PRINTED: 01/03/2025 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345252	B. WING				C <b>09/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	03/2024
WARSAW	NURSING AND REHABI	LITATION CENTER			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	from 12/2/24 through information received I 12/5/24. Onsite valida jeopardy removal plai						
	The following intakes NC00220682 and NC 1 of the 4 complaint a deficiency. Intake NC00224589 r jeopardy.	00224589. Ilegations resulted in					
	Past-noncompliance of CFR 483.25 at tag F6 (J)	was identified at: 89 at a scope and severity					
	Immediate Jeopardy and was removed on	for F689 began on 11/15/24 11/18/24.					
	Immediate Jeopardy CFR 483.25 at tag F6	was identified at: 84 at a scope and severity					
	Immediate Jeopardy and was removed on	for F684 began on 11/15/24 12/5/24.					
	The tags F684 and F6 Quality of Care.	689 constituted Substandard					
F 684 SS=J	,	rvey was conducted.	F	684			12/9/24
	§ 483.25 Quality of ca	are					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

12/24/2024

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.

**Electronically Signed** 

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345252	B. WING		C <b>12/09/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/03/2024
				214 LANEFIELD ROAD	
WARSAW	NURSING AND REHABI	LITATION CENTER	ı	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 684	Continued From page	÷ 1	F 684	1	
F 684	Quality of care is a further applies to all treatments. Bas assessment of a resident residents received accordance with professor accordance with pr	and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of densive person-centered sidents' choices.  It is not met as evidenced  ew, and resident, Physician, and staff interviews, the Resident #4 in place to be all professional following a cansportation van. Resident a medical appointment in an and when Transporter #1 ment site and parked, ewas sliding from his ter #1 was not trained for and went to back of van lent #4 from the floor of the elechair. Transporter #1 did about the fall until he to the facility from his follow the surgeon for a left leg station completed on 4 's right hand became ter in the day and x-ray. There was a high adverse outcome including oving a resident after a fall ed by a licensed medical curred for 1 of 3 residents	F 684	1. Resident #4 was assessed immediately after returning to the facility on 11/15/24 when Transporter #1 notifithe nurse on duty of the incident by the licensed nurse. Upon initial assessmenthe resident #4 denied any type of pair injury. The facility nurse practitioner was notified of the fall by the nurse on duty later the same day Resident #4 hand wereddened, swollen and painful. An x-rawas ordered and obtained the same day Resident #4 complained of pain 3 out of 10 and was administered one dose hydrocode-acetaminophen 5-325 at 3: PM which was documented as effectiv 6:36 PM. Results of the x-ray showed acute fracture or dislocation, mild osteopenia, and osteoarthritis. Resider #4 was assessed by physician on 11/18/24 and per the physician note Resident #4 was found to have mild swelling and Resident #4 stated that his symptoms were improved.  2. Any resident experiencing a fall me have the potential to be affected. On 12/03/2024, the Unit Manager and	ed et tt toor as yas y ay. of 49 e at no
		Resident #4 from the floor of a without being assessed by		Assistant Director of Nursing reviewed facility falls for the previous 30 days to	

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		345252	B. WING _			C <b>12/09/2024</b>	
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY,	STATE ZIP CODE	12/03/2024	
	101.52.1 01.1 00.1 2.2.1			214 LANEFIELD ROAD	0.7.1.2, 2.1. 0022		
WARSAW	NURSING AND REHAB	ILITATION CENTER		WARSAW, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		TION
F 684	Continued From pag	e 2	F 6	34			
	removed when 12/5/ implemented a credil jeopardy removal. The compliance at a lower (no actual harm with minimal harm that is complete education a	al. Immediate jeopardy was 24 when the facility ble allegation of immediate ne facility will remain out of er scope and severity of D potential for more than not immediate jeopardy) to and ensuring monitoring see for resident assessment		transferring, prop intervention prior issues were found 3. On 12/3/24, Assistant Director Manager provider	The Administrator, or of Nursing, and Unit d education to staff th t experience a fall, the	o	
	The findings included:			12/03/2024 staff the Administrator trained to transfe	urse or physician. On were also educated by that only staff who are r a resident may do so	e	
	9/24/24 with a most in 10/21/24. His diagnor mellitus, right leg bel	mitted to the facility on recent readmission on ses included type 2 diabetes ow the knee amputation and see amputation (10/12/24).		staff who are qua assessments for none are present	It following a fall, facilit alified to perform clinic injury must be notified at the time of the fall.	al	
