resident grievance, discussing the grievances from resident council as an IDT, ensuring the resolution of each grievance in a timely manner, and reporting the results of the grievances to the Individual filing the grievance and to the resident council to update on progress and ensure resolution. Education completed by Corporate Director of Nursing on 4/1/2025. With the invitation of the council, the social worker will participate in resident council meetings and actively initiate the grievance process.

In the event that the council does not wish for the sta¿ to participate, then the resident council president will bring the list

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F 565	Continued From page 3 following grievances were expressed during the meeting: nursing assistants with bad attitudes, staff forgetting to pick up food trays after meals, the bed control not replaced on bed 52-B, the television remote for room 66 was missing, the television remote for room 7 was not working, staff was not setting up residents to eat breakfast, and staff not getting a resident up when requested. A review of the Resident Council minutes completed by the Activities Director dated 2/6/25 revealed it was attended by Residents #32, #39, #38, #23, #33, #14, #49, #21, #20, #10, #34, #36, and #58. The minutes indicated the following for grievances voiced during the previous month's meeting: ice being passed was somewhat improved and verbal responses from the staff were somewhat improved. There was no indication the other grievances from the previous month's meeting were addressed. The following grievances were expressed during the meeting: there was no cleaning after housekeeping left for the day, they would like to have more salad toppings, and the staff needed to be quieter during the night when assisting other residents. A review of the Resident Council minutes completed by the Activities Director dated 3/12/25 indicated it was attended by Residents #38, #48, #32, #36, #39, #61, #60, #58, #48, #34, #14, #10, #21, #54, and #23. There was no indication in the 3/12/25 minutes that the grievances voiced during the 2/6/25 Resident Council meeting were addressed. The following grievances were expressed during the meeting: call light response time. A Resident Council meeting was held on 3/20/25	F 565	of concerns to the social worker for initiation of the grievance process. The Resident Council president is agreeable to this system of notification. At the proceeding resident council meeting, the social worker or sta¿ designee will update the council on the progress of filed concerns. 4. To prevent recurrence of this deficient practice, the Administrator or designee will monitor monthly after resident council to ensure concerns are initiated as grievances and e¿orts are made to resolve concerns. This should continue monthly x 3 months, and then quarterly thereafter Administrator or designee to also monitor monthly to ensure results of previous council concerns are reported to the Council for 3 months and then quarterly thereafter. 5. Audits will be reviewed by the Quality Improvement Committee monthly and discussion to ensure substantial compliance. Once the Quality Improvement Committee determines consistent substantial compliance, audits will be done on a random basis.	

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F 565	Continued From page 4	F 565		

at 3:00 PM with Residents #48, #23, #38, #59, #20, #58 and #56. During the meeting, Resident #58 expressed that the Resident Council was not informed of resolutions or progress of grievances voiced at the previous meeting. Resident #48 stated it was if what the Resident Council said did not matter. All of the residents present agreed with Resident #48's statement. The members present at the Resident Council meeting expressed their collective frustration regarding the feeling of powerlessness in attempting to get their voices heard. Resident #38 stated that it seemed pointless to express any grievances because nothing was ever done about them, which the members present collectively agreed with.

An interview with the Activities Director on 3/20/25 at 3:30 PM revealed that she did not fill out a grievance form for issues brought up in Resident Council. She stated she gave the department heads a copy of the minutes of the meeting after she completed them and waited for a response to the concerns. She further indicated that she was not sure what process she was supposed to follow and was unaware of whether or not a grievance form should have been filled out with the grievances brought forth by the Resident Council. She stated that if she did not receive a response from the department head(s) within a week or two then she either went to that department head or mentioned it in the morning meeting. She added that she did not always get a response from the department head. The Activity Director revealed that she had not reported to the Administrator or Director of Nursing if she received no response from a department head. She further revealed that if she had received a response she just noted it in the

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F 565	Continued From page 5 notes and did not inform Resident Council of the response. An interview with the Administrator on 03/21/25 at 08:48 AM revealed he was the Grievance Official, and he had not received a grievance form related to grievances brought up in the monthly Resident Council meeting. The Administrator stated that moving forward, he will check with the Activities Director on the day of the Resident Council meetings to ensure that a grievance is filled out with each concern and the grievance form is completed and reviewed at the next Resident Council meeting. He further stated that the process was for a grievance form to be filled out with each individual grievance voiced by the Resident Council and the Resident Council updated on the solution or progress to the solution for each grievance.	F 565		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		4/4/25

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F 582	Continued From page 6 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a CMS-10055 (Center for Medicare and Medicaid Services) Skilled Nursing	F 582	1. No immediate action for resident #27 or #280 as timeframe for issuing ABN has already passed.	

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F 582	Continued From page 7 Facility Advance Beneficiary notice of Non-Coverage (SNF ABN) prior to discharge from Medicare part A services for 2 of 3 residents (Residents #27 and #280) reviewed for SNF Beneficiary Protection Notification Review. The findings included: 1. Resident #27 was admitted to the facility under part A Medicare Services on 12/3/24. A review of Resident #27's medical record revealed a CMS 10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #27's court appointed designee on 12/20/24. The notice indicated that Medicare coverage for skilled services were to end on 12/22/24 and the resident would remain in the facility. A review of Resident #27's medical record revealed that a CMS-10055 SNF ABN was not provided to Resident #27, or his court appointed designee. An interview conducted with the Business Office Manager on 3/21/25 at 10:00 AM indicated that she was confused over the SNF ABN process and did not realize she had to administer one to every Medicare Part A resident who had days remaining when discharged from Medicare Part A services. She now understood the process and will ensure an SNF ABN was provided appropriately. An interview conducted with the Administrator on 3/21/25 at 10:30 AM indicated that SNF ABNs should have been issued and would be discussed at the morning meeting with therapy when they	F 582	2. To identify other residents at risk of this deficient practice, a review of current residents receiving Medicare part A benefits in the last 30 days was completed to assess the need for an ABN. 3. To prevent recurrence of this practice, education completed with the Business O¿ce Manager and Administrator regarding the need to issue an Advanced Beneficiary Notice for any resident who is discharging from Medicare A with benefit days remaining. Education completed of 4/2/25 by the Corporate Director of Nursing. 4. To ensure compliance with this requirement, the Administrator or designee will review Medicare Part A discharges to ensure compliance with ABN issuance. This monitoring to be completed weekly for 4 weeks, then biweekly for 4 weeks, then monthly x 2. If no other issues are identified, then this will then be monitored on a random basis. 5. Audits will be reviewed by the Quality Improvement Committee monthly and discussion to ensure substantial compliance. Once the Quality Improvement Committee determines consistent substantial compliance, audits will be done on a random basis.	

