STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515037	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weirton Geriatric Center	2525 Pennsylvania Avenue Weirton, WV 26062

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to ensure four (4) of seven (7) residents were not abused or neglected. Resident #89 did not have incontinence care in a timely manner. This is Past Non Compliance (PNC). Resident #57 was physically abusive towards Resident #89. This was PNC. Resident #11 was physically abusive towards Resident #3. This was PNC. Resident #69 was sexually abusive towards Resident #105. The sexual abuse involved Resident #69 and Resident #105 was PNC. The facility failed to ensure This was true for one (1) of seven (7) records reviewed during a facility reported incidents (FRIs) survey. Resident identifier: #89, #57, #11, #3, #69, and #105. Facility census: 121. Findings included: a) Resident #89 The above-mentioned deficient practice began on 04/24/24 when the facility failed to complete two (2) hour checks on Resident #89 to assess for incontinence. On 04/25/24 at 9:20 AM, Nurse Aide #140 reported to LPN #311 that resident was soaked all over and had fecal matter all over herself and on the floor mat and the floor itself. The facility had implemented corrective action to prevent recurrence by 05/01/24, prior to the start of the survey. Therefore, the deficiency was cited as past noncompliance. Social Worker #45 interviewed Resident #89 on 04/25/24. Resident was alert, oriented, and pleasant. She was noted to be following her usual routine. The resident could not recall the event in question. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker #45 also contacted the evening staff that worked the previous night. Nurse Aide #81 had been assigned to work with Resident #89. Nurse Aide #81 stated she visited the resident at 6:00 PM when the resident's son was in the room. There was no identified issue at that time and her son had reported she had recently been changed. Nurse Aide #81 stated she conducted a bed check at midnight and that resident was OK. Nurse Aide #81 stated her last check was done at approximately 5:30 AM and that resident was sleeping so she did not enter the room, but she did not detect an odor and resident did not appear wet. Social Worker #45 spoke to all Nurse Aide staff working the morning shift of 04/25/24 and all denied entering Resident #89's room early morning. Nurse Aide #140 reported she presented Resident #81with a breakfast tray at about 7:15 AM but did not report the resident was wet or that resident needed changed. Resident was first found to be incontinent when Nurse Aide #140 had re-entered the resident's room at 9:20 AM. The facility was unable to determine what time Resident #89 urinated or had bowel movement. The resident had a history of not asking for assistance and timely bed checks had not been completed. Resident #81's care plan reflected she had a history of refusing bed checks and being combative with care. The facility completed a root cause analysis and determined it was necessary to complete an in-service regarding the facility's expectation for two-hour bed checks to be completed. The facility completed an in-service regarding bed checks on 05/07/24. Social Worker #45 provided the following information regarding the details of the in-service: - Per policy, bed checks are to be done every two (2) hours. There have been recent claims that bed checks are not always being done. During recent investigations, many statements from staff indicated that a few residents are resistant to care and can be aggressive when awakened during a bed check, and therefore may be 'skipped'. This is not acceptable. - Additionally, the following tips were shared with staff in the hopes they would assist staff when dealing with more difficult residents: -- Take a deep breath -- Remain calm -- Do not show anger, fear, alarm, or anxiety -- Speak using a calm, reassuring voice -- Acknowledge the resident's feelings -- Maintain eye contact -- Distract -- Reapproach (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-- Ask for help

There have been no further issues with the two-hour bed checks and provision of incontinent care on a timely basis.

50795

b) Resident #57

On 04/07/24 at approximately 7:30 PM, Resident #89 was near the nurse's station, at the table where books were laid out for the resident's use. She was selecting some books from the table when Resident #57 took exception to it. Resident #57 beckoned her over, grabbed her fingers and twisted hard, yelling Give me the books. Put them back!

Resident #89 was a [AGE] year-old female diagnosed with dementia, short term memory loss, inability to process information, and a lack of capacity to make medical decisions. Resident has resided at the facility since March 2024. Her Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 07/12/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment.

