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	02/26/2026

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

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, the Consultant Pharmacist, and the Physician Assistant, the facility failed to evaluate the continued need for a medication prescribed for wheezing. This deficient practice had the potential to result in residents receiving medications without clinical indication, ongoing monitoring, or justification of continued use for 1 of 6 residents reviewed unnecessary medications (Resident #75).The findings included:Resident #75 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbances, pleural effusion (abnormal accumulation of excess fluid in the space between the lungs and chest wall), and congestive heart failure (CHF). The nursing progress note dated 11/20/25 at 8:03 pm revealed the Physician Assistant (PA) was notified by Nurse #2 that Resident #75 had a wheeze (a high-pitched, whistling sound produced during breathing caused by narrowed or obstructed airways). Nurse #2 noted that the PA ordered a chest x-ray and ipratropium bromide 0.5 milligram (mg)/albuterol sulfate 2.5 mg, 3 mg/3 milliliters, inhalation solution (combination bronchodilator medication used via a nebulizer to open airways and reduce mucus) every 4 hours.Resident #75 had an active physician order dated 11/20/25 for ipratropium bromide 0.5 milligram (mg)/albuterol sulfate 2.5 mg, 3 mg/3 milliliters, inhalation solution. Administer one (1) inhalation orally via nebulizer (medical device used to deliver medication directly to the respiratory system) every 4 hours for wheezing. The health status note dated 11/23/25 revealed Resident #75's radiology results for the chest x-ray revealed no acute findings. The PA was notified and no new orders were received.The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #75 had moderate cognitive impairment with unclear-slurred or mumbled words.The Medical Director visit note dated 12/02/25 revealed Resident #75 denied chest pain and shortness of breath. Resident #75 was noted to have even and unlabored respirations which were clear to auscultation (listening by stethoscope).The Medical Director visit note dated 1/20/26 revealed Resident #75 denied chest pain and shortness of breath. Resident #75 was noted to have even unlabored respirations which were clear to auscultation.The PA visit note dated 1/30/26 revealed Resident #75 had no complaints, denied any chest pain, shortness of breath, or other discomforts. The PA further noted the resident did not exhibit any signs of respiratory distress and was found to have clear lungs without wheeze. The Medical Director visit note dated 2/17/26 revealed Resident #75 denied any shortness of breath and was noted to have even and unlabored respirations which were clear to auscultation.The Medication Administration Record (MAR) for November 2025 through February 2026 revealed Resident #75 was administered the medication as ordered with the exception of refusals. The medication was last administered on 2/25/26 at 12:00 pm. An observation was conducted on 2/23/26 at 1:10 pm of Resident #75. Resident #75 was in bed with no wheeze or shortness of breath noted. A nebulizer machine was noted to be placed at the foot of the bed. Support Nurse #2 was interviewed on 2/25/26 at 3:21 pm who confirmed she was responsible for the oversight of Resident #75. Support Nurse #2 stated that she was not sure why Resident #75 was still receiving the bronchodilator medication because she had not observed any wheezing from the resident. She stated she had discussed Resident #75 with nursing staff on 2/25/26 and no staff member had reported continued wheezing to support the need for the (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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication. Support Nurse #2 stated she would discuss discontinuation of the medication with the PA.A telephone interview was conducted on 2/25/26 at 2:42 pm with the Consultant Pharmacist who revealed she reviewed Resident #75's medications monthly during the medication regimen review to evaluate the need of the medications prescribed. The Consultant Pharmacist stated she would not address the bronchodilator medication order with the provider because based on the PA visit notes the provider reviewed medications and noted to continue with current treatment plan for Resident #75. A telephone interview was conducted with the Physician Assistant on 2/26/26 at 11:21 am. The PA reported that Resident #75 had CHF with occasional wheeze so the medication order would be warranted to be an as needed (PRN) order. The PA stated she had not observed Resident #75 to have wheezing and it had not been reported by any staff so she would not have expected the medication to continued being used. The PA stated she did review the medications and assess Resident #75 at each visit, but she was not aware the medication continued to be administered, and she did not notice the order was not written for an as needed medication. An attempt to conduct a telephone interview with the Medical Director on 2/26/26 at 12:55 pm was unsuccessful. During an interview with the Director of Nursing (DON) on 2/26/26 at 10:32 am she revealed that when the order was initially received for Resident #75 it should have been written as a PRN order instead of scheduled. The DON stated that the nursing staff should have identified no symptoms were being exhibited by Resident #75 and contacted the provider to discuss changing the order to PRN or discontinuing the order. The DON stated that while physician orders were reviewed in the clinical meeting, they normally reviewed new orders during the meeting and did not have a process in place for older standing orders. The Administrator was interviewed on 2/26/26 at 12:24 pm and she stated the PA wrote the order for Resident #75's medication and should have identified it was ordered and remained in place as routine for the extended period.