PRINTED: 01/08/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONST			(X3) DATE COMP	SURVEY LETED
		345252	B. WING _				12/:	31/2015
	ROVIDER OR SUPPLIER	TION CENTER		214 LAN	ADDRESS, CITY, STATE, ZIP COD EFIELD ROAD NW, NC 28398	DE	1 12.	5172510
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 159 SS=B	483.10(c)(2)-(5) FACI PERSONAL FUNDS Upon written authoriz facility must hold, safe account for the person deposited with the facility must deposited in excess of \$5 account (or accounts) the facility's operating all interest earned on account. (In pooled a separate accounting funds that do not exceed bearing account, interpetty cash fund. The facility must estat that assures a full and accounting, according accounting principles, funds entrusted to the behalf. The system must precipied in the system in the s	ation of a resident, the eguard, manage, and nal funds of the resident cility, as specified in of this section. Disit any resident's personal on in an interest bearing that is separate from any of accounts, and that credits resident's funds to that accounts, there must be a for each resident's personal end \$50 in a non-interest rest-bearing account, or ablish and maintain a system of complete and separate to generally accepted to generally accepted to feach resident's personal end facility on the resident's clude any commingling of cility funds or with the funds nan another resident.	F	59				
	through quarterly stat the resident or his or	al record must be available ements and on request to her legal representative.						
	Medicaid benefits who	y each resident that receives en the amount in the aches \$200 less than the						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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.

AND DI AN OF CORRECTION IN IMPRED		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345252	B. WING _			C 12/31/2015
	ROVIDER OR SUPPLIER HEALTH & REHABILIT	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	·	12/3//2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 159	section 1611(a)(3)(I amount in the accounthe resident's other reaches the SSI res	ge 1 or one person, specified in B) of the Act; and that, if the unt, in addition to the value of nonexempt resources, ource limit for one person, the ligibility for Medicaid or SSI.	F1	59		
	by: Based on documer	IT is not met as evidenced station & interviews the facility t balancews were within \$ ity limit.				
		tation and interviews, the sre account balances were e eligibiity limit.				
	is being pulled late at December a little ur get clothes to keep comes out quite ofte catch. Lassiter- Nov pulled until Decemb	7 PM Harriett Darden- Liability and rolling to next month. In oder \$2,000.00. Told her to under. Do a preneed. She en. Have not been able to rember liability did not get er 3rd. DSS is guardian. NC tracks. Do not send				
	Eason- Getting SS a money back to SS a it, but she is still get and it has not stopp	PM Lassiter - Jennifer and SSI. Last year sent and spoke to Etle Barns aboyt ting SSI. MOney sent back ed. ut money. Don't know reason				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345252	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	040202	1	STREET ADDRESS, CITY, STA	TE. ZIP CODE	12/31/2015	
	HEALTH & REHABILITA	TION CENTER	214 LANEFIELD ROAD				
				WARSAW, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		
F 159	Continued From page	2	F 1	59			
	she is getting money. message.Talked to St fam or DSS	1/22/15, left a S. Did not send latters to					
	-His wife and grandau She pays PML. Get s money again. Do not now. Letters sent to fa a preneed. Need to g	PM Frank Fauser- Lassiter ughter handling his PML. tatement and she sends have a set PML on him right amily member, trying to get et account straight. Calls bid not send letters to fam or					
	is aware of it. Talked of doing spending on letters to fam. 12/31/2015 1:28:49 F. Hospice fr a while- un	PM Francis Houston- owing up in NC track. Family to fam. about it. In process her account. Did not send PM Mary Johnson- on older \$2, 000.00. On hospice o pull. Right now she is					
F 160 SS=B	Make sure when see certifaied letter to mal certified letter. 483.10(c)(6) CONVE	PM Admin Expectation: that money is over send ke sure they receive it. Do a YANCE OF PERSONAL H	F 1	60			
	deposited with the fac within 30 days the res accounting of those for	esident with a personal fund cility, the facility must convey sident's funds, and a final unds, to the individual or dministering the resident's					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345252	B. WING _			C 12/31/2015
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 214 LANEFIELD ROAD WARSAW, NC 28398	DE	12/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	DATE
F 160	by:	T is not met as evidenced	F 1	60		
	facility failed to forwaresident 's personal for two of four reside	ation and interviews, the ard the balance of expired funds to the Clerk of Court nt personal fund accounts #40 and Resident #108				
	The findings included	d:				
		xpired on 6/6/15. On 6/9/15, a check for \$250.00 to a				
	Business Office Man facility was not the passocial Security. She family member made beauty shop appoint She stated the family for Resident #108's passocial was deposited into hoffice Manager Assis 's family member red	on 12/31/15 at 11:31 AM, the ager Assistant revealed the ayee for Resident #108 's stated Resident #108 's edeposits in her account for ments and it depended on. If member also wrote a check patient liability and the money er account. The Business stant revealed Resident #108 quested the balance of count be forwarded to the ne expired.				
