STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115321	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warrenton Health and Rehab	813 Atlanta Highway Warrenton, GA 30828

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49673 Based on observations, staff interviews, record review, and review of the facility's policy titled Promoting/Maintaining Resident Dignity, the facility failed to maintain dignity by ensuring a dignity bag was provided for one of four residents (R) R51 who had an indwelling urinary catheter. Findings include: A review of the facility's undated policy titled Promoting/Maintaining Resident Dignity under the Compliance Guidelines section revealed, 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . 12. Maintain resident privacy. Review of medical records revealed, R51 admitted with diagnoses but not limited to muscle weakness (generalized), megalencephalic leukoencephalopathy with subcortical cysts, hypo-osmolality and hyponatremia, other inflammatory disorders of penis. Review R51's Admission Minimum Data Set (MDS) dated [DATE] for Section C (Cognitive Patterns) revealed, a Brief Interview for Mental Status (BIMS) score of 3, which indicated moderate cognitive impairment; Section H (Bladder and Bowel) indicated the resident had an indwelling catheter. Review of R51's care plans a plan of care with an initiated date of 1/30/2025 revealed, Focus: R51 had an indwelling catheter in place and is at risk for UTIs and skin breakdown around the catheter site. Dx (diagnosis): inflammatory disorder of penis. Intervention: Check tubing for kinks each shift. Observations on 2/22/2025 at 9:38 am revealed, R51 lying in bed with his catheter bag uncovered and visible from the doorway with 50 ml (milliliters) of amber colored urine noted. Observations on 2/23/2025 at 10:29 am and 2/24/2025 at 10:27 am revealed, R51's catheter bag was uncovered with amber colored urine noted. Interview on 2/24/2025 at 9:46 am with Certified Nursing Assistant (CNA) HH confirmed R51 catheter did not have a dignity bag covering it. CNA HH revealed, CNAs are responsible for providing catheter care at the beginning of the shift at 7:00 am, as needed, and at the end of the shift. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/24/2025 at 9:54 am with the Administrator confirmed that R51 should have a dignity bag. Interview on 2/24/2025 at 9:57 am with Licensed Practical Nurse (LPN) II confirmed R51's catheter bag should have a dignity bag covering it. LPN II then went to retrieve a dignity bag and covered R51's catheter with it. A follow-up interview with LPN II and CNA HH on 2/24/2025 at 10:42 am revealed they had received in-service training on catheter care.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38997 Based on resident interviews, staff interviews, and review of the facility's policy titled, Resident Trust Fund Account, the facility failed to provide resident trust fund account quarterly statements for two of three residents (R) (R24 and R38) reviewed. There were 34 resident trust fund accounts that were managed by the facility. This deficient practice had the potential to affect all residents who had a personal funds account with the facility. Findings include: Review of the facility's policy titled Resident Trust Fund Account, dated 1/9/2022, revealed the Quarterly Statements section included, These are to be done quarterly. Resident Fund Management Service (RFMS) sends them to your facility to be given to the residents. Quarterly statements are to be distributed by the 15th of the month. 1. Review of R24's Minimum Data Set (MDS) End of Prospective Payment System (PPS) Part A Stay assessment dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of (indicating little to no cognitive impairment). Review of the facility-provided document titled Trial Balance revealed R24 had a trust fund account that the facility manages. In an interview on 2/22/2025 at 8:54 am, R24 stated he had a trust fund account that the facility manages. The resident stated he had been a resident for three years and had never received a statement. The resident stated he would like to see his statement to see how much money was in his account. 