On 04/07/24 at approximately 7:30 PM, Resident #89 was near the nurse's station, at the table where books were laid out for the resident's use. She was selecting some books from the table when Resident #57 took exception to it. Resident #57 beckoned her over, grabbed her fingers and twisted hard, yelling Give me the books. Put them back!

Resident #89 was a [AGE] year-old female diagnosed with dementia, short term memory loss, inability to process information, and a lack of capacity to make medical decisions. The resident had resided at the facility since March 2024. Her Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 07/12/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment.

Resident #57 was an [AGE] year-old female diagnosed with bipolar disorder, cognitive communication disorder, and anxiety disorder. The resident had resided at the facility since 03/08/24. Her Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 07/16/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Per the physician's capacity determination, the resident did not have capacity to make medical decisions.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation revealed an eyewitness report by Nursing Assistant (NA) #14, on 04/07/24 at approximately 7:30 PM, which stated that Resident #89 was by the nurse's station, in the living room area at around 7:30 PM on 04/07/24, looking at books on the table to read. Resident #57 started yelling, those aren't her books; she needs to put them back! NA #14 intervened and separated the two residents. She explained to Resident #57 that the books belonged to the facility, and that it was okay if Resident #89 wanted to take them and return them later. NA #14 walked away but continued to observe them. A few seconds later Resident #57 beckoned Resident #89 to come closer. She had then grabbed Resident #57's index and middle fingers and twisted hard yelling, Give me the books. Put the books back! NA #14 had rushed over and separated them, and stated to Resident #57 that she could not place her hands on other residents. When NA #14 had asked Resident #57 why this happened, the resident had stated, Those aren't her books. NA #14 had then reported the incident to RN #43, and LPN #132, while NA #191 watched the residents. During an assessment of Resident #89's right hand on 04/07/24 at 8:27 PM by RN #43, she documented that resident had stated that her right hand hurt, but that she would be okay. RN noted that no swelling was visible, but the resident experienced slight pain upon movement of the hand. Resident #89's Medical Power of Attorney (MPOA) had arrived a few minutes later and had been notified of the incident. He had then accompanied Resident #89 to her room. MPOA later stated that Resident #57 had apologized to his mother. He further stated, things like this happen. The physician had been notified of the incident on 04/07/2024 at 8:36 PM. He had ordered an x-ray of the right hand for the next morning, and ice packs for swelling if needed. Review of the X-ray on 04/09/24 revealed no acute fractures, or other injuries. A note by RN #127 on 04/08/24 at 11:17 AM stated that Resident #57's urine had been tested to rule out a urinary tract infection. She documented that the test was negative for nitrates, leucocytes, and blood. Record review on 08/27/24 at 2:18 PM revealed that Resident #57 had demonstrated multiple episodes of aggressive behavior, anxiety and cognitive communication disorder. She had been care planned for aggressive behavior. Her care plan, initiated on 6/12/23 states: Intervene as needed to protect the rights and safety of others. Approach/speak in a calm manner, divert attention. Remove from the situation and take to another location as needed. Facility had implemented a behavior management plan for Resident #57 on 06/12/23. This plan was updated on 04/10/24 to include close supervision, encouraging resident to sit near nurses' station so that she could be observed, encouraging her to join activities, and taking her meals in the dining room. Care plan notes that the resident seeks constant attention from staff. Resident's husband visits almost daily. Facility staff were in-serviced on aggressive behavior when dealing with dementia residents. This in-service had been previously conducted on 08/228/23 by Social Worker (SW) #45. c) Resident #3 Resident #3 was noted with blood on her upper lip at the doorway to the solarium. She stated that Resident #11 had smacked her in the face. Activities Staff Member (ASM) #2 noted that Resident # 3's walker was beside a table where Resident #11 was sitting. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 is an [AGE] year-old female diagnosed with dementia, major depressive disorder, and anxiety disorder. The resident had resided at the facility since 11/28/2023. Her Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 08/13/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating that the resident could not complete the interview. Her physician's capacity determination revealed that the resident did not have capacity to make medical decisions. Resident #11 was a [AGE] year-old female diagnosed with dementia, major depressive disorder, insomnia and cognitive communication deficit. The resident had resided at the facility since 02/09/2021. Her Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 06/18/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Per the physician's capacity determination, the resident did not have capacity to make medical decisions. The resident had a long history of chest pain, resulting in placement of a neurostimulator for pain management with pre-installed settings. Care plan states that level of stimulation should be adjusted every shift based on the resident's physical, verbal or facial response to pain relief. This care plan was revised on 07/13/2023. Record review revealed the following: On 05/01/24 at approximately 5:20 PM, Resident #3 and Resident #11 were in the solarium. Licensed Practical Nurse (LPN) #207 was passing medications and had heard a noise coming from the end of the hall. She had asked Activities Staff Member (ASM) #2 to check the area. ASM #2 had noted Resident #3 walking up the hall, with blood on her upper lip. Resident #3 was tearful and had stated that Resident #11 had hit her. A nursing note by LPN # 207 on 05/01/24 at 5:20 PM stated that the cut on the resident's lip had been cleansed with soap and water and left open to air. LPN #207 had further noted that Resident #3 had calmed down quickly, and begun eating her dinner, showing no further signs or symptoms of distress. Upon being questioned, Resident #11 denied hitting Resident #3 and went back to her room to have dinner. Record review revealed that Social Worker (SW) #110 had been notified of the incident on 05/01/24 at 5:22 PM. SW #110 had interviewed Resident #3 at approximately 5:45 PM. She stated that the resident had stated That woman hit me. When questioned about what had happened, the resident had stated, I don't know, she just hit me. A social worker note dated 05/01/24 at 6:26 PM stated: . resident was showing no ill effects from the incident upon this social worker speaking to her. This social worker apologized to (Resident #3) that this happened. SW #110 had notified Resident #3's Medical Power of Attorney (MPOA) at 6:05 PM on 05/01/24 and explained that the incident would be reported and investigated. SW #110 revealed documentation that verified that the report to Office of Health Facility Licensure and Certification (OHFLAC), Adult Protective Services, and the Ombudsman was faxed on 05/01/24 at 7:19 PM, and that the five (5) day follow up report was faxed on 05/07/24 at 4:08 PM. Record review further revealed a nurses notes dated for the following days which stated: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/02/24 at 4:36 AM: Resident has been awake periodically throughout this shift. Noted with increased tearfulness at times yelling out I don't want to live anymore. Redirection lasts for short intervals before yelling out again. Area to top lip remains. No active bleeding noted at this time.VSS. 05/02/24 at 11:01 AM: Alert and verbal, denies pain or discomfort. Area remains to left upper lip. No active bleeding noted. No bruising observed. Detailed fax to send to physician to update on previous resident to resident occurrence. Awaiting response 05/02/24 at 12:19 PM: Physician responded to fax sent regarding resident to resident with no new orders 05/02/24 at 6:46 PM: area remains to left upper lip, denies pain or discomfort. No acute distress noted. MPOA in for visit. No concerns voiced. 05/02/24 at 9:15 PM: Walking halls no c/o pain or distress at this time. Record review on 08/27/24 at 12:28 PM revealed an in-service to facility staff on 05/01/24 by SW #110, with instructions which stated: Due to the recent altercation, please do not allow residents to be alone together in the solarium or other locations without staff supervision. During an interview with SW #45 on 08/27/24 at 1:49 PM, she stated that due to the recent resident to resident altercations, facility staff were further in-serviced on aggressive behavior when dealing with dementia residents that had been previously conducted on 08/228/23 by Social Worker (SW) #45. A signed statement by SW #110 on 05/06/24 stated: Upon review of the security cameras in the solarium, it was noted that Resident #3 stood up off pf the couch, started walking toward the door with her walker, and approached Resident #11 who was sitting at a table putting a puzzle together. At this time, Resident reached out and grabbed the clothing protector that Resident #3 was wearing. Resident #11 didn't remove the protector but then reached out again and pulled the clothing protector off Resident #3. At this time Resident #11 began hitting out and swatting at Resident #3 several times making contact with Resident #3's face at one point. Resident #11 continued to swat at Resident #3 causing her to leave her walker behind and walk toward the door without it. As she went to go through the doorway, she turned around and re-entered the solarium. At this time, staff came into the solarium and assisted Resident #3 by giving her the walker and escorting her out of the solarium. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Resident #105 On 05/05/24 at approximately 1:30 AM, Resident #69 was found in Resident #105's room, kissing her, and touching her breast over her shirt. NA #17 immediately attempted to redirect Resident #69 and get him out of the room. Resident #69 became combative and began punching NA #17 as she tried to redirect him. Eventually Resident #89 was redirected out of the room and began to walk toward the lobby. Record review revealed that on 05/5/24 at 1:32 AM, LPN #152 immediately performed a Head-to-toe assessment (Including vaginal assessment) of Resident #105. No marks or bruising noted. The Resident's Medical Power of Attorney (MPOA) was contacted by LSW and notified of the incident. Record review also revealed and in-service that had been conducted by SW #110 immediately after the incident, which instructed all staff that: Due to the recent incident (Resident #69) is to be supervised at ALL TIMES and not to be kept in the lobby unless supervised by staff. A note on 05/05/24 at 3:49 AM by Social Worker (SW) #110 stated: Administrator #94 was notified of the incident at 2:35 am. A review of facility records on 08/28/24 at 9:14 AM revealed that the facility staff had faxed a report to the Office of Health Facility Licensure and Certification (OHFLAC), Adult Protective Services, and the Ombudsman on 05/05/24 at 3:15 AM, which was within the required two (2) hour window for reporting allegations of sexual abuse. The five (5) day follow up report was submitted on 05/07/24 at 3:58 PM Record review revealed that the facility had conducted an investigation of the alleged sexual abuse on 05/05/24. The facility had substantiated the allegation through interviews with staff. Resident #105 was a [AGE] year-old female diagnosed with severe dementia, Parkinson's disease, Alzheimer's, and epileptic seizures. The resident has resided at the facility since December 2023. Her Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 03/21/24 showed the resident was non reviewable, and unable to answer the questions. Facility conducted a staff interview and questioned staff on whether the resident was able to answer questions or make requests. It was revealed that the resident is unable to make her needs known, indicating severe cognitive impairment. Physicians' determination was that the resident does not have capacity to make medical decisions. Resident #69 was an [AGE] year-old male diagnosed with dementia, and depression. The resident had resided at the facility since November 2023. His Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 05/01/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. Based on the physician's capacity determination, the resident does not have capacity to make medical decisions. Record review revealed an eyewitness report by Nursing Assistant (NA) #17, on 05/05/24 which stated: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon bed check me and another CNA were also passing linens. This CNA went into Resident #69's room to put linens in there, upon leaving and moving into the next room, me and said CNA were getting a two (2) assist up out of bed to the bathroom, when three (3) alarms started going off. The nurse was getting one on the other end of the hall, I had turned Resident #69's off because he was in the hallway already, then assisted other CNA with the assist off the toilet back into bed. This CNA came down the hallway to the other alarm, and upon coming down the hallway I found Resident #69 in a female resident's bed with her. He had his hand on her chest, on top of her shirt and was kissing female resident. This CNA tried to redirect Resident #69, and he became very combative with this CNA and was punching CNA as she continued to try to redirect him. Once resident was redirected out of female resident's bed and room he began to walk toward lobby. Once this CNA got Resident #69 redirected CNA went back to help with resident that had fallen out of bed, with the nurse and the second CNA. Resident #69 then made his way back down out of the lobby to the long hallway where this CNA tried to get him to turn back around into the lobby so he can be monitored by either CNA or nurse while bed check was completed. Resident #69 then began to swing on CNA balling his fists and saying Yeah, I got em Then he walked back into the lobby and sat in recliner chair and has since been calm Further record review revealed the following notes by facility staff: 05/05/24 at 01:30 AM a note by Licensed Practical Nurse (LPN) #152 which stated: During bed check resident alarm was going off, Resident #69 came out of room, started walking towards lobby, CNAs were getting up female