	Business Office Man #108 's family memb forwarded to the fund	on 12/31/15 at 10:14 AM, the ager revealed Resident per wanted the money to be eral home, however she all have been forwarded to				
		on 12/31/15 at 1:00 PM, the her expectation was the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345252	B. WING			C 2/31/2015
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	12	131/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 160	money should have be Court. 2. Resident #40 exphis personal fund accurate was withdrawn from this patient liability/rood. During an interview of facility Business Office #40's family member account before he exthought the money waccount before Resident re expired. During an interview of the Business Office Mesident #40's family	pieen sent to the Clerk of spiece on 11/7/15. Review of count revealed \$4,771.80 his account and applied to om and board. In 12/31/15 at 10:14 AM, the see Manager stated Resident or wanted to clear her pired. She revealed she as withdrawn from the lent #40 expired instead of in 12/31/2015 at 11:28 AM, Manager Assistant revealed by member requested that	F 16			
F 161 SS=C	supposed to be application the resident still owed revealed she was now have been forwarded. During an interview of Administrator stated is money should have becourt. 483.10(c)(7) SURETY PERSONAL FUNDS. The facility must pure otherwise provide assessed as Secretary, to assure the resident still owe of the resident still owe o	40 owed the facility, it was ed to his bill. She reported the facility \$39.36. She waware the money should to the Clerk of Court. In 12/31/15 at 1:00 PM, the ner expectation was the been sent to the Clerk of Y BOND - SECURITY OF shase a surety bond, or surance satisfactory to the the security of all personal posited with the facility.	F 16	.1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345252	B. WING		42	C
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398		2/31/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 161	Continued From page		F 1	61		
	by: Based on staff intervi provide a surety bond	is not met as evidenced lews, the facility failed to I to protect resident funds for with personal fund accounts ty.				
	The findings included	:				
	AM the Administrator copy of the surety bor	n 12/31/2015 at 10:10:10 revealed she did not have a nd. She stated the surety prate office was closed and eopen until Monday.				
	Business Office Mana Office Manager did no bond and they had be	n 12/31/15 at 10:30 AM, the ager revealed the Business of have copies of the surety een trying to get the surety ate office for the past couple				
F 241 SS=D	the Administrator reve out of her hands. She they copy of the suret 483.15(a) DIGNITY A	•	F 2	41		
	manner and in an env	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.				
	This REQUIREMENT by:	is not met as evidenced				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345252	B. WING		C 12/31/2015
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	12/31/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 241		ervations the facility failed to of two dining rooms were	F 24	41	
		ervations the facility failed to of two dining rooms were be fed.			
	tater tots, fish stcks, s 12/28/2015 12:55:03	slaw, tea, water, bread- PM			
	flies landing on food				
	7 res. at table. 12/28 feeding res. sitting in	3/2015 1:10:23 PM 1 staff geri chair			
	12/28/2015 1:10:35 fam. member feeding 1 res. in room has no				
	8;39am- three reside eating . two staff feed residents in dining ro on cart. Two resident resident in a geri char margaret being fed. resident in geri chair geri chair- staff place resident. 8;46 am- re feeding res. while she	om. three residents trays still as at main table and one ir. 843 am resident 1 male res at table and not being fed. Resident in d tray on table beside sident now being fed. staff e is in geri chair. Not dining res. at table being fed. Now			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		, ,	PLE CONSTRUCTION G	' '	COMPLETED		
		345252	B. WING		1	C 2/31/2015	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398		2/3 1/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 241	Continued From pag	e 7	F 24	41			
		esidents sitting at table One resident sleep with her					
		AM 12 residents in dining eing fed by staff person. i chair.					
	on tabe for other resi on table, one on res. plate cober, Flies one of resident apple juic tray, on res tray, on r staff. 12/30/2015 8:5	AM Breakfast trays placed dents. Three flies observed table cover, one on res. served on res. trays, on top e, on residenttray, on res, res. tray, while being fed by 8:58 AM landing on res arm on table. fly on female res.					
