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 09/14/2022

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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/13/2022 through 09/14/2022. Event ID# VQNS11. The following intakes were investigated NC00193003, NC00192856, NC00191754 and NC00191296. 2 of the 16 complaint allegations were substantiated with a deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to place a resident ' s call light (Resident #1) within reach to allow for the resident to request staff assistance if needed for one of one resident reviewed for accommodation of needs. The findings included: Resident #1 was admitted to the facility on 08/10/2022 with multiple diagnoses that included schizoaffective disorder, myocardial infarction, major depressive disorder and intracranial injury without loss of consciousness. The Admission Minimum Data Set (MDS) assessment dated 08/15/2022 indicated Resident #1 ' s cognition was moderately impaired. She had no behaviors and no rejection of care. She	F 558	1. The call light cord was unwrapped from the bedrail immediately upon identification and secured within reach of Resident #1 by the assigned Certified Nursing Assistant on duty immediately. 2. All residents have the potential to be affected by the deficient practice. All call lights were checked immediately to ensure they were in reach and accessible to the residents by the Director of Nurses (DON). No other residents were identified as being affected by the deficient practice. All staff were re-educated on call light placement by the DON on 10-6-2022. 3. All staff will ensure call lights are in reach of residents upon exiting a room.	10/6/22

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

Electronically Signed | 10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 1 required extensive assistance of 2 or more staff with bed mobility, transfers, personal hygiene and required total dependence with toilet use. Resident #1's Care plan dated 07/14/2022 indicated the resident had a problem area of cognitive impairment related to medication, mental illness, traumatic brain injury. An observation and interview were conducted with Resident #1 on 09/13/2022 at 10:50 AM. Resident #1 was lying on her back in bed and the cord to her call light was wrapped around her bed rail. The call light was hanging toward the ground and out of her reach. Resident #1 was alert and interviewable. She indicated she needed her call light to be within reach when she requires staff assistance when trying to reach her phone and when she needs to be changed when she is wet. An observation was conducted of Resident #1 on 09/14/2022 at 9:40 AM. She was observed in her room in bed. Resident #1's call light cord was wrapped around her bed rail and the call light was hanging toward the ground out of her reach. An interview was conducted with Nursing Assistant (NA) #1 on 09/14/17 at 9:45 AM. He indicated he was familiar with Resident #1. He stated Resident #1 was able to use her call light to request staff assistance. He indicated she used the call light frequently. He reported he normally placed Resident #1's call light on her side so she was able to reach it. An interview was conducted with the Director of Nursing (DON) on 09/14/17 at 12:29 PM regarding Resident #1's call light not being placed within reach. The DON indicated her	F 558	The assigned nurse on duty to each unit will monitor call light placement throughout their shift to ensure compliance with corrective action occurring immediately as needed. The DON and/or Designee will monitor call light placement 5 days a week with corrective action immediately as needed to ensure compliance. 4. The DON will report all findings of the call light monitoring audits to QAA monthly. The process will be adjusted as needed with any identified concerns to ensure compliance until there is substantial compliance.	

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F 558	Continued From page 2 expectations were for staff to place resident call lights within the resident ' s reach at all times.	F 558		