STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515047	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worthington Healthcare Center	2675 36th Street Parkersburg, WV 26104

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 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. 45173 Based on record review and staff interview, the facility failed to develop and/or implement the care plan for Resident #92, #84, #39 and #95, four (4) of four (4) residents reviewed. Resident identifiers: #92, #84, #39 and #95. Facility Census: 93. Findings included: a) Resident #92 On 04/03/24 at 9:00 AM, a record review was completed for Resident #92. The review found the care plan had not been developed to include all the interventions based on the physician's orders and the Treatment Administration Record (TAR) dated 03/01/24 through 03/31/24. The interventions that were not found were as follows: --Daily assessment of the unstageable (UN) wound on the right heel --Wound care as ordered On 04/03/24 at 10:00 AM, the Corporate Registered Nurse (RN) was notified and confirmed the interventions were not listed. b) Resident #84 On 04/03/24 at 9:15 AM, a record review was completed for Resident #84. The record review found the care plan had not been developed to include an Unstageable wound on the sacrum and the interventions found in the physician's orders and the TAR dated 03/01/24 through 03/31/24. The following interventions were not found as follows: --Daily wound assessment on the bullae of the right thumb, the unstageable wound of the sacrum, vascular wound of the lateral thigh, the vascular wound of the right lower extremity --Wound care as ordered --Float heels while in bed (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Encourage to turn and reposition while in bed On 04/03/24 at 10:00 AM, the Corporate Registered Nurse (RN) was notified and confirmed the interventions were not listed. c) Resident #39 On 04/03/24 at 9:25 AM, a record review was completed for Resident #39. The review found the care plan had not been implemented based on the TAR dated 03/01/24 through 03/31/24. The following interventions were not implemented: --Administer preventative treatment as ordered --Administer treatments as ordered and monitor for effectiveness --Daily wound assessments per orders --Resident may use pillowcases between knees and to prevent skin breakdown due to contractures On 04/03/24 at 10:00 AM, the Corporate Registered Nurse (RN) was notified and confirmed the interventions were not implemented. d) Resident #95 On 04/03/24 at 9:40 AM, a record review was completed for Resident #95. The review found the care plan had not been implemented based on the physician's orders and the TAR dated 02/01/24 through 02/29/24. The following interventions were not implemented: --Daily wound assessment of the surgical wound of the right iliac crest --Turn resident every 2 (two) hours (alternate right side and left side and back for meals as tolerated On 04/03/24 at 10:00 AM, the Corporate Registered Nurse (RN) was notified and confirmed the interventions were not listed.

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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 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. 45173 Based on record review and staff interview, the facility failed to follow physician's orders four (4) of four (4) residents. Resident identifiers: #92, #84, #39 and #95. Facility Census: 93. Findings included: a) Resident #92 On 04/03/24 at 9:00 AM, a record review was completed for Resident #92. The review found the physician's orders on the Treatment Administration Record (TAR) for 03/01/24 through 03/31/24 were not followed. The following treatments and dates were left blank: --Daily wound treatment to the stage III to the sacrum --03/02/24 day shift --Daily wound assessment for the stage III to the sacrum --03/02/24 day shift --Preventative treatment to the coccyx and bilateral buttocks twice daily --03/25/24 night shift --Bilateral palm guards on hands may remove twice daily to clean and monitor skin --03/25/24 night shift --Float heels when in bed twice daily for preventative measures --03/25/24 night shift --Resident may use pillow cases between knees to prevent skin breakdown due to contractures twice daily --03/25/24 night shift --Ensure resident has been turned and repositioned every 2 (two) hours for stage 2 (two) --03/03/24 at 12:00 AM, 2:00 AM, and 4:00 AM --03/15/24 at 6:00 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--03/25/24 at 8:00 PM and 10:00 PM --03/26/24 at 12:00 AM, 2:00 AM, and 4:00 AM --03/28/24 at 4:00 AM On 04/03/24 at 10:00 AM, Corporate