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F 582	Continued From page 8 were getting ready to discharge a Medicare part A resident to ensure the SNF ABN was issued. 2. Resident #280 was admitted to the facility under part A Medicare Services on 2/11/25. A review of Resident #280's medical record revealed a CMS 10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by his responsible party on 2/28/25. The notice indicated that Medicare coverage for skilled services were to end on 3/2/25 and the resident would return home on 3/3/25. A review of Resident #280's medical record revealed that a CMS-10055 SNF ABN was not provided to Resident #280 or his responsible party. An interview conducted with the Business Office Manager on 3/21/25 at 10:00 AM indicated that she was confused over the SNF ABN process and did not realize she had to administer one to every Medicare Part A resident who had days remaining when discharged from Medicare Part A services. She now understood the process and will ensure an SNF ABN was provided appropriately. An interview conducted with the Administrator on 3/21/25 at 10:30 AM indicated that SNF ABNs should have been issued and would be discussed at the morning meeting with therapy when they were getting ready to discharge a Medicare part A resident to ensure the SNF ABN was issued.	F 582		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		4/4/25

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F 600	Continued From page 9 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and interviews with Police Officer, staff, Resident, Psychiatric Nurse Practitioner, and Physician, the facility failed to protect a Resident's right to be free from staff to resident abuse perpetrated by Nurse Aide (NA) #3 while giving care to a resident with a history of being combative. On 03/08/2025 during morning rounds, Medication Aide #2 observed Resident #9 in his bed with scratches on the left side of his forehead, side of face, nose and left eye redness (bruising). This affected 1 of 4 Residents reviewed for abuse (Resident #9). The findings included: Resident #9 was admitted to the facility on 06/23/2012 with diagnoses including cerebral infarct (stroke). The quarterly Minimum Data Set (MDS) dated 12/26/2024 had Resident #9 coded as cognitively intact and needed total care with activities of daily	F 600	1. At the time of report on 3/8/2025, the facility immediately assessed resident #3 for injuries. Scratches were noted to the forehead, side of head and left eye was reddened. Accused NA #3 was immediately suspended. Physician was notified and orders obtained for facial x-rays which were negative and no further treatment was required. Neurological checks were initiated. The local sheriff's office was notified. 2. To identify other residents at risk of this deficient practice, skin checks were completed on current residents with cognitive impairment evidenced by a BIMS of 11 or below. No further injuries were identified. Additionally, residents who are cognitively intact were interviewed to assess for any additional abuse allegations. None were identified.	

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WARSAW NURSING AND REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

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F 600	Continued From page 10 living (ADL). There were no behaviors or moods reported. His vision was severely impaired, and he was also always incontinent with bowel and bladder. The care plan dated 01/24/2025 had a focus of Resident #9 needing total assistance with ADL, was incontinent of bowel and bladder, had a history of behaviors: verbal insults towards staff, will refuse medication at times, verbal aggression towards staff during ADL care, behaviors (striking out at staff and roommate) and cussing at staff during care. Review of the Initial Allegation Report (2-hour report) dated 03/08/2025 revealed an allegation of abuse. The incident was reported at 7:15 AM. The details of the report stated Nurse #1 was informed that Resident #9 had an injury to his forehead, nose, and left eye. Visible injuries include scratches to the forehead, side of head, and left eye redness noted (initial stages of bruising). He complained of pain with palpitation to nose and left eye. Resident #9 stated that this morning around 6:45 AM, "She told me to turn on the bed and I did not want to, then she hit me in the face". The resident denied any other injuries or complaints of pain other than his nose and left eye. The incident was reported to the local law enforcement. Immediate interventions include suspension of the accused nurse aide, facial x-ray, and neurological checks. Currently, there was no ongoing risk to other residents. We are conducting a thorough investigation to ensure the safety and well-being of everyone in our care. A review of a witness statement from Nurse #1 dated 03/08/2025 revealed at around 6:45 AM Medication Aide #2 came to her and reported	F 600	3. Education on abuse and neglect completed with current staff members to be completed by DON or designee to include review of the Abuse and Neglect policy. Education to be completed on 4/2/25 and 4/3/25. New hire staff will be educated on Abuse and Neglect during the orientation process to include the Abuse and Neglect Policy and the set forth process of immediately “Rescuing the Resident” and immediately alerting supervisory staff. The Regional Director of Nursing then educated Director of Nursing, Assistant Director of Nursing and Unit Managers on the facility abuse related policies, including ensuring all staff receive Abuse and Neglect education annually. (Completed 3/8/25) Moving forward, Abuse and Neglect education and assessment will be completed during resident council to ensure residents are aware of their right to remain abuse free and the process of immediately calling for assistance. Staff present in resident council will inquire with residents about any experiences of abuse and neglect and offer residents the opportunity to speak with staff confidentially. 4. To ensure continued compliance with this requirement, DON or designee to review skin checks for any indications of abuse or neglect. Additionally, 5 random residents to be interviewed weekly to assess for any reports of maltreatment. Finally, DON or designee to interview 5 random employees to assess for proper	

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW NURSING AND 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 600	Continued From page 11 Resident #9 had visible injuries to his forehead, side of head and left eye. The resident complained of pain from his nose and left eye area. She asked what happened and he stated, "she hit me". The Nurse asked when it happened and if he knew her name. The Resident stated it just happened this morning. She told me to turn in the bed and he did not want to then she hit him in the face. The resident stated just his head and face hurt. A telephone interview with Nurse #1 was conducted on 03/19/2025 at 9:43 AM. The nurse stated she worked the night shift from 7:00 PM to 7:00 AM and worked in facility that night but was not Resident #9's nurse. On 03/08/2025, around 6:45 AM, Med Aide #2 reported to her to look in on Resident #9 because he had scratches on head and believed he was hit. She went to Resident #9's room and saw he had small scratches to the left side of his forehead, nose and eye. His eye was swollen and it would not fully open. She told Resident #9 he had an injury to his head and asked if he remembered what happened and he said, "she hit me". The Nurse also asked if he remembered who hit him and stated, "she told him to roll over in bed and he did not want too and then she hit me". She did not know if it was a slap or punch. He could not say a name but stated, "she worked with him that night". The Nurse also stated his injuries were fresh because the scratches had not clotted yet and were easy to clean. The Nurse asked Resident #9 if she could touch the areas, and he allowed. She used normal saline to clean his face and offered a cold pack, but he refused. He said he was not in pain. The areas stopped bleeding when cleaned. The wounds did not look as if he could inflict them on himself and he never had a	F 600	knowledge related to Abuse and Neglect and proper actions should they suspect abuse is occurring. These items to be completed weekly x 4 weeks, biweekly x 4 weeks, monthly x 4 weeks. If no further issues are identified, monitoring will occur on a random basis. 5. Audits will be reviewed by the Quality Improvement Committee monthly and discussion to ensure substantial compliance. Once the Quality Improvement Committee determines consistent substantial compliance, audits will be done on a random basis.	