2. Review of R38's MDS assessment revealed section C (Cognitive Patterns) documented a BIMS of 11 (indicating moderate cognitive impairment). Review of the facility-provided document titled Trial Balance revealed R38 had a trust fund account that the facility manages. In an interview on 2/23/2025 at 1:34 pm, R38 stated there was no reason the facility would give him a quarterly statement. The resident stated he didn't have any money. The resident stated he was not aware that he had a trust fund account with a large balance that the facility manages until informed by the surveyor. In a post-survey interview on 3/5/2025 at 2:08 pm, R38's financial responsible party stated she had not received any quarterly statements for the trust fund account that the facility manages for R38. In an interview on 2/22/2025 at 9:23 am, the Business Office Manager (BOM) stated she was responsible for the resident trust fund account. The BOM confirmed that R24 had a trust fund account that the facility manages. The surveyor accompanied the BOM to R24's room. The resident gave BOM permission to look through his nightstand and stated he was sure there were no statements in his nightstand drawer. The BOM did not find quarterly statements in R24's room. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/22/2025 at 12:50 pm, the Regional Human Resource Coordinator confirmed that the facility document titled Resident Trust Fund Account was the facility's policy. She stated she previously oversaw the business office managers. She further stated that the residents should receive a quarterly statement of the residents' trust fund account that the facility manages. She confirmed the facility policy and procedure was to make two copies of the quarterly statement, provide a copy to the resident, have the resident sign a copy, and the signed copy should be maintained in the business office. She verified that R24 and R38 had trust fund accounts managed by the facility and stated she was unable to provide proof that the quarterly statements had been provided to the residents or their responsible parties.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 38997 Based on staff interview and record review, the facility failed to ensure two of two residents' (R) (R38 and R8) trust fund accounts remained under the $2,000.00 limit to maintain eligibility for Medicaid services. There were 34 residents with trust fund accounts that were managed by the facility. This deficient practice had the potential to affect all residents who had a personal funds account with the facility. Findings include: Review of the facility's policy titled Resident Trust Fund Account, dated 1/9/2022, revealed the Spend Downs section included Accounts over $2,000 are to be spent down within 10 days of reaching that amount. 1. Review of R38's Resident Fund Statement dated 10/1/2024 through 12/31/2024 revealed a beginning balance of $2801.28 and an ending balance of $3743.51. 2. Review of the facility-provided document titled Trial Balance revealed that R8's balance on 2/22/2025 was $2075.58. In an interview on 2/23/2025 at 1:00 pm, the Regional Human Resource Coordinator confirmed that R38 and R8's accounts exceeded the $2,000 limit to maintain eligibility for Medicaid services. She stated the Business Office Manager for the facility was in the process of obtaining a burial policy for the residents that have exceeded the $2000.00 limit. In an interview on 2/23/2025 at 4:45 pm, the Administrator confirmed that the facility has some residents who were exceeding the $2,000 limit to maintain eligibility for Medicaid services. She stated that the Business Office Department was in the process of identifying the residents and establishing a burial fund for those residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47947 Based on observations, staff interviews, and review of the facility's policy titled Safe and Homelike Environment, the facility failed to maintain a homelike environment for eight of 54 resident rooms on two of four halls and in the main dining room (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] on Hall 100 and Hall 307). These deficient practices had the potential to place residents at risk of living in an unsanitary and unsafe living environment and a potential for diminished quality of life. Findings include: Review of the facility's undated policy titled Safe and Homelike Environment revealed the Policy Explanation and Compliance Guidelines section included, 1. The facility will create and maintain, to the extent possible, a homelike environment that deemphasizes the institutional character of the setting. Observations on 2/22/2025 from 10:10 am to 10:40 am revealed eight ceiling tiles in the dining room had large brown stains on them, one ceiling light in the dining room was without a cover over the bulb, and floor tiles with dark stains in the shared bathrooms of resident rooms [ROOM NUMBERS]. Observations on 2/22/2025 at 1:00 pm revealed that the ceiling fan in resident room [ROOM NUMBER] was detached from the ceiling. Observations on 2/22/2025 at 1:05 pm revealed a detached wall plate covering for the outlet for the television cable in resident room [ROOM NUMBER] and a detached ceiling exhaust fan in resident room [ROOM NUMBER]. 