Registered Nurse (RN) #147 was notified and confirmed the TAR should have been completed as ordered. The Corporate RN #147 stated, I can't fix holes. b) Resident #84 On 04/03/24 at 9:15 AM, a record review was completed for Resident #84. The review found the physician's orders on the Treatment Administration Record (TAR) for 03/01/24 through 03/31/24 were not followed. The following treatments and dates were left blank: --Daily treatment to the bullae to the right thumb --03/03/24 day shift --03/06/24 day shift --03/12/24 day shift --Daily wound assessment of the bullae to the right thumb --03/03/24 day shift --03/06/24 day shift --03/12/24 day shift --Dressing change to Peripherally Inserted Central Catheter (PICC) line site every Tuesday --03/19/24 day shift --Daily wound care to the unstagable (UN) to the sacrum --03/03/24 day shift --03/12/24 day shift --03/15/24 day shift --03/19/24 day shift --Daily wound assessment to the vascular wound lateral thigh --03/03/24 day shift (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--03/06/24 day shift --03/12/24 day shift --03/15/24 day shift --03/19/24 day shift --03/20/24 day shift --03/21/24 day shift --Daily wound care to the vascular wound lateral thigh --03/03/24 day shift --03/15/24 day shift --03/19/24 day shift --03/21/24 day shift --Wound care to the vascular wound right lower extremity every other day --03/06/24 day shift --03/12/24 day shift --03/20/24 day shift --Daily wound assessment to the vascular wound right lower extremity --03/03/24 day shift --03/06/24 day shift --03/12/24 day shift --03/15/24 day shift --03/19/24 day shift --03/20/24 day shift --03/21/24 day shift --Encourage to turn and reposition while in bed every shift (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--03/06/24 day shift --Monitor Peripherally inserted central catheter (PICC) line site for signs/symptoms of infection every shift --03/06/24 day shift On 04/03/24 at 10:00 AM, Corporate Registered Nurse (RN) #147 was notified and confirmed the TAR should have been completed as ordered. The Corporate RN #147 stated, I can't fix holes. c) Resident #39 On 04/03/24 at 9:25 AM, a record review was completed for Resident #39. The review found the physician's orders on the Treatment Administration Record (TAR) for 03/01/24 through 03/31/24 were not followed. The following treatments and dates were left blank: --Daily wound care to the stage III sacrum --03/02/24 day shift --Preventative care to the coccyx and bilateral buttocks every shift --03/25/24 night shift --Bilateral palm guards on hands every shift --03/25/24 night shift --Float heels when in bed every shift --03/25/24 night shift --Pillow cases between knees to prevent skin breakdown every shift --03/25/24 night shift --Ensure resident has been turned and repositioned every 2 (two) hours for stage 2 (two) --03/03/24 12:00 AM, 2:00 AM and 4:00 AM --03/15/24 6:00 PM --03/25/24 8:00 PM and 10:00 PM --03/26/24 12:00 AM, 2:00 AM and 4:00 AM --03/28/24 4:00 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 10:00 AM, Corporate Registered Nurse (RN) #147 was notified and confirmed the TAR should have been completed as ordered. The Corporate RN #147 stated, I can't fix holes. d) Resident #95 On 04/03/24 at 9:25 AM, a record review was completed for Resident #95. The review found the physician's orders on the Treatment Administration Record (TAR) for 02/01/24 through 02/29/24 were not followed. The following treatments and dates were left blank: --Cleanse suprapubic catheter and apply drain sponge daily --02/03/24 day shift --Encourage resident to wear prevalon boots during the night --02/03/24 night shift --02/04/24 night shift --Daily wound assessment for surgical wound right iliac crest --02/03/24 day shift --02/04/24 day shift --Daily wound care to right iliac crest --02/03/24 day shift --02/04/24 day shift --Suprapubic catheter to BSD (bedside drain) document output every shift --02/03/24 day shift --02/03/24 night shift --0204/24 day shift --02/04/24 night shift --Encourage resident to wear gray fleece AFO (ankle foot orthosis) boots daily apply during AM (morning) medication pass and remove around 2:00 PM --02/03/24 application and removal --02/04/24 application and removal (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Encourage resident to allow staff to turn and reposition every shift --02/03/24 day shift --02/03/24 night shift --02/04/24 day shift --02/04/24 night shift In addition, there were multiple physician's orders to encourage resident to turn and reposition every two (2) hours which at times did show on the TAR and other times the physician's orders did not. The following