	A care plan initiated 10/4/24 revealed a focus that Resident #4 required assistance with ADL (activities of daily living) related to: cognition, muscle weakness, bilateral BKA (below the knee amputation). The interventions included transfer with one-person physical assistance and reposition with one-person physical assistance as needed.			Regional Corpora to the facility Dire Assistant Director Managers on the policies, how to p prior to being mon Moving forward, of Assistant (CNA) of transportations por	lso conducted by the ate Nurse on 12/03/20 ector of Nursing, or of Nursing and Uniter facility fall related properly assess a residualized after a fall. only a Certified Nursin will be present on rovided by the facility.	dent g	
	revealed an order for 5mg-Acetaminophen tablet by mouth ever The Admission Asset (MDS) dated 10/1/24 moderate cognitive in	n 's order dated 10/21/24 Hydrocodone 325 mg (milligrams)- Take 1 y 6 hours as needed for pain.  ssment Minimum Data Set indicated Resident #4 had mpairment. He required plus one-person physical		a certified or licer professional, a C accompany the redriver for the app 11/14/2024, The was educated ab been responsible Nurse is present	nsed medical NA or Nurse will esident and transport	as r a	

Facility ID: 923122

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		ATE SURVEY MPLETED
		245252	B. WING			С
		345252	B. WING		•	12/09/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	Æ	
WARSAW	NURSING AND REHABI	I ITATION CENTER		214 LANEFIELD ROAD		
MAROAN	NONOINO AND INCIDADI	ENAMON SERVER		WARSAW, 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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page	∋ 3	F 68	34		
	assistance for transfer Resident #4 had fund motion to both lower wheelchair as a mobil weighed 114 pounds.  Review of a statement 11/15/24 revealed he medical appointment. When he got to the distance of the front of the resident to the transport driver resident to the transport driver resident #4 wheelchair. The note was right beside Resident #4 wheelchair. The note was right beside Resident #1 neck and he assisted lifting him up by the was a contraction of the resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted lifting him up by the was contracted Resident #1 neck and he assisted he assisted he assisted lifting him up by the was contracted Resident #1 neck and he assisted	ers and bed mobility.  Itional limitation of range of extremities and used a lity device. Resident #4  In the transporter #1 dated had taken Resident #4 to a in the transportation van. estination, Resident #4  In Transporter #1 reported he was and put his arm in the support him. The note said emoved the van shoulder slid down slowly off his said the transport driver ident #4 and partially mote said Transporter #1  If to put his arms around his him back into the chair by vaist of his pants.  It did not be the control of the co		1:1 education with the Transp Coordinator that all facility trate be accompanied by a C.N.A completed on 12/4/24.  Moving forward, should a rest experience a fall outside of the while under the care of facility license nurse is not present, imminent danger, 911 will be assess the resident prior to transferring/mobilizing. If a licent qualified for clinical assessment present, the nurse will assess and determine the need to caperforming transfer of resider.  4. The administrator/design monitor transportation schedule weekly x4 weeks, 3 x weekly then weekly thereafter to ensign CNA or nurse is present for transportations. Additionally, administrator/designee to integrated to assess for the members weekly to assess for the control of	insports will or Nurse was ident he facility by staff, if a if not in activated to be ensed nurse ent is at the resident hall 911 and/or ht.  Incee will he by a weeks are that a erview 5 staff	
	that on the morning of 11/15/24, Resident #4 knowledge of wasn't ready when it was time to leave, so he not moving re		knowledge of process/practic not moving residents until clir assessed by a qualified profe	es related to nically essional.		
	stated he was starting indicated he went to a the seatbelt securem was assisted to the fl #1 stated Resident #4 the very edge of the went to assist, and he have continued to slid system had not been	pped the van, Resident #4 g to slip. Transporter #1 the resident and unbuckled ent system, and the resident oor of the van. Transporter 4 's buttocks were almost at wheelchair seat when he e felt that Resident #4 would de if the seatbelt securement removed. Transporter #1 m in front of the resident and		5. Audits will be reviewed be Improvement Committee more discussion to ensure substant compliance. Once the Qualit Improvement Committee dete consistent substantial compli- will be done on a random base	nthly and tial y ermines ance audits	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY LETED
		345252	B. WING _			1	09/ <b>2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CIT 214 LANEFIELD ROAL WARSAW, NC 2839	D	, , , ,	00/2027