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	345252	A. BUILDING _____ B. WING _____	C 03/21/2025

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F 600	Continued From page 12	F 600		

history of making anything up. He can be combative at times. The NA that worked with him that night was NA #3. The Nurse stated she asked if it was okay to leave him and if he felt safe, he stated he did. She went to find NA #3 and she had left the building. She then called the Unit Manager on-call supervisor.

A review of a witness statement from Medication Aide (Medication Aide #2) no date revealed on March 08, 2025, as she was in the middle of her morning med pass and giving medicine to a resident. She heard Resident #9 yelling and then he stopped. When this Med Aide went into his room, she noticed blood and cuts on his face. She immediately notified Nurse #1 on duty.

A telephone interview with Medication Aide #2 was conducted on 03/19/2025 at 4:11 PM. Medication Aide #2 stated she was the med aide on 03/07/2025 at 11:00 PM to 03/08/2025 at 7:00 AM. On 03/08/2025 at approximately 5:45 to 6:00 AM, she and NA #2 were getting supplies from the supply room. As they passed Resident #9's room, his roommate, Resident #69, yelled out for help. He wanted his television turned on. She observed Resident #9 at that time, and he was fine and did not have any scratches or bruises. She went to get the medications for Resident #69 and came back to the room and while giving him his medications, NA #3 came in and told Resident #9 she was there to change his brief. Resident #9 and NA#3 were calm, and he allowed her to assist him. She left the room and went to another resident's room to give medications. While in the Residents room, she heard Resident #9 yell out but could not understand what he was saying. It was not out of the ordinary for him to yell out and he did not yell after that. She exited the resident's

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 03/21/2025

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F 600	Continued From page 13	F 600		

room and saw NA #3 walk by and figured she took care of Resident #9's needs. NA #3 looked normal and did not seem angry. She went to her next resident room to administer medications and after she finished administering medications to that resident, she went to peek in on Resident #9. She observed scratches on his face and forehead, he had scratches on his left side of his eye and left inner eye. The scratches were fresh, and she noticed blood on his face. She asked the resident what happened to his face, and he did not say anything. She then went to get Nurse #1. The nurse went into Resident #9's room and took care of the resident, and she went back to administering medications. The Medication Aide also stated Resident #9 was alert and oriented and he cannot see very well. To her knowledge, he had never made false allegations against staff and his nails were short and neat. The Medication Aide further stated she worked with Resident #9 regularly after the incident and he had not had any behavior changes. He did not appear to be afraid, had not had any sleeping changes and he still yells out if he needed something.

A telephone interview with NA #2 was conducted on 03/19/2025 at 12:31 PM. The NA stated he worked 7:00 PM o 3/07/25 to 7:00 AM on 03/08/2025 and he was familiar with the care for Resident #9. Resident #9 needed total assistance with activities of daily living (ADL) care. The morning of 03/08/2025 he saw NA #3 walk in the room and within a minute he heard her tell Resident #9 to roll over to be changed and she did sound agitated. Within another minute he heard sounds like a hand hitting a hand and was walking away from the room. He would usually go in and see what was going on, but NA #3 was not the type of person that you confront when she

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW NURSING AND REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

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F 600	Continued From page 14	F 600		

was upset. When she (NA #3) left the room, he and Medication Aide #2 went in and observed blood coming down Resident #9's left or right temple. Medication Aide #2 asked if he was okay, but he did not hear what the Resident said because they left to find a nurse and went in opposite directions. The NA also stated he had not observed NA #3 abusing residents or treating them roughly in the past.

A review of the witness statement from NA #3 dated 03/08/2025 revealed she was assigned to rooms 64-70 and she did her roll call at 11:30 PM. All of her residents were accounted for and did her 1st round at 12:30 AM. Resident #9 was not soiled at all, and he doesn't like to be bothered throughout the night. She doesn't get too close to him because he is a fighter and he can't see and is afraid at times, but she checked on him every round. At 5:30am she asked if she could check him to see if he needed to be changed and he said, "Yes". As she was changing him, she talked with him, so he knew what she was doing, so he didn't get afraid and fight her. He let her change him and she left the room. She didn't see anything on him because he didn't let anybody get close to him. He wasn't upset at all when she changed him.

A telephone interview with NA #3 was conducted on 03/19/2025 at 2:28 PM. The NA stated she came in on overtime on 03/07/2025 for a 11-7 shift. It was a pleasant night. She was in a good mood and Resident #9 was in good spirits as well. She went in to do her rounds and the last round was around 5:30 AM. He was fine when she left the room around 5:45 AM. The NA also stated she would always announce what she was going to do and loud enough for him to hear her.

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 15	F 600		

The Resident is half blind, so you must tell him what you are there for. She told him she was there to check and change his brief and he allowed it. There were no other interactions with the Resident. She left and she did not return to the room. The NA also stated she feels she was being set up at the facility because she and Resident #9 got along well, and she would never do anything like this.

A review of an x-ray dated 03/08/2025 revealed a history of injury and pain, 4 views of facial bones with no prior studies. There were no definite displaced or depressed facial fractures.

A review of the local Police Department incident/investigation report dated 03/08/2025 revealed on 03/08/2025 the Police Officer #1 was dispatched to [name of the facility] in reference to an elderly man who was assaulted by an employee. When he arrived, he and Officer #2 walked to Resident #9's room where he spoke to the resident. Resident #9 stated that earlier that morning "a he-she hit him in the face and scratched his head." He asked the resident who it was and what they were doing. He was having a hard time communicating but was able to inform me that she was there to give him a bath and when she asked him to sit up, he didn't move fast enough for her, and she struck him. Officer #1 asked Resident #9 if it was possible that it was an accident and if she apologized and doctored him up afterwards and he stated "No, she was mean". I observed a bruised left cheek below his eye, a small amount of dried blood in his tear duct, and a long scratch going from the top of his left eye to the top of his head. It was easy to see due to the resident not having hair on his head.

