

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/25/2025
NAME OF PROVIDER OR SUPPLIER  Martinsburg Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Clover Street Martinsburg, WV 25404	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on record review and staff interview, the facility failed to provide the resident or resident's representative of the risks and benefits of an anti-psychotic medication. This was found to be true for 1 (one) of six (6) residents reviewed. Resident identifier: #95. Facility census: 115.</p> <p>Findings included:</p> <p>a) Resident #95</p> <p>Resident #95 had a diagnosis of depressive disorder on 05/10/24 and was prescribed Sertraline HCl tablet 50 mg on 05/10/24.</p> <p>The facility failed to inform the resident's medical representative of the risks and benefits of the medication, other treatment options or alternatives. The resident did not have capacity to make her own medical decisions.</p> <p>During the survey process, on 06/18/25 at 0:38 AM, the surveyor requested to see an informed consent for Sertraline. On 06/18/25 at 02:01 PM, the DON stated she was not able to locate the consent form. The DON did present a note from the medical record where the facility had tried to call the resident's representative, but the representative never returned the call.</p> <p>On 06/24/25 at 2:02 PM, surveyor met with DON and NHA to re-verify lack of informed consent and reviewed the potential deficiency with them.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure that incontinence care was provided to dependent residents. Namely, dependent residents were not aided with toileting, cleaning themselves, and changing absorbent pads or briefs in a timely manner. This was true for one (1) of four (4) residents surveyed. Resident Identifiers: Resident identifier: #50. Facility Census: 116.</p> <p>Findings Include:</p> <p>a) Resident #50</p> <p>Record review on 06/18/25 at approximately 10:00 AM revealed that Resident #50 does not have capacity. The record review revealed the following:</p> <p>The facility had submitted an initial report of an allegation of neglect in the area of incontinence care for Resident #50 on 03/26/25 at 1:49 PM. The facility had submitted the five-day follow-up report on 03/28/25 at 1:53 PM. The report stated that the alleged perpetrator, Nursing Assistant (NA) #15 was suspended pending the completion of the investigation.</p> <p>The five-day follow-up report stated that 'After thorough investigation, the allegation of incontinence care not provided timely has been unsubstantiated.'</p> <p>Record review of the investigative notes revealed a phone statement obtained by the Director of Nursing (DON) from NA #15 stated: I worked on South Unit last pm. I had 150-156. The following residents are incontinent 150 A&amp;B, 151 A, 152 A7B, 153 A7B, 155 A&amp;B, 156 A&amp;B will ring. I have always been told we do not do anything for him, he is independent and will use his urinal and will ring for anything else. My last rounds were started before 5:20 AM. At approximately 5:20, I started with the four rooms on stretch. I am 85% I started with them. It was around or not very long after that for I did not have to change many of my incontinent. [NAME] was dry, I changed 151 A, 152 A, B was dry, 153 A dry all night and B bed was changed. Both residents 153 A&amp;B changed. I washed up 150 B and 150 B and NA #104 and I completed their baths. I did not have anyone to complete walking rounds with, but did write the reports with booth of their names on it. I left floor 6:36 AM. I wrote report with their names on it. I spoke with Registered Nurse (RN) #36 and NA #93 was standing there and I asked if they would make sure if NA #70 and NA #58 would get their report.</p> <p>A written statement by NA #58 reviewed on 06/18/25 at approximately 10:11 AM, stated the following:</p> <p>I went in to check my section. I went into [Room]. NA # 85 and NA #93 were in the middle of stripping Resident #50's bed. The sheets were soaked with brown ring from the middle of the sheets to almost the bottom.</p> <p>Further review revealed written statements by NA #93 and NA #85:</p> <p>NA #93 stated:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Around 6:40 me and NA #83 went into Resident #50's room to get him up for breakfast, when we pulled the blankets back, he was soaked, and shirt and sheets were wet. We went ahead and gave him a full head to toe bed bath. When we got done, we let his aide know. When I came out there was a report paper on the desk. When I opened it, it said he was changed and washed and dressed.</p> <p>NA #85 stated the following:</p> <p>Around 6:40 AM on 03/26/25 NA #93 and I were helping get residents up for breakfast. When we went to get Resident #50 up he was soaked up to his shirt and bed with bed with urine. We bathed him, and got him up and informed his aide of the situation. The night shift aide left a paper report stating he was changed and bathed already.</p> <p>During an interview on 06/18/25 at approximately 1:15 PM, NA #58 confirmed that when she went into Resident #50's room on 03/26/25, she had observed a brown ring on Resident #50's sheets.</p>		