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	him to the floor of the described he instruct arms around his need by his belt loops to list wheelchair. Transpot had no complaints of surgeon 's office staresident inside. Transport called back to the factility. Transport training in transferring in transferring in transferring the method in the facility. Transport training in transferring in transfer in the transport in the transfer in the online Falls traing in transfer of residents the online Falls traing in transporter #1 complete in the includent in the transport in the includent in th	side and he slowly assisted e van. Transporter #1 ted Resident #4 to put his sk and he picked up resident ft him back up into the rter #1 stated Resident #4 f pain at that time and the aff came out and pushed the appointment and returned to ter #1 stated he would have cility if the resident was hurt not stated he was not hurt he lurse #1 when he returned to ter #1 confirmed he had no ag residents.  Inducted with Surgical surgical Technician #2 on a Surgical Technician #1 was asked to go the Resident room to assist with de Surgical Technician #2 echnician #2 stated Resident desipped from his chair to the atton van. Surgical technicial #2 stated Resident desipped from his chair to the atton van. Surgical technicial #2 stated Resident desipped from his chair to the atton van. Surgical technicial #2 stated Resident designed from his chair to the atton van. Surgical technicial #2 stated Resident designed from his chair to the atton van. Surgical technicial #2 stated Resident designed from his chair to the atton van. Surgical technicial #2 stated Resident designed from his chair to the atton van. Surgical technicial #2 stated Resident designed from his chair to the atton van. Surgical technicial #2 stated Resident designed from his chair to the atton van. Surgical #4 she did not assess Resident designed from his chair to the atton van. Surgical #4 she did not assess Resident designed from his chair to the atton van.	F	584			

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 <b>12/09/2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	<u>'</u>	12/00/2024
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	regarding not movin fall or accident or can accident or incident an accident or incident and incident and incident and had no injury at that time. The sident #4 had no was unable to keep A nurse 's note writh 11/15/24 at 4:21 Phright hand was swol painful. Resident #4 hurt his hand when in the transport van was notified and an (urgent order) x-ray received as needed effective.	ded there was no content ag the resident if there was a alling the facility if there was ent immediately.  Iten by Nurse #1 dated M indicated Resident #4 was a and slid out of wheelchair dent #4 did not complain of  Ithe transport driver reported t hit his head and the resident his balance in chair.  Iten by Nurse#1 dated I indicated Resident #4 ' s llen, warm to touch and was unable to recall if he had he slid out of the wheelchair The on-call health provider order a new order for a stat was given. Resident #4 pain medication which was	F 6	,		
	12/3/24 at 9:00 AM. working on Unit 3 or Transporter #1 whe #4. Nurse #1 stated #4 had slid out of th Transporter #1 stop Nurse #1 stated Resliding when Transp Resident #4 reporte the seat belt and as the floor. Resident #	Nurse #1 stated she was In 11/15/24 and she spoke with In he returned with Resident Is she was informed Resident Is wheelchair when Is ped at the appointment. Is sident #4 reported that he was It wonter #1 went to assist him. It Transporter #1 unbuckled Is sisted the resident to slide to It reported he did not hit his Is cated she assessed Resident				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345252	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343232	D. WING_	STREE	T ADDRESS, CITY, STATE, ZIP CODE		12/09/2024
TVAME OF T	NOVIDER OR GOLF EIER				NEFIELD ROAD		
WARSAW	NURSING AND REHABI	LITATION CENTER			SAW, NC 28398		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 684	Continued From page	<b>9</b> 6	F	684			
	at 4:30 PM on 11/15/2 reported Resident #4 swollen. Nurse #1 sta if he had hurt his han resident could not rer that time. Nurse #1 st	ny injury. Nurse #1 reported 24 Medication Aide #1 's right hand was warm and ated she asked Resident #4 d while on the van and the member being on the van at tated she notified the ed an order for an x-ray.					
	Note dated 11/15/24 seen due to a fall inju 11/15/24. The note in hand was swollen anwere given for stat xneeded) hydrocodone	dicated Resident #4 's right d warm to the touch. Orders ray of right hand and prn (as e (a narcotic pain t #4 was to be seen by his					
	revealed an order for on Resident #4 's rig dated 11/15/24 revea	n order dated 11/15/24 a stat x-ray to be completed ht hand. The x-ray results led no acute fracture or s mild osteopenia and a arthritis.					
