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 10/27/2016

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

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F 000	INITIAL COMMENTS On 10/24/2016 until 10/27/2016 , the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an onsite revisit to a complant,a recertification survey and new complaints. While tags F157,F309 and F329 were corrected effective October 27, 2016, the facility remains out of compliance with tag F285, F371 and F520.	F 000		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental	F 285		11/17/16

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

Electronically Signed | 11/17/2016

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F 285	Continued From page 1 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to coordinate with the Preadmission Screening and Resident review Program(PASRR) for evaluation of PASRR for continued stay at the facility for one of one sampled resident with a level II screening(Resident # 1). The findings included: Resident # 1 was admitted to the facility on 6/11/2015 with multiple diagnoses including bipolar disorder, coronary artery disease, hyperlipidemia and hemiplegia. The resident ' s quarterly Minimum Data Set (MDS) dated 9/19/2016 indicated the resident ' s cognition was moderately impaired, exhibited delusions behavior and was verbally abusive towards others at least 6 to 4 days in a week. A review of the Preadmission Screening and	F 285	Submission of this response and Plan of Correction is not a legal admission that a deficiency was correctly cited. It is not to be construed as an admission of interest against the facility, the Administrator, Director of Nursing or any employee, agent or other individuals who draft or maybe discussed in this response or the Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged nor the correction of any conclusions set forth in this allegation by the survey agency. For the deficiencies cited during this survey, this facility has developed and implemented a facility-wide system to assure correction and continued compliance with the regulations. This	

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F 285	Continued From page 2 Resident Review (PASRR) Level II Determination Notification dated 3/13/2012 was conducted. The PASRR Number was noted to end in the letter F. The PASRR Expiration Date was 5/12/2012. The notification stated "If the resident is expected to extend beyond the end date, further approval and screening must be obtained through N.C. (North Carolina) Medicaid Uniform Screening Program. The admitting facility is responsible for initiating further screening through a Level II evaluation process, if appropriate, within five (5) calendar days of the PASSR expiration date. " An interview was conducted with Social worker on 10/26/2016 at 3:00 PM. She stated the application for the renewal of the PASSR level II for Resident # 1 had not been completed since its expiration date of 5/12/2012. She added in the future the PASSR Level II application for the residents at the facility will be completed before expiration dates. An interview was conducted with Administrator on 10/27/2016 at 4:11 PM. She reported the PASRR level II renewal was not completed for Resident # 1 because she was not aware the facility was required to renew PASRR level II. She added in the future she will make sure the applications for PASRR level II for the residents with mental illness or developmental disability will be completed timely.	F 285	facility will provide a complete copy of the deficiency list to the QAA Committee for review and appropriate actions. We would like you to accept this PoC as our credible allegation of compliance. Tag 285 D 1.Resident #1 PASSR Level II has been obtained on 10/26/16 2.All PASSR Level II has been reviewed 3.All PASSR Level II has been applied for that are outdated. 4.A PASSR Leger has been created to keep PASSR information in, This Ledger will be kept with the Social Worker, the MDS & Administrator. 5.An in service was conducted 10/31/16 with Social Worker, MDS & Administrator. 6.PASSRs will be reviewed every 30 days to ensure they are current and have not expired. 7.PASSRs will be reviewed in QA meetings	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		11/17/16