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review and staff interviews the facility failed to implement their infection prevention program policies and procedures and follow their Hand Hygiene policy when Nurse #3 failed to perform hand hygiene and change gloves when flushing a peripherally inserted central catheter (PICC) line (a long thin flexible tube inserted through an arm vein near the heart for long term intravenous access) and connecting the intravenous (IV) antibiotic tubing to the PICC line tubing. In addition, the Wound Treatment Nurse failed to change the disposable gloves and perform hand hygiene during wound care observation for Resident #2 and Resident #22. The deficient practice occurred for 2 of 4 staff observed for infection control practices (Nurse #3 and Wound Nurse).The findings included: The facility's Infection Prevention and Control Standards policy, last approved September 2025, revealed the purpose of the policy was to implement the Infection Prevention and Control Program (IPCP) to minimize the risk of infection to the residents and staff. The policy further read that staff were to support resident safety by adhering to all policies and procedures related to infection prevention including standard and transmission-based precautions. The facility's Hand Hygiene policy, last approved June 2025, stated that hand hygiene was regarded as the single most important means of preventing the spread of infections. The policy further noted that hand hygiene was to be performed after contact with non-intact skin, before performing dressing care or touching wound of any kind, after handling used dressings, and after touching equipment or furniture that is near a resident. The IV Therapy policy last approved on October 2025 read in part that the PICC line flushing procedure stated the nurse was to wash hands thoroughly prior to flushing the PICC line. 1. A continuous observation of medication administration for Resident #28 was conducted with Nurse #3 on 2/24/26 at 9:13 am through 9:19 am. Nurse #3 was observed to don gloves, remove and prepare prescribed medications from the medication cart outside Resident #28's room. Nurse #3 was then observed to depress and lock the medication cart, gather the medications, which included IV antibiotics and enter Resident #28's room without removing her gloves or performing hand hygiene. Nurse #3 then administered the oral medications to Resident #28 and proceeded to prepare the IV antibiotics for administration through the PICC line in the right upper arm of Resident #28. Without removing her gloves and performing hand hygiene, Nurse #3 then hung the bag of IV antibiotics on the IV pole, inserted the end of the new IV tubing into the antibiotic bag, and primed the IV tubing (filled the tubing with the solution from the IV medication to remove air). Nurse #3 then opened the IV pump chamber and placed the IV tubing in the chamber and closed the chamber latch with the gloved hand. Nurse #3, without removing the gloves and performing hand hygiene, then removed the disinfecting cap from the PICC line, wiped the hub with an alcohol wipe, flushed the PICC line with normal saline, connected the IV tubing from the antibiotic to the PICC line and started Resident #28's IV antibiotics. Nurse #3 was observed to remove her gloves and perform hand hygiene with hand sanitizer and exited Resident #28's room at 9:19 am. An immediate interview was conducted with Nurse #3 on 2/24/26 at 9:20 am who revealed she should have removed the gloves after pulling the medications from the medication cart, performed hand hygiene, and put on clean gloves before working with Resident #28's IV antibiotic and PICC line. Nurse #3 was unable to state why she did not remove the gloves and perform hand hygiene before working with Resident #28's PICC line, she stated she just didn't do it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Infection Preventionist (IP) was interviewed on 2/26/26 at 8:57 am and revealed Nurse #3 should have removed the gloves and performed hand hygiene before she entered Resident #28's room to administer medications. The IP stated Nurse #3 was to perform hand hygiene and don clean gloves before she flushed the PICC line and administered the IV antibiotics to Resident #28. The Director of Nursing (DON) was interviewed on 2/25/26 at 4:22 pm. The DON stated that Nurse #3 should have removed the gloves worn and performed hand hygiene after preparing the medication, touching the medication cart, IV pole, and IV pump. The DON stated Nurse #3 was required to perform hand hygiene prior to flushing the PICC line and starting Resident #28's IV antibiotic. During an interview with the Administrator on 2/26/26 at 12:19 pm she revealed Nurse #3 should have performed hand hygiene prior to starting the process of administering Resident #28's IV antibiotic. 