	12/2/24 at 1:56 PM. F fall on the transportat surgeon 's office a fe he was strapped in hi to slide out of the who recalled calling out to sliding. Resident #4 s buttocks onto the tran	Transporter #1 he was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTE	RUCTION		(X3) DATE COMP	SURVEY LETED
		345252	B. WING					09/ <b>2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHAE	BILITATION CENTER		214 LANE	DDRESS, CITY, STATE, ZIP CODE EFIELD ROAD N, NC 28398		, , , ,	00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 684	not have any pain at became swollen and Resident #4 stated of felt himself sliding in to reposition himself leg. The interview fur was a different drive took him to appoint and the pain and the pain and swelling the pain, and swelling indicated Resident # pain as needed.  An interview was contacted Resident # pain as needed.  An interview was contacted Resident # pain as needed.  An interview was contacted Resident # pain as needed.  An interview was contacted Resident # pain as needed.  An interview was contacted Resident # pain as needed.	Resident #4 recalled he did that time, but his hand I painful a few hours later. during previous transports he the wheelchair but was able back up using his prosthetic rther revealed Transporter #1 r, not the "ladies" that usually nents.  In progress note dated esident #4 was evaluated in and swelling in the right sated Resident #4 was and swelling on the dorsum of the hand) of his right hand oms were better. Resident # in x-ray and was told the egative. Resident #4 stated in had improved a lot but had wed. The note further if was on hydrocodone for inducted with the Physician on the Physician stated ways be assessed after a fall all professional prior to hysician stated the resident ced additional injury without a prior to being moved. The inted he did not feel that would have been prevented in place.	F	684				
	An interview was con Administrator on 12/	nducted with the 3/24 at 3:51PM. The						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	, ,	TE SURVEY MPLETED
		345252	B. WING			C
NAME OF B	ROVIDER OR SUPPLIER	3-3232	1 2	STREET ADDRESS, CITY, STATE, ZIP CO		2/09/2024
NAME OF I	NOVIDEN ON SOLT EIEN			214 LANEFIELD ROAD	DDL	
WARSAW	NURSING AND REH	ABILITATION CENTER		WARSAW, NC 28398		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTIVE ACTIVE)  CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From p	page 8	F	684		
	Administrator state the fall until the new to see Resident # Administrator state not have his prosting to his appoint he did not get hur stated Resident # took off his seather Administrator state trained in transfer Administrator furth assessed by the resident # the facility, and he time. The Administransporters had reproviding safe transporters had residents. The Administrator state the resident if he had the transported would have done alright because he back to the facility or injury.  The facility Administrator state the resident if he had the transported would have done alright because he back to the facility or injury.  The facility Administrator state the resident if he had the transported would have done alright because he back to the facility or injury.  The facility provid Jeopardy removal	ed he was not made aware of ext day (11/16/24) and he went 4 on Monday 11/18/24. The ed Resident #4 indicated he did hetic leg on, so he fell once he ment. Resident #4 reported that t when he fell. The Administrator 4 reported the transport driver elt and had to catch him. The ed Transporter #1 had not been ring residents. The her stated Resident #4 was hurse when he arrived back at a had no known injury at that strator stated all three received education on falls, his portation and viewed the ideos on use of the van 's imprior to transporting any ministrator indicated the falls residents being assessed for ea/MD before moving them. The ed Transporter #1 had asked was hurt prior to moving him er did what any other person. He felt that the resident was event to his appointment and without any complaints of pain istrator was notified of dy on 12/3/24 at 12:04 PM.  ed the following Immediate plan.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		OMPLETED
		345252	B. WING _			C <b>12/09/2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	· ·	12/00/2024
(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 COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 9	F 6	84		
	11/15/24 while bein physician appointm sliding down in his Transporter #1 rem he was assisted to Transporter #1. Wh distress or injury, This chair by instruct arms around Trans Transporter #1 gral loops to lift him bac returning Resident proceeded into the #4 was assisted wit two surgical techs i Transporter #1 is no does not have speciassessing a resider facility, Transporter	g transported to an outside ent. Resident was noted to be wheelchair and when oved the securement device, the floor of the van by en he complained of no ransporter #1 assisted him to ing Resident #4 to place both porter #1 's neck and then obed Resident #4 's pant belt k up into the wheelchair. After #4 to his chair Transporter #1 physician 's office. Resident th repositioning in his chair by in the physician 's office. ot a medical professional and cific training on transferring or int. After returning to the #1 notified the nurse on duty the resident was immediately ensed nurse				
	denied any type of nurse practitioner was notified by the was reddened, swoordered and obtain complained of pain administered one dhydrocode-acetami which was docume Results of the x-ray dislocation, mild os The resident was a	I assessment the resident pain or injury. The facility vas notified of the fall by the the same day when the nurse CNA that the resident 's hand allen and painful. An x-ray was sed that same day. Resident #4 3 out of 10 and was ose of nophen 5-325 at 3:49 PM anted as effective at 6:36 PM. It showed no acute fracture or teopenia and osteoarthritis.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OMPLETED
		345252	B. WING _	<del></del>		C <b>12/09/2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	•	
(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 COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 10	F 6	884		
		und to have mild swelling and that his symptoms were				
	o Residents experie be affected.	encing a fall have potential to				
	reviewed facility fall ensure proper asse transferring, proper	Assistant Director of Nursing is for the previous 30 days to essment, trained staff notification and intervention dent. No issues were found.				