	12/30/2015 8:59:14 being fed. other res	AM one res. sitting in w/c not eating.					
	12/30/2015 8:59:54 swatting away flies.	AM Res. at end of table					
		AM Another res brought into her res. eating and not being males					
	12/30/2015 9:04:49	AM flie on me. fly on table.					
		AM res sitting in geri chair e now being fed. two flies g on table.					
		AM one res. still not fed dining room. fly on table and AM fly on table.					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345252	B. WING				31/2015
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CENTER	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD NARSAW, NC 28398	· · -	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From pag	ne 8	F	241			
	12/30/2015 9:10:36 one on plate cover,	AM three flies, one on table,					
	12/30/2015 9:11:26 at table, two eating.	AM two flies on table. six res					
	12/30/2015 9:12:58 arm of res geri chair	AM fly on table, fly on res sitting in recliner					
	12/30/2015 9:15:03	AM fly on res finger					
	12/31/2015 8:49:06 AM 10 residents 3 staff feeding three res resident sitting next to tv has not received tray to be fed, one staff at table. one staff feeding res. next to chri tree. one staff						
	12/31/2015 8:51:22 near first door not fe	AM Male res. at end of table d yet					
	12/31/2015 8:54:11 from res. tray. At fro	AM Staff member swatted fly nt end of table.					
		AM Fly landing on res, ies landing on coffee cups.					
	12/31/2015 8:56:37 res. at end of table.	AM fly landing on napkin.					
	12/31/2015 8:59:04	AM fly landing on tray top.					
	12/31/2015 9:00:45 cup.	AM Fly landing on res. coffee					
	12/31/2015 9:01:16	AM staff swatting fly away.					
	1. walter wilson 12/	/31/2015 9:05:21 AM					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345252	B. WING				C 31/2015
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CENTER	l	2	TREET ADDRESS, CITY, STATE, ZIP CODE 14 LANEFIELD ROAD VARSAW, NC 28398		5 II 25 I 5
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	staff member came i 9. dwight moore 10 monica simmons 12/31/2015 9:07:19 food 12/31/2015 9:07:51 12/31/2015 9:08:54 fly away while feedin 12/31/2015 9:10:00 forehead. staff swatt 12/31/2015 9:12:32 front of monicas tray 12/31/2015 9:19:31 15 yrs Revealed the Yes, real bad and race Comany comes in alseen worst. Res. has Deal with best they comed five best they can think for day. Was off today her 12/31/2015 9:25:15	2015 9:04:21 AM fed . Fourth in to finish feeding monica. AM fly on lorraine taylor's AM fly on lorraine taylor tray AM Staff member swatting g monica. AM fly landed on ann nunn's ed away. AM fly landing on plate top in the sed away. AM Frances Edmonds, NA, e fly problem is real bad. Sches, Report it, not better. Shout a month and spray, have be complained. an. Need more help. people back there. Do the pour is enough. Every elping out. AM Deborah Bell, NA, 4 obem. Every day. Kill, report in provement.	F	241			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	COMPLETED		
		345252	B. WING		C 12/31/201	5	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	12/3/12013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLI	ETION	
F 241	waiting so long. Happer reported to anyone. Toom. 12/31/2015 9:31:16 Yes, when hot outside room. Have fly swatth Sometime sres comparts of the hall, and tghat or have extra person. Had five aides at one	AM Kerry Bizzell. NA, 3yrs., de it is bad. Some in ding ers, Admin, a while back. blain. The ones that feed on any front. 1 has to feed on ally leave with two. unless lave to do the best you can. et time. but cut down to four other person to mote dispersion of the person to monitor the	F 24				
	Have seen some flie comes in. Do not know usally call maintenant doors opened i up wo Not with her personal res. that are able to fithen get residents the few minutes in between more aides. 12/31/2015 12:27:40 No one has reported fan. Do not know if the Expectation: Want flie someone. Expect staffly swatters at this posmaintenance.	I res. complints. Usually get reed themselves first and at are totally fed. May be a ren. Thinks there needs to be of PM Barbar Johnson, DON Know she has flies. Turn on they can hang fly strips. The ses gone, but will talk to refer to keep flies away and get					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345252	B. WING _			C 12/31/2015