2. A continuous observation of Resident #2's pressure ulcer treatment was conducted on 2/24/26 at 11:48 am through 12:00 pm with the Wound Treatment Nurse. The Wound Treatment Nurse was observed to perform hand hygiene, don clean gloves and prepared to cleanse Resident #2's sacral and left buttock pressure ulcers. The Wound Treatment Nurse was observed to spray the wound bed of the stage 4 sacral pressure ulcer with wound cleanser and wipe the wound bed with gauze. The stage 4 sacral pressure ulcer presented with slough (yellow/white, dead tissue that accumulates in the wound which harbors bacteria) present on the wound bed. The Wound Treatment Nurse then sprayed the stage 3 left buttock pressure ulcer with wound cleanser and wiped the wound bed with gauze. The Wound Treatment Nurse did not change gloves or perform hand hygiene after cleansing the stage 4 pressure ulcer and before cleansing the stage 3 pressure ulcer. The Wound Treatment Nurse was then observed to prepare and place the new wound treatment dressings on Resident #2's sacral and left buttock wounds. The Wound Treatment Nurse did not remove the soiled gloves or perform hand hygiene after cleansing Resident #2's pressure ulcers or before preparing and placing the wound treatments. The Wound Treatment Nurse was observed to remove soiled gloves and perform hand hygiene and exited Resident #2's room at 12:00 pm. An immediate interview was conducted with the Wound Treatment Nurse on 2/24/26 at 12:01 pm. The Wound Treatment Nurse stated she should have removed the soiled gloves and performed hand hygiene between cleaning the wounds and putting on new dressings. The Wound Treatment Nurse stated she was nervous and just forgot to change her gloves. An interview was conducted on 2/26/26 at 8:56 am with the Infection Preventionist (IP) who stated the Wound Treatment Nurse should have removed the soiled gloves and performed hand hygiene after cleansing Resident #2's pressure ulcers. The IP stated the new treatment dressings should not have been placed on the wound bed with the soiled gloves. During an interview with the Director of Nursing (DON) on 2/25/26 at 4:22 pm she revealed the Wound Treatment Nurse should have removed the gloves and performed hand hygiene after cleansing the wound beds and putting the new dressings on to prevent contamination of the new dressings. The Administrator was interviewed on 2/26/26 at 12:19 pm. The Administrator stated the Wound Treatment Nurse had been educated on the hand hygiene policy and should have followed the policy when the pressure ulcer treatment was completed. 3. An observation was conducted of wound care with the Wound Nurse for Resident #22 on 2/24/26 at 2:17 PM. The Wound Nurse was already in the resident's room when the surveyor entered the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Wound Nurse performed hand hygiene, donned a gown and clean gloves. The Wound Nurse removed the old dressing and without removing her gloves and performing hand hygiene the Wound Nurse proceeded to clean the pressure ulcer to Resident #22's left buttock with gauze soaked in wound cleanser. Without changing her gloves or performing hand hygiene the Wound Nurse opened the new dressings. The Wound Nurse then removed her gloves and completed hand hygiene. The Wound Nurse donned a new pair of gloves and placed calcium alginate (wound dressing) to the wound bed. The Wound Nurse then applied Zinc Oxide ointment to the wound edges and outer wound area. She then applied a dry dressing to left buttock wound, gathered trash, removed her gloves and completed hand hygiene. The Wound Nurse assisted Resident #22 on his back with the head of bed elevated. During an interview with the Wound Nurse on 2/24/26 at 2:33 PM, the Wound Nurse stated she should have removed her gloves and performed hand hygiene after removing the old dressing and prior to cleaning the wound. The Wound Nurse stated she became nervous and forgot this step. During an interview with the Infection Preventionist on 2/24/26 at 3:10 PM it was revealed that all staff received infection control training which included hand hygiene annually. The IP stated the Wound Nurse should have removed the old dressing, performed hand hygiene and donned a new pair of gloves prior to cleaning the wound. An interview was conducted with the Director of Nursing on 2/24/26 at 3:35 PM. The DON stated the Wound Nurse should have performed hand hygiene and changed her gloves to prevent cross contamination of Resident #22's wound. The DON stated the Wound Nurse should have performed hand hygiene and changed her gloves after removing the old dressing and prior to cleaning the wound.