STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515039	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martinsburg Healthcare Center	209 Clover Street Martinsburg, WV 25404

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 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. Findings included: a) Resident #95 Resident #95 had a diagnosis of depressive disorder on 05/10/24 and was prescribed Sertraline HCl tablet 50 mg on 05/10/24. 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. 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. 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.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for residents in six (6) rooms. Room identifiers: #136, #143, #147, #149, #151, and #160. This was a random opportunity for discovery. Facility census: 117. Findings included: a) Upon survey entrance on 06/16/25 at 1:58PM, it was observed the following issues in Resident room numbers: room [ROOM NUMBER]: - wallpaper loose with air bubbles on the wall beside the bathroom door approximately 3 feet from the floor - wallpaper loose with air bubbles on the window wall beside bed B, approximately 2 feet from the floor - scuffs and black marks on the inside of the bathroom door - A Large circular hole in the bathroom wall behind the toilet approximate size 6 inches wide room [ROOM NUMBER]: - scrapes and tears in the wallpaper on the wall next to the sink - black scuff marks and loose trim inside bathroom door - A Large circular hole in the bathroom wall behind the toilet approximate size 6 inches wide room [ROOM NUMBER]: - paint chips approximately 1/2inch wide in the wooden trim around the air conditioner/heating unit room [ROOM NUMBER]: - black scuff marks and scrapes on wall next to the bathroom door - black scuff marks and scrapes on both sides of the bathroom door - cracks in paint under the grab bar handle on the bathroom wall room [ROOM NUMBER]: - black scuff marks and scrapes across the bottom of the wall next to the bathroom door (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- black scuff marks and scrapes inside on the bottom of the bathroom door room [ROOM NUMBER]: - wallpaper loose with air bubbles on the wall beside bathroom door approximately 3 feet high from the floor - wallpaper loose with air bubbles inside Resident's room door to the right of bed A approximately 3 feet high from the floor - A Large circular hole in the bathroom wall behind the toilet approximate size 6 inches wide On 06/17/25 at 1:30 PM, during a walk through with the administrator regarding environment issues in room [ROOM NUMBER], #143, #147, #149, #151, and #160. She acknowledged the environmental issues in these resident rooms and stated she will start a facility wide repair list for the maintenance department.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interviews, the facility failed to perform an accurate discharge process for two (2) of 3 residents reviewed during the survey process for hospitalization. Resident identifiers: #30, and #279. Facility census: 115 Findings included: a) Resident #30 Resident has capacity to make her own medical decision. The resident was on hospital leave from 03/23/25 until 03/26/25. There was no documentation to support the ombudsman was notified of the transfer. The facility was unable to provide a Bed Hold Notice for this hospital leave. This form was requested from the DON on 06/18/25 at 11:57 AM. On 06/18/25, late afternoon, the DON stated she was unable to find one. On 06/24/25 at 2:05 PM, discussion was held with the DON and NHA about the transfer process for this hospitalization. At this time the surveyor asked if they had any additional information to provide. NHA stated no. b) Resident #279 Resident #279 sustained a fall with injury in the facility on 02/24/25 and was transported to an acute care facility Emergency Department (ED) for evaluation. Resident did not return to the facility. DON stated on 06/18/25 at 3:47 PM that she could not locate a bed hold notice. On 06/24/25 at 2:05 PM, discussion was held with the DON and NHA about the transfer process for this hospitalization. At this time, the surveyor asked if they had any additional information to provide. NHA stated no.