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 03/21/2025

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F 600	Continued From page 16	F 600		

A telephone interview with Police Officer #2 was conducted on 03/18/2025 at 2:49 PM. Officer #2 stated they were called in on 03/08/2025 for alleged abuse of a Resident from a staff member. They went to the Residents room and asked if he could tell them what happened and he stated he was hit by a he/she, because he did not move fast enough and that it just happened. The Resident just said he was hit and did not explain how he was hit. The Resident also showed signs of an altercation with bruises and scratches that were visible on his face. There was no arrest yet and the case was still open.

A telephone interview with Nurse #2, the 7:00 PM to 7:00 AM nurse on 03/08/2025 was conducted on 03/19/2025 at 1:42 PM. The nurse stated she did work the night shift when the incident occurred and was Resident #9's nurse. That morning (3/08/25), she was completing her night rounds and did not see or hear anything but was told about it after it happened. The Nurse stated the last time she was in Resident #9's room was in the middle of her shift around 1:00 AM. Resident #9 did not have any bruising or scratches.

A review of a witness statement from Nurse #3, no date, revealed at the start of my shift on 03/08/2025, as charge nurse (7:00 AM to 7:00 PM), it was reported to him a potential abuse involving Resident #9. Upon going to assess Resident #9, he was adamant he was hit. He had visible injuries to forehead, left eye and head. When asked when and by whom, the Resident stated, "early this morning by this girl". Emotional support was offered to Resident #9, and first aid was offered.

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 600	Continued From page 17	F 600		

A telephone interview with Nurse #3 was conducted on 03/19/2025 at 9:23AM. The Nurse stated he still worked at the facility as 7:00 AM to 7:00 PM charge nurse. An incident happened on Saturday morning, 03/08/2025 at end of the night shift. Nurse #1 reported to him that suspected abuse may have happened to Resident #9 and went to his room a little after 7:00 AM to assess him. He noticed he had injuries including and a bruise on his left eye and scratches on his face. He did not complain of pain at that time. Resident #9 allowed him to apply an ice pack to the bruise on his face. He did a full assessment and body check and there were no other issues found. The resident stated, "That girl hit me", when asked what girl he said it was the girl working with him that night. He could not give her name. The Resident worked with NA #3 that night shift. The Nurse also stated he had not seen NA #3 treat or had any reports of her treating the residents any other residents ruff or would have reported it. The Nurse also stated Resident #9 had dementia and got agitated at times and refuses his care. The Resident's behavior had not changed since the incident and, he had not complained about the pain.

An interview with the Unit Manager was conducted on 03/20/2025 at 1:01 PM. She stated the incident was reported to her by phone between 7:00 AM and 7:30 AM because she was the on-call Nurse that weekend. Nurse #1 reported Resident #9 had a developing bruise on the inner left eye and small scratches on his forehead, left side of nose and face. Resident #9 had a history of being combative with staff in the past. The Unit Manager also stated she told Nurse #1 to start neurological checks and then she contacted the provider and DON. The

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 600	Continued From page 18	F 600		

provider gave orders for a facial x-ray and there were no fractions found. She also contacted the Responsible Party (RP) to say that there was an alleged abuse involving Resident #9. The DON completed the reports and notified authorities. The DON stated she would handle the investigation. The Unit Manager further stated the Resident had not had any change of behavior or sleep habits. When she went to visit him on that Monday, 03/10/2025, he was his normal self and stated he was okay and did not have any pain or discomfort.

An observation and interview with Resident #9 were conducted on 03/18/25 at 02:03 PM. Resident #9's face was observed to be free from bruising and scratches. He stated he did not have any pain. The Resident stated he was hit by a girl that worked at the facility. She asked him to lie down so she could change him, and he guessed it wasn't fast enough for her, and she started hitting him in the face and head. He did not remember who she was, but it was the person that was working with him that night. He stated he feels safe at the facility, he was mad, but the incident did not bother him at all anymore because she must have been crazy. He has not seen the NA at the facility since the incident. He was already seeing psychiatric services but not for this issue. He also stated he still can sleep without any issues and his moods had not changed.

An interview with Resident #69, Resident #9's roommate was conducted on 03/18/2025 at 02:13 PM. The Resident stated he did not hear or see anything because he was asleep.

A follow up interview with Resident #9 was

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 600	Continued From page 19	F 600		

conducted on 03/19/2025 at 12:02 PM. The Resident stated he could not see how she was hitting him but knew she was hitting him. The Resident also stated there was no need to go to the hospital when it happened, and he was fine.

A review of the Trauma Informed Screen completed 03/11/2025 revealed Resident #9 was in a recent confrontation with a staff member. Resident #9 stated he was, "OK". There were no anxiety issues, the Resident denied any mental anguish or anxiety. X-ray of face was obtained and is included. The resident was also followed up by the provider and that note is also included.

A review of a social services note dated 03/11/2025 revealed he met with Resident #9 in his room. Questions concerning "Trauma Inform Screen" and discussions of altercation with staff member. Resident #9 stated he was, "OK" and has no anxiety issues. The Resident also stated he was not in need of any other psychological services at present and was thankful for his visit.

An interview with the Social Worker (SW) was conducted on 03/21/2025 at 9:09 AM. The SW stated he was made aware of the incident with Resident #9 that happened the past weekend (03/08/2025). He went down to Resident #9's room to check on him and to make sure he was not in any distress or suffering from trauma. He completed the screen for trauma, and it did not show any trauma. He stated he was okay; he was not fearful or in any pain.

A telephone interview with the Psychiatric Nurse Practitioner was conducted on 03/20/2025 at 10:36 AM. She stated she visits Resident #9 twice a month on Wednesdays for his combative

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW NURSING AND 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 600	Continued From page 20	F 600		

behaviors and diagnosis of vascular dementia with behavioral disturbances. On 03/12/2025 Resident #9 had a scheduled chronic visit and med review. He was in his bed, asleep and easily aroused. He was calm and content, alert and oriented. He stated he did not have any anxiety or issues sleeping and eating well. When asked if there were any issues, he wanted to discuss, he stated, "no", and did not mention the incident. On 02/26/2025, he was ordered a new as needed (PRN) order for 0.5 milligrams Ativan for agitation prior to the incident and it was not administered within that look back period of 14 days. He had a history of being agitated and striking out at times during care. He can identify people by voices. Resident #9 had not had a history of fabrications. He was still alert and oriented even though he is blind. The Nurse Practitioner also stated Resident #9 did not have any notable bruising or scratches visible or complained of pain on 03/12/2025 when she visited him.