49138 Observations on 2/22/2205 at 9:19 am, 2/23/2025 at 10:15 am, and 2/24/2025 at 11:15 am revealed brown stains and discolorations on the floor of the shared restroom in rooms [ROOM NUMBERS]. An observation on 2/22/2025 at 9:28 am revealed a water leak around the toilet in the shared bathroom of rooms [ROOM NUMBERS]. During concurrent observations and an interview on 2/24/2025 at 1:15 pm, the Maintenance Director (MD) confirmed the findings and stated all work orders were being submitted through the electronic maintenance reporting system.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49396 Based on observations, staff interviews, and record review, the facility failed to ensure that one of seven residents (R) (R36) receiving respiratory care received respiratory care in accordance with professional standards of practice and regulatory requirements. Specifically, the facility failed to obtain a physician's order for oxygen (O2) therapy and ensure proper storage and handling of O2 equipment. The deficient practice had the potential to place R36 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: A review of R36's face sheet revealed they were admitted with diagnoses not limited to chronic systolic (congestive) heart failure, paroxysmal atrial fibrillation, hyperlipidemia, cardiomyopathy due to drug and external agent, essential hypertension, chronic kidney disease, and hemiplegia following cerebral infarction. A review of R36's Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has a Brief Interview for Mental Status (BIMS) score of 13, indicating she is cognitively intact, Section O (Special Treatments, Procedures and Programs) noted O2 use. A review of R36's physician's orders revealed no active order for O2 therapy. A review of R36 ' s care plan revealed the care plan did not reflect the residents' ongoing use of O2. Observation on 2/22/2025 at 10:38 am revealed R36 wearing O2 at 2 LPM (liters per minute) via nasal cannula (NC). The resident refused to speak with the surveyor. Observation on 2/23/2025 at 9:27 am revealed R36 wearing O2 at 2 LPM via NC. The resident refused to speak with the surveyor. Observation on 2/23/2025 at 4:37 pm revealed R36 not wearing her O2. The NC tubing was on the floor, dirty, and not stored in a plastic bag. During an interview on 2/23/2025 at 4:40 pm, the Director of Nursing (DON) stated that the facility failed to obtain a physician's order for O2 therapy after the resident's discharge from the hospital on 1/17/2025. The DON acknowledged that the standard protocol was to reconcile orders upon readmission, but this was not done for R36. She stated that the resident had been receiving O2 without a formal order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49673 Based on observations, staff interviews, record review, and review of the facility's policy titled, Date Marking for Food Safety, the facility failed to discard refrigerator food by expiration dates and ensure proper food labeling, storage, and dating, and to ensure dishwasher and sink testing strips were not expired. The deficient practices had the potential to affect all residents who receive meals from the kitchen. Findings include: Review of the undated facility policy titled Date Marking for Food Safety revealed under Policy Explanation and Compliance Guidelines for Staffing: . 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 5. The discard day or date may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. During the initial tour and observation of the kitchen on [DATE] at 7:49 am with the Dietary Manager (DM) revealed two one-gallon pitchers of brown-like liquid labeled sweet-tea with an expiration date of [DATE] and two five-pound bags of diced onions with an expiration date of [DATE] in the double refrigerator. The DM immediately discarded the expired food items. Interview on [DATE] at 7:40 am with the Dietary Manager confirmed she was responsible for labeling and dating and just checked dates recently on [DATE] with the Registered Dietitian during an inspection. The DM mentioned she updated most everything. During a follow-up observation and interview on [DATE] at 8:47 am with the DM, the dishwasher and sink were tested for the concentration of sanitizer by the DM which revealed the [name of test manufacturer] test paper expired [DATE]. The DM confirmed she did not have any more testing papers with valid expiration dates and will have to order some but will use the dishwasher.