dates are the multiple times the physician's order was input: --01/12/24 to 02/05/24 The review under the task tab entitled Turn and reposition, the documentation was not complete or multiple duplicate times were documented. A review of the January, 2024 documentation found the following: --01/01/24 No documentation 12:00 AM 2:00 AM 4:00 AM 6:00 AM 8:00 AM 10:00 AM 2:00 PM 6:00 PM 10:00 PM --01/02/24 12:00 AM 2:00 AM 6:00 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:00 AM 12:00 PM 2:00 PM 4:00 PM 8:00 PM 10:00 PM --01/09/24 No documentation found --01/10/24 No documentation found --01/11/24 No documentation except for 10:00 PM --01/13/24 12:00 AM 2:00 AM 4:00 AM 6:00 AM 8:00 AM 10:00 AM 2:00 PM 4:00 PM 6:00 PM 10:00 PM --01/14/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:00 AM 2:00 AM 6:00 AM 8:00 AM 10:00 AM 2:00 PM 6:00 PM 10:00 PM --01/15/24 2:00 AM 6:00 AM 8:00 AM 2:00 PM 4:00 PM 6:00 PM 8:00 PM 10:00 PM --01/16/24 12:00 AM 2:00 AM 6:00 AM 8:00 AM 12:00 PM 2:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:00 PM 6:00 PM --01/17/24 6:00 AM 8:00 AM 2:00 PM 6:00 PM 10:00 PM --01/18/24 12:00 AM 2:00 AM 4:00 AM 8:00 AM 12:00 PM 6:00 PM 10:00 PM --01/19/24 12:00 AM 2:00 AM 4:00 AM 8:00 AM 10:00 AM 2:00 PM 6:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--01/20/24 12:00 AM 2:00 AM 6:00 AM 8:00 AM 4:00 PM 6:00 PM 10:00 PM --01/21/24 12:00 AM 6:00 AM 10:00 AM 12:00 PM 4:00 PM 6:00 PM 10:00 PM --01/22/24 12:00 AM 2:00 AM 4:00 AM 6:00 AM 8:00 AM 12:00 PM 4:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6:00 PM 10:00 PM --01/23/24 12:00 AM 2:00 AM 8:00 AM 10:00 AM 2:00 PM 6:00 PM 8:00 PM --01/24/24 6:00 AM 8:00 AM 12:00 PM 4:00 PM 6:00 PM 10:00 PM --01/25/24 4:00 AM 8:00 AM 12:00 PM 4:00 PM 8:00 PM --01/26/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:00 AM 2:00 PM 4:00 PM 6:00 PM --01/27/24 12:00 AM 6:00 AM 8:00 AM 10:00 AM 2:00 PM 4:00 PM 8:00 PM 10:00 PM --01/28/24 12:00 AM 4:00 AM 8:00 AM 10:00 AM 12:00 PM 4:00 PM 6:00 PM 8:00 PM --01/29/24 12:00 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:00 AM 2:00 PM 4:00 PM 6:00 PM 8:00 PM --01/30/24 6:00 AM 8:00 AM 2:00 PM 6:00 PM 8:00 PM --01/31/24 12:00 AM 2:00 AM 6:00 AM 8:00 AM 12:00 PM 4:00 PM 6:00 PM 10:00 PM On 04/03/24 at approximately 11:00 AM, the Corporate Registered Nurse (RN) #147 was notified and stated, I don't know why the physician's order is not showing on the TAR. --

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on observation, record review and staff interview, the facility failed to maintain a safe and accident-free environment as possible. This deficient practice had the potential for Resident #46 to harm himself in the absence of 1:1 supervision. Resident identifier: #46. Facility census: 93. The state agency determined this failure placed Resident #46's 1:1 observation status in an immediate jeopardy situation due to the potential of serious injury and/or death because of recent documented suicidal ideations and recent suicide attempt. The state agency notified the Nursing Home Administrator of the immediate jeopardy at 3:52 PM on 04/03/24. The facility submitted a plan of correction (POC) at 5:41 PM. At 5:48 PM, the POC was accepted by the state agency. The state agency verified the POC was implemented by conducting staff interviews and the immediate jeopardy was abated at 12:05 PM on 04/08/24. Findings included: a) Resident #46 On 04/03/24 at 2:16 PM, an observation was made of Resident #46 alone lying in his bed with eyes open. The resident was asked, where is the staff that was sitting with you? The resident stated, I don't know. On 04/03/24 at 2:18 PM, Licensed Practical Nurse (LPN) #33 was walking down the hall. LPN #33 was asked if the resident was still on 1:1 observation. LPN #33 stated, yes .I don't know where the staff member is. On 04/03/24 at 2:20 PM, Nurse Aide #101 returned to the resident's room. While standing at the doorway, NA #101 was asked, where did you go? You left the resident alone. NA #101 stated, I've just been gone for a few minutes, I went and got the resident some ice. NA #101 had been observed down the hall at the nurses' station during this time frame. Upon review of the medical record, the resident was admitted to the facility on [DATE]. The resident has a documented diagnosis of depression, unspecified. The resident was prescribed Zoloft (antidepressant) 25mg (milligram) by mouth daily and Remeron (antidepressant) 15 mg at bedtime. The resident was noted with a Brief Interview for Mental Status of 06 (six) on a Minimum Data Set (MDS) quarterly assessment dated [DATE]. The score indicates severe cognitive impairment. The resident demonstrated