STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Hills Nursing Center	864 US Hwy 158 Business West Warrenton, NC 27589

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45044 Based on record review, staff and resident interviews, the facility failed to provide written notification of a roommate change for 1 of 1 resident reviewed for notification of a change (Resident #37). The findings included: Resident # 37 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively intact. An interview was completed on 11/18/24 at 10:00 a.m. with Resident #37. Resident #37 stated approximately 2 to 3 weeks ago she received a new roommate. Resident #37 stated prior to that day she was in a room alone. The Resident stated she went out to an appointment and when she returned, she had a new roommate. Resident #37 stated she had not received written or verbal notification she would be getting a new roommate. Review of facility records revealed Resident #37 received a new roommate on 10/29/24. There was no documentation in the medical record for Resident #37 indicating a discussion or notification of a new roommate in October 2024. An interview was completed on 11/20/24 at 2:10 p.m. with the facility's Social Worker (SW). The SW stated it was her process to contact residents and their responsible party prior to the resident receiving a new roommate. The SW revealed she only notified a resident and their Responsible Party (RP) verbally and not in writing when there was a change in roommates. The SW stated she did not notify Resident #37 or their RP verbally or in writing that Resident #37 would be getting a roommate. The SW was unable to say why she did not provide notification. An interview was completed on 11/21/24 at 11:30 a.m. with the Director of Nursing and the facility Administrator. The Administrator stated it was his expectation a resident and their RP would be notified of a roommate change verbally and in writing prior to the roommate change.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Hills Nursing Center	864 US Hwy 158 Business West Warrenton, NC 27589

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772 Based on record review, resident, and staff interviews, the facility failed to provide written documentation for advance directive information and the opportunity to formulate an advance directive for 13 of 22 residents reviewed for advanced directives. Residents #57, #71, #58, #55, #70, #68, #29, #72, #38, #52, #65, #61, #45. The findings included: a. Resident #57 was admitted to the facility on [DATE]. Resident #57 had severe cognitive impairment. Review of a physician ' s order dated 7/24/24 revealed Resident #57 was a full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. b. Resident #71 was admitted to the facility on [DATE]. Resident #57 was cognitively intact. Resident #71 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. c. Review of Resident #58 was admitted to the facility on [DATE]. Resident #58 was cognitively intact. Review of a physician ' s order dated 9/25/24 revealed Resident #58 was a full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. d. Resident #55 was admitted to the facility on [DATE].Resident #55 had moderate cognitive impairment. Resident #55 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. e. Resident #70 was admitted to the facility on [DATE]. Resident #70 was cognitively intact. Review of a physician ' s order dated 10/23/23 revealed Resident #70 was a full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. f. Resident #68 ' s was admitted to the facility on [DATE]. Resident #68 was cognitively intact. Resident #68 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Hills Nursing Center	864 US Hwy 158 Business West Warrenton, NC 27589

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Resident #29 was admitted to the facility on [DATE]. Resident #29 had severe cognitive impairment. Resident #29 held a physician order for Do Not Resuscitate (DNR). There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. h. Resident #72 was admitted to the facility on [DATE]. Resident #72 was cognitively intact. Resident #72 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. i. Resident #38 was admitted to the facility on [DATE]. Resident #38 was cognitively intact. Resident #38 held a physician order for Do Not Resuscitate (DNR). There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. j. Resident #52 was admitted to the facility on [DATE]. Resident #52 was cognitively intact. Resident #52 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. k. Resident #65 was admitted to the facility on [DATE]. Resident #65 had severe cognitive impairment. Resident #65 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. l. Resident #61 was admitted to the facility on [DATE]. Resident #61 was cognitively intact. Resident #61 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. m. Resident #45 was admitted to the facility on [DATE]. Resident #45 was cognitively intact. Resident #45 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. An interview was conducted with the Social Worker on 11/21/24 at 1:06 PM. The Social Worker stated advance directives were reviewed during the care plan meeting. She stated the review of advance directives was documented on the Care Plan assessment or in the Social Services assessment upon admission and readmission. The Social Worker stated she filled out an advance directive form to show that advance directive was discussed with the residents or family during care planning. The Social Worker stated the Advance Directive form was uploaded into the electronic medical record. There was no documentation of education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party on the advance directive form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Hills Nursing Center	864 US Hwy 158 Business West Warrenton, NC 27589

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator on 11/21/24 at 1:30 PM. The Administrator stated the education and discussion of Advanced Directives should have been documented for each resident in the facility. The Administrator stated he expected that residents would be reassessed for advance directives when readmitted and during the care plan meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Hills Nursing Center	864 US Hwy 158 Business West Warrenton, NC 27589

