	-	ID HUMAN SERVICES				RM APPROVED
						NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			TE SURVEY
			5.14/110			С
		345240	B. WING			1/21/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARREN	HILLS NURSING CENTE	R		864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589		
(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 COR (EACH CORRECTIVE ACTION ( CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0		
F 000	investigation survey v through 11/21/24. Th compliance with the r	ertification and complaint vas conducted on 11/18/24 le facility was found in equirement CFR 483.73, ness. Event ID #1A9311.	F 00	0		
	survey was conducte 11/21/24. Event ID# intakes were investig NC00216787, NC002	complaint investigation d from 11/18/24 through 1A9311. The following ated: NC00214658, 22899, and NC00223787. It allegations did not result in				
	deficiency. The Statement of Def 12/06/24 at tag F578.	iciencies was amended on				
F 559 SS=D	CFR(s): 483.10(e)(4) §483.10(e)(4) The rig or her spouse when r	f Room/Roommate Change -(6) ht to share a room with his narried residents live in the n spouses consent to the	F 55	9		12/16/24
	or her roommate of cl when both residents I both residents conser §483.10(e)(6) The rig including the reason f	ht to share a room with his hoice when practicable, ive in the same facility and ht to the arrangement. ht to receive written notice, for the change, before the				
	resident's room or roo changed.	ommate in the facility is				
LABORATORY	_	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
	cally Signed					12/13/2024

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.

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/19/2024 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345240	B. WING _			C 11/21/2024		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WARREN	HILLS NURSING CENTE	B		8	64 US HWY 158 BUSINESS WEST			
				N	VARRENTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 559	Continued From page	e 1	F	559				
	This REQUIREMENT	「 is not met as evidenced						
	Based on record rev	iew, staff and resident			The statements made on this plan of			
		/ failed to provide written			correction are not an admission to and	d do		
		mate change for 1 of 1			not constitute an agreement with the alleged deficiencies.			
	(Resident #37).	notification of a change			To remain in compliance with all feder	al		
					and state regulations the facility has ta	aken		
	The findings included	1:			or will take the actions set forth in this			
	Resident # 37 was a	dmitted to the facility on			plan of correction. The plan of correcti constitutes the facility⊡s allegation of	on		
	5/31/23.				compliance such that all alleged			
					deficiencies cited have been or will be			
	The quarterly Minimu	· · · · · ·			corrected by the dates indicated.			
		4/24 revealed Resident #37			F559			
	was cognitively intact	L.			The facility failed to provide written notification of roommate change for 1			
	An interview was con	npleted on 11/18/24 at 10:00			resident reviewed			
		37. Resident #37 stated			1. Corrective action for resident(s)			
		weeks ago she received a			affected by the alleged deficient practi	ce:		
		dent #37 stated prior to that m alone. The Resident			On 12/6/24, a new user defined assessment was added to Point Click			
		o an appointment and when			Care Room or Roommate Change Us			
		d a new roommate. Resident			Defined Assessment. This assessme			
		ot received written or verbal			will be completed and printed to provid			
	notification she would	d be getting a new			written notification. On 12/12/2024 the			
	roommate.				Social Service Director completed the UDA and provided written notification			
	Review of facility rec	ords revealed Resident #37			the room change to resident #37.			
	received a new room				2. Corrective action for residents wit			
					the potential to be affected by the alle	ged		
		entation in the medical 37 indicating a discussion or			deficient practice. On 12/9/24, the Director of Nursing			
		roommate in October 2024.			audited the last month of room change	es to		
					ensure written notification was provide			
		npleted on 11/20/24 at 2:10			Two residents had changed rooms an	d		
		Social Worker (SW). The			both had been provided written notice	and		
		process to contact residents			notified of roommate change.			
	and their responsible	party prior to the resident			Room or Roommate User Defined			