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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. Based on observation, interview and record review, the facility failed to ensure that a physician's order for oxygen administration was followed. This was a random opportunity for discovery. Resident Identifier: #6. Facility Census: 116. Findings include: a) Resident #6 During an observation on 06/16/25 at approximately 3:47 PM, the resident was observed asleep. The oxygen concentrator was noted to be set at three (3) liters per minute. A review of Resident #6's medical record revealed that the resident was diagnosed with Acute and Chronic Respiratory failure with Hypoxia. A review of Resident #6's care plan revealed a note that stated: 'Resident takes off O2 at times. Encourage the resident to allow the staff to replace the O2. Date Initiated: 02/27/2025 During the survey period, there were no observations of the resident with her nasal cannula removed. Physicians' orders prescribed Oxygen at two (2) liters per minute. Follow-up observations over the next few days revealed the following: 6/17/25 at 11:15 AM - Resident observed asleep with oxygen concentrator set at 3 liters per minute. 06/17/25 at 3:42 PM - Resident observed asleep with oxygen concentrator set at 3 liters per minute. 06/18/25 at 8:55 AM - Resident observed asleep with oxygen concentrator set at 2.5 liters per minute. 06/18/25 at 1:19 PM - Resident observed asleep with oxygen concentrator set at 2.5 liters per minute. On 06/18/25 at 1:21 PM, Licensed Practical Nurse (LPN) #17 was notified of the incorrect oxygen dose. LPN #17 stated that she would check the physician's orders, and confirmed that the resident's prescribed oxygen delivery rate should be 2 liters per minute. LPN #17 adjusted the oxygen concentrator to deliver the prescribed dose and stated that she would monitor the concentrator to ensure it was not malfunctioning.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the consulting pharmacist failed to identify and notify the physician of potential Adverse Drug Reactions (ADR's) related to the concurrent administration of opioids, benzodiazepines. Further, the pharmacist failed to identify that a medication had been prescribed to a resident with a documented allergy to it. Resident identifier: #6. Facility Census: 116. Findings Include: a) Resident #6 Record review on 06/16/25 at approximately 12:25 PM revealed that Resident #6 was an [AGE] year-old female. Resident #6 did not have capacity and a Brief Interview for Mental Status (BIMS) assessment on 05/07/25 revealed a BIMS of 02. The resident has been diagnosed with the following: Acute and Chronic Respiratory Failure with Hypoxia. Paroxysmal Atrial Fibrillation Chronic Obstructive Pulmonary Disease Alzheimer's Disease Major Depressive Disorder Atherosclerotic Heart Disease of Native Coronary Artery without angina pectoris Following the record review, Resident #6 was observed at frequent intervals throughout the survey and the following was noted: 06/16/25 at 1:55 PM - Resident observed asleep 06/16/25 at 3:47 PM - Resident observed asleep 6/17/25 at 11:15 AM - Resident observed asleep 06/17/25 at 2:21 PM - Resident observed asleep 06/17/25 at 3:42 PM - Resident observed asleep 06/18/25 at 8:55 AM - Resident observed asleep 06/18/25 at 1:19 PM - Resident observed asleep 06/18/25 at 4:05 PM - Resident observed asleep (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/19/25 at 8:59 AM - resident observed awake and in Geri chair - very vocal, loud, and making unintelligible statements. 06/19/25 at 11:15 AM - resident observed asleep 06/24/25 at 2:32 PM - resident observed asleep 06/24/25 at 4:10 PM - resident observed asleep 06/25/25 at 9:15 AM - Resident observed asleep 06/25/25 at 11:21 AM - Resident observed asleep 06/25/25 at 1:49 PM - resident observed asleep During an Interview with Registered Nurse (RN) #36 on 06/19/25 at approximately 10:30 AM, RN stated that Resident #6 usually preferred to sleep in her room for most of the day. RN #36 stated that the physician had prescribed Tramadol a few months back due to resident's behaviors. RN #36 further stated that resident's husband visits every evening, and that he would try to wake her up and talk to her. Further record review on 06/16/25 at 2:10 PM revealed that the resident was prescribed the following medications: Lorazepam Oral Tablet 1 MG (Lorazepam) Give one tablet every 8 hours as needed for anxiety. Tramadol Tablet 50 MG *Controlled Drug* Give 1/2 tablet = 25 MG by mouth daily Trazodone HCl Oral Tablet 50 MG (Trazodone HCl) - Give 50 mg by mouth at bedtime for Insomnia Both lorazepam (a benzodiazepine) and tramadol (an opioid) are CNS depressants. FDA guidance states that providers should take precautions when prescribing Tramadol (an opioid) and Lorazepam (a benzodiazepine), as concurrent use of these drug classes can result in excessive drowsiness, respiratory depression, overdose and death. The guidance also stated that physicians should reserve concurrent use of prescribing of opioid analgesics with benzodiazepines or other CNS depressants for use in patients for whom alternative treatment options are inadequate. . Record review further revealed that Resident #6 had a documented allergy to Tramadol. The allergic reaction to Tramadol was documented as 'Hallucinations'. During an interview with the Director of Nursing (DON) and Regional Clinical Nurse (RCN) #300 on 06/19/25 at 11:43 AM, they confirmed that no physicians note was available acknowledging the use of Tramadol even though the resident was allergic to it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After a comprehensive review of the