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398		12/31/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241	remains back there. other than staff delay eat now. Expectation all residents. Someon someone would have available to go. She of 12/31/2015 12:54:4 have been flies with Maintenance guy sa Expectation: Might go prevent flies from there are pribelm. So write it on clipboard. 12/31/2015 12:57:4 Expectation; Was now would find someone one had told her about 12/31/2015 1:43:50 Directo- No one report dining room. Have a	big dining room and one Some residents for reason yed in being fed, dont want to n: Have enough staff to feed one would have to wait the towait until someone is lid not know it was a problem. 6 PM Admiin, Ingrid- There last couple of days. id light would zap them. let more of lights to get more coming in. Let staff know if taff will leave her a note or 1 PM Admin. Ingrid- ot aware of it. If know about it else to help with feeding. No	F 2	41		
	control came today. Sometimes comes in terms of what he can down hallway. purple boards. One in dinin on rehab hall and or hallway from cocomithem at best location on door riser room of	Comes once a mont. In twice. He is limitedd in a do. Fly tary located up and the fluerecent light with glue groom two in kitchecn. ONe are on abc hall. Outside in the ut ding room. Orkin placed as. Process: Have clipbiard door. If have prob. wite the er, etc. He keeps the				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345252	B. WING			1	C 31/2015
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	TION CENTER	'	214	EET ADDRESS, CITY, STATE, ZIP CODE LANEFIELD ROAD RSAW, NC 28398	1 12/	5 II 25 15
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 241	Was not aware about they try to get them. Smaintenance if they small	PM Donna Allsbrook, RN,- flies. They do get in and Staff should call ee pests. PM Donna Allsbrook, RN- ncern about residents e said normally they would b: Get enough staff in dining	F	241			
F 328 SS=D			F	328			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		345252	B. WING		C	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	12/31	//2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 328	Continued From pag	e 13	F 32	28		
	facility failed to refer	riews and observations, the a resident to a podiatrist er for a resident with long,				
	6/16/10, DMII, Anem beh., Paranoid schiz major depressive dis parkinsons, Insomni related Nuclear cata	a, Mononeuropathy, Age rract, Macular Cyst, ension, nontraumatic				
	Help with bath. Help make bed serve tray ups. Quite person. It say anything unless except if has accided Sometmes assit her back and bootom do diabetic- send to pook Make sure feet claer podiatrist to get clipped in a couple of weeks clipped. Let nurse kny podiatrist. Was here she needed to go to and Juanita on first surplements.	PM Monica Hill, NA- 1year. with cootherb if needed has accidents help with pull loes not ask for a lot. Will not shurts. Toilets inedpendently. Int. Does not resist care. with nathing cannot wash it for her. Nail care- she is a diatrist to have them clipped. In and wahsed. Send to loed. First day worked withher so. They do need to be how and do a referral for Sunday and Nurse informed podiatrist. Ms. Cynthia- 3-11 shift. Nursev told on both wrote her name down to see				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, ST 214 LANEFIELD ROAD WARSAW, NC 28398	TATE, ZIP CODE	12/31/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)	DATE	N	
F 328	both feet. toe nail on over toe, 1/2 of an incover toe, 1/2 of an in	PM Observed toenails on left foot curled toward right ch long. Toe nail on right ter inch long. Ms. Nobles thurt. 5 Res. on shower list today. a shower. Res. toe nails cheduled. Podiatry closed siting. Colleen Res. refuses to showr. SN o soak res. feet. SN washed cream, clean under toenails k file to toenails to moderate apt to get into podiatrist. I 2nd week on Jan. 2016.	F3	28				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		INSTRUCTION	' '	SURVEY PLETED
		0.45050	D WING				С
NAME OF PE	ROVIDER OR SUPPLIER	345252	B. WING _	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	12	/31/2015
	HEALTH & REHABILITA	TION CENTER		214 L	LANEFIELD ROAD RSAW, NC 28398		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	Continued From page	e 15	F3	28			
	12/28/15 MD note in	chart- Referral to Podiatrist.					