A review of a physician note dated 03/12/2025 revealed Resident #9 was stable and there were no new complaints. His skin was normal temperature and normal color. Summary from 03/08/2025 revealed resident noted with multiple scratches to forehead, left side of scalp, and on the inner corner of his left eye. Bruising was noted to left eye and nose as well. When asked what happened the resident stated that he was told by a nursing assistant to turn over and he did not want to and when he said that he did not want to "she hit me in the face". The resident reported pain to the left side of face and nose. The area was cleansed with wound cleanser and patted dry. The provider was notified and gave telephone order for an x-ray of nose and left orbit and neurological checks were implemented.

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 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 600	Continued From page 21	F 600		

A telephone interview with the Physician was conducted on 03/20/2025 at 1:44 PM. The Physician stated she was new to the facility but did visit Resident #9 on 03/12/2025 as her note indicated. She did not observe any facial bruises or scratches on his face and there were no complaints of pain. If there was, she would have addressed it in her note. She also stated she could not say if the scratches could have been self-inflicted due to the incident because she did not see the areas when the incident happened. The physician also stated she would expect all residents at the facility to be free from abuse.

A review of the investigation Report (5-day report) dated 03/14/2025 revealed the alleged employee (NA#3) was suspended starting 03/08/2025 through the duration of the investigation. After investigation, NA #3 was terminated. Skin audits were completed on the residents with BIMS scores less than or equal to 11. Interviews completed with resident with BIMS greater than and equal to 12. Statements were received from the resident, resident's roommate, and other staff that were present during the day of the incident. Staff were re-educated on the abuse policy. Employees were re-educated about abuse and the importance of timely notification to management. Weekly skin checks will be continued on in-house residents. No other residents were noted to be in any immediate danger.

An interview with the Director of Nursing (DON) was conducted on 03/20/2025 at 1:31 PM. The DON stated she received a call from her Unit Manager a little after 7:00 AM on 03/08/2025 and reported Resident #9 had been hit in the face and

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 03/21/2025

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WARSAW NURSING AND REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

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F 600	Continued From page 22	F 600		

had some scratches and bruise under the left eye forming with fresh blood. The DON asked which NA was scheduled and was told NA #3 and her shift ended at 7:00 am and she had already left the facility. The DON had the Unit Manager take NA #3 off the schedule and look for a replacement. She then called NA #3 and asked if she had Resident #9 the last shift and if anyone was in the room with her. She stated she did have him last night and no one else was in the room with her when she finished his care. She said he can fight you and be combative at times, but it went ok and there were no issues. NA #3 emailed her the statement. The DON called her back and told her he was hit in the face and was observed with fresh blood and a bruise that was forming. The DON informed the NA #3 she would investigate the incident and get back to her. The DON had the Unit Manager contact the physician and got an order for an x-ray and no fractures were found. Skin was assessed for Resident #9 and no other issues aside from the face scratches and redness, bruise to left eye. He did not require treatment for his face, it resolved on its own. He also did not require pain medication, just an ice pack. The DON stated she completed the Initial Report and called 911 and reported it to police and their investigation was ongoing. The DON received a statement from Nurse #1. The abuse and neglect education began on 03/08/2025 by Nurse #3. Resident #9 or any other resident were not in immediate danger. He was not showing any emotional distress and stated he was fine and did have a psychiatric visit on 03/12/2025. He has not complained of pain since the incident and did not require further treatment for his face. The DON indicated she reported the incident to the Administrator. The DON also stated she called NA #3 and let her

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F 600	Continued From page 23	F 600		

know the allegation was substantiated and had to let her go. There were no previous issues with Resident #9 and NA #3 ever reported. The Resident did have a history of striking out at staff but that was no excuse. The DON stated she expected her staff not to abuse residents and for her residents to be free of abuse and feel safe at the facility.

An interview with the Administrator was conducted on 03/20/2025 at 3:52 PM. The Administrator stated he was called by the DON on 03/08/2025 who reported there was a situation with Resident #9 and NA #3. She stated it looked like the NA, that worked that night, may have abused the resident. The nurses evaluated the resident for any other issues to his body and skin. There were scratches and a bruise on his left eye and there were x-rays completed and there were no fractures found. The resident did not complain of pain after the day of the incident and his bruising and scratches went away quickly. The Administrator also stated he made sure the DON completed the initial review and reported the incident to the police who were in the building while he was on the phone with her. He also reminded the DON that the NA could not work there until the investigation was completed. The NA had not been in the facility since that morning at 6:50 AM. The Administrator also stated the RP was made aware. The investigation was substantiated. The staff member was fired but there were no prior issues with NA #3 before the incident and there were no problems between her and Resident #9. There was no abuse found by the alert and oriented Residents that completed questionnaires and interviews. The staff were questioned about what happened and they received witnesses' statements. They educated

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F 600	Continued From page 24 the staff that they must report abuse as soon as possible and that abuse is not supposed to happen and will continue to educate staff about abuse. The Administrator stated he expected the residents to be free from abuse.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced	F 607		4/4/25

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F 607	Continued From page 25 by: Based on record review and staff interviews, the facility failed to follow and implement abuse policies for identifying and intervening in situations of abuse for 1 of 4 residents reviewed for abuse (Resident #9). When Nurse Aide (Nurse Aide) #2 thought he heard a physical altercation between NA #3 and Resident # 9, NA #2 did not enter the room, did not intervene, or report NA #3. Resident #9 was observed with scratches to his forehead, nose and eye. His eye was swollen and it would not fully open. The findings included: A review of the abuse policy revised/reviewed 04/29/2024 revealed "III. Prevention of abuse neglect and exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse neglect misappropriation or resident property and exploitation that achieves: B. Identifying correcting and intervening in situations in which abuse neglect exploitation and or misappropriation of resident property is more likely to occur with the deployment of trained and qualified registered licensed and certified staff on each shift. Review of the investigation completed by the Director of Nursing (DON) related to Resident #9's incident revealed the following: A review of a witness statement from NA #2 dated 03/12/2025 revealed at around 5:00 to 6:00 AM (03/08/2025) in the morning when he was able to see NA #3 walk into Resident #9's room to change him. He was waiting for time to pass to do a shower for a resident closer to 6:30 AM to accommodate the resident. At that time	F 607	1. At time of discovery during the investigation process, NA #2 immediately educated on Abuse and Neglect Policy to include immediately intervening with suspected/witnessed abuse. Education completed by the Director of Nursing on 3/12/2025. 2. Current residents are at risk of this deficient practice. 3. Education on abuse and neglect completed with current staff members to be completed by DON or designee to include review of the Abuse and Neglect policy including immediately intervening with suspected/witnessed abuse. Education to be completed on 4/2/2025 and 4/3/25. New hire staff will be educated on Abuse and Neglect during the orientation process to include the Abuse and Neglect Policy and the set forth process of immediately “Rescuing the Resident” and immediately alerting supervisory staff. 4. To ensure continued compliance with this requirement, DON or designee to interview 5 random staff members weekly for assess for adequate knowledge and understanding of the Abuse and Neglect Policy. This should occur weekly x 4 weeks, biweekly x 4 weeks and monthly x 3 months. If no further issues are identified, audits will occur randomly thereafter.	

