STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515051	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph's Hospital	Amalia Drive #1 Buckhannon, WV 26201

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40595 Based on observation and staff interview the facility failed to provide dignity for Resident #8 during care. A glucose check was obtained without providing privacy. This failed practice was a random opportunity for discovery. Resident identifier: #8. Facility census: 15. Findings include: On 04/22/24 at 4:44 PM, an observation was made of LPN #17 performing a glucose check for Resident #8 in the day area resident lounge. No privacy was provided for the resident during the procedure. Resident #14 was present and facing Resident #8 when the finger stick was obtained. Resident #8 does not have capacity, as of 02/07/24, due to dementia. During an interview on 04/22/24 at 4:58 PM, Clinical Care Coordinator Register Nurse (RN) #7 stated, I just spoke with her [LPN #17] and she didn't realize it was a dignity issue. Education will been given to all staff. Facility failed to provide privacy during finger stick for R #8. PS and findings - BC Resident #8 FTag Initiation 04/22/24 4:44 PM Observation was made of LPN #17 performing a glucose check for Resident #8 in the Day area community lounge. No privacy was provided. Resident #14 was present and facing Resident #8 when the finger stick was obtained. Resident #8 does not have capacity, as of 02/07/24 due to dementia. BIMS score of . Clinical Care Coordinator Register Nurse (RN) #7 stated, I just spoke with her [LPN #17] and she didn't realize it was dignity issue. Education has been given to all staff.

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 45174 Based on record review and staff interviews, the facility failed to ensure the resident's Pre Admission Screening and Resident Review (PASARR) reflected pre-admission diagnoses for one (1) of one (1) residents reviewed for the category of PASARR. Resident #10 had a diagnosis of Bipolar Disorder on admission The lack of pre-screening resulted in the resident's condition not being evaluated through the Level II PASRR process. Resident identifier #10. Census 15. Findings Include: a) Resident #10 During a record review on 04/22/24 at 3:50 PM, Resident #10's medical record revealed a diagnosis of bipolar disorder dated 03/13/23. Further review of the medical record revealed a PASARR dated 11/09/23, Section 30 titled Current Diagnosis, was not coded k. Affective Bipolar Disorder. During an interview on 04/23/24 at 8:04 AM, the Clinical Care Coordinator acknowledged the PASARR was not coded for the Bipolar Disorder.

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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. 50552 Based on medical record review and staff interview the facility failed to ensure each resident received care in a manner which promoted their highest practicable physical, mental and psychosocial well being. The facility failed to provide Resident #8 with a comprehensive assessment by a Registered Dietician. This was a random opportunity for discovery. This is true for one (1) resident reviewed for the Long-Term Care Survey Process. Resident Identifiers: Resident #08. Facility Census: 15 Findings Include: a) Resident #8 During a medical record review on 04/22/24 at 2:30 PM, it was identified Resident #8 did not have a comprehensive assessment completed by a Registered Dietician. In review of the facility policy and procedure it was identified that Swing bed and skilled nursing patients will be assessed by a Registered Dietician within 72 hours of admission in order to evaluate nutritional status, identify patient status for nutritional risk and provide timely interventions. Resident #8 was identified as being in the facility for 77 days. During an interview with the facility Registered Dietician (RD) #35, RD #35 acknowledged she had not completed this comprehensive assessment stating, I am behind on this, I acknowledge that.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45174 Based on observation, record review and staff interview the facility failed to store food in accordance with professional standards for food service safety. The facility failed to monitor temperatures for an ice cream freezer. This failed practice had the potential to affect a limited number of residents. Facility Census: 15. Findings Include: a) Ice Cream Freezer During the initial tour of the kitchen with the Nutrition Services Supervisor beginning on 04/22/24 at 11:52 AM, an observation was made of the ice cream cooler. There was no documentation that the temperature of the ice cream freezer was monitored. An Immediate interview the Nutrition Services Supervisor acknowledged the temperatures were not being recorded for the ice cream freezer. She stated we never have monitored the ice cream freezer. During a revisit to the kitchen on 04/23/24 at 10:47 AM, the ice cream cooler was still void of any temperature records. During an interview on 04/23/24 at 10:53 AM the Director of Nutrition #35 acknowledged the temperatures were not being monitored. And stated we will start the monitoring immediately. Facility failed to monitor temperatures for the ice cream freezer. PS and findings TB FACILITY Kitchen 812 Based on observation, record review and staff interview the facility failed to store food in accordance with professional standards for food service safety. The facility failed to monitor temperatures for a ice cream freezer. This failed practice had the potential to affect a limited number of residents. Facility Census: 15. Findings Included: a) Ice Cream Freezer An initial tour of the kitchen with the CDM beginning on 04/22/24 at 11:52 AM, observation was made of the ice cream cooler. There was no documentation the temperature of the ice cream freezer was monitored. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediate interview the CDM acknowledge the temperatures was not being recorded for the ice cream freeze. She stated we never have monitored the ice cream freezer. During a revisit to the kitchen on 04/23/24 at 10:47 AM, the ice cream cooler was still void of any temperature record. During an interview on 04/23/24 at 10:53 AM the Director of Nutrition #35 acknowledged the temperatures were not being monitored. Temps on the serving line: 04/23/24 at 11:05 AM the following temperatures were obtained by the Cook with the facility thermometer -Green Beans: 190 -Meatballs: 157 Chicken Alfredo: 148 Gravy: 168 Chicken Nuggets: 207

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50552 Based on medical record review and staff interview the facility failed to ensure a complete and accurate medical record. The facility failed to ensure the Physician Orders for Scope of Treatment (POST) form was completed per directions specified by the [NAME] Virginia Center for End of Life Care. This is true for one (1) of 15 residents reviewed for the Long-Term Care Survey Process. Resident Identifiers: Resident #08. Facility Census: 15 Findings Include: a) Resident #8 During a medical record review on 04/23/24 at 10:30 AM, Resident #8's medical record revealed a Physician Orders for Scope of Treatment (POST) form which failed to include the date the Medical Power of Attorney (MPOA) for Resident #08 and facility Social Worker (SW) #18 signed and completed the POST form. On 04/23/24 at approximately 10:45 AM, during a reivew of the 2021 POST form guidance titled, Using the POST Form: Guidance for Health Care Professionals, 2021 edition,available on-line, stated, The patient (or incapacitated patient' s MPOA representative or health care surrogate) must sign and date this section for the form to be legally valid. During an interview on 04/23/24 at 1:18 PM, SW #18 acknowledged she and Resident #8's MPOA had not dated the POST form as specified by the 2021 POST form guidelines.