peer to go to bathroom, who is a two assist. stopped in front of door of female peer. CNA told Resident #69 to keep going to lobby and he started walking towards lobby. CNAs were done in female peer room, a bed alarm was going off, CNA went to get it and saw Resident #69 in another female peer room, kissing her and touching breast on top of her shirt, CNA tried to redirect him out of room, Resident #69 got combative, started hitting CNA, he then tried going into another female peer room, he was brought out to lobby and is sitting in chair, Resident #69 has no bruising or marks on hands from hitting CNA. Social worker was called at this time. 05/05/24 at 3:45 AM a note by Social Worker (SW) #110 which stated: This social worker was informed by nursing at 1:58 am that Resident #69 was found kissing and fondling Resident #105's breasts while she was laying in bed. This social worker entered the building at 2:15 am and went to the dementia unit. This social worker spoke with nursing as well as the CNAs regarding the situation. Resident #69 was redirected to the lobby where he remains at this time. Staff instructed to provide 1:1 to him at this time to ensure the safety of his female peers. Incident was reported to APS Centralized Intake, APS local office, Ombudsman and OHFLAC as well as to Administrator #94 at 2:35 am. Weirton Police Department was called 3:15 am and arrived at the facility at 3:30 am. Report was filed- incident #2024050040. Resident #69's MPOA will be notified later this AM. (name of behavior health unit) and physician will be notified for further instruction/evaluation. 05/05/24 at 4:00 AM a note by SW #110 which stated: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This social worker called and spoke with (name of behavior health unit) regarding a referral for admission. They requested a consent form be signed by Resident #69's MPOA. Form was faxed to this social worker (will obtain signature later this AM). They requested that the consent form and other documentation be sent (Face sheet, diagnosis list, physician order, covid and influenza vaccine records, MAR/TAR, H&P, nurse's notes, allergy list). They stated that once they receive the consent and information, their doctor will review everything to see if he will accept him as a patient. If he does, then Resident #69 will need to be sent to (name of hospital emergency department) for them to admit to behavioral health. 05/5/2024 at 08:30 AM a note by SW #110 which stated: This social worker placed a call to Resident #105's MPOA/husband 8:30 am to explain the situation that occurred regarding a male peer being sexual with resident. MPOA did not answer; message left to return the call at his earliest convenience. 05/05/24 8:15 AM a note by SW #110 which stated: This social worker called and spoke with Resident #69's MPOA regarding the incident. This social worker also explained that due to there being several incidents and an increase in aggressive behaviors and for the safety of his female peers, the facility would like to send him to the (name of behavior health unit). MPOA expressed many concerns about sending him to that facility and asked that his physician be notified. This social worker explained that physicians would be notified after ending the call with her. This social worker explained that a consent form would need to be signed by her. MPOA stated that she would need to speak with her children before making a decision. She stated she would call this social worker back. 05/05/24 at 9:00 AM a note by SW #110 which stated: This social worker received a call from Resident #69's daughter regarding the situation. This social worker explained everything to her. She expressed her concerns about the geri-psych facility as well as how long he might be there. All issues were addressed with her. Nursing paged physician and he returned call. This social worker and nurse on duty explained the situation of Resident #69 being sexual with a female peer (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician stated to send the resident to (name of geriatric psychiatric unit). Nursing also paged physician with a return call. This social worker and nurse on duty spoke with the physician and explained the situation. He stated that prior to resident being admitted to Weirton Geriatric Center (WGC) he had seen him in the office and was very well aware of his aggressive behaviors and difficulty in being redirected and was concerned with his placement at that time but seems to have adjusted well although there has been an increase in sexual behaviors stating that he had his wife at home but now he doesn't and his behaviors are not acceptable in the current environment although he cannot control it due to his dementia. He stated that he was in agreement that resident be sent to a geri psych facility- either (name of towns). He stated that resident #69 requires 1:1 staff supervision at this time but stated that is not possible at Weirton Geriatric