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	345252	A. BUILDING _____ B. WING _____	C 03/21/2025

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F 607	Continued From page 26 Medication Aide #2 was still passing meds, so she would pop in and out of rooms. He heard NA #3 say something along the lines of "Roll over [Resident #9], I'm trying to change you" in a very agitated tone, soon after I was able to hear what sounded like a physical altercation between her and Resident #9. In that moment I began to move away from the room. It wasn't long after that, NA #3 stepped out of the room in a hurried manner, she disappeared up the hall. He and Medication Aide #2 walked into the room, when she needed to give his roommate, Resident #69 his medicine. He followed in, that's when he and Med Aide #2 saw blood on Resident #9's right temple, bruising at the time wasn't visible but the blood was a clear indication of the severity of the situation. Soon after, Med Aide #2 asked Resident #9 if he was feeling alright, and they left the room. A telephone interview with NA #2 was conducted on 03/19/2025 at 12:31 PM. The NA stated he worked 7:00 PM o 3/07/25 to 7:00 AM on 03/08/2025 and he was familiar with the care for Resident #9. Resident #9 needed total assistance with activities of daily living (ADL) care. The morning of 03/08/2025 he saw NA #3 walk in the room and within a minute he heard her tell Resident #9 to roll over to be changed and she did sound agitated. Within another minute he heard sounds like a hand hitting a hand and was walking away from the room. He would usually go in and see what was going on, but NA #3 was not the type of person that you confront when she was upset. When she (NA #3) left the room, he and Medication Aide #2 went in and observed blood coming down Resident #9's left or right temple. Medication Aide #2 asked if he was okay, but he did not hear what the Resident said because they left to find a nurse and went in	F 607	5. Audits will be reviewed by the Quality Improvement Committee monthly and discussion to ensure substantial compliance. Once the Quality Improvement Committee determines consistent substantial compliance, audits will be done on a random basis.	

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	345252	A. BUILDING _____ B. WING _____	C 03/21/2025

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F 607	Continued From page 27 opposite directions. The NA also stated he had not observed NA #3 abusing residents or treating them roughly in the past. An interview with the DON was conducted on 03/20/2025 at 1:31 PM. The DON stated Med Aide #2 reported the incident immediately after she observed Resident #9's face. NA #2 was educated on abuse and neglect, and he should have gone to find someone as soon as he thought abuse was happening. The DON stated she expected to have an abuse free facility and if abuse is suspected then the staff is to intervene immediately. An interview with the Administrator was conducted on 03/20/2025 at 3:52 PM. The Administrator stated NA #3 had been out of the facility since 03/08/2025 at 6:50 AM. NA #2 was educated and should have known to go get help when he suspected abuse. Staff have been educated on reporting and intervening when abuse is suspected and will continue to be educated. The Administrator stated he expected his staff to intervene if they believe a resident is being abused.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of level II Preadmission Screening and Resident Review	F 641	1. Immediately modified identified assessment on Resident #57. 2. Residents requiring Level II PASRRs	4/4/25

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	345252	A. BUILDING _____ B. WING _____	C 03/21/2025

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F 641	Continued From page 28 (PASRR) for 1 of 3 residents (Resident #57) reviewed for PASRR. The findings included: Resident #57 was admitted to the facility on 9/1/24 with diagnoses that included major depressive disorder, generalized anxiety disorder and bipolar disorder. Record review indicated Resident #57 had a level II PASRR number issued 12/13/24. The annual MDS assessment dated 2/23/25 indicated a "No" to question A1500 which asked if Resident #57 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition. During an interview with the MDS Coordinator on 3/19/25 at 3:38 PM, he confirmed that Resident #57 had a level II PASRR. The MDS Coordinator verbalized that the MDS was coded inaccurately and that it was an oversight. An interview was conducted with the facility Administrator on 3/20/25 at 2:29 PM. He indicated Resident #57's MDS should have been completed accurately to reflect level II PASRR.	F 641	are at risk of this practice. Current residents requiring PASRR level II were reviewed for accuracy in coding the level II on the MDS 3. MDS coordinators and Social Worker educated by the Administrator on accurate coding of MDS assessments to including thorough review of the resident record to include resident's PASRR level prior to coding the MDS. Education completed 3/25/2025 4. To ensure continued compliance with this requirement, DON or designee to monitor resident's with PASRR level II's monthly to ensure accurate coding on the MDS. This will occur monthly x 3 months. If no further issues are identified, then audits will occur randomly thereafter. 5. Audits will be reviewed by the Quality Improvement Committee monthly and discussion to ensure substantial compliance. Once the Quality Improvement Committee determines consistent substantial compliance, audits will be done on a random basis.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		4/4/25

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	345252	A. BUILDING _____ B. WING _____	C 03/21/2025

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F 688	Continued From page 29 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews, the facility failed to apply a left-hand splint for 1 of 3 sampled residents reviewed for limited range of motion (Resident #3). Findings included: Resident #3 was admitted to the facility on 10/31/23 with diagnoses that included contracture of left-hand muscle, hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis). Resident #3's annual Minimum Data Set Assessment (MDS) dated 12/29/24 coded the resident as moderately cognitively impaired. She was coded as dependent with toileting and transfers. She required setup/clean-up assistance with eating and required substantial assistance with bathing and rolling in bed. Her functional limitation in range of motion indicated she had impairment on one side to her upper extremity and lower extremity.	F 688	1. Resident #3 immediately evaluated by Occupational Therapy for splinting management. No decrease in range of motion or injury identified. Resident placed on OT caseload for development of splinting program. 2. Residents requiring splints/braces are at risk of this practice. Current residents with splints/braces reviewed for brace/splint placement and proper fit. 3. Nursing staff educated on splint fit, placement and monitoring including locating splinting program directions in the electronic medical record and promptly reporting any concerns to therapy and/or charge nurse. Education completed by the DON or designee to be completed on 4/2/25 and 4/3/25. Moving forward, when a splinting/brace program is developed for execution by nursing, therapy will notify the Director of Nursing or designee of the program	