Facility ID: 923530

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/19/2024 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345240	B. WING				C 21/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WARREN	HILLS NURSING CENTE	R		86	64 US HWY 158 BUSINESS WEST			
				W	ARRENTON, NC 27589			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 559	only notified a resider Party (RP) verbally ar was a change in room did not notify Resider in writing that Reside roommate. The SW was unable to provide notification. An interview was com a.m. with the Director Administrator. The Ad expectation a resider	amate. The SW revealed she that and their Responsible and not in writing when there anates. The SW stated she at #37 or their RP verbally or ant #37 would be getting a to say why she did not appleted on 11/21/24 at 11:30 of Nursing and the facility dministrator stated it was his at and their RP would be e change verbally and in	F	559	Assessment and provided written documentation to the resident. 3. Measures /Systemic changes to prevent reoccurrence of alleged defici practice: On 12/6/24, the Nurse Consultant provided education to the Director of Nurses, Admission Coordinator and th Social Service Director that written notification is to be provided to resider and/or Responsible Party prior regard a room change or roommate change, included in this education a new user defined assessment was added to Poi Click Care Room or Roommate Change UDA. This assessment will be comple and printed to provide written notificati 4. Monitoring Procedure to ensure the the plan of correction is effective and to specific deficiency cited remains corre and/or in compliance with regulatory requirements The Director of Nursing and/or design will audit all room and roommate chang for notification of the Resident and/or Responsible Party for compliance. Thi monitoring will be completed weekly x weeks and then monthly times 3 mont or until resolved. Reports will be presented to the monthly Quality Assurance committee by the Director Nurses to ensure corrective action is initiated as appropriate. Compliance w be monitored and the ongoing auditing program reviewed at the monthly Qua Assurance Meeting. The monthly Qua Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit	nts ing int ge ted ion. that tected ee ges is 2 hs of <i>v</i> ill J ity		

Facility ID: 923530

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/19/2024 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE	
		345240	B. WING _				C 21/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		R		86	4 US HWY 158 BUSINESS WEST		
WARREN	HILLS NURSING CENTE	ĸ		W	ARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 559	Continued From page	2.3	F	559	Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager.		
F 578 SS=E		ntnue Trmnt;Formlte Adv Dir 8)(g)(12)(i)-(v)	F	578	Date of Compliance: 12/16/2024		12/16/24
	discontinue treatment	ht to request, refuse, and/or , to participate in or refuse imental research, and to directive.					
	construed as the right the provision of medic	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or					
	requirements specifie subpart I (Advance D) (i) These requirement inform and provide we residents concerning medical or surgical tre resident's option, form (ii) This includes a we facility's policies to im and applicable State I (iii) Facilities are perm entities to furnish this legally responsible for requirements of this s (iv) If an adult individu time of admission and	irectives). is include provisions to itten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. itten description of the plement advance directives aw. nitted to contract with other information but are still r ensuring that the ection are met. ual is incapacitated at the					

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345240	B. WING		C 11/21/2024
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
		_	8	64 US HWY 158 BUSINESS WEST	
WARREN	HILLS NURSING CENTE	:K	v	VARRENTON, NC 27589	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETIC
F 578	Continued From page	⊃ <b>4</b>	F 578		
	-		1 570		
		ance directive, the facility rective information to the			
		epresentative in accordance			
	with State law.				
		relieved of its obligation to			
	•	on to the individual once he			
	or she is able to rece	ive such information.			
	Follow-up procedures	s must be in place to provide			
	the information to the	individual directly at the			
	appropriate time.				
		is not met as evidenced			
	by:				_
		iew, resident, and staff		The statements made on this plan of	
	-	r failed to provide written		correction are not an admission to an	id do
		vance directive information		not constitute an agreement with the	
		o formulate an advance residents reviewed for		alleged deficiencies. To remain in compliance with all fede	ral
	-	Residents #57, #71, #58,		and state regulations the facility has	
		\$72, #38, #52, #65, #61, #45.		or will take the actions set forth in this plan of correction. The plan of correct	6
	The findings included	l:		constitutes the facility⊡s allegation of compliance such that all alleged	
		admitted to the facility on		deficiencies cited have been or will be	e
		7 had severe cognitive		corrected by the dates indicated.	
		of a physician 's order dated		F623***F578	
		sident #57 was a full code.		The facility failed to provide written	
		entation in the medical		documentation for advance directive	
		regarding formulation of an documentation that an		information and the opportunity to formulate ab advance directive for 13	of
		ate an advance directive was		22 residents reviewed.	
		it or their responsible party.		1. Corrective action for resident(s)	
				affected by the alleged deficient prac	tice:
	b. Resident #71 was	admitted to the facility on		On 12/6/24, the Social Service Direct	
		57 was cognitively intact.		provided written documentation for	
		physician order for full code.		advance directives and provided revi	ew
		entation in the medical		for advance directive with documenta	
		regarding formulation of an		in medical record for resident #57, #7	
	advance directive or	documentation that an		#58, #55, #70, #68, #29, #72, #38, #	
	opportunity to formula	ate an advance directive was		#65, #61, and #45. This was comple	ted