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789 Based on record review and staff interviews, the facility failed to provide written notification for reason of discharge to the Ombudsman for 4 of 6 residents reviewed for hospitalization (Resident #38, Resident #51, Resident #61, Resident #71). The findings included: a. Resident #71 was admitted to the facility on [DATE]. Resident #71 transferred to the hospital on 7/15/2024 and returned to the facility on [DATE]. A record review revealed there was no documentation the Ombudsman received written notification for transfer to the hospital. b. Resident #51 was admitted to the facility on [DATE]. Resident #51 transferred to the hospital on 10/18/2024 and returned to the facility on [DATE]. A record review revealed there was no documentation the Ombudsman received written notification for transfer to the hospital. c. Resident #38 was admitted to the facility on [DATE]. Resident #38 transferred to the hospital on 6/15/2024 and returned to the facility on [DATE]. A record review revealed there was no documentation the Ombudsman received written notification for transfer to the hospital. d. Resident #61 was admitted to the facility on [DATE]. Resident #61 transferred to the hospital on 12/21/2023 and returned to the facility on [DATE]. Additionally, Resident #61 transferred to the hospital on 9/10/2024 and returned to the facility on [DATE]. A record review revealed there was no documentation the Ombudsman received written notification for transfer to the hospital. During an interview with the Social Worker (SW) on 11/19/2024 at 12:58 p.m. she revealed she had not sent discharge information to the Ombudsman's office for those residents who were sent to the hospital. The SW reported she was not aware she had to send written notification to the Ombudsman when a resident transferred to the hospital. During an interview with the Administrator on 11/21/2024 at 10:30 a.m. he revealed he was not aware the SW had not submitted monthly discharge reports to the Ombudsman. He stated it was the responsibility of the SW to send discharge notifications to the Ombudsman.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Hills Nursing Center	864 US Hwy 158 Business West Warrenton, NC 27589

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789 Based on record review and staff interviews, the facility failed to refer a resident with a serious mental illness for a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents reviewed for PASRR (Resident #34). Findings included: Resident #34 was admitted to the facility on [DATE] and readmitted on [DATE]. On 8/7/2023 Resident #34 was diagnosed with delusional disorder. A Level I PASRR determination notification letter dated 3/3/2020 indicated No further PASRR screening is required unless a significant change occurs with the individual's status which suggest a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. No facility documentation was discovered indicating a Level II PASRR referral had been completed for Resident #34 after the diagnosis of a serious mental illness had been made. An interview with the Social Worker (SW) on 11/20/2024 at 2:50 p.m. revealed she was not aware Resident #34's Level II PASRR screening had not been completed. She stated the Admissions Director would let her know if a resident required screening. During an interview with the Admissions Director on 11/21/2024 at 9:35 a.m. she revealed she checked residents' PASRR screening upon admission. She explained she had failed to check Resident #34's PASRR upon readmission. After reviewing his diagnosis, she indicated Resident #34 met the criteria for serious mental illness and she should have submitted a referral for a Level II PASRR screening. During an interview with the Administrator on 11/21/2024 at 10:35 a.m. he revealed he was not aware Resident#34's PASRR screening had not been completed upon readmission and explained this was a problem.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Hills Nursing Center	864 US Hwy 158 Business West Warrenton, NC 27589

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41772 Based on observation, staff interviews, the facility failed to dispose/discard expired medications in 1 of 3 medication carts (600 Hall medication cart) observed for medication storage. The findings included: An observation was conducted of the 600 Hall medication cart on 11/21/24 at 10:48 AM. One opened bottle of Senna -Plus with an expiration date of October 2024 was found on the cart. An interview was conducted with Medication Aide #2 on 11/21/24 at 10:50 AM. Mediation Aide #2 stated the medication should have been discarded. Medication Aide #2 stated the medication aide/ nurse assigned to the cart was responsible for checking for expired medications each shift. An interview was conducted with the Director of Nursing (DON)on 11/21/24 at 11:28 AM. The DON stated the medication aides and nurses assigned to the medication cart were responsible for checking carts for expired medication. The DON stated expired medications were to be removed from the cart immediately. An interview was conducted with the Administrator on 11/21/24 at 1:28 PM. The Administrator stated the medication aides and nurses assigned to the medication cart were responsible for checking carts for expired medication. The Administrator stated expired medications were to be removed from the cart immediately.