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	345252	A. BUILDING _____ B. WING _____	C 03/21/2025

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F 688	Continued From page 30 A review of Resident #3's medical record revealed an Occupational Therapy (OT) discharge summary note dated 10/18/24 that indicated a splint/brace program had been established, and a left-hand splint was to be worn 6 hours daily. The summary note also indicated the prognosis to maintain Resident #3's level of function at that time was good with consistent staff follow-through. The note further indicated that nursing staff had been trained and demonstrated the ability to don and doff the splint to ensure carryover of splinting schedule after OT discharge. A review of Resident #3's Kardex (care card) revealed a task under devices that indicated apply resting hand splint to the left arm. Resident #3 was observed on 3/18/25 at 11:27 AM without a splint to the left hand and the left hand was noted to be flaccid (limp and lacking voluntary movement). During an interview, Resident #3 stated she was supposed to have a splint to her left hand, but nursing staff did not put it on most of the days. During an interview conducted in conjunction with an observation with Nurse #4 on 3/19/25 at 1:43 PM. Resident #3 was observed in bed without a splint to her left hand. Nurse #4 found the splint in Resident #3's bedside drawer and stated she was not sure if Resident #3 was still supposed to utilize the left-hand splint, and she would find out from OT. Nurse #4 stated it would be noted on the Kardex (care guide) if nursing assistants were supposed to put the splint on. During an interview with Medication Aide (MA) #1	F 688	development to ensure proper implementation. 4. To ensure continued compliance with this requirement, the Director of Nursing or Designee to monitor residents with splint/brace requirements to ensure splint/brace is in place according to care plan requirements twice weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months. If no further issues are identified, audits will then occur on a random basis. 5. Audits will be reviewed by the Quality Improvement Committee monthly and discussion to ensure substantial compliance. Once the Quality Improvement Committee determines consistent substantial compliance, audits will be done on a random basis.	

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	345252	A. BUILDING _____ B. WING _____	C 03/21/2025

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WARSAW NURSING AND REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

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F 688	Continued From page 31	F 688		

on 3/19/25 at 1:46 PM she stated therapy staff normally put the splint on Resident #3. MA #1 stated she could not recall if she had seen Resident #3's care card indicating to apply the splint.

During an interview on 3/19/25 at 1:55 PM with the Assistant Director of Nursing (ADON), she stated that Resident #3's splint should have been applied as indicated and nursing staff should have reached out to OT if they were having any difficulties putting the splint on.

An interview was conducted on 3/20/25 at 12:37 PM with the Occupational Therapist. She stated when she discharged Resident #3 from OT services on 10/18/24 the resident had built up a tolerance to wear the left-hand splint for up to 6 hours. The Occupational Therapist indicated she had trained nursing staff at that time, and they had demonstrated the ability to don and doff the splint and were to continue utilizing the splint for at least 6 hours a day. The Occupational Therapist stated if nursing staff had any issues applying the splint or needed more training, they should have notified her, and she would have retrained or provided the assistance the staff needed. She further stated the splint was for joint protection to prevent injury because Resident #3's left hand was flaccid, and to prevent any potential contractures and skin breakdown. The Occupational Therapist indicated she had just evaluated Resident #3 prior to the interview and Resident #3's left hand mobility had not gotten worse since the last evaluation on 10/18/24 and she had not developed any skin breakdown or new injury to the left-hand.

During an interview on 3/20/25 at 1:19 PM with

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F 688	Continued From page 32 the Director of Nursing (DON), she stated if the splint was noted on Resident #3's care card then nursing staff should ensure that they put it on. The DON stated it was her expectation for nursing assistants to apply the splint and if they had any difficulties then they should have informed their supervising nurse or OT so they could be retrained. During an interview on 3/20/25 at 3:58 PM with the facility Administrator, he stated the nursing staff should have applied the splint as indicated.	F 688		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(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 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		4/4/25

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 03/21/2025

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WARSAW NURSING AND REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

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F 758	Continued From page 33 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Pharmacist, Nurse Practitioner and Medical Director interviews the facility failed to document the continuing need of a psychotropic medication in the Electronic Medical Record for 1 of 2 residents reviewed for psychotropic medication (Resident #34). The findings included: A review of Resident #34's discharge summary from the hospital dated 12/6/23 indicated she was admitted to the hospital due to visual hallucinations and sundowning (increased	F 758	1. Resident immediately referred to psychiatry services for evaluation of medication. Resident's non-pharmacological interventions on the MAR updated to reflect that non-pharmacological interventions are used to deter and prevent behaviors. 2. Residents receiving psychotropic medication are at risk of this practice. Current residents on psychotropic medications reviewed for psych services referral, assessment for GDR assessment, behavior monitoring	

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F 758	Continued From page 34 agitation, confusion, disorientation, and anxiety that typically occurs in the late afternoon or evening). She was started on an Seroquel (a medication that helps regulate mood, behaviors, and thought) 50 mg at bedtime while at the hospital and discharged to the facility. Resident #34 was admitted into the facility on 12/11/23 with diagnoses of unspecified dementia unspecified severity without behavioral, psychotic, or mood disturbance and anxiety. A review of Resident #34's annual Minimum Data Set dated 11/12/24 indicated she was cognitively intact, exhibited no signs of delirium, had no mood indicators, no hallucinations or delusions, no rejection of care and no behavioral symptoms. She had active diagnoses of non-Alzheimer's dementia and depression and had received an antipsychotic with no gradual dose reduction attempted and the physician had not documented a gradual dose reduction as clinically contraindicated. A review of Resident #34's Physician orders for December 2024 revealed an order for Seroquel 50 milligrams (mg) at bedtime for behaviors with a start date of 9/6/2024. A review of Resident #34's quarterly Minimum Data Set dated 1/24/25 indicated she was severely cognitively impaired, exhibited no signs of delirium, had no mood indicators, no hallucinations or delusions, no rejection of care and no behavioral symptoms. She had an active diagnoses of non-Alzheimer's dementia and depression and had received an antipsychotic with no gradual dose reduction attempted and the physician had not documented a gradual dose	F 758	accuracy, and non-pharm intervention presence on care plan. 3. Nursing staff to be educated on correct behavior documentation including not normalizing abnormal behavior, only documenting non-pharmacological when attempting to deter abnormal behaviors. Education to be completed by the Director of Nursing or designee on 4/2/2025 and 4/3/2025. Nursing admin educated on ensuring psychological services referral for residents admitted on psychoactive medications. Education completed by the Corporate Director of Nursing on 4/2/2025. 4. Director of Nursing or Designee to monitor behavior monitoring documentation and non pharmacological interventions for completeness and accuracy three times weekly x 4 weeks, weekly x 4 weeks, and monthly thereafter. Director of nursing or designee to monitor weekly for new admission referral to psych services if admitted on psychotropic medication. This will occur x 4 weeks, biweekly x 4 weeks, monthly x 2 months and if no other issues are identified, audits will occur on a random basis. 5. Audits will be reviewed by the Quality Improvement Committee monthly and discussion to ensure substantial compliance. Once the Quality Improvement Committee determines consistent substantial compliance, audits will be done on a random basis.	