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38997 Based on observations, staff interviews, and a review of the facility's policy titled, Blood Glucose Monitoring, the facility failed to ensure the infection control process was followed during glucometer (a device used to test blood sugar results) use for one of eight residents (R) R104) with a physician order for a glucometer reading. The deficient practices had the potential to place residents with a physician's order for glucometer testing at risk of infection due to cross-contamination and increase the spread of infection. Findings include: Review of the facility's undated policy titled Blood Glucose Monitoring, revealed the Policy Explanation and Compliance Guidelines section included .3. The nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy. An observation on 2/23/2025 at 11:05 am of Licensed Practical Nurse (LPN) AA performing a glucometer test on R104 revealed that LPN AA gathered the supplies, entered the resident's room, and laid the supplies on the overbed table without a barrier. LPN AA then picked the supplies up and laid them on the bed without a barrier. LPN AA then exited the resident's room and laid the machine on the top of the medication cart without a barrier. After LPN AA performed hand hygiene, the meter was then placed inside of the medication cart. LPN AA completed hand hygiene, removed the same meter from the medication cart, and gathered supplies for a glucometer test on R37. The LPN was asked not to perform the glucometer test on R37 and to please return to the medication cart. In an interview on 2/23/2025 at 11:33 am, the Assistant Director of Nursing (ADON) stated the glucometer machine should be cleaned with a germicidal disposable wipe after each use. She further stated that a barrier must be used when placing the glucometer and supplies on any surface. The ADON stated she would start educating the staff on the proper way to disinfect the glucometer and use a barrier before placing the meter and supplies on any surface. In an interview on 2/23/2025 at 11:40 am, LPN AA stated she had not received education on cleaning a glucometer from the facility.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 49673 Based on observations, staff interviews, and record review, the facility failed to ensure essential kitchen equipment was in working order as evidenced by the kitchen hood extinguishing system not operating. This deficient practice had the potential to affect 50 residents receiving an oral diet from the kitchen. Findings include: A review of the facility-provided document titled Kitchen Auto Extinguishing Systems, dated 1/30/2025, revealed the kitchen hood passed the inspection, and inspection results documented that the exhaust fan(s) were not operable. A review of the facility's work order from an electrical service dated 2/22/2025 revealed an on-site inspection that documented there was no voltage to the kitchen hood motor, and the recommendation was made to order a motor. A review of the facility's work order from an electrical service dated 2/24/2025 revealed an on-site service visit documented the kitchen hood motor was operating, and it had no belt. The belt was replaced, and the hood was working. During the initial kitchen tour and observation on 2/22/2025 at 7:49 am, observation revealed the kitchen hood ventilation fan would not turn on. The Dietary Manager (DM) stated she did not remember the fan being in operable order since November 2024. Additional observations on 2/23/2025 starting at 8:47 am during follow-up visits to the kitchen revealed the hood ventilation fan was still not in operation. In an interview on 2/22/2025 at 10:42 am, Life Safety Code (LSC) DD confirmed the facility's kitchen staff and leadership were informed they could not cook on anything under the hood until it was repaired and operable. In an interview on 2/22/2025 at 11:37, the Administrator stated she was not informed about the hood ventilation fan malfunction. The Administrator confirmed the residents would be served alternative meals. In an interview on 2/22/2025 at 11:43 am, the DM stated the residents would be served alternative meals that did not require cooking under the kitchen ventilation hood. In an interview on 2/22/2025 at 11:47 am, Dietary [NAME] EE revealed she did not know when the hood vent went out but thinks it happened sometime after January when there was bad weather. In an interview on 2/22/2025 at 11:53 am, Dietary [NAME] FF revealed she did not know when the hood system stopped working. In an interview on 2/23/2025 at 8:47 am, the DM stated the hood fan was not working. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 2/23/2025 at 9:06 am, Maintenance Director GG stated he had not been informed of the malfunction of the kitchen hood ventilation fan until 2/22/2025. In an interview on 2/23/2025 at 9:13 am, the Administrator stated that an electrical repair service provided service on 2/22/2025 and ordered a new motor for the kitchen hood ventilation system.