Facility ID: 923530

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/19/203 M APPROVE <u>D. 0938-039</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	Сом	E SURVEY PLETED	
		345240	B. WING _			C 11/21/2024		
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•		
		-		86	4 US HWY 158 BUSINESS WEST			
WARREN	HILLS NURSING CENTE	:R		w	ARRENTON, NC 27589			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 578	Continued From page	a 5	F 5	70				
1 0/0			F J	10	an 10/ 00 /00			
	onered to the resider	t or their responsible party.			on 12/ 09 /20 2. Corrective action for residents w	ith		
	c Review of Posidon	t #58 was admitted to the			_			
		Resident #58 was cognitively			the potential to be affected by the alle deficient practice.	yeu		
		nysician 's order dated			On 12/09/24, the Director of Nursing			
		sident #58 was a full code.			began auditing all current residents for	or		
		entation in the medical			documentation of advance directive			
		regarding formulation of an			review and documentation in medical			
		documentation that an			record of this review. This audit was			
	opportunity to formula	ate an advance directive was			completed on 12/12/2024.			
	offered to the resider	t or their responsible party.			On 12/6/24, The Social Worker or			
					designee began completing resident	and		
	d. Resident #55 was	admitted to the facility on			resident representative interviews to			
	9/8/21.Resident #55	had moderate cognitive			determine wishes for Advanced Direc	tives		
	impairment. Resident	t #55 held a physician order			and completing documentation in me	dical		
		as no documentation in the			record of decision of Advance Directive	ve.		
	medical record for ed				This was completed on 12/13/24.			
	formulation of an adv				Measures /Systemic changes to prev			
		n opportunity to formulate an			reoccurrence of alleged deficient prac	ctice:		
		is offered to the resident or			On 12/6/24, the Nurse Consultant			
	their responsible part	y.			provided education to the Social Serv			
					Director, Admissions Coordinator, an	d		
		admitted to the facility on			Director of nursing on written	-l		
		70 was cognitively intact.			documentation to be provided to resid			
		n ' s order dated 10/23/23			and/or RP on advance directives and			
		70 was a full code. There on in the medical record for			documentation to be in medical recor review and who review was conducte			
		formulation of an advance			with.	iu ii		
		tation that an opportunity to			3. Monitoring Procedure to ensure	that		
		e directive was offered to the			the plan of correction is effective and			
	resident or their resp				specific deficiency cited remains corre			
					and/or in compliance with regulatory			
	f. Resident #68 ' s wa	as admitted to the facility on			requirements			
		8 was cognitively intact.			The Director of Nursing or designee v	vill		
		physician order for full code.			audit 5 residents for compliance. This			
		entation in the medical			monitoring will be completed weekly			
	record for education	regarding formulation of an			weeks and then monthly times 3 mon			
		documentation that an			or until resolved. Reports will be			
	opportunity to formula	ate an advance directive was			presented to the monthly Quality			