incapacity for making medical decisions. A progress note dated 03/08/24 at 6:09 PM states, Nurse states patient using grabber to pull pillow tight over his face. When she asked what he was doing, patient states, I'm trying to kill myself. Requests order to send patient out as 1:1 is not available for patient. (Typed as written.) (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a progress note dated 03/11/24 at 11:36 AM states, Resident noted to have suicidal ideation with plan/attempt on 03/08/24. Resident was sent to an (Name of the acute care facility) and returned to the facility 03/10/24. See new orders. Resident remains a 1:1 at this time. (Name of psychologist) notified of ideation/attempt and visit requested. LSW (Licensed Social Worker) has also made a referral to (Name of in house psychiatric facility) for in house psychiatric tx (treatment). POC (plan of care) has been updated. (Typed as written.) A progress note dated 03/11/24 at 12:45 PM states, Updated HCS (Health Care Surrogate) on all that has transpired from Friday. States she was aware of the incident Friday and the hospital made her aware that he was being sent (Name of inpatient psychiatric facility). She has been updated that they sent Resident back to (Name of facility) instead. Also updated on new orders and that (Name of psychologist) would be in be in to see Resident today. HCS states Resident has a hx (history) of suicidal ideation/attempts prior to coming to the (Name of the facility) and that he was also dx (diagnosis) with Schizophrenia before coming to (Name of facility). (Typed as written.) A progress note dated 03/11/24 at 7:47 PM states, (Name of psychologist) in to see resident, order received to send resident back to (Name of acute care facility) d/t (due to) suicidal ideations. (Typed as written.) A progress note dated 03/11/24 11:12 PM states, Resident returned from (Name of acute care facility), according to d/c (discharge) papers (Name of psychologist) agreed to have resident returned to the facility. CNA (certified nursing assistant) sitting 1:1 with resident. (Typed as written.) On 03/13/24 at 7:43 AM, a progress note states, Change in condition noted today: Resident remains 1:1 for suicidal ideation. (Typed as written.) A progress note dated 03/14/24 at 11:37 AM states, Change in condition noted today. Resident remains a 1:1 and is being followed by (Name of psychologist). (Typed as written.) On 03/18/24 at 1:41 PM a progress note states, .Resident continues to be 1:1. No further suicidal ideation/attempts however Resident acknowledge depression (negative thoughts) . A progress note dated 03/19/24 at 2:23 PM states, .He (resident) did ask this nurse when he will be by himself and not have someone with him, I told him that is up to the physician and we have 1:1 for his safety, he stated he understands, no other concerns at this time. (Typed as written) A progress note dated 04/02/24 at 10:57 AM states, 1:1 sitter. On 04/03/24 at approximately 2:35 PM, the Corporate Registered Nurse (RN) #147 was notified of the observation of the resident being alone. Corporate RN #147 confirmed the resident should not be alone. Corporate RN #147 stated, we have kept him on 1:1 for safety reasons. b) Facility Policy The facility policy entitled One on One Intervention Process states, The expectation of this intervention is the staff are in observation of the resident at all times until the intervention is no longer required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515047	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worthington Healthcare Center	2675 36th Street Parkersburg, WV 26104

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Abatement Plan 1. Resident # 46 was again placed on 1:1 Supervision. The C N A was removed from 1:1 assignment reported for unintentional neglect, reeducated on not leaving resident alone. 2. All residents who are receiving 1:1 have the potential to be affected by the alleged deficient practice. All other residents receiving 1:1 were checked, and no issues identified. 3. All staff members in the facility on 4/3/24 were immediately re-educated on 1:1 process including not leaving resident alone at any time. OHFLAC, APS, Ombudsman or other licensing board contacted. All staff not available, will be re-educated on 1:1 process at the start of their next scheduled shift. 4. The DON or designee will monitor that he is 1:1 during duration of 1:1 orders. If they need to leave the 1;1 assignment, they will ring call light and remain with resident until another employee relieves them. All allegations of unintentional neglect will be reviewed at the facility QA&A monthly .