Center. This social worker asked if he would be willing to speak with resident's daughter, and he agreed. This social worker called resident's daughter and joined the calls. Physician spoke with resident's daughter and wife, who was also on the call, in length regarding the situation. He stated to them that it is in the best interest of all involved that resident be sent to the geri-psych facility. He reinforced that for the safety of the other residents that the transfer was necessary. He stated to them that if they needed anything at all to call him as he is available any time. Resident's daughter and wife thanked physician for speaking with them and physician ended the call on his end. This social worker continued to speak with resident's wife and daughter. Resident's daughter stated that she and her mom would come to the facility and sign the consent papers around 11 am. This social worker explained to them the process and that after the paperwork and consent would be signed and sent to the facility, their doctor would review it, and they would let this social worker/nursing know if they would accept him as a patient. They asked if WGC would transfer him, and this social worker stated yes. Resident's daughter and wife thanked this social worker for everything and ended the call. Administrator #94 updated. 05/05/24 at 10:41 AM a note by SW #110 which stated: Spoke with physician regarding the incident of male peer being sexual with Resident #105. No new orders received. 05/05/24 at 1:08 PM a note by SW #110 which stated: This social worker received a call back from Resident #105's MPOA/husband. This social worker explained to MPOA that a male peer was laying in bed with (name of Resident #105), kissing her and touching her breasts. This social worker informed him that the police were called, and a report was filed, that an investigation is being completed by this social worker, and that Resident #105 was assessed from head to toe including her vaginal area and no marks or bruising were noted. This social worker informed him that resident showed no ill effects from the incident. MPOA stated that he realizes that the male peer didn't know what he was doing and that he understands that things like this happen. He asked if resident seemed okay today, and this social worker stated she was in good spirits. He stated he understands that the residents have dementia and that they don't know what they are doing. MPOA stated that he would be visiting today and bringing Resident #105 some snacks. He thanked this social worker for calling to let him know what happened. This social worker stated that the staff will continue to ensure Resident #105's safety. 05/05/24 at 1:38 PM a note by SW #110 which stated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER: Weirton Geriatric Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2525 Pennsylvania Avenue Weirton, WV 26062	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This social worker received a call from SW at East Liverpool Senior Behavioral Health Unit stating that they would accept Resident #69 as a patient. She stated that he could bring 3 outfits with no hoods or strings and 1 pair of shoes also without strings. She stated that they would provide everything else for him. She stated to take him first to (name of hospital emergency department) to be medically cleared. This social worker spoke with Resident #69's wife and daughter and informed them that the (name of behavior health unit) accepted him as a patient and relayed all the other information to them. They stated that they would transport resident to the hospital. This social worker and nurse on duty called (name of hospital emergency department) and gave report to their nurse. 05/05/24 at 2:48 PM a note by SW #100 stated: Resident #69 left the facility with his family at 2:36 pm in stable condition to be transferred to East Liverpool Hospital. Vitals obtained by nurse on duty and all vitals were within normal limits. Wander guard removed from left arm. No distress noted. Physician and Administrator #94 notified. 05/06/24 at 1:19 PM a note by SW #110 which stated: This social worker received a call from the discharge planner, from (name of behavior health unit). She asked if WGC would be taking resident back, and this social worker stated yes. Discharge planner then stated that they do not do the significant change PASSAR, and that WGC would need to complete that. This social worker stated that this would be communicated to our director of nursing. This social worker asked how Resident #69 was doing. She stated that he was very combative in the ER last night and was given Geodon. She stated that resident was up most of the night and is very sleepy today. She stated that physician at the facility started him on Celexa stating that it usually works for getting rid of sexual behavior. This social worker asked about a possible discharge time frame. She stated that on average, resident would be there for at least 5-7 days but that could vary. She stated that WGC would be notified 1 day before discharge. Discharge planner stated that she would be faxing updates and asked for the fax number which was provided by this social worker. She stated that she would be providing updates M-W-F. This social worker thanked her for calling with an update. Information was communicated to Director of Nursing (DON) #102, RN #183, and Administrator #94. 05/07/24 at 1:08 PM a note by SW 110 which stated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weirton Geriatric Center	2525 Pennsylvania Avenue Weirton, WV 26062