	process or system	n the entity will take to alter the failure to prevent a serious om occurring or recurring, and I be complete:				
	Administrator to start facility that should a they must not be m by a nurse or physical start for the start facility that should be start for the start facility and start facility that should be start for the start facility and start facility fac	on was provided by the  ff currently working in the a resident experience a fall, oved before being assessed cian. Those not currently on ted prior to the start of their and 12/3/24)				
	educated by the Adare trained to trans	nding agency staff, were ministrator that only staff who fer a resident may do so.  Working will be educated prior next shift. (12/3/24)				
	educated by the Ad facility staff who are assessments for inj	uding agency staff, were ministrator that following a fall, e qualified to perform clinical ury must be notified, if none time of the fall. Those not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345252	B. WING			C <b>12/09/2024</b>	
	ROVIDER OR SUPPLIER  NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	<u> </u>	12/03/2024	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	start of their next shall start of their next shall for staff notification residents, and quality assessment through learning and 1:1 ed during orientation.  The Corporate Nu educated Director of Nursing and Unit related policies, how prior to being mobil 12/3/24)  Moving forward, a (CNA) or nurse will provided by the facifacility van not be a professional, a CNA resident and transp All staff including again change through the as well as in persor transport staff by the coordinator will be reconstructed 1:1 educa Coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanied by a feature of the coordinator that all accompanies of the coordinator	ill be educated prior to the hift. (12/3/24) be educated on the process of falls, safely transferring fications of clinical nonline education platform ucation by the Administrator  rse/Consultant Nurse then of Nursing, Assistant Director Managers on the facility fall who properly assess a resident fized after a fall. (Completed  Certified Nursing Assistant be present on transportations lity. Should the driver of the certified or licensed medical A or Nurse will accompany the cort driver for the appointment. Bency staff were notified of this proprietary software system of education provided to be Administrator. The transport responsible for ensuring a present on all transports.  (4)  ctor of Clinical Compliance tion with the Transport will be CNA or nurse. (12/4/24)  ew hire transport coordinator,	F 6	84			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		ATE SURVEY OMPLETED	
		345252	B. WING _			C <b>12/09/2024</b>	
	PLAN OF CORRECTION  345252  ME OF PROVIDER OR SUPPLIER  ARSAW NURSING AND REHABILITATION CENTER  X4) ID  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	BILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	, 12/00/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	for 1:1 education re ensure a CNA/nurs This will be comple  Moving forward, s fall outside of the fa facility staff, if a lice resident will be maddanger, 911 will be resident prior to trailicensed nurse qual present, that nurse determine the need agency staff were experson education b Nursing. (Complete Nursing/designee withis education to need to their next shift to	garding the responsibility to e is present on all transports. Ited in orientation.  hould a resident experience a scility while under the care of insed nurse is not present, the de safe. If not in imminent activated to assess the insferring/mobilizing. If a sified for clinical assessment is will assess the resident and to call 911. All staff, including including ducated on this through in the Assistant Director of de 12/3/24). The Director of de 12/3/24. The Director of de the responsible for providing the whire transport staff.  Indesignee will track and the othose staff not present prior tensure completion.	Fé	· ·			
	The IJ removal plar it concluded the fact acceptable correcting Review of staff edus heets for the educ determine that educ transportation staff nursing and nursing who experiences fabeing assessed by licensed medical pralso included only statement of the plant of	n was validated on 12/9/24 and illity had implemented an we action plan on 12/05/24. cation materials and sign-in ation were reviewed to cation was provided to all including Transporter #1, g assistant staff that a resident					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345252	B. WING _		1	C / <b>09/2024</b>	
	ROVIDER OR SUPPLIER  NURSING AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, 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 CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 689 SS=J	resident has a fall out be activated to assest transferring/mobilizat documents revealed facility 's plan of correconducted with the number of confirmed they realicensed medical prassess a resident prica fall and call 911 if the facility before more free of Accident Hazz CFR(s): 483.25(d)(1)  §483.25(d) Accidents The facility must ensure \$483.25(d)(1) The reast free of accident has \$483.25(d)(2)Each resupervision and assist accidents.  This REQUIREMENT by:  Based on observation resident, staff and phy failed to ensure Resident that the transporter #1, he feen his wheelchair. Transfersident's doctor's off stop at the front entrallocation at the time the him. Transporter #1 gets for the confirmation of the transporter #1 gets for the transporter #1 g	clinical assessment when a tside the facility, then 911will as the resident prior to ion. Review of the facility audits were done per the ection. Interviews were cursing staff and nurse aides eccived education regarding ofessional needing to or to transferring them after the fall happens outside of ving ards/Supervision/Devices (2)  i		Past noncompliance: no plan of correction required.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		OATE SURVEY OMPLETED
