

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2024
NAME OF PROVIDER OR SUPPLIER  Madison Park Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Madison Avenue Huntington, WV 25704	

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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to complete transfer forms to an acute care facility for Resident #4 and #30. This was true for two (2) of three (3) residents reviewed under the care area of hospitalization s. Resident identifiers: #4 and #30. Facility Census: 40.</p> <p>Findings included:</p> <p>a) Resident #4</p> <p>On 08/06/24 at 1:30 PM, a record review was completed for Resident #4. The review found the resident had been transferred to an acute care facility on 07/23/24 for hyponatremia (low sodium). The review, also, found there was no transfer form completed for the transfer.</p> <p>On 08/06/24 at 2:00 PM, Licensed Practical Nurse (LPN) #18 was notified. LPN #18 confirmed the transfer form was not completed.</p> <p>b) Resident #30</p> <p>On 08/06/24 at 1:42 PM, a record review was completed for Resident #30. The review found the resident had been transferred to an acute care facility on 03/05/24 for acute encephalopathy and on 05/28/24 for a hip fracture. The review, also, found there was no transfer forms completed for the transfers.</p> <p>On 08/06/24 at 2:00 PM, Licensed Practical Nurse (LPN) #18 was notified. LPN #18 confirmed the transfer forms were not completed.</p>

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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45173</p> <p>Based on record review and staff interview the facility failed to notify the Ombudsman of resident transfers to an acute care setting. This failed practice was found true for (3) three of (3) three residents reviewed for hospitalization s during the Long Term Care Survey Process. Resident identifiers #38, #30 and #4. Facility Census 40.</p> <p>Findings included:</p> <p>a) Resident #38</p> <p>A record review on 08/06/24 at 3:12 PM, revealed Resident #38 was transferred to the hospital on 07/22/24. Further record review revealed no notification was sent to the ombudsman for the acute transfer on 07/22/24. During an interview on 08/06/24 at 3:46 PM, Licensed Practical Nurse Unit Manager (LPNUM) confirmed the notification was not sent to the Ombudsman.</p> <p>b) Resident #30</p> <p>On 08/06/24 at 1:42 PM, a record review was completed for Resident #30. The review found the resident had been transferred to an acute care facility on 03/05/24 for acute encephalopathy and on 05/28/24 for a hip fracture. The review, also, found the State Ombudsman was not notified of the transfers.</p> <p>On 08/06/24 at 2:10 PM, Licensed Practical Nurse (LPN) #18 was notified. LPN #18 confirmed the State Ombudsman had not been notified regarding both transfers. LPN #18 stated, I'll make sure they are sent monthly.</p> <p>c) Resident #4</p> <p>On 08/06/24 at 1:30 PM, a record review was completed for Resident #4. The review found the resident had been transferred to an acute care facility on 07/23/24 for hyponatremia (low sodium). The review, also, found the State Ombudsman was notified of the transfer.</p> <p>On 08/06/24 at 2:00 PM, Licensed Practical Nurse (LPN) #18 was notified. LPN #18 confirmed the State Ombudsman had not been notified regarding the transfer. LPN #18 stated, I'll make sure they are sent monthly.</p> <p>Surveyor: Richmond, [NAME] D.</p> <p>49465</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to provide a bed hold policy for a transfer to an acute care setting for Resident #4. This was true for one (1) of three (3) residents reviewed under the care area of hospitalization s. Resident Identifier: #4. Facility Census: 40.</p> <p>Findings Include:</p> <p>a) Resident #4</p> <p>On 08/06/24 at 1:30 PM, a record review was completed for Resident #4. The review found the resident had been transferred to an acute care facility on 07/23/24 for hyponatremia (low sodium). The review, also, found the resident and/or resident representative was not provided a bed hold policy by the facility.</p> <p>On 08/06/24 at 2:15 PM, Licensed Practical Nurse (LPN) #18 was notified. LPN #18 confirmed the bed hold policy had not been provided upon transfer to the acute care setting.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>49751</p> <p>Based on record review and staff interview the facility failed to update a Preadmission Screening and Resident Review(PASARR). This was found true for one (1) of one (1) residents reviewed for the PASRR care area during the long term care survey process. Resident identifier: #5. Facility Census: 40.</p> <p>Findings include:</p> <p>A review of Resident #5's on 08/05/24, revealed Resident #5 had a diagnosis of Psychotic disturbance and Major Depressive disorder, and psychosis.