	daughter stated she with a podiatrist in Gr 2016 and she wanted would transport Ms. Not want to make the facility would transport 12/29/2015 4:42:54 I and she stated they with the podiatry appt. So but she might want the facility to see if she corefused to go on the attransport res to podiat 1/4/16 at 3:00 PM.	PM Talked to Administrator would transport Ms. Nobles scheduled by her daughter, se daughter to come to build talk to Ms. Nobles if she appt. She stated staff would try appt. in Greenville on					
		PM Informed Ms. Maultsby, Ms. Nobles to appt. on					
	Tx. nurse, Refused to remember if tee to go b/c of dis . will not hel verify if referred to po SW will usally let Tran Monday spoke to ms soaked her feet anbp toe nails not too close on mood. Has appt. In Would not let her tout them down. moisten.	AM Colleen Rivenbark, LPN, o let her cut them, Cant et podiatrist or not. Refuses lp bathe or anything. Can't diatrist. Not aware of appt. Inspot know about appts. On Magnolia washed and t thrity minute and trimmed et at approp lenght. Depends informed upcoming appt. In the control of the c					

PRINTED: 01/08/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345252	B. WING				34/2045	
NAME OF P	ROVIDER OR SUPPLIER	040202	1 2		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	31/2015	
	HEALTH & REHABILITA	TION CENTER		2	14 LANEFIELD ROAD VARSAW, NC 28398			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOULD E			(X5) COMPLETION DATE	
F 328	them to see when perassessment in Dec. Weeded services. But to Dr. Ucata when ship Daughter and her dis location. Daughter had into building to actual some. Not sure about arrangement for it to sometimes not allow spray perfume to thin care. Appt. book kept in baprgress section to see and she wil call back be referred. 12/30/2015 4:24:33 Fourved to right over to toenail thick 1/2 inch. MDS Coordinator Care Plan, CAAS, As 12/31/2015 9:57:54 A Daughter came and graw toenails as ling and and diabetic. Usually Aide but she did not know 12/31/2015 12:21:01 DON, Notified on Mor Daughter came to he	nake appt. might go behind rson has had an appt. Did Vill refuse personal care. It she refused. She took her e was transporting. Cussed going tgo Greenville is agreed to come out to go ly have it done. Try to fill in the tit. Should have prob. made be done. Sometimes will staff to do anything. Will k you have had personal compared to the compared t	F	328				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		0.45050					C
NAME OF D		345252	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	31/2015
NAME OF PI	ROVIDER OR SUPPLIER				14 LANEFIELD ROAD		
WARSAW	HEALTH & REHABILITA	TION CENTER			ARSAW, NC 28398		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371 SS=E	Expect nails to be clip Treatment nurse can prefer tx nurse. If una 12/31/2015 12:50:33 Made a referral- Tell vgo. Whether refusal a MD appt. If try and refamily know there is a address but she is no 12/31/2015 2:11:53 If Supposed to make a did not get done. Bar appt. Notofied about Monday. Nurses usua podiatry appt. for feet tme. Expectation: Ma podiatry appt. if toena 483.35(i) FOOD PROSTORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and (2) Store, prepare, dis under sanitary condit	s because res refuses oped as other residents. clip nails or nurse on cart able to do referr to podiatrist. PM Admin Expectation- what happned - why did not and let family know about sident kept refusing so a prob and they try to ot letting you. PM Donna Allbrook, RN, referral. Do not know why it bara Malpass makes all the toenails being long on ally cut toenails. Make as She will cut nails at any ke sure resident have a ails are long. DCURE, ERVE - SANITARY		371			
		ns and staff interviews the ain kitchen equipment clean					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3	(X3) DATE SURVEY COMPLETED		
		345252	B. WING			C	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	l	12/31/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 371	Continued From pag	e 18	F 3	71			
	illness by failing to cl	dition to prevent food borne ean four of four sheet pans, am tables and failed to clean					
	Cook, under Assignm (dining room) Steam Conventional Oven. 1. During the initial kit manager on 12/28/15 oven was observed. top of the convection black food residual 1 the outer edges of th A second observation sheet pans stacked owere observed with thick baked onto the third observation on sheet pans stacked owere observed with thick baked onto the 2. During a kitchen of 4:04 PM the 4 foot unshelf was observed oparticles. The four foattached to the steam that was observed winner edges of the shape A second observation 4 foot underside of the observed covered will the four foot wooder.	ted Healthcare Services PM ment, reads; "Clean DR table, Degrease " tchen tour with the dietary 5 at 9:27 AM the convection Four sheet pans stacked on oven were observed with /8th inch thick baked onto e pans. n on 12/30/15 at 8:47 AM two on top of the convection oven olack food residual 1/8th inch outer edges of the pans. A 12/20/15 at 10:05 AM four on top of the convection oven olack food residual 1/8th inch outer edges of the pans. bservation on 12/29/15 at nderside of the steam table covered with dark dried food out wooden steam table shelf in table had a 1/2 inch gap ith dried food particles on the neelf. In on 12/30/15 at 8:47 AM the ne steam table shelf was th dark dried food particles. In table top shelf attached to					
