STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345252	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/28/2014

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
The facility failed to provide accurate information on comprehensive assessments for 2 of 23 residents (Resident #2) by inaccurate assessment of oral/dental status and (Resident 104) by an inaccurate assessment of number of falls.

Findings included:

1.Resdient #15 was admitted to the facility on 1/7/2013.

Review of the resident's comprehensive Minimum Data Set (MDS) dated 12/24/2013 indicated under Section L "Oral/Dental Status" the resident had no dental issues.

Review of the Quarterly and Comprehensive assessment forms in the resident's record indicated these areas under "Oral Condition" 0=Own Teeth, dentures or removable Bridge 1=Few Teeth or Lost Dentures 2=Edentulous (No teeth) 3=Poor Condition or Difficulty Chewing. Review of nutrional assessments dated 1/7/2013, 3/29/2013, 7/3/2013, 9/22/2013 indicated the resident was documented under 0 on all the assessments.

The resident was observed and interviewed on 2/24/2014 at 4:35 PM. The resident stated she was missing a lot of her natural teeth and further reported before she came into this facility, she had 19 of her natural teeth

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1

pulled. She stated she had asked to go to a dentist since she had been here but was told she could not be seen by a dentist. She stated she did not recall to whom she had spoken about going to a dentist and further reported she had mentioned it several times since she was admitted but was always told her insurance would not cover it. She further stated she ate okay but just felt like she needed dentures to replace her missing teeth. Upon observation on 2/24/2014 at 4:35 PM, the resident's mouth was observed with no upper teeth, no teeth on either of the bottom side areas. The only teeth oberved in the resident's mouth were on the bottom in the front of the mouth. There were many black areas observed on the few remaining teeth along with chipped areas.

In an interview with Staff Nurse #1 MDS Staff on 2/26/2014 at 2:45 PM, the nurse reported she conducted the section L of the comprehensive MDSdated 12/24/2013 for resident #15. The nurse reported she used various means to complete the assessment of oral conditions. She stated she looked at the documentation of other staff in the resident's clinical record as well as conducting an interview with the resident. She stated she asked residents if they had dentures or any chewing problems. She also reported she looked at residents' mouths when she assessed them for oral issues. The nurse could not recall if she looked inside the mouth of resident #15 when she conducted the assessment. The nurse reported further that based on what she documented on the MDS, the resident had no oral/dental issues.

In an interview with the facility Director of Nursing (DON) on 2/26/2014 at 4:00 PM, the DON indicated the expectation for comprehensive assessments was the assessments should reflect the condition of the resident accurately.

2. Resident #104 was admitted on 8/27/13 with diagnoses of stroke with some paralysis on one side, cerebral artery disease, diabetes, and seizures.

The admission Minimum Data Set (MDS) dated 9/3/13 noted that Resident #104 was cognitively intact, and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical assistance of one to two persons. The Care Area Assessment (CAA) noted falls as an area of concern, and that falls would go to care plan.

The care plan dated 9/16/13 noted a focus of high risk for falls, and a goal of the resident will have no falls in the next 90 days, and no fall related injuries in the next 90 days. The interventions included: place frequently used personal items in reach of resident to right side. Ensure resident can easily locate the call bell and reinforce to the resident how and why to use the call light. Maintain a safe, clutter free environment. Be alert to pressure relief needs. Monitor for impaired skin integrity, such as red or open areas. Monitor for signs of deep vein blood clots such as: heat, swelling and pain in extremities. Monitor for signs and symptoms of infection, such as fever, lethargy, and mental status changes. Be alert to signs and symptoms of pain or discomfort. Monitor for dizziness, faintness, fatigue or shortness of breath with activity or increased anxiety.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 2

Keep bed in low position. Keep wheelchair brakes locked for safe transfers. Observe for decline in level of ability. Utilize appropriate amount of assistance as indicated. Occupational/ Physical therapy as ordered for mobility, safety, gait, transfers, and balance. Fall risk scale quarterly with med evaluation for indications for increased fall risk. Transfer with 1-2 persons in a manual assist. Place call light within reach. Encourage the res to call for assistance when needed and answer all calls promptly. Ensure that the resident has properly fitting, non-skid shoes. Remind the resident to ask for assist with transfers. Notify Physical Therapy of any falls.

The MDS dated 11/29/13 stated that the resident had a fall with no injury on 11/25/13. The 2/21/14 MDS noted no falls this assessment period.

A review of incident reports for Resident #104, revealed falls on 9/7/13, 9/28/13, 10/14/13, 11/25/13, 12/26/13, and 2/23/14.

On 2/26/14 at 4:23 PM, in an interview, the MDS coordinator stated that when she created an assessment for falls, she reviewed the nurse notes and any incident reports for the resident. The MDS coordinator stated that she did the chart review.

On 2/28/14 at 10:00 AM in an interview, the Director of Nursing (DON) stated that falls were reviewed in Quality Assurance meetings. The DON indicated that the types and times of falls were reviewed. If the times were patterned, then staff could be added for those times. The DON stated that her expectation was that the assessment would reflect the condition of the resident accurately.