</p> <p>Further Record review revealed the most recent and only PASRR was done on 01/17/08 and contained the following diagnosis:</p> <ul style="list-style-type: none"> <li>~ Bipolar disorder</li> <li>~Psychosis</li> <li>~Constipation</li> <li>~Depression</li> <li>~Nutrition</li> </ul> <p>Continued record review found there was no current medical diagnosis for Bipolar disorder.</p> <p>On 08/06/24 at 03:58 PM , the Director of Nursing (DON) confirmed the PASRR should have been updated to address Major depressive disorder, and stated not sure why there was no diagnosis for Bipolar Disorder and why it would be on the PASARR.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49751</p> <p>Based on record review and staff interview the facility failed to implement Resident #5's Preadmission Screening and Resident Review (PASRR) care plan. This was a random opportunity for discovery. Resident Identifier: #5. Facility Census: 40.</p> <p>Findings include:</p> <p>A review of Resident #5's record on 08/06/24 found the following care plan:</p> <p>Focus</p> <p>~PASRR I: Resident is PASRR level 1</p> <p>Goal</p> <p>~ Resident will remain at current level through next review target date: 08/27/24</p> <p>Interventions</p> <p>~ Complete/maintain Preadmission Screening/Resident Review(PASRR).</p> <p>~ Observe for symptoms that would trigger a referral to PASRR for review of current level.</p> <p>A further review of Resident #5's medical record on 08/05/24, revealed Resident #5 had a diagnosis of Psychotic disturbance and Major Depressive disorder, and psychosis.</p> <p>Further Record review revealed the most recent and only PASRR was done on 01/17/08 and contained the following diagnosis:</p> <p>~ Bipolar disorder</p> <p>~Psychosis</p> <p>~Constipation</p> <p>~Depression</p> <p>~Nutrition</p> <p>Continued record review found there was no current medical diagnosis for Bipolar disorder.</p> <p>On 08/06/24 at 03:58 PM , the Director of Nursing (DON) confirmed the PASRR should have been updated to address Major depressive disorder, and stated not sure why there was no diagnosis for Bipolar Disorder and why it would be on the PASRR.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON confirmed the PASRR should have been updated as directed by the residents care plan and the diagnosis Major depressive disorder should have been addressed on the care plan and was not.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49751</p> <p>Based on record review and staff interview, the facility failed to follow physician's orders for monitoring pain four (4) times a day and documenting medication given. This was true for one (1) of five (5) residents reviewed for Unnecessary medications during the long term care survey. Resident Identifier: #31. Facility Census: 40.</p> <p>Findings include:</p> <p>A) Resident #31.</p> <p>A review of Resident #31's medical record on 08/06/24 found the following:</p> <p>Review of the Medication Administration Record (MAR) on 08/06/24 revealed for the month of April 2024, one (1) Xanax was not administered on 04/20/24 at 9:00 AM as scheduled. and one Oxycodone on 04/21/24 at 10:00 PM hours as scheduled.</p> <p>For the month of June 2024 one(1) Xanax was not administered on 06/04/24 at 9:00 AM as scheduled and two (2) Oxycodone on 06/10/24 and 06/19/24 at 10:00 PM hours as scheduled.</p> <p>Also for the month of June 2024 the Treatment Administration Record (TAR) revealed pain monitoring was not completed on the 16th, 17th at 4:00 AM, the 19th at 12:00 PM and on the 27th at 8:00 AM and 12:00 PM.</p> <p>On 08/07/24 at approximately 10:00 AM the Director of nursing (DON) confirmed te aboe information.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to complete a monthly medication review for Resident #9. This was true for one (1) of five (5) residents reviewed under the care area of unnecessary medications during the long-term care survey. Resident Identifier: #9. Facility Census: 40.</p> <p>Findings Include:</p> <p>On 08/06/24 at 3:00 PM, a record review was completed for Resident #9. The review found a pharmacy review for December 2023 was not completed and available for review.</p> <p>On 08/06/24 at 4:45 PM, the Director of Nursing (DON) was notified and confirmed the monthly pharmacy review was not completed. The DON stated, I don't have the pharmacy review for December 2023.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>45173</p> <p>Based on observation, record review and staff interview, the facility failed to record temperatures for the medication refrigerator on the third floor. This was a random opportunity for discovery and has the potential to affect more than a limited number of residents currently residing in the facility. Facility Census: 40.</p> <p>Findings Include:</p> <p>a) Medication Refrigerator</p> <p>On 08/07/24 at 8:55 AM, a tour of the third floor medication room was completed. The tour found the medication refrigerator temperatures were not being checked twice daily. The following dates and times were blank for each month:</p> <p>06/01/24 PM</p> <p>06/02/24 PM</p> <p>06/03/24 AM</p> <p>06/03/24 PM</p> <p>06/08/24 PM</p> <p>06/09/24 PM</p> <p>06/10/24 PM</p> <p>06/11/24 PM</p> <p>06/12/24 PM</p> <p>06/15/24 PM</p> <p>06/16/24 PM</p> <p>06/17/24 AM</p> <p>06/17/24 PM</p> <p>06/18/24 PM</p> <p>06/19/24 PM</p> <p>(continued on next page)</p>