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) Assessments for 3 of 29 residents whose MDS assessments were reviewed for accuracy (Resident #2, Resident #28 and Resident #38).The findings included: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses which included dementia with behaviors. The wound provider visit note dated 1/16/26 revealed Resident #2 was treated for a stage 4 pressure ulcer to the sacrum, a stage 3 pressure ulcer to the left buttock, and an unstageable deep tissue injury (DTI) to the right heel. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #2 was coded for one stage 3 pressure ulcer and one unstageable deep tissue injury (DTI). An interview was conducted with the MDS Nurse on 2/25/26 at 3:38 pm who confirmed Resident #2 had a stage 3 pressure ulcer, a stage 4 pressure ulcer, and a DTI at the time of the MDS quarterly assessment based on the documentation from the wound provider. The MDS Nurse stated she just overlooked the stage 4 pressure ulcer when she completed Resident #2's quarterly assessment. During an interview conducted on 2/26/26 at 12:18 p.m., the Administrator stated that the MDS Nurse was responsible for accurately completing Resident #2's MDS assessment for pressure ulcers. The Administrator stated the MDS Nurse had the information for Resident #2's pressure ulcers and the assessment should have been accurately coded. 2. Resident #28 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis (infection of the bone) of the right ankle and foot. Resident #28 had a physician order dated 2/07/26 for vancomycin intravenous (IV) solution; use 1.25 gram intravenously every 24 hours for infection related to osteomyelitis right ankle and foot until 3/04/26. The care plan dated 2/09/26 revealed Resident #28 had a care plan in place for IV medication via PICC (peripherally inserted central catheter used for long-term intravenous access) with risk for complications such as infection and infiltration. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #28 was cognitively intact. The MDS assessment further noted that Resident #28 was coded for intravenous medication use but was not coded for IV access. During an interview conducted on 2/25/26 at 3:38 p.m., the MDS Nurse stated that Resident #28's PICC IV access should have been coded as IV access on the assessment. She acknowledged that she inadvertently overlooked the IV access when completing Resident #28's assessment. During an interview conducted on 2/26/26 at 12:18 p.m., the Administrator stated that the MDS Nurse was responsible for accurately completing Resident #28's MDS assessment. She further explained that Resident #28's assessment should have been coded accurately for the IV access. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #38 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease and cerebral infarction.Review of Resident #38's electronic health record revealed a physician's order dated 3/11/19 for Clopidogrel (an antiplatelet medication) 75 milligram (mg) one tablet by mouth daily. A review of Resident #38's December 2025 Medication Administration Record (MAR) revealed documentation of Clopidogrel 75mg one tablet by mouth daily. A review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was coded as receiving an anticoagulant. An interview was conducted with Support Nurse #2 on 2/26/26 at 1:11 PM. Support Nurse #2 confirmed she had completed Resident #38's quarterly MDS dated [DATE]. Support Nurse #2 indicated she was being trained to complete the MDS. She stated that coding Resident #38 as receiving an anticoagulant was an error. During an interview with the Administrator on 2/2626 at 2:30 PM she stated Resident #38's MDS assessment should have been coded accurately.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to place a resting hand orthosis ([NAME], a device designed to support the hand, wrist, and fingers in a functional position) to the right hand for contracture management for 1 of 3 resident reviewed for position, mobility and range of motion (Resident #6).The findings included:Resident #6 was admitted to the facility on [DATE] with diagnoses which included stroke with hemiparesis (weakness caused by stroke) affecting the right dominant side. The care plan initiated on 11/19/25 and under review on 2/23/26 revealed Resident #6 had right hemiplegia/hemiparesis related to stroke with interventions which included perform range and motion exercises with am and pm care daily, apply [NAME] daily, complete hand hygiene and skin checks. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #6 had severe cognitive impairment and was coded for functional limitation in range of motion on the upper and lower extremity on one side. The Occupational Therapy (OT) Discharge summary dated [DATE] revealed Resident #6 was discharged from OT services due to reaching her maximum potential and an order for the [NAME] was in place. The OT discharge summary further noted that Resident #6's family and the nursing staff were provided education on splinting. Resident #6 had a physician order dated 2/06/26 for splint; apply right upper extremity [NAME] daily, complete hand hygiene and skin checks every day shift to prevent contracture and skin breakdown.Observations were conducted on 2/23/26 at 10:56 am, 12:57 pm, and 2:45 pm of Resident #6. Resident #6 was observed in bed without a splint in place. Resident #6's right arm rested along the abdomen and leg with slight bend noted at the wrist that