		345252	B. WING			C <b>12/09/2024</b>
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398		12/03/2024
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Transporter #1's ass stated Resident #4's of the wheelchair wheelchair wheelchair that Resident #4's lide if the seatbelt I Transporter #1 states ame way on the restand that the same way on the restand that the second that the second that the second that the second that the seat belt and buckle seat belt occupant's shoulder Resident #4 was accupant's shoulder Resident #4 was accupant's shoulder the seat belt occupant's shoulde	the floor of the van with sistance. Transporter #1 was almost at the very edge men he went to assist, and he would have continued to had not been removed. It has been the turn trip to the facility. Later 4's right hand was swollen, painful requiring narcotic pain was a high likelihood of or death from unsafe ansportation van. This fected 1 of 3 residents hts.  d:  instructional video indicated over the occupants' chest to removable pelvic belt. height so that belt rest on	F 6	89		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONST	TRUCTION		(X3) DATE COMP	SURVEY LETED
		345252	B. WING _					09/ <b>2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHAB	ILITATION CENTER		214 LAN	ADDRESS, CITY, STATE, ZIP CODE  EFIELD ROAD  NW, NC 28398			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 689	Continued From pag	e 15	F	689				
	at 11:02 AM indicated transport van and slid floor. Resident #4 did had no injury at that reported Resident #4 resident was unable  A nurse's note writter at 11:40 AM indicated his follow up appoint the knee amputation. The note further indicated for the satisfactory healing.  A nurse's note writter at 4:21 PM indicated was swollen, warm to #4 was unable to recombe when he slid out of the van. The on-call hear an order a new order x-ray was given. Respain medication which resident #4 slid out Resident #4 was but slide. Resident #4 did was no apparent injurt transport driver note head. Resident could the fall interventions time of the fall was the locked. The immedia	the by Nurse #1 dated 11/15/24 de Resident #4 was on the dout of wheelchair onto the dout of wheelchair of pain and time. The transport driver had not hit his head and the to keep his balance in chair.  The by Nurse #1 dated 11/15/24 de Resident #4 returned from ment related to his left above (AKA) with no new orders. Cated the surgical wound had be by Nurse#1 dated 11/15/24 Resident #4's right hand to touch and painful. Resident all if he had hurt his hand he wheelchair in the transport the provider was notified and for a stat (urgent order) dident #4 received as needed the was effective.  The dated 11/15/24 at 5:01 PM 4 was on transport van and of wheelchair to floor. Skled in but continued to do not complain of pain. There are not eat that time. The de Resident #4 did not hit his dout keep balance in chair. That were in place at the ne wheelchair was to be te intervention to prevent ansport Resident #4 with 2						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION		E SURVEY PLETED
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	ROVIDER OR SUPPLIER  NURSING AND REHAB	LITATION CENTER		214 LAI	TADDRESS, CITY, STATE, ZIP CODE  NEFIELD ROAD  AW, NC 28398		103/2024
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689 Continued From page 16		F	889				
	11/15/24 revealed he medical appointment When he got to the d stated he was sliding went to the back of the front of the resident to the transport driver reand Resident #4 slid wheelchair. The note was right beside Ressupporting him. The instructed Resident #	said the transport driver					
	on 12/2/24 at 2:22 PI that on the morning of wasn't ready when it sent without his prost when he arrived at the stopped the van, Restarting to slip. Transto the resident and us securement system, assisted to the floor of stated Resident #4's very edge of the where assist, and he felt the continued to slide if the been removed. Transfarm in front of the rest the side and he slow! Transporter #1 description with the side and he slow! Transporter #1 description with the side and he slow! Transporter #1 description with the side and he slow!	ducted with Transporter #1  M. Transporter #1 reported of 11/15/24, Resident #4  was time to leave, so he was thesis. Transporter #1 stated e medical appointment and sident #4 stated he was porter #1 indicated he went abuckled the seatbelt and the resident was of the van. Transporter #1 buttocks was almost at the elchair when he went to at Resident #4 would have the securement belt had not exporter #1 stated he had one sident and was standing to y assisted him to the floor. ibed he instructed Resident bound his neck and picked up tops to lift him back up into sporter #1 stated Resident					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345252	B. WING _			C <b>12/09/2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 214 LANEFIELD ROAD WARSAW, NC 28398	DE	.2.00/202
(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DATE	