Facility ID: 923530

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/19/2024 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345240	B. WING				C 21/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARREN	HILLS NURSING CENTE	R			64 US HWY 158 BUSINESS WEST /ARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	<ul> <li>offered to the resident</li> <li>g. Resident #29 was a 11/25/19. Resident #2 impairment. Resident #2 impairment. Resident #2 impairment. Resident for Do Not Resuscitat documentation in the education regarding frequence or document formulate an advance resident or their response.</li> <li>h. Resident #72 was a 6/21/24. Resident #72 Resident #72 held a p There was no documer record for education r advance directive or copportunity to formulate offered to the resident #38 was a 10/31/23. Resident #38 held a p Resuscitate (DNR). T in the medical record formulation of an advance directive was their responsible party j. Resident #52 held a p There was no documer advance directive was their responsible party j. Resident #52 held a p There was no documer advance directive was their responsible party j. Resident #52 held a p There was no documer advance directive was their responsible party j. Resident #52 held a p There was no documer advance directive or copportunity to formulation precord for education part advance directive or copportunity to formulation precord for education part advance directive or copportunity to formulation part part part part part part part part</li></ul>	t or their responsible party. admitted to the facility on 29 had severe cognitive #29 held a physician order the (DNR). There was no medical record for ormulation of an advance tation that an opportunity to a directive was offered to the onsible party. admitted to the facility on 2 was cognitively intact. ohysician order for full code. entation in the medical regarding formulation of an documentation that an ate an advance directive was t or their responsible party. admitted to the facility on 38 was cognitively intact. ohysician order for Do Not here was no documentation for education regarding ance directive or n opportunity to formulate an s offered to the resident or	F	578	Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance w be monitored and the ongoing auditing program reviewed at the monthly Qual Assurance Meeting. The monthly QA Meeting is attended by the Administrat Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Heal Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 12/16/2024	ill ity or,	

Facility ID: 923530

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMF	PLETED
<b>345240</b> B. WING						C 11/21/2024	
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
		_			864 US HWY 158 BUSINESS WEST		
WARREN	HILLS NURSING CENTE	R		,	WARRENTON, NC 27589		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG			IAG		DEFICIENCY)	~~ <b>_</b>	
F 578	Continued From page	e 7	F	578	3		
		admitted to the facility on					
		65 had severe cognitive #65 held a physician order					
		as no documentation in the					
	medical record for ed						
	formulation of an adv						
		n opportunity to formulate an					
		s offered to the resident or					
	their responsible part	у.					
	I. Resident #61 was a	idmitted to the facility on					
		1 was cognitively intact.					
		physician order for full code.					
		entation in the medical					
		regarding formulation of an					
		documentation that an ate an advance directive was					
		t or their responsible party.					
	m. Resident #45 was	admitted to the facility on					
		5 was cognitively intact.					
		physician order for full code.					
		entation in the medical					
		egarding formulation of an					
		documentation that an					
		ate an advance directive was t or their responsible party.					
		tor their responsible party.					
	An interview was con	ducted with the Social					
	Worker on 11/21/24 a	it 1:06 PM. The Social					
		ce directives were reviewed					
		neeting. She stated the					
	review of advance dir the Care Plan assess	ectives was documented on					
	Services assessment						
		cial Worker stated she filled					
		tive form to show that					
	advance directive was	s discussed with the					

Facility ID: 923530

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		345240	B. WING			C /21/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WARREN	HILLS NURSING CENTE	R		864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578 F 623 SS=B	residents or family du Social Worker stated was uploaded into the There was no docume regarding formulation documentation that al advance directive was their responsible party form. An interview was com Administrator on 11/2 Administrator on 11/2 Administrator stated to of Advanced Directive documented for each Administrator stated for would be reassessed readmitted and during Notice Requirements CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and mannee facility must send a co representative of the Long-Term Care Omb (ii) Record the reason discharge in the reside accordance with para and	ring care planning. The the Advance Directive form a electronic medical record. entation of education of an advance directive or in opportunity to formulate an soffered to the resident or y on the advance directive ducted with the 1/24 at 1:30 PM. The he education and discussion as should have been resident in the facility. The he expected that residents for advance directives when g the care plan meeting. Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The py of the notice to a Office of the State budsman. as for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in	F 57			12/16/24