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F 758	Continued From page 35	F 758		

reduction as clinically contraindicated.

A review of Resident #34's comprehensive care plan revised on 2/19/25 included a focus problem of: Resident has displayed behaviors of fall allegations and false claims against staff. She rejects care by pulling away from staff while staff is giving care. Interventions include, in part: gently inform her that false accusations against staff or other residents will not be tolerated, Social Worker to speak with resident about her behavior, investigate resident claim with her encouraging her to speak honestly remembering details, psychiatric consult as needed, take her to a calm quite place if she became upset to allow her to calm down.

A review of Resident #34's Physician orders for March 2025 revealed an order for Seroquel 50 mg at bedtime for behaviors with a start date of 12/6/2024.

A review of Resident #34's nursing and physician progress notes from 1/1/25 through 1/31/25 revealed there were no behaviors or symptoms documented related to her psychiatric diagnosis.

A review of Resident #34's MAR for 2/25 revealed no behaviors related to the use of psychoactive medication. The MAR did reflect non-pharmacological interventions to deter behaviors or symptoms related to her psychiatric diagnosis.

A review of Resident #34's nursing and physician progress notes from 2/1/25-2/28/25 indicated there were no behaviors or symptoms documented related to her psychiatric diagnosis.

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F 758	Continued From page 36	F 758		

A review of Resident #34's MAR for 3/25 noted on 3/6/25 a behavior of compulsive behavior was indicated and 3/17/25 a behavior of striking out was noted. The MAR did reflect non-pharmacological interventions to deter behaviors or symptoms related to her psychiatric diagnosis.

A review of the nursing notes for 3/1/25 through 3/21/25 revealed there were no behaviors or symptoms related to her psychiatric diagnosis. Specifically, on 3/6/25 there was no documentation as to what the compulsive behavior was, where the behavior occurred, what interventions were used to deter the behavior and the effectiveness of those interventions, and on 3/17/25 there was no documentation of what caused the documented behavior on the MAR, who did Resident #34 strike out at, where the behavior occurred, what interventions used and the effectiveness of those interventions. The physician progress notes indicated there were no behaviors or symptoms documented related to her psychiatric diagnosis.

Observations of Resident #34 on 3/19/25 at different times during the day noted no behaviors.

An interview conducted on 3/19/25 at 2:00 PM with Nurse Assistant #1 indicated that she was unaware of any behavioral issues related to Resident #34.

An interview conducted on 3/19/25 at 12:30 PM with Medication Aide #2 indicated that she was unaware of any behavioral issues related to Resident #34.

A telephone interview was conducted with the

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F 758	Continued From page 37	F 758		

Pharmacy Consultant on 3/20/25 at 8:23 AM revealed that he had requested a gradual dose reduction (GDR) in September of 2024 which was declined by the Physician due to Resident #34 was stable and a change in medication would risk decompensation. He stated that he does medication reconciliation reviews monthly and noted for Resident #34 that there had been marked non-pharmacological interventions used which meant (to him) that she was having a behavior of some type, and he had not noticed the behavior monitoring had reflected no behaviors. He further stated that he does not look at the Minimum Data Set assessment for behaviors. He indicated that he had sent another gradual dose reduction request to the physician for the month of March 2025 but had not received it back yet.

A telephone interview with the Nurse Practitioner on 3/20/25 at 10:13 AM indicated she had only been at this facility for a couple of months; however, she had no concerns regarding Resident #34's behaviors the three times that she had seen her. She was unable to answer why a GDR was not attempted or why the psychoactive medication was still ordered in light of no behaviors were exhibited.

An interview conducted on 03/20/25 at 11:14 AM with the Corporate Nurse Consultant stated that if the interventions were being used to prevent a behavior the documentation would be correct on the Medication Administration Record however, with the word deter the interventions are inappropriate because there are no behaviors marked. The MDS coding was correct due to the nurses coding no behaviors on the Medication Administration Record. She further stated that

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F 758	Continued From page 38	F 758		

there were times when if the resident was not in distress related to a behavior they were exhibiting, then an intervention is not needed.

An interview conducted on 3/20/25 at 11:45 AM with the Director of Nursing revealed education to the staff regarding documentation has taken place and the team will look at the MAR to decide how the documentation of non-pharmacological interventions will be documented. She further revealed she had planned to educate the staff on documentation of what the behavior is, why it occurred (as best they could), what interventions were used, and if the interventions were effective. She further stated that she had only been the Director of Nursing for a month and was unaware of Resident #34 having any behaviors.

A telephone interview with the Medical Director on 3/20/25 at 2:37 PM indicated that the nursing staff had not informed her of any behavioral issues related to Resident #34. She stated that she had not been the Medical Director for long, approximately 4 months, and was unable to state why a gradual dose reduction of Resident #34's psychoactive medication had not been completed or state the reason for the psychoactive medication.

An interview conducted on 3/20/25 at 2:15 PM with the Administrator revealed that Resident #34 should have been being seen by the psychiatric services and he was aware that a consultation request had been issued today. He further stated that he was unaware of any behaviors of Resident #34 other than when she was first admitted. He further stated that the process for all new admissions with a psychoactive medication was to ensure a psychiatric consult was made,

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F 758	Continued From page 39 that the reason for the medication still existed after the physician and psychiatric services had seen and evaluated the resident, and that if appropriate a gradual dose reduction be conducted or possibly a discontinuation of the medication. He indicated that Resident #34 had some how fallen between the cracks when she was admitted.	F 758		