STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265566	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warsaw Health and Rehabilitation Center	1609 Sunchase Drive Warsaw, MO 65355

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43010 Based on interview and record review, facility staff failed to properly assist one resident (Resident #1) up in bed, when Nursing Aide (NA) B wrapped his/her arms around the resident and moved the resident up in bed, which results in a injury. The facility census was 87. The administrator was notified on 11/1/24 of past Non-Compliance which occurred on 10/24/24. On 10/24/24 it was reported NA B wrapped his/her arms around Resident #1 on 10/23/24, and moved him/her up in bed which resulted in bruising to his/her left and right sides. Upon discovery on 10/24/24, staff started an investigation, inserviced staff on proper techniques for assisting residents while in bed, notified the physician and suspended the NA. Staff corrected the deficient practice on 10/24/24. 1. Review of the Facility's Moving a Resident with a Sheet/Pad Policy, dated 11/1/2001, showed staff are directed to grasp the lift sheet/pad with both hands and lift the resident toward the head of the bed. 2. Review of the facility's investigation, dated 10/24/24, showed Registered Nurse (RN) A reported to Licensed Practical Nurse (LPN) C, Resident #1 had bruising to his/her left side. Review showed LPN C notified the Director of Nursing (DON) was and an investigation was started. The resident said NA B bear hugged him/her to move him/her back up in bed. He/She said he/she felt discomfort when NA B moved him/her. Review showed staff documented NA B immediately suspended and staff were in-serviced, on 10/28/24, on abuse and neglect, positioning a resident, turning a resident, moving a resident with a sheet/pad. Review showed as of 11/1/24 all staff had not been inserviced. 2. Review of Resident #1's Discharge Minimum Data Set (MDS), a federally mandated assessment tool, dated 9/19/24, showed staff assessed the resident as: -Cognitively intact; -Diagnosis of Osteoporosis (a condition in which bones become weak and brittle); -Required two staff assistance for transfers. Review of the resident's care plan, dated 11/2024, showed the care plan did not contain direction for on how to assist the resident in bed. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the nurses notes, dated 10/24/24, showed RN A documented bruising to the residents left and right sides. Review of the resident's nurses notes, dated 10/27/24, showed the physician ordered X-rays of the residents left side and ribs. Review of the residen'ts xray results showed fractures to the residents left sixth and seventh rib. During an interview on 11/1/24 at 10:10 A.M., the DON said he/she was made aware of the resident's bruising, on 10/24/24, by LPN C and started an investigation. He/She said NA B was suspended immediately. He/She said the resident said the NA moved him/her up in bed by himself/herself. He/She said staff were in-serviced for abuse and neglect, positioning, cares, and moving a resident up in bed and they were ongoing. He/She said staff are to use two people and a draw sheet to move a resident up in bed. During an interview on 11/1/24 at 10:50 A.M., the resident said NA B laid the bed flat and grabbed him/her under his/her arms and pulled him/her up in the bed. He/She said normally two staff use the draw sheet to move him/her up in the bed. During an interview on 11/1/24 at 12:15 P.M., LPN C said it was reported to him/her on 10/24/24, by RN A, the resident had bruising to his/her right underarm and left side. He/She said the DON was contacted on 10/24/24 and an investigation was started. During an interview on 11/1/24 at 12:20 P.M., RN A said he/she went into the resident's room with NA D and noticed bruising to the resident's right underarm and left side. He/She said the resident complained of discomfort to his/her left side. He/She said he/she told LPN C about the bruising and an investigation was started. He/She said the resident should have two people and be moved up in bed using the draw sheet. During an interview on 11/1/24 at 12:55 P.M., NA D said the resident had complaints of pain to his/her left side on 10/24/24. He/She said he/she did not notice any bruising the day before on 10/23/24. He/She said the resident said NA B pulled him/her up in bed by pulling under his/her arms. NA D said staff are expected to use a draw sheet and two staff to move a resident up in bed. During an interview on 11/1/24 at 1:14 P.M., NA B said he/she did not assist the resident up in bed but did help the resident with turning. He/She said he/she did not bear hug the resident. NA B if the resident needed to be moved up in bed he/she would use the draw sheet and another person. He/She said he/she received training on positioning and moving a resident up in bed because of the allegations of the complaint. During an interview on 11/4/24 at 8:01 A.M., Certified Nurse Aide (CNA) F said he/she worked the night of 10/23/24, but did not assist NA B with moving the resident. He/She said staff are expected to use two people and a draw sheet to move residents up in the bed. He/She said if a draw sheet was unavailable staff are expected to get one before trying to move the resident if the resident is unable to help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/4/24 at 8:42 A.M, the physician said he/she was made aware of the bruising to the resident and ordered an xray of his/her left side. He/She said the xray results revealed a fracture to the resident's sixth and seventh rib. He/She said moving the resident up in bed by bear hugging him/her and his/her comobidities could have cause the rib fracture. During an interview on 11/4/24 at 10:09 A.M. the administrator said staff are expected to move a resident up in bed using two person assist and a draw sheet. If there was not a draw sheet staff are expected to get one before moving the resident. MO00244080