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F 0761  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>07/20/24 PM</p> <p>07/21/24 PM</p> <p>07/22/24 PM</p> <p>07/23/24 PM</p> <p>07/24/24 PM</p> <p>07/27/24 PM</p> <p>07/28/24 AM</p> <p>07/28/24 PM</p> <p>07/29/24 AM</p> <p>07/29/24 PM</p> <p>07/30/24 PM</p> <p>07/31/24 PM</p> <p>08/04/24 PM</p> <p>08/05/24 PM</p> <p>08/06/24 PM</p> <p>On 08/07/24 at 9:00 AM, the Director of Nursing was notified and confirmed the refrigerator temperatures were not documented.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49465</p> <p>Based on policy review, observation and staff interview the facility failed to store food in accordance with professional standards of practice. This failed practice had the potential to affect more than a limited number of residents currently residing in the facility. Facility Census: 40.</p> <p>Findings include:</p> <p>a) Reach-in refrigerator</p> <p>During the initial tour of the kitchen on 08/05/24 at 12:05 PM, the following items was found to be out of date or not labeled at all in the reach-in refrigerator:</p> <ul style="list-style-type: none"> <li>-- Broccoli soup with an expiration date of 08/01/24</li> <li>-- Boiled eggs in a plastic container which was not labeled with a use by date.</li> <li>-- (2) two bowls of spiral cooked noodles which was not labeled with a use by date</li> <li>-- Tomato soup in a plastic container which was not labeled with a use by date.</li> </ul> <p>During an interview on 08/05/24 at 12:30 PM, Dietary [NAME] (DC) #17 stated, Yes, they are out. I will get them out of there. I didn't realize it. I think we just put the eggs in there this morning.</p> <p>A review of the facilities policy on 08/06/24 at 11:00 AM, titled {Food receiving and storage} number (8) eight reads as follows:</p> <p>All foods stored in the refrigerator or freezer will be covered, labeled and dated ( use by date).</p> <p>b) Walk-in refrigerator</p> <p>During the initial tour of the kitchen on 08/05/24 at 12:15 PM, the following items was found to be out of date in the walk-in refrigerator:</p> <ul style="list-style-type: none"> <li>-- Lunch meat ham with a use by date of 07/27/24</li> <li>-- Lunch meat bologna with a use by date of 08/02/24</li> </ul> <p>During an interview on 08/05/24 at 12:30 PM, Dietary [NAME] (DC) #17 stated, I will get the lunch meat out of there as soon as I can She confirmed it was out of date.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45173</p> <p>Based on record review and staff interview, the facility failed to maintain an accurate and complete record for Resident #26's Physician's Scope of Treatment (POST) form and immunization documentation. This is true for one (1) of five (5) residents reviewed under the care area of infection control. Resident Identifier: #26. Facility Census: 40.</p> <p>Findings Include:</p> <p>a1) Resident #26</p> <p>On [DATE] at 3:30 PM, a record review was completed for Resident #26. The review found the POST form dated [DATE] stating, CPR (cardiopulmonary resuscitation), Full Treatments and no artificial means of nutrition desired. However, the physician's order dated [DATE] stated, CPR, Selective Treatment and No Artificial Nutrition.</p> <p>On [DATE] at 11:00 AM, the Director of Nursing (DON) provided an order audit report for Resident #26. The report was reviewed and the DON confirmed the physician's order was incorrect from [DATE] through [DATE].</p> <p>a2) Resident 26</p> <p>On [DATE] at 11:30 AM, a record review was completed for Resident #26. The review found the resident had a Prevnar 13 (pneumococcal vaccination) on [DATE]. After reviewing the CDC (Center for Disease and Control and Prevention) guidelines, the resident was eligible for a PCV20 in 2023. However, the documentation found under the immunization tab, stated the resident was not eligible.</p> <p>On [DATE] at 1:00 PM, Licensed Practical Nurse (LPN) #18 confirmed the vaccination should have been offered to Resident #26.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45173</p> <p>Based on observation, record review and staff interview, the facility failed to provide an appropriate infection control program for administration of medications to Resident #34 and Resident #13, cleansing of glucometer for Resident #13 and catheter care for Resident #38. There were random opportunities for discovery. Resident identifiers: #34, #13, and #38. Facility Census: 40.