	observed with dried fedges of the shelf.	a 1/2 inch gap that was food particles on the inner During a third observation on the steam table was					

STATEMENT OF D AND PLAN OF COI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(С
		345252	B. WING			12/	31/2015
	IDER OR SUPPLIER ALTH & REHABILITA	TION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 14 LANEFIELD ROAD VARSAW, NC 28398		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
ob 3 . ma ov ins bla ind A : the rig ob foo In 12 in the Sh cle that it he us wh F 431 48 SS=D Th a I Go co acc recorrect.	anager on 12/28/15 yen was observed. The side the convection ack greasy buildup ches wide and deep second observation are convection over the conv	same condition. Itchen tour with the dietary is at 9:27 AM the convection The front right lower shelf oven was observed with of charred food residual 2 o. In on 12/31/15 at 10:12 AM was observed. The front the the convection oven was greasy buildup of charred as wide and deep. The Dietary Manager on If he revealed that first thing these a walk thru of the kitchen, staff what needs cleaning. If worked on cleaning the the would add that onto the the Dietary Manager stated wen was cleaned weekly but the diet his week. He stated that medule but had not been did not keep a record of the diet.		431			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345252	B. WING		C 12/31/2015	
	ROVIDER OR SUPPLIER HEALTH & REHABIL	ITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398		12/3//2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 431	appropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and permit have access to the The facility must proper manently affixe controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districtions.	oles, and include the sory and cautionary are expiration date when a State and Federal laws, the all drugs and biologicals in ants under proper temperature it only authorized personnel to exeys. Tovide separately locked, and compartments for storage of ated in Schedule II of the rug Abuse Prevention and a and other drugs subject to an the facility uses single unit ibution systems in which the minimal and a missing dose can	F 43			
	by: Based on observation interviews, the facinsulin from 2 of 4 include: The 2006 America Pharmacists and Medications with Stated vials of Nov discarded 28 days 1a. On 12/31/15 at medication cart for made with Med (M #1. There were 2 b	NT is not met as evidenced Ition, record review and staff lity failed to remove expired medication carts. The findings In Society of Consultant MED-PASS, Inc. Appendix 29: Inhortened Expiration Dates loog Insulin should be after being punctured. In 9:45AM, an observation of the residents in rooms 55-76 was edication) Tech (Technician) mottles of Novolog Insulin with corrate residents and both were				

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45050				С	
		345252	B. WING _		<u> </u>	12/31/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WADCAW	LICALTU O DELIADULTA	TION CENTED		214 LANEFIELD ROAD			
WARSAW	HEALTH & REHABILITA	HON CENTER		WARSAW, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 469 SS=D	Tech stated that both facility and both resid Novolog Insulin. The gave the insulin and vexpiration dates prior The Director of Nursir interview on 12/13/15 the insulin and should the 28 days after ope Insulin from the medic vial of insulin. 1b. On 12/31/15 at 10 the medication cart for through 17 was made one bottle of Novolog 11/3/15. Nurse #1 staname was on the both had a current order for bottle of Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the order for Novolog Insucart with another resident was still in the	residents were still in the ents had current orders for Med Tech stated the nurses were supposed to check the to giving the insulin. Ing (DON) stated in an at 12:46PM the nurses give I look at the date and if past ned should remove the cation cart and get a new 10:15AM, an observation of or residents in rooms 1 with Nurse #1. There was Insulin dated as opened on ted the resident whose the was still in the facility and or Novolog Insulin. A second willin was observed on the dent's name and was dated 5. Nurse #1 stated the e facility and had a current willin. Ing (DON) stated in an at 12:46PM the nurses give I look at the date and if past ned should remove the cation cart and get a new INS EFFECTIVE PEST	F 4				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	OATE SURVEY COMPLETED
		345252	B. WING			C 12/31/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	!	12/3 //2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 469	Continued From pag	e 22	F 4	69		
	by: he facility failed to m	T is not met as evidenced naintain a pest free dining dining rooms with flies.				
