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 05/05/2016

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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to assess a Geri-chair as a restraint, failed to obtain a physician ' s order and failed to provide a medical symptom for the restraint for 1 of 3 residents reviewed for restraints (Resident #1). The findings included: Resident #1 was admitted to the facility on 10/10/13 and had a diagnosis of Psychosis, Mild Intellectual Disabilities, Osteoporosis and a history of falls with fractures. The resident ' s Care Plan for falls dated 10/30/13 noted the resident was at risk for falls and had osteoporosis. The Care Plan interventions included the following: Transfer with 1-2 person manual assist, non-skid shoes, low bed with mattress on the floor when in bed, wheelchair and bed alarms to alert staff of unsafe movement. The Care Area Assessment (CAA) dated 11/13/15 for Cognitive Loss/Dementia revealed the resident was forgetful and easily confused. The CAA dated for Activities of Daily Living (ADLs) revealed the resident was dependent on staff for ADLs. The CAA for Falls revealed the resident had a balance problem during transitions and had a history of walking very fast with a shuffled gait and a history of falls. The Care Plan updated 3/16/15 revealed the resident was at high risk for falls, was very unsteady and would ambulate by pushing	F 221	Submission of this response and Plan of Correction is not a legal admission that a deficiency was 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 may be 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 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.	5/19/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/19/2016

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F 221	Continued From page 1 wheelchair. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 2/16/16 revealed the resident had short and long term memory loss and had moderate cognitive impairment. The MDS revealed the resident required extensive assistance for transfers and ambulation in room or corridor. The MDS revealed the resident ' s balance during transitions and walking was not steady and was only able to stabilize with human assistance. The MDS revealed the resident had 2 falls with no injury since the last assessment. The MDS revealed the resident did not have a restraint. A physician ' s progress note dated 2/23/16 noted the most significant problem was her repeated falls for multiple reasons, including her frailty, muscle weakness, disequilibrium and her psychiatric problems. The current medications were reviewed, specifically looking for anything that might contribute to her falls. She is actually on minimal medication and rehabilitation potential and prognosis was poor. A nurse ' s notes dated 4/15/16 (7A-3P) read: " Wheelchair has been replaced by Geri-chair due to res. (resident) continuing to get OOF (out of) chair and attempting to ambulate without assistance. " The note revealed a chair alarm was in place and the Geri-chair was most appropriate for the resident at that time. Review of the clinical record revealed no assessment for the Geri-chair as a restraint, no medical symptom for a restraint and no physician ' s order for a Geri-chair. Review of the current Care Plan revealed no information regarding a Geri-chair or a restraint. On 5/4/16 at 12:20 PM Resident #1 was observed in a Geri-chair and was reclined in the chair.	F 221	A. Corrective action has been accomplished for the resident found to have been affected by the deficient practice described in the following: 1.Resident #1 has been assessed by MDS Nurse for use of Geri-chair; MDS section P4 Restraints. 2.Physicians order has been obtained for Resident #1 use of Geri-chair. 3.Resident #1 medical symptom for the use of Geri-chair has been addressed in Physician's order and MDS. 4. Resident #1 Plan of Care has been updated. 5.QA team reviewed use of restraints in facility. B. The MDS Nurse will compete restraint Pre-Assessment tool on all residents and when applicable Restraint Determination form. C. The MDS Nurse or designee will obtain physician order for use of restraint. D. MDS Nurse will re-evaluate restraints quarterly using the Restraint Determination form and the restraint Elimination Assessment tool ,when a restraint is used. E. ADON will lead IDT committee to review restraints/falls monthly. F. Restraint and falls data will be reviewed by QA team.	

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F 221	Continued From page 2 On 5/4/16 at 12:25 PM the NA (nursing assistant) assigned to Resident #1 on the day shift stated in an interview the resident was in a Geri-chair because it was more comfortable for the resident. The NA stated the resident could not get out of the Geri-chair and she had not observed the resident trying to get out of the chair. 5/4/16 at 2:14 PM Nurse #1 stated in an interview the charge nurse and the physician looked at the resident and decided she would be better in the Geri-chair. The Nurse stated the chair would keep her from falling. On 5/4/16 at 3:15 PM the MDS Nurse stated in an interview the facility was restraint free and the Geri-chair had not been assessed as a restraint. The MDS Nurse stated she did not have an assessment tool for determining if a resident needed a restraint. The MDS Nurse stated the interdisciplinary team had discussed the resident ' s falls and had tried many options to prevent the resident from falling. The MDS Nurse stated they tried a reclining, high-backed wheelchair and she would still get up. The MDS Nurse stated if the Geri-chair was in an upright position she could get up and that was why she had an alarm on the chair. The MDS Nurse stated they had been monitoring the resident and the resident was due for another MDS assessment in a few weeks. The MDS Nurse stated it looked like the Geri-chair would be coded as a restraint on her next MDS assessment. On 5/5/16 at 8:45 AM the Director of Nursing (DON) stated in an interview they did not use restraints in the building. The DON was observed to review the nurse ' s note dated 4/15/16 regarding the resident was put in the Geri-chair due to the resident continuing to get out of the chair and attempting to ambulate without assistance. The DON agreed the Geri-chair was	F 221		

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F 221	Continued From page 3 a restraint for the resident because it prevented her from getting up.	F 221		