</p> <p>Findings included:</p> <p>a1) Resident #34</p> <p>On 08/07/24 at 8:55 AM, an observation was made during medication administration by Registered Nurse (RN) #59. While preparing the medication for Resident #34, RN #59 touched two pills with bare hands. The following medication was touched by RN #59:</p> <p>--Flecainide 150mg</p> <p>--Zofran 4mg</p> <p>On 08/07/24 at 9:30 AM, the Director of Nursing (DON) was notified and confirmed the medication should not be touched with bare hands during medication administration.</p> <p>a2) Resident #13</p> <p>On 08/07/24 at 9:10 AM, RN #59 touched one (1) pill during medication for Resident #13. The following medication was touched with bare hands by RN #59:</p> <p>--Buspar 5mg</p> <p>On 08/07/24 at 9:30 AM, the Director of Nursing (DON) was notified and confirmed the medication should not be touched with bare hands during medication administration.</p> <p>b) Resident #13</p> <p>On 08/07/24 at 9:15 AM, upon completion of checking the resident's glucose level, RN #59 cleaned the glucometer with alcohol. The manufacturer's guidelines state, the following products have been approved for cleaning and disinfecting (Name of Brand of the glucometer):</p> <p>--Dispatch Hospital Cleaner Disinfectant Towels with Bleach</p> <p>--Medline Micro-Kill Disinfecting, Deodorizing, Cleaning Wipes with Alcohol</p> <p>--Clorox Healthcare Bleach Germicidal and Disinfectant Wipes</p> <p>--Medline Micro-Kill Bleach Germicidal Bleach Wipes</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2024
NAME OF PROVIDER OR SUPPLIER  Madison Park Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Madison Avenue Huntington, WV 25704	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/07/24 at 9:40 AM, the DON was notified and confirmed the glucometer should have been cleaned per Manufacturer's guidelines.</p> <p>c) Resident #38</p> <p>On 08/07/24 at 2:10 PM, catheter care for Resident #38 was observed. The catheter care was provided by Nurse Aide (NA) #42. Upon completion of the catheter care and emptying the catheter storage bag at 2:25 PM, NA #42 did not remove the soiled gloves or complete hand hygiene. NA #42 began placing the blankets on the resident, touching the side rails, bedside table and privacy curtain with soiled gloves.</p> <p>On 08/07/24 at 2:40 PM, the DON was notified and confirmed the soiled gloves should have been removed and hand hygiene completed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2024
NAME OF PROVIDER OR SUPPLIER  Madison Park Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Madison Avenue Huntington, WV 25704	
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)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45173</p> <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on record review and staff interview, the facility failed to offer a pneumococcal vaccination to Resident #26. This was true for one (1) resident of five (5) residents reviewed under the infection control care area. Resident Identifier: #26. Facility Census: 40.</p> <p>Findings Include:</p> <p>a) Resident #26</p> <p>On 08/07/24 at 11:30 AM, a record review was completed for Resident #26. The review found the resident had a Prevnar 13 (pneumococcal vaccination) on 10/24/18. After reviewing the CDC (Center for Disease and Control and Prevention) guidelines, the resident was eligible for a PCV20 in 2023. However, the documentation found under the immunization tab, stated the resident was not eligible.</p> <p>On 08/07/24 at 1:00 PM, Licensed Practical Nurse (LPN) #18 confirmed the vaccination should have been offered to Resident #26.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2024
NAME OF PROVIDER OR SUPPLIER  Madison Park Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Madison Avenue Huntington, WV 25704	

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)
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>45173</p> <p>Based on observation and staff interview, the facility failed to provide access of a call bell with in reach of Resident #4. This was a random opportunity for discovery. Resident Identifier: #4. Facility Census: 40.</p> <p>Findings Include:</p> <p>a) Resident #4</p> <p>On 08/05/24 at 1:00 PM, an observation of the call light being not in reach of Resident #4 was made. The call bell was located across the room on top of a refrigerator.</p> <p>On 08/05/24 at 1:04 PM, Nurse Aide (NA) #29 entered the resident's room. NA #29 was asked, is the resident's call bell near her? NA #29 stated, oh, it's over there .let me get it.</p> <p>On 08/05/24 at 1:20 PM, the DON was notified the call bell was not in reach of Resident #4. The DON stated, we will make sure the call bells are accessible to the residents.</p>