	_	naintain a pest free dining dining rooms with flies.				
	tater tots, fish stcks, 12/28/2015 12:55:03	slaw, tea, water, bread- PM				
	flies landing on food					
	7 res. at table. 12/28 feeding res. sitting in	3/2015 1:10:23 PM 1 staff geri chair				
	12/28/2015 1:10:35 fam. member feeding 1 res. in room has no	-				
	8;39am- three reside eating . two staff feet residents in dining ro on cart. Two residen resident in a geri cha margaret being fed. I resident in geri chair geri chair- staff place resident. 8;46 am- re	AM food arrived 8;30 am - ents not fed, other resdents ding two residents. 9 som. three residents trays still ts at main table and one air. 843 am resident 1 male res at table and not being fed. Resident in ed tray on table beside esident now being fed. staff e is in geri chair. Not dining				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION IG	· ,	(X3) DATE SURVEY COMPLETED	
		345252	B. WING			C	
	ROVIDER OR SUPPLIER HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP COD 214 LANEFIELD ROAD WARSAW, NC 28398		2/31/2015	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 469	Continued From pag	e 23	F 4	69			
	table. 8;47 am male 4 staff in dining room	res. at table being fed. Now 1.					
	1	desidents sitting at table One resident sleep with her					
12/30/2015 8:44:35 AM 12 residents room. one resident being fed by staff resident sitting in geri chair.	eing fed by staff person.						
	on tabe for other res on table, one on res. plate cober, Flies on of resident apple juic tray, on res tray, on staff. 12/30/2015 8:5	AM Breakfast trays placed idents. Three flies observed table cover, one on res. served on res. trays, on top i.e, on residenttray, on res, res. tray, while being fed by 8:58 AM landing on res arm is on table. fly on female res. e.					
	12/30/2015 8:59:14 being fed. other res	AM one res. sitting in w/c not eating.					
	12/30/2015 8:59:54 swatting away flies.	AM Res. at end of table					
		AM Another res brought into their res. eating and not being emales					
	12/30/2015 9:04:49	AM flie on me. fly on table.					
		AM res sitting in geri chair e now being fed. two flies g on table.					
	12/30/2015 9:07:51	AM one res. still not fed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345252	B. WING		C 12/31/2015	
NAME OF PROVIDER OR SUPPLIER WARSAW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398		12/31/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 469	on plate tops 12/30/2015 9:09:10 12/30/2015 9:10:30 one on plate cover, 12/30/2015 9:11:20 at table, two eating 12/30/2015 9:12:50 arm of res geri chair 12/30/2015 9:15:00 12/31/2015 8:49:00 feeding three res. not received tray to staff feeding res. not 12/31/2015 8:51:20 near first door not for 12/31/2015 8:55:30 lorraines food. two 12/31/2015 8:56:30 res. at end of table.	in dining room. fly on table and AM fly on table. AM three flies, one on table, AM two flies on table. six res AM fly on table, fly on res ir sitting in recliner AM fly on res finger AM 10 residents 3 staff resident sitting next to tv has be fed, one staff at table. one ext to chri tree. one staff AM Staff member swatted fly ont end of table. AM Fly landing on res, flies landing on coffee cups. AM fly landing on napkin.	F 46	9		
	cup.	5 AM Fly landing on res. coffee				
	12/31/2015 9:01:10	6 AM staff swatting fly away.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345252	B. WING			1	31/2015
NAME OF PROVIDER OR SUPPLIER WARSAW HEALTH & REHABILITATION CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD VARSAW, NC 28398	<u> 121</u>	31/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 469	Continued From pag	e 25	F	469			