Event ID: 1A9311

Facility ID: 923530

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345240	B. WING			C 11/21/2024		
NAME OF P	ROVIDER OR SUPPLIER	•	•	ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
WARREN	HILLS NURSING CENTE	R			864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 623	§483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follor (i) The reason for tran (ii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request;	of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; of transfer or discharge; ich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how	F	623				

Facility ID: 923530

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DEPARTMENT OF HEALTH AND HUMAN SERVICES								
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY	
		345240						
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		•	
		_		8	64 US HWY 158 BUSINESS WEST			
WARREN	HILLS NURSING CENTE	R		V	VARRENTON, NC 27589			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			MEDICAID SERVICES     OMB NO. 0938-0091       (X1) PROVIDERSUPPLENCIAL IDENTIFICATION NUMBER:     A BUILDING       345240     B. WING       345240     B. WING       STREET ADDRESS, CITY, STATE, ZIP CODE       84 US HWY 158 BUSINESS WEST WARRENTON, NC 27589       TEMENT OF DEFICIENCES C IDENTIFYING INFORMATION)       PREFX C IDENTIFYING INFORMATION       PAGE       TEMENT OF DEFICIENCES C IDENTIFYING INFORMATION       PAGE       TEMENT OF DEFICIENCES C IDENTIFYING INFORMATION       PAGE       TAG       PREFX Filles or related g and email address and he agency responsible for coccacy of individuals with this established under Part al Disabilities, the mailing and aphone number of the rt he protection and sphone number of facility closure lakeart, the individual who is e facility must provide rt ot the ingending closure pency, the Office of the Ombudsman, residents of addent representatives, as e transfer and adequate ents, as required at §				
F 623	Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailing telephone number of the protection and add developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individu §483.15(c)(6) Change If the information in th effecting the transfer must update the recip as practicable once th becomes available. §483.15(c)(8) Notice i In the case of facility of the administrator of th written notification priot to the State Survey Ag State Long-Term Care the facility, and the re well as the plan for the relocation of the resid 483.70(k). This REQUIREMENT by:	the Office of the State budsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and als with a mental disorder Protection and Advocacy uals Act. es to the notice. the notice changes prior to or discharge, the facility bients of the notice as soon the updated information in advance of facility closure closure, the individual who is the facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at §	F	523	The statements made on this plan of			
	by:	ew and staff interviews, the			The statements made on this plan of			

Facility ID: 923530

If continuation sheet Page 11 of 19

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/19/2024 DRM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		OMPLETED
		345240	B. WING				C 11/21/2024
NAME OF PI	ROVIDER OR SUPPLIER	I		TREET ADDRESS, CITY, STATE, ZIP CODE	-		
WARREN	HILLS NURSING CENTE	R			64 US HWY 158 BUSINESS WEST VARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	- 15	e 11 le written notification for	F	623	correction are not an admission to a	nd do	
	reason of discharge t residents reviewed fo	o the Ombudsman for 4 of 6 r hospitalization (Resident esident #61, Resident #71).			not constitute an agreement with the alleged deficiencies. To remain in compliance with all fed and state regulations the facility has	eral	
	The findings included	: admitted to the facility on			or will take the actions set forth in the plan of correction. The plan of correction.	is ction	
	6/19/2024. Resident a				constitutes the facility s allegation of compliance such that all alleged deficiencies cited have been or will b corrected by the dates indicated. F623		
	notification for transfe	mbudsman received written er to the hospital.			The facility failed to provide written notification for reason of discharge t Ombudsman for 4 of 6 residents 1. Corrective action for resident(s)	)	
	1/24/2024. Resident a	admitted to the facility on #51 transferred to the 24 and returned to the facility			affected by the alleged deficient pra On 12/09/2024, the Social Service Director provided written documenta for the reason for discharge to the Ombudsman for resident #38, #51, 3	ation	
	A record review revea documentation the O notification for transfe	mbudsman received written			and #71. (will need info sent and confirmation)	·	
	10/31/2023. Resident	admitted to the facility on #38 transferred to the and returned to the facility			<ol> <li>Corrective action for residents with potential to be affected by the all deficient practice.</li> <li>On 12/12/24, the Administrator com audit for the month of November 20, ensure written documentation for</li> </ol>	leged pleted	
	A record review revea documentation the O notification for transfe	mbudsman received written			discharges was provided to the Ombudsman.	_	
	8/23/2022. Resident a hospital on 12/21/202 on 12/27/2023. Additi	3 and returned to the facility			<ol> <li>Measures /Systemic changes to prevent reoccurrence of alleged def practice:</li> <li>On 12/6/24, the Nurse Consultant provided education to the Social Se Director on written notification to be</li> </ol>	icient	