did not appear to be lying flat. The splint was observed to be on the table in the room. Observations of Resident #6 were conducted on 2/24/26 at 8:28 am, 12:06 pm, and 2:44 pm. Resident #6 was observed in bed without the splint in place. The splint was observed to be on the table in the room. The Treatment Administration Record (TAR) revealed Resident #6 was documented to have the right upper extremity splint in place on 2/23/26 and 2/24/26 by Nurse #3.An interview was conducted with Nurse #3 who revealed the therapy staff placed Resident #6's right upper extremity splint and would then notify her that it was in place and she documented the splint as in place on the TAR. Nurse #3 stated she believed the splint was to stay in place for 8 hours but she did not manage the splint placement or removal for Resident #6. The Rehabilitation Manager was interviewed on 2/25/26 at 3:15 pm who revealed the therapy staff were responsible for Resident #6's right upper extremity [NAME] splint when she was on the therapy caseload but once the resident was discharged from therapy services the nursing department was responsible for the splint. The Rehabilitation Manager stated once Resident #6 discharged from therapy on 2/06/26 a physician order was placed for nursing to manage the splinting for the right upper extremity. She stated the therapy department met with nursing staff and provided education regarding the use and management of the right upper extremity [NAME] and signed off the care to nursing. The Rehabilitation Manager stated Resident #6's splint was recommended to be worn for up to 4 hours during the day shift. During an interview on 2/25/26 at 4:26 pm the Director of Nursing (DON) stated once the resident was no longer on therapy the Nurse was responsible for putting the splint in place for Resident #6. The DON stated that Nurse #3 would have seen the order for Resident #6's splint to place the splint on during the day shift so the order should have been followed by Nurse #3. The Administrator was interviewed on 2/26/26 at 12:22 pm and revealed that Nurse #3 would have been the staff member responsible to manage Resident #6's splint on 2/23/26 and 2/24/26 and Nurse #3 should have ensured the splint was in place as ordered.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and resident and staff interviews, the facility failed to secure the indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 1 resident reviewed for indwelling urinary catheter (Resident #22).Resident #22 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of bladder and urinary retention. A physician's order dated 9/5/2025 indicated Resident #11 had an indwelling urinary catheter for urinary retention.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact. He was coded as having an indwelling urinary catheter.An observation was conducted of wound care on 02/24/2026 at 2:17 PM with the Wound Nurse. During the observation Resident #22 did not have a leg band in place to secure the tubing for his indwelling urinary catheter. There was no tension on the catheter tubing during the observation. An interview was conducted with Resident #22 on 2/24/26 at 2:22 PM. Resident #22 stated that staff sometimes forgot to place a securement device on his indwelling urinary catheter tubing. Resident #22 was unable to say how long it had been since he's had a leg band on. Resident #22 denied any discomfort or tension on the catheter tubing. An observation was conducted of Resident #22's urinary catheter on 02/25/2026 at 9:54 AM with the Infection Preventionist. During the observation Resident #22 was observed to be lying in bed with urinary catheter tubing not secured. There was no tension on the catheter tubing during the observation.An interview was conducted with the Infection Preventionist (IP) on 2/25/2026 at 10:00 AM. The IP stated the resident was supposed to have a leg band in place because it prevented the indwelling catheter from becoming dislodged and causing trauma to the bladder. She stated the nurse on the hall was responsible for making sure the leg band was in place. The IP nurse further stated the nurse aide caring for the resident should let the nurse know when the leg band was not in place. An interview was conducted with Nurse # 4 on 2/25/26 at 10:07 AM. Nurse #4 stated the nurse was responsible for checking to see if the resident had a leg band in place. Nurse # 4 stated he had not been made aware that Resident #22 did not have a leg band in place. During an interview with Nurse Aide (NA) #1 on 02/25/2026 at 2:14 PM, she stated the IP nurse had made her aware that Resident #22 did not have a leg band in place. NA #1 stated the resident usually had a leg band and she just had not gotten to him during her care rounds so that she could notify the nurse that the leg band was missing. NA #1 stated Resident #22 received his bath on the night shift. Multiple attempts to contact NA #2 who cared for Resident #22 the night of 2/24/26 (7:00 PM on 2/24/26 through 7:00 AM on 2/25/26) were unsuccessful. An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 2:33 PM. The DON stated that the nurse or nurse aide should have made sure Resident #22's indwelling urinary catheter tubing had a securement device in place.