	staff member came i 9. dwight moore 10 monica simmons 12/31/2015 9:07:19 food 12/31/2015 9:07:51 12/31/2015 9:08:54 fly away while feedin 12/31/2015 9:10:00 forehead. staff swatth 12/31/2015 9:12:32 front of monicas tray 12/31/2015 9:19:31 15 yrs Revealed the Yes, real bad and race Comany comes in also seen worst. Res. have Deal with best they can think for day. Was off today here	2015 9:04:21 AM fed . Fourth in to finish feeding monica. AM fly on lorraine taylor's AM fly on lorraine taylor tray AM Staff member swatting g monica. AM fly landed on ann nunn's ed away. AM fly landing on plate top in . AM Frances Edmonds, NA, ie fly problem is real bad. Ches, Report it, not better. Sout a month and spray. have be complained. San. Need more help. people back there. Do the bur is enough. Every					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		345252	B. WING _			C 12/31/2015	
NAME OF PROVIDER OR SUPPLIER WARSAW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 469	housekeepers. No in Dont have enough is Smetimes feed two waiting so long. Hay reported to anyone. room. 12/31/2015 9:31:16 Yes , when hot outs room. Have fly swaft Sometime sres comed 4 na-, 1 to kitchen, 2 themeselves first. Moserve in there, one of the hall, and tghat of have extra person. Had five aides at one aides. They want are halls, but that's hard 12/31/2015 9:52:00 Have seen some flick comes in. Do not know usally call maintened doors opened in up on Not with her person res. that are able to	robem. Every day. Kill, report improvement. staff to feed each res. at a time so they will not be opens everyday. Have not Just do it. More help in dining of AM Kerry Bizzell. NA, 3yrs., ide it is bad. Some in ding iters, Admin, a while back. Inplain. The ones that feed lost are up. 1 dining room from up front. 1 has to feed on only leave with two. unless Have to do the best you can. Ite time. but cut down to four nother person to monitor the it to do. AM Sharon Sholar, LPN, es. Maintenance usually low if been reported. Would nce. Not all the time, but	F 4	· · · · · · · · · · · · · · · · · · ·			
	more aides. 12/31/2015 12:27:4 No one has reporter fan. Do not know if the Expectation: Want f	40 PM Barbar Johnson, DON-d. Know she has flies. Turn on they can hang fly strips. lies gone, but will talk to taff to keep flies away and get oint. Report it to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345252	B. WING		C 12/31/2015	
NAME OF PROVIDER OR SUPPLIER WARSAW HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	12/3/12013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRENCED TO THE APPRENC	JLD BE COMPLETION	
F 469	DON, - One goes to remains back there. other than staff delayeat now. Expectation all residents. Someosomeone would havavailble to go. She do 12/31/2015 12:54:4 have been flies with Maintenance guy sa Expectation: Might go to prevent flies from there are pribelm. So write it on clipboard. 12/31/2015 12:57:4 Expectation; Was now would find someone one had told her about 12/31/2015 1:43:50 Directo- No one report of the properties of what he can down hallway. Sometimes comes in terms of what he can down hallway. purple boards. One in dinin on rehab hall and or hallway from cocomit them at best location.	O PM Barbara Johnson, big dining room and one Some residents for reason yed in being fed, dont want to he Have enough staff to feed one would have to wait to to towait until someone is id not know it was a problem. O PM Admiin, Ingrid- There last couple of days. id light would zap them. to the more of lights to get more coming in. Let staff know if the taff will leave her a note or to help with feeding. No	F 46	69		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED			
		345252	B. WING		C 12/31/2015	
NAME OF PROVIDER OR SUPPLIER WARSAW HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	12/31/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION	
F 469	records.	er, etc. He keeps the	F 46	69		
	Was not aware of co waiting to be fed. Sh	PM Donna Allsbrook, RN- oncern about residents he said normally they would on: Get enough staff in dining ill not have to wait.				
	(C) Pest Control (Re	•				
	that apply) = 1 (B: Walls, flo furniture are not clea	ollowing observed? (Mark all ors, ceilings, drapes, or an or are in disrepair) of insects or rodents in oms)				
	Observed one roach the bathroom.	12/29/2015 08:25:44 AM) In the corner by the door in as 2 holes in the door.				