F 689	facility, he reported the An interview was con 12/2/24 at 1:56 PM. fall on the transportar surgeon's office a few was strapped in his was strapped in his was strapped in his was decided out of wheelchar calling out to Transport Calling out to Transport Resident #4 stated have transport driver assist wheelchair. Resident any pain at that time, swollen a painful a few stated during previous sliding in the wheelch reposition himself balleg.  An interview was con 12/3/24 at 12:45 PM. not touch the seat between for his safety.  Review of a statement dated 11/15/24 reveal an appointment, and his prosthetic leg on appointment. Medical Resident #4 came be blood sugar and notic swollen. Medication with immediately.  An interview was considered was conside	s of pain at that time. d when he got back to the ne fall to Nurse #1.  Inducted with Resident #4 on Resident #4 stated he had a tion van on the way to the w weeks ago. He reported he wheelchair when he began to hir. Resident #4 recalled orter #1 he was sliding. e slid onto his buttocks onto or. Resident #4 stated the hited him back up into the the H4 recalled he did not have but his hand became his transports he felt himself hair but was able to ock up using his prosthetic  aducted with Resident #4 on Resident #4 stated he did but because he knew it was	F6	689		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345252	B. WING			C
	ROVIDER OR SUPPLIER  NURSING AND REHAB			STREET ADDRESS, CITY, STATE 214 LANEFIELD ROAD WARSAW, NC 28398	, ZIP CODE	12/09/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)	5.475
F 689	Resident #4 was rea Medication Aide #1 s and she had not look that morning. She re that was assisting Re went in and assisted stated they were hav #4's prosthetic leg in did not want him to be appointment. Medica decided to send Resprosthetic leg.  Nurse Aide #1 that a #4 ready on 11/15/24 interview.  An interview was con 12/3/24 at 9:00 AM. working on Unit 3 an working on Unit 4. N notified that the aide placing Resident #4's had left the building. with Transporter #1 Nurse #1 stated she had slid out of the wl and at the appointme #4 reported that he w #1 went to assist him the restraint and ass the floor. Resident #head. When Reside facility, she assessed not hurt. Nurse #1 re 11/15/24 Medication #4's right hand was well as well as the session of the work of the	d by Transporter #1 if dy for his appointment. stated she was being rushed sed at the appointment log eported the nurse assistant esident #4 was new, so she her. Medication Aide #1 ring difficulty getting Resident place that morning and she se late or miss his stion Aide #1 stated she ident #4 without his  assisted with getting Resident 4 was not available for  aducted with Nurse #1 on Nurse #1 stated she was d Medication Aide #1 was surse #1 stated she was not se were having difficulty se prosthetic leg until after he Nurse #1 stated she spoke when resident returned. was informed Resident #4 neelchair when he stopped ent. Nurse #1 stated Resident vas sliding when Transporter n. Transporter #1 unbuckled sisted the resident to slide to 4 reported he did not hit his int #4 came back to the d him and he stated he was	F	589		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVE COMPLETED				
		345252	B. WING		12/09/20	24	
	NAME OF PROVIDER OR SUPPLIER  WARSAW NURSING AND REHABILITATION CENTER  (X4) ID PREFIX TAG  CONTINUED FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 19 hand while on the van and the resident could not remember being on the van at that time. Nurse #1 stated she notified the physician and received an order for an x-ray.  A review of the x-ray results dated 11/15/24 revealed no evidence of fracture or dislocation. Mild osteopenia and mild degree of osteoarthritis.  Review of a statement by the Administrator dated 11/18/24 revealed Resident #4 had a fall from his wheelchair and the transport driver was there to help him. Resident #4 indicated he did not have his prosthetic leg on, so he fell once he got there.			STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	,		
PRÉFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COM	(X5) PLETION DATE	
F 689		<u> </u>	F 68	39			
	remember being on #1 stated she notific	n the van at that time. Nurse ed the physician and received					
	revealed no eviden	ce of fracture or dislocation.					
	11/18/24 revealed F wheelchair and the help him. Resident	Resident #4 had a fall from his transport driver was there to #4 indicated he did not have					
	Resident #4 reported did not hit the groun reported the transp	n, so he fell once he got there.  ed that he did not get hurt and  nd when he fell. Resident #4  ort driver took off his belt and  desident #4 stated he did not					
	know what happene	ed to his hand. Resident #4 whether he hurt his hand					
	Administrator stated the fall until the nex Administrator stated Director of Nursing to take to complete	conducted with the 2/3/24 at 3:51PM. The d he was not made aware of at day 11/16/24. The d he prompted the former on the steps that she needed the fall investigation. The d the facility had put a full plan					
	An interview was conthat followed up with 1:11PM. The physical #4 on 11/18/24 and better. The physicial	ce related to the resident's fall.  conducted with the physician  h Resident #4 on 12/4/24 at  cian stated he saw Resident  he reported that his hand was  an stated Resident #4 was  at had happened to his hand.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345252	B. WING _			C <b>12/09/2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398	l	12/00/2024
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 20	F 6	89		
	Resident #4's fall wwith his prosthetic le	ould have been prevented eg in place.				
	The Administrator w jeopardy on 12/3/24	vas notified of immediate at 12:07PM				
		I the following corrective ompletion date of 11/19/24.				
