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	04/24/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50551 Based on observation, staff interview and review of documentation the facility failed to ensure the right to personal privacy and confidentiality of personal and medical records by leaving Resident #34's electronic chart open and unattended on medication cart in hallway. This was a random opportunity for discovery. Facility Census 121. Findings included: On 04/21/25 at 4:12 PM observed Licensed Practical Nurse (LPN) #54 was administering medication in resident #34's room and her computer screen was open at the medication cart in the hallway. Resident's chart was open on the computer, unattended. On 04/21/25 at 4:15 PM an interview with LPN #54 she acknowledged that resident's chart was left open and unattended on the medication cart in the hallway. On 04/24/25 at 9:19AM a review of facility document titled Maintenance of Electronic Clinical Records stated the following: - Policy: This facility will maintain electronic clinical records for each resident in accordance with acceptable standards of practice. -7. The facility shall not release resident-identifiable information to the public. Information that is resident-identifiable may be release only in accordance with a contract under which the agent agrees to disclose information except to the extent the facility itself is permitted to do so. -8. Unauthorized persons are permitted to review records only with the signed permission of the resident or a legal document allowing such access.

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 51553 Based on record review and staff interview, the facility failed to ensure the resident's Pre-Admission Screening (PAS) reflected a pre-admission diagnosis for Resident #101 during the annual long-term care survey. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #101. Facility Census: 121. Findings Included: a) On 04/23/2025, a record review was completed for Resident #101's PAS submitted 11/21/23. Sections III (MI/MR Assessment) and V (Supplemental Questions for Major Mental Illness or suspected MI) of the PAS indicated no diagnoses. Resident #101 had an admission diagnosis of Bipolar Disorder, Unspecified. b) On 04/23/2025 at 3:31, the Director of Nursing confirmed there was no bipolar diagnosis on the initital PAS and stated, it was an oversight on our part.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50551 Based on staff interview and review of documentation the facility failed to develop and implement a comprehensive person-centered care plan to include trauma informed care for resident who had diagnosis of Post Traumatic Stress Disorder (PTSD). This is true for resident #59. Facility Census 121. Findings included: a) On 04/22/25 at 10:23 AM a reviewed resident's diagnosis list included: F43.10 Post-Traumatic Stress Disorder, Unspecified with an onset date of 08/26/24. b) On 04/22/25 at 10:30 AM review of resident's care plan and there was no evidence that Post Traumatic Stress Disorder was addressed on Resident #59's care plan. c) On 04/23/24 at 3:12 PM during an interview with social worker #97 who reported that she was not aware that resident had a diagnosis of Post Traumatic Stress Disorder (PTSD). She acknowledged that resident had a behavior management program and was not receiving trauma-informed care. She also acknowledged that PTSD was not addresses in resident's care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 50795 Based on observation, inspection, and record review, the facility failed to follow a physician's order for the administration of oxygen. This was a random opportunity for discovery. Resident Identifier: #108. Facility Census: 121. Findings Include: a) Resident #108 During an interview with Resident #108 on 04/21/25 at approximately 2:37 PM, it was noted that the resident was receiving oxygen therapy. An inspection of the oxygen concentrator showed that it was set to deliver 3.0 liters per minute. The resident mentioned that she had just finished her breakfast and expressed that she was comfortable. Record review on 04/22/25 at 9:12 AM revealed a physician's order that stated: OXYGEN AT 2 LPM CONTINUOUS VIA NC D/T COPD Ongoing observation during the course of the survey revealed the following readings: On 04/22/25 at approximately 8:37 AM, the oxygen concentrator was observed to be set at 3.0 liters per minute. On 04/23/25 at approximately 11:29 AM the oxygen concentrator was observed to be set at 2.5 liters per minute. On 04/23/25, at approximately 11:31 AM, RN #73 was informed that the oxygen concentrator was not set to the prescribed dosage. The prescribed dose was 2.0 liters per minute, and RN #73 adjusted the concentrator to the correct setting. 04/24/25 at approximately 9:16 AM, the Director of Nursing (DON) stated that the oxygen concentrator in Resident #108's room had been tagged, and removed from service.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 50551 Based on record review and staff interview the facility failed to provide Trauma informed care for resident with a diagnosis of Post Traumatic Stress Disorder (PTSD). This is true for resident #59. Facility Census #121. Findings Included: a) On 04/22/25 at 10:23 AM a reviewed resident's diagnosis list included: F43.10 Post-Traumatic Stress Disorder, Unspecified with an onset date of 08/26/24. b) On 04/22/25 at 10:30 AM review of resident's care plan and there was no evidence that Post Traumatic Stress Disorder was addressed on Resident #59's care plan. c) On 04/23/24 at 3:12 PM during an interview with social worker #97 who reported that she was not aware that resident had a diagnosis of Post Traumatic Stress Disorder (PTSD). She acknowledged that resident had a behavior management program and was not receiving trauma-informed care. She also acknowledged that PTSD was not addresses in resident's care plan.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 50551 Based on observation, staff interview and review of facility policy, the facility failed to ensure waste was properly contained in dumpsters/compactors and were covered with lids. Facility Census 121. Findings included: a) On 04/23/25 at 01:43 PM an observation of dumpster/compactor below kitchen, was observed with lids removed and kitchen trash (plastic lid, plastic food cup, towels, mustard packet, pepper packet, paper etc.) surrounding the dumpster and on top of it. b)During an interview on 04/23/25 at 1:46 PM with Maintenance Staff #172 stated that the dumpster used to have a shoot that the trash was dropped in from the kitchen. He reported that they had to cut the shoot off due to trash getting stuck and smelling in the facility. He reported that if they close the lids on the dumpster, the kitchen still throw trash in the hole where the shoot was and it falls on the ground and they have to pick it up. He then found the lids and placed them on the dumpster/compactor. c) On 04/23/25 at 1:50PM observed the second dumpster on the other side of the building with lid open and latex gloves, drink lid, and multiple cigarette butts surrounding the dumpster. Further observation around the grounds of the facility revealed medical trash (such as latex gloves and masks as well as various other debris) along the edge of the parking lot. d) On 04/24/25 at 9:37 AM, review of form titled Policy #F011 Section: Sanitation and Infection Prevention/Control, Subject: Solid Waste Disposal a bulletin under Procedures: heading stated Keep lids closed on all outside receptacles.