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This social worker spoke with Resident #69's MPOA regarding how resident is doing. MPOA expressed her dissatisfaction of resident being in the (Name of behavior health unit) stating that she felt it was rushed and didn't understand why he had to go there. This social worker reiterated with MPOA that per resident's physicians, with whom MPOA spoke, they recommended that resident be sent to the behavioral health unit. MPOA stated that she has a lot of faith in physician, but that she is just still upset about the entire situation. She stated that she felt that resident #69 was being punished. This social worker explained that resident was not being punished in any way and reminded her that this wasn't the first incident as well as him masturbating frequently, and this social worker again reiterated to her that his physicians wanted resident sent to the behavioral health unit. MPOA then stated that the process of getting him there was not a good experience and that she felt they were forced to take him themselves. This social worker once again reiterated to MPOA that this social worker gave them the option of having WGC transport him there or her and her family could transport him, and they decided to transport him themselves. This social worker apologized to MPOA that it was such a bad experience. MPOA requested that WGC transport resident back once he is discharged from the behavioral health unit. This social worker stated that this would be discussed with Administration. MPOA stated that she and her family had to sit in the ER for 6 hours. This social worker apologized that they had to sit there that long; however, this was out of anyone's control. MPOA stated that she just wants him back at WGC as soon as p[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Weirton Geriatric Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Pennsylvania Avenue Weirton, WV 26062	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43340 Based on record review and staff interview, the facility failed to ensure that all alleged violations involving abuse and the administration of physician ordered medication in excessive doses were reported in a timely fashion to all appropriate state agencies. This was true for two (2) out of seven (7) facility reported incidents (FRIs) reviewed. Resident identifier: #89. Facility census: 121. Findings included: a) On 07/17/24, RN #183 was notified of a rumor that LPN #406 may be administering extra melatonin to the residents on the dementia unit to help them sleep better. On 07/22/24, the Director of Nursing was notified by RN #183 of the rumor and was told that RN #183 believed it to be true. The facility reported the allegation on 07/25/24. During an interview on 08/27/24 at 11:25 AM, Assistant Administrator #130 reported that the facility had been so involved in investigating the validity of the allegation that it had been an oversight that the allegation had not been reported timely. 50795 b) Resident #89 On 04/07/24 at approximately 7:30 PM, Resident #89 was near the nurse's station, at the table where books were laid out for the resident's use. She was selecting some books from the table when Resident #57 took exception to it. Resident #57 beckoned her over, grabbed her fingers and twisted hard, yelling Give me the books. Put them back! During an assessment of Resident #89's, right hand on 04/07/24 at 8:27 PM, by RN #43, she documented that resident had stated that her right hand hurt, but that she would be okay. RN noted that no swelling was visible, but the resident experienced slight pain upon movement of the hand. Physician had been notified of the incident on 04/07/2024 at 8:36 PM. He had ordered an x-ray of the right hand for the next morning, and ice packs for swelling if needed. Review of the X-ray on 04/09/24 revealed no acute fractures, or other injuries. A review of facility records, on 08/28/24 at 9:42 AM, revealed that the facility staff had faxed an initial report to the Office of Health Facility Licensure and Certification (OHFLAC), Adult Protective Services (APS), and the Ombudsman on 04/08/24 at 8:50 AM, which was not within the required two (2) hour window for reporting allegations of abuse with injury. During an interview with SW #45, on 08/28/24 at 9:13 AM, she confirmed that the report was not faxed out in a timely manner.