	Address how correct accomplished for the been affected the de	ose residents found to have				
	secure Resident #4 transport van. Durin reported to Transpo sliding out of his wh appointment locatio back of the van and system. Resident #4 the wheelchair and to the floor of the va facility, Transporter of the incident and t assessed by the lice	orter #1 failed to safely in his wheelchair in the facility g the transport, Resident #4 rter #1 that he felt like he was eelchair. When arriving to the n, Transporter #1 got into the removed the securement 4 continued to slide down from Transporter #1 assisted him an. After returning to the #1 notified the nurse on duty the resident was immediately ensed nurse on duty. Upon				
	pain or injury. The notified of the fall by same day when the CNA that the reside swollen and painful obtained that same of pain 3 out of 10 a dose of hydrocode-PM which was docuPM. Results of the fracture or dislocation	esident denied any type of facility nurse practitioner was the nurse on duty, later the nurse was notified by the nt's hand was reddened,  An x-ray was ordered and day. Resident #4 complained and was administered one acetaminophen 5-325 at 3:49 amented as effective at 6:36 x-ray showed no acute on, mild osteopenia and esident was assessed in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		345252	B. WING _			C <b>12/09/2024</b>	
	AN OF CORRECTION  345252  SAW NURSING AND REHABILITATION CENTER  SAW NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21 person by the physician on 11/18/24 and per the physician note Resident #4 was found to have mild swelling and Resident #4 stated that his symptoms were better.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice  All residents who are transported by the facility have the potential to be affected.  An audit of all transports for the last 30 days was completed by the Administrator and the Transport Coordinator. No deficient practice was identified (Completed 11/18/24)  Address what measure will be put into place or systemic changes made to ensure that the deficient  The Maintenance Director inspected all securement devices in facilities transport buses. All were found to be in proper working order. (11/15/24)  All policies and procedures specific to resident transports were reviewed by Regional Director of Clinical Services to ensure compliance with manufacturer's recommendations and guidelines. No revisions were warranted. (11/18/24)  The Administrator facilitated transport staff education through a manufacturer's video on the use of the bus securement system, return demonstration and a validation checklist. The Transport Coordinator, the Maintenance Director, and Maintenance Assistants were included in this	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 LANEFIELD ROAD WARSAW, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	person by the physician note Resimild swelling and Resymptoms were better and the same deficient participation. All residents who are have the potential to the same deficient of the same deficient o	cian on 11/18/24 and per the dent #4 was found to have esident #4 stated that his ter.  cility will identify other expotential to be affected by bractice  the transported by the facility to be affected.  ports for the last 30 days was administrator and the Transport ficient practice was identified 4)  sure will be put into place or made to ensure that the  irector inspected all in facilities transport buses.  In proper working order.  cedures specific to resident lewed by Regional Director of ensure compliance with	F6				
	The Administrator fareducation through a use of the bus secu demonstration and a Transport Coordinat	acilitated transport staff n manufacturer's video on the rement system, return a validation checklist. The tor, the Maintenance Director, ssistants were included in this					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345252	B. WING _			C <b>12/09/2024</b>
	ROVIDER OR SUPPLIER  NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STAT  214 LANEFIELD ROAD  WARSAW, NC 28398	E, ZIP CODE	12/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	
F 689	be checked by 2 sep transportation skills of completed with return include transport staff Maintenance Director and Administrator.  Transport staff will have upon hire and annual proper procedures. The manufacturer's videous system, return demonstration check off sheet. The responsible for observand validation check. Indicate how the facing performance to make sustained.  Plan of correction was the Quality Assurance attendance were the Director of Nursing/Incoordinator, Unit Madirector, Human Resimps Coordinator, Dio of Rehab. The Medicithe plan of correction (11/18/24).  The Maintenance Director incomplete the plan of correction (11/18/24).	Il residents' securements will arate staff who have current validation checklist in demonstration. This may ff, Transport Coordinator, r, Maintenance Assistants, ave a competency completed lly to ensure knowledge of this will include the on the bus's securement instration, and validation Maintenance Director will be riving return demonstration off sheets.  Ility plans to monitor its extremely sure that solutions are  as reviewed and discussed by extremely committee. In Administrator, Assistant infection Prevention in agers (2), Maintenance sources, Activities Director, etary Manager and Director is all Director was notified of in via phone conversation.	F	689	TOLINO!)	
	monthly to ensure pr					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345252	B. WING _			C <b>12/09/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	12/03/2024
WARSAW	NURSING AND REHABI	LITATION 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	PROVIDER'S PLAN C ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA	DATE
F 689	Gorianasa i rom page 20		F 6	689		
	weeks then the plan or reassessed by the Act further monitoring is r	Iministrator to determine if equired.				
		ported to the QA Committee monthly for review and				
	Alleged date of IJ ren	noval: 11/19/24				
	12/9/24. Review of st sign in sheets for the determine that educa Maintenance staff and a return demonstration had been conducted, documents revealed a facility's plan of correconducted with the tra- confirmed they receive proper use of the facilithat 2 separate staff of securement system propersus were connecting the secure securing a resident in	d Transportation drivers, and on and validation check off Review of the facility audits were done per the ction. Interviews were ansport drivers who red education regarding the lity bus seatbelt system and would check the resident's				