resident's medical record, it was observed that there were no nursing notes or other documentation related to the resident's sleep patterns during the day or her overall quality of life. Additionally, no documentation was provided showing that the drug-to-drug interactions and possible adverse reactions were considered. Further, none of the completed Monthly Monitoring Reports (MMRs) or Gradual Dose Reductions (GDRs) addressed the concurrent use of opioids and benzodiazepines. During an interview on 06/25/25 at approximately 1:20 PM, Pharmacist #301 and RCN #300 attempted to explain the documentation provided. The pharmacist did not provide a reason for failing to identify and notify the physician about the potential adverse reactions associated with the concurrent use of benzodiazepines, and opioids. RCN #300 noted that the physician had already put orders in place for monitoring the side effects of antianxiety medications, mood stabilizers, and antipsychotics. As a result, RCN #300 did not believe it was necessary to inform the physician about the potential dangerous adverse reactions of using these medications concurrently.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to monitor the expiration dates of medical supplies. Further, the facility failed to ensure that expired medical supplies were disposed of and not left accessible for use by staff for resident care. Facility Census: 116. Findings Include: a) North Medication Room During an inspection of the North Medication Room on [DATE] at approximately 9:16 AM, accompanied by Licensed Practical Nurse (LPN) #17, the storage bins holding medical supplies revealed the following: 31 - BD 1 ML Syringes - expiration date [DATE] 7 - Insyte 24 GA x 0.75 in injection syringes - expiration date [DATE] LPN #17 counted and confirmed the expiration dates on the syringes. LPN #17 further stated that she would notify the DON of the finding, and dispose of the expired syringes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and policy review the facility failed to properly store and serve food in accordance with professional standards for food service safety. This had the potential to affect all residents in the facility. Facility census: 117. Findings included: a) On 06/16/25 11:35 AM, during the Initial Brief Tour of Kitchen, with Assistant Dietary Manager #182 acknowledged the following: In the Freezer it was observed that a bag of frozen Hamburger patties were left opened and exposed. On 06/17/25 at 1:00 PM a review facility policy labeled HCSG Policy 019, Food Storage: Cold Foods. Procedures, number 5 stated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A bag of macaroni was observed left open and exposed in the pantry On 06/17/25 at 1:00 PM a review facility policy labeled HCSG Policy 018, Food Storage: Dry Goods. Procedures, number 5 stated All packaged and canned food items will be kept cleam, dry, and properly sealed. The temperature inside the kitchen refrigerator was 45 degrees verified by two different thermometers and witnessed by the Assistant Dietary Manager employee #182 . During the initial brief kitchen walk through and interview with the Assistant Dietary Manager employee #182, she acknowledged the bag of open macaroni in the pantry, the box of frozen burgers left open and exposed in the freezer, and the fridge temperatures at 45 degrees and stated she would take care of them and would report the refrigerator temps to the Kitchen manager to have the refrigerator checked for repair. In an interview on 06/16/25 at 1:10pm with the Dietary Manager (DM) #181, she stated she was aware of the previous mentioned issues in the pantry, freezer, and the temperature in the refrigerator. Observations made on 06/17/25 at 12:015 PM while preparing resident food trays on the tray line, It was observed that Employee #175 walked over to the freezer, touched the freezer door stepped inside and took out a chocolate ice cream cup and then walked back to the tray line and began to prep resident food trays without changing gloves or washing her hands. At 12:20PM, she pulled the delivery cart up to the prep line and opened the cart doors in preparation to load resident trays and then began preparing resident food trays again without changing gloves or washing her hands. In an interview with DM #181 on 06/17/25 at 12:20 PM, she acknowledged Employee #181 had not changed her gloves after leaving the tray line both times, touching the freezer door handle, then again touching the floor delivery cart and returning to tray prep without changing her gloves nor washing her hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections with regards to the residents and unsanitary practices. This failed practice was a random opportunity of discovery. Facility Census: 117. Findings included: a) During a facility walk through on 06/16/25 at 3:34 PM, an opened box of tissues, an opened box of gloves and an opened package of wipes, was found on the middle shelf sitting on top of the clean linen of the linen cart in the South Hall. On 06/17/25 at 9:56 AM, during a facility walk through, an opened box exam gloves, a small roll of clear garbage bags, and an opened package of wipes was found on top of the clean linen on the top shelf of the linen cart in the South Hall . On 06/16/25 at 3:45 PM, in an interview with Licensed Practical Nurse (LPN) #107, she acknowledged the items on the linen cart and stated nothing should be on the linen cart with the clean linen and removed the package of wipes, box of gloves and tissues, immediately. In an interview, on 06/17/25 at 10:05 AM with Nurses Aid (NA) #117, she acknowledged the items on the linen cart and immediately removed them.