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	02/26/2026

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 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** Based on observation, record review and staff and resident interviews, the facility failed to obtain a physician order for supplemental oxygen for 1 of 2 residents reviewed for respiratory care (Resident #28). The findings included:Resident # 28 was admitted to the facility on [DATE] with diagnoses which included cellulitis of the right lower leg and pneumonia. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #28 was cognitively intact and was not coded for supplemental oxygen therapy. The nursing progress note dated 2/14/26 at 11:27 am by Nurse #3 revealed Resident #28 complained of shortness of breath. Resident #28 was noted to have an oxygen saturation in the 80's (normal range of oxygen saturation is 95-100%) on room air. Nurse #3 placed 2 liters of supplemental oxygen via nasal cannula on Resident #28 and the oxygen saturation increased to 94 to 96%. Nurse #3 further noted that the provider was notified via electronic communication. An interview was conducted with Nurse #3 on 2/24/26 at 2:50 pm who revealed she did notify the provider on 02/14/26 that Resident #28 required oxygen and did get the order, but she stated she had trouble entering the order. Nurse #3 stated she could usually fumble her way through putting in an order, but she must have not realized the order for the oxygen was never put in when she had the trouble. She stated the Support Nurse normally entered physician orders, so it was not something she had to do often. Nurse #3 stated she did not notify any Support Nurse or reach out for assistance to enter Resident #28's oxygen order when she had difficulty entering the order on 02/14/26. A review of the physician orders revealed no physician order for supplemental oxygen use for Resident #28.An observation and interview were conducted with Resident #28 on 2/23/26 at 11:16 am. Resident #28 was observed with supplemental oxygen in place at 2 liters via nasal cannula. Resident #28 stated she had recently been diagnosed with pneumonia and had been on oxygen since having trouble breathing a while ago. Resident #28 stated the oxygen was not something she had required prior to coming to the facility. Support Nurse #2 was interviewed on 2/25/26 at 3:27 pm who confirmed she was the Support Nurse assigned to Resident #28. Support Nurse #2 stated that when additional orders were received by a provider the nurse that obtained the order was responsible to enter the order. Support Nurse #2 stated she just did not think to review Resident #28's order to make sure the oxygen order was in place. An attempt to conduct a telephone interview with the medical provider on 2/26/26 at 12:55 pm was unsuccessful. An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 4:22 pm who revealed that Nurse #3 was responsible to notify the provider and enter any orders obtained for Resident #28's supplemental oxygen. The DON further noted that Nurse #3 should have reached out to her or asked another nurse that was working for assistance if she was having difficulty entering the oxygen order. The DON stated the physician orders were normally reviewed in the clinical meetings but she was unable to recall if Resident #28's orders were reviewed.

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	02/26/2026

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. Based on record review, observations, and staff interviews the facility failed to date open medications for 1 of 3 medication carts reviewed for medication storage (Hall 100 medication cart). The findings included:During an observation of Hall 100 medication cart with Nurse #1 on 2/24/26 at 3:15 pm the following was observed: - one plastic squeeze bottle of brimonidine/timolol solution 0.2/0.5% eye drops (a medication used to treat eye conditions like glaucoma) was observed open with no open date noted. The manufacturer's recommendation for the brimonidine/timolol solution 0.2/0.5% was to be used or discarded within 4 weeks of opening.- one plastic squeeze bottle of olopatadine solution 0.2% eye drops (an antihistamine eye drop used for relief of allergic conjunctivitis) open with no open date noted. The manufacturer's recommendation for the olopatadine solution 0.2% eye drops was to be used or discarded within 4 weeks of opening, even if the bottle was not empty.Nurse #1 was interviewed on 2/24/26 at 3:19 pm who revealed the medications were to be dated when initially opened. Nurse #1 stated she was not present when the medications were opened and was unable to state why they were not dated. An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 3:03 pm who revealed the medications were to be dated when opened by the nurse. The DON further stated that nurses should check any medication that was open to ensure an open date was noted before use on the resident.