STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	1539 Country Club Road Fairmont, WV 26554

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, interview, and investigation, the facility failed to conduct the required training and education for staff on issues which impacted resident care. Resident Identifier: #74. Facility Census: 110. Findings include: a) Resident #74 A Facility Reported Incident (FRI) report submitted on 05/01/24, indicated Resident #74 had complained of abuse by staff. The complaint stated, staff were rough when providing care. During an interview, with Resident #74 on 01/29/25 at approximately 11:55 AM, she stated, she had pain in her left leg, was be bound, and incontinent. She stated, she wears briefs, but her bed linen frequently becomes soiled. Upon being questioned about the staff