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F 371	Continued From page 3 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure dinnerware and 67 of 87 serving trays were in good condition, clean and adequate dinnerware was on hand to serve residents' meals. The findings included: 1. Observation was made on 10/26/16 at 11:53 AM of 67 of 80 serving trays that were greasy, discolored and chipped on the edges ready use. During an interview with the Administrator on 10/27/16 at 3:20 PM, she stated it is her expectation that residents' meals are served on serving trays that are in good condition and clean. During an interview with the Dietary Manager on 10/27/16 at 4:15 PM, he stated it is his expectation that resident's meals are served on serving trays that are in good condition and clean. The Dietary Manager further stated that the dietary staff should report to him when dinnerware and serving trays are looking worn. 2. Observation was made on 10/26/16 at 12:00 - 12:30 PM of the Cook on the serving line serving using Styrofoam (disposable) four ounce bowls for vegetables. A total of 27 four ounce Styrofoam (disposable) bowls were used.	F 371	Tag 371 E 1.Dietary Manager in-serviced staff to use paper products for emergency only and with authorization. Also, to use communication with Dietary Manager if par levels on small wares get low or unserviceable.11/14/16 2.Dietary Manager will perform a monthly inventory of all small wares and report to the administrator for purchase. This will be an on-going procedure for the manager. 3.Dietary Manager will communicate monthly to the administrator with monitoring tool attached for any dietary needs. 4.Small wares order placed and in house for 9" serving plates, 4 oz. fruit bowls, section plates and therapeutic serving plates as of November 4,2016. 5.Another order has been placed for serving trays and will be on- going to keep a par level of 1.5 in- house for each resident. 6.Dietary Manager will continue to do a daily walk through to ensure dishes are clean and serviceable. 7.Dietary Manager will report findings and remedies of corrective measures on-going, in QA meeting for review.	

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F 371	Continued From page 4	F 371		

a. A second observation was made on 10/27/16 at 8:24 AM of the Cook on the serving line serving grits in four ounce Styrofoam (disposable). A total of 27 four ounce Styrofoam (disposable) bowls were used.

During an interview with the Cook on 10/26/16 at 12:30 PM, stated that the facility has four dinnerware four ounce bowls on hand and that was why she was using the Styrofoam (disposable) bowls so that the food would not run together. The Cook further stated that the facility did not have enough sectional plates on hand or four ounce dinnerware bowls. The Cook stated that she had told the Dietary Manger that there were only a few dinnerware bowls on hand and additional sectional plates were needed.

During an interview with the Administrator on 10/27/16 at 3:20 PM, stated it is her expectation that residents' meals are served on dinnerware and serving trays that are in good condition and clean. The Administrator further stated that it is her expectation that food be served to residents on dinnerware and disposable should only be used in emergency situations.

During an interview with the Dietary Manager on 10/27/16 at 4:15 PM, stated it is his expectation that resident's meals are served on dinnerware and serving trays that are in good condition and clean. The Dietary Manager further stated that the dietary staff should report to him when dinnerware and serving trays are looking worn. The Dietary stated the facility was using Styrofoam (disposable) bowls due to shortage of dinnerware bowls.

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F 371	Continued From page 5 3. Observation was made on 10/26/16 at 12:20 PM of 3 plastic high rim sectional plates that were discolored, worn and peeling on the serving line. During an interview with the Administrator on 10/27/16 at 3:20 PM, stated it is her expectation that residents' meals are served on dinnerware and serving trays that are in good condition. During an interview with the Dietary Manager on 10/27/16 at 4:15 PM, stated it is his expectation that resident's meals are served on dinnerware and serving trays that are in good condition and clean. The Dietary Manager further stated that the dietary staff should report to him when dinnerware and serving trays are looking worn.	F 371		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		11/17/16

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F 520	Continued From page 6 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place in December of 2015 and in July 2016. The deficiencies were in the area of failure to provide and maintain a sanitary kitchen and dining room. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to F 371: Based on observation and staff interviews, the facility failed to ensure dinnerware and 67 of 87 serving trays were in good condition, clean and adequate dinnerware was on hand to serve residents' meals. During an interview with the Administrator on 10/27/2016 at 3:00 PM, stated that she was not aware of any concerns related to dinnerware and serving trays at the facility. She further stated the kitchen staff had not reported any concerns related to dinnerware or serving trays.	F 520	Tag 520 E 1.Dietary Manager has performed a monthly inventory of all small wares, dietary manager will perform a monthly inventory on all small wares, he will inspect condition of kitchenware. 2.Dietary Manager will use small wares inventory tool to track how much is on hand and what is needed and when it was last ordered 3.Small wares inventory tool will be audited once a month by Dietary Manager and data will be reviewed by Administrator 4.The QAA committee meeting will review plans of correction and monitor compliance for F 285 and F 371 at each QAA Committee meeting for a minimum of six months. 5.Trends identified will be presented to the QAA committee at each meeting by the NHA or designee and performance improvement plans will be developed as needed, implemented and monitored by the committee.	