Facility ID: 923530

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/19/2024 MAPPROVEI D. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED	
		345240	B. WING				C / <b>21/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	•	-
WARREN	HILLS NURSING CENTE	R		864 US	HWY 158 BUSINESS WEST		
				WARF	RENTON, NC 27589		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From page	e 12	F 62	23			
	returned to the facility A record review revea documentation the O notification for transfe During an interview w on 11/19/2024 at 12:5 had not sent discharg Ombudsman's office were sent to the hosp was not aware she ha to the Ombudsman w to the hospital. During an interview w 11/21/2024 at 10:30 a aware the SW had no discharge reports to t it was the responsibil	y on 9/12/2024. aled there was no mbudsman received written er to the hospital. with the Social Worker (SW) 58 p.m. she revealed she ge information to the for those residents who bital. The SW reported she ad to send written notification when a resident transferred with the Administrator on a.m. he revealed he was not of submitted monthly the Ombudsman. He stated		pro wh 4. the sp an ree Th Di Or Me or an ree As to an res Me Di Ur	ovided to the Ombudsman for resident to discharge. Monitoring Procedure to ensure the plan of correction is effective and the ecific deficiency cited remains corrected ad/or in compliance with regulatory quirements the Administrator or designee will autor scharges for notification of the mbudsman for compliance. This ponitoring will be completed weekly x eeks and then monthly times 3 montor until resolved. Reports will be esented to the monthly Quality surance committee by the Administ ensure corrective action is initiated opropriate. Compliance will be monitor ad the ongoing auditing program viewed at the monthly Quality surance Meeting. The monthly QA eeting is attended by the Administra rector of Nursing, MDS Coordinator nit Manager, Therapy Manager, Heat formation Manager, Social Service rector, and the Dietary Manager.	hat that ected dit all : 2 ths rator as ored tor,	
F 644 SS=D	CFR(s): 483.20(e)(1)		F 64		ate of Compliance: 12/16/2024		12/16/24
	pre-admission screer (PASARR) program u of this part to the max	tion. hate assessments with the hing and resident review under Medicaid in subpart C kimum extent practicable to ing and effort. Coordination					

Facility ID: 923530

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/19/2024 MAPPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345240	B. WING _				C 21/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		_		80	64 US HWY 158 BUSINESS WEST		
WARREN	HILLS NURSING CENTE	R		W	VARRENTON, NC 27589		
							0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 644	Continued From page	9 13	F	644			
	from the PASARR lev PASARR evaluation r	rating the recommendations el II determination and the eport into a resident's nning, and transitions of					
	all residents with new serious mental disord related condition for le a significant change in	er, intellectual disability, or a evel II resident review upon					
	facility failed to refer a mental illness for a Le Screening and Reside	ew and staff interviews, the a resident with a serious evel II Preadmission ent Review (PASRR) for 1 of for PASRR (Resident #34).			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tal or will take the actions set forth in this	I	
	Resident #34 was admitted to the facility on 11/16/2022 and readmitted on 8/7/2023.				plan of correction. The plan of correction constitutes the facility □s allegation of compliance such that all alleged deficiencies cited have been or will be	n	
	On 8/7/2023 Residen delusional disorder.	t #34 was diagnosed with			corrected by the dates indicated. F644 The facility failed to refer a resident with	ha	
	dated 3/3/2020 indica screening is required occurs with the individ a diagnosis of mental				serious mental illness for a level II Preadmission Screening and Resident review (PASRR) for 1 of 2 residents 1. Corrective action for resident(s) affected by the alleged deficient practic On 11/19/24, the Social Service Director submitted PASRR screen for resident # and it was completed 12/11/2024.	e: or	
	indicating a Level II P.	ASRR referral had been nt #34 after the diagnosis of			<ol><li>Corrective action for residents with the potential to be affected by the alleg</li></ol>		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/19/2024 1 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345240	B. WING				C 21/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HILLS NURSING CENTE	P		8	64 US HWY 158 BUSINESS WEST		
WARKEN	HILLS NURSING CENTE	R		v	VARRENTON, NC 27589		
(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 644	a serious mental illne: An interview with the 11/20/2024 at 2:50 p. aware Resident #34's had not been complet Admissions Director w resident required scree During an interview w on 11/21/2024 at 9:35 checked residents' P/ admission. She expla Resident #34's PASR reviewing his diagnos #34 met the criteria for she should have subr PASRR screening. During an interview w 11/21/2024 at 10:35 a aware Resident#34's	ss had been made. Social Worker (SW) on m. revealed she was not a Level II PASRR screening ted. She stated the would let her know if a sening. tith the Admissions Director 5 a.m. she revealed she	F	644	<ul> <li>deficient practice.</li> <li>On 12/10/2024, the Director of Nurses completed an audit of the last 30 days new psychoactive medication orders, at a list was given to the social worker for PASRR screen on 12/10/2024. The soct worker completed submission for PASR review for 3 residents which was completed on 12/12/2024.</li> <li>Measures /Systemic changes to prevent reoccurrence of alleged deficies practice:</li> <li>On 12/6/24, the Nurse Consultant provided education to the Director of Nurses and the Social Service Director PASRR- what it is, it□s purpose, and when it is needed.</li> <li>Monitoring Procedure to ensure th the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements</li> <li>The Administrator or designee will audit for compliance of PASRR screens. This monitoring will be completed with 5 residents weekly x 2 weeks and then monthly times 3 months or until resolved. The Director of Nurses will audit for new psychoactive medication orders and/or newly diagnosed mental disorder, intellectual disability, or related condition This audit will be completed weekly usit the order listing report in PCC weekly x 2 weeks and then monthly for 3 months until resolved. Reports will be present</li> </ul>	nd cial R R ant on at at cted t s ed. w on. ng c or	
					the order listing report in PCC weekly x 2weeks and then monthly for 3 months	or	

Event ID: 1A9311

Facility ID: 923530

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/19/2024 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345240	B. WING				C 21/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WARREN	HILLS NURSING CENTE	B		80	64 US HWY 158 BUSINESS WEST		
		i v		N	VARRENTON, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 644	Label/Store Drugs an CFR(s): 483.45(g)(h)( §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the faci biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently a storage of controlled of	d Biologicals 1)(2) of Drugs and Biologicals used in the facility must be with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized		761	committee by the Administrator and Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at t monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director Nursing, Minimum Data Set Coordinato Unit Manager, Therapy Manager, Healt Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 12/16/2024	of or,	12/16/24

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FOR OMB N	D: 12/19/202 MAPPROVE 0.0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345240	B. WING			11/21/2024	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
WARREN	HILLS NURSING CENTE	R			4 US HWY 158 BUSINESS WEST ARRENTON, NC 27589		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 761	abuse, except when the package drug distribution quantity stored is miniple readily detected. This REQUIREMENT by: Based on observation failed to dispose/disc. of 3 medication carts observed for medicate the findings included. An observation was comedication cart on 11 opened bottle of Sentidate of October 2024. An interview was context was context of the medication aide/ nurses responsible for check each shift. An interview was context Nursing (DON) on 11/DON stated the medication for checking carts for the carts of the medication carts of the medication for checking carts for the carts of the medication for checking carts for the carts of the medication for checking carts for the carts of the medication for checking carts for the ca	nd other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can is not met as evidenced on, staff interviews, the facility ard expired medications in 1 (600 Hall medication cart) ion storage. conducted of the 600 Hall 1/21/24 at 10:48 AM. One na -Plus with an expiration was found on the cart. ducted with Medication Aide 50 AM. Mediation Aide #2 n should have been in Aide #2 stated the se assigned to the cart was sting for expired medications ducted with the Director of 21/24 at 11:28 AM. The cation aides and nurses cation cart were responsible expired medication. The medications were to be	F	761	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder, and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correcti constitutes the facility alleged deficiencies cited have been or will be corrected by the dates indicated. F761 The facility failed to dispose/discard expired medications in 1 of 3 medicati carts (600 Hall medication cart) 1. Corrective action for resident(s) affected by the alleged deficient practi On 11/21/24, the medication aid #2 disposed of Senna-Plus dated 10/2022 On 11/21/24, the DON re-educated Medication aide #2 on medication cart 2. Corrective action for residents wit the potential to be affected by the alleged deficients of any expired medication cart 3.	al aken on ce: 4. rage arts. h	
	Administrator stated t	ducted with the 1/24 at 1:28 PM. The the medication aides and he medication cart were			deficient practice. On 11/21/24, the DON and unit manage conducted 100% cart audits for expire medications. No other expired medications found.		

Facility ID: 923530

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/19/2024 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	IPLE CONSTRUCTI			E SURVEY PLETED
		345240	B. WING			11	C / <b>21/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
	HILLS NURSING CENTE	Ð		864 US HWY 15	58 BUSINESS WEST		
		.N		WARRENTON	N, NC 27589		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOU SS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 761			F	<ul> <li>prevent repractice:</li> <li>On 11/21, all FT, PT</li> <li>Medicatic and expir</li> <li>provided:</li> <li>Recommendation selected</li> <li>This infor</li> <li>the stand</li> <li>required in all staff id</li> <li>reviewed</li> <li>process to been susting receive set 12/13/24</li> <li>training h</li> <li>4. Monit the plan of specific di and/or in</li> <li>requirementation requirementation in the DON medication appropriation carts will weeks, with the modication appropriation and the original set in the modication appropriation and the original set in the set</li></ul>	rmation has been integrate dard orientation training an in-service refresher course dentified above and will be l by the Quality Assurance to verify that the change h stained. Any staff who doe scheduled in-service trainin will not be allowed to wor has been completed. hitoring Procedure to ensur of correction is effective and deficiency cited remains co compliance with regulator	eficient cation of es, forage y and on ed into nd in the es for es as es not ng by k until re that nd that prrected ry hitor bired ation ek for 2 ly x 3 or ented es to as	

Event ID: 1A9311

Facility ID: 923530

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/19/202 1 APPROVEI ). 0938-039	
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345240	B. WING				_ 21/2024	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
WARREN HILLS NURSING CENTER					64 US HWY 158 BUSINESS WEST			
				N	ARRENTON, NC 27589			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 761	Continued From page	2 18	F	761	Assurance Meeting. The monthly QA Meeting is attended by the Administra Director of Nursing, MDS Coordinator Unit Manager, Therapy Manager, Hea Information Manager, and the Dietary Manager. Date of Compliance: 12/16/2024	, ilth		
	7(02-99) Previous Versions Obs	olete Event ID: 1A			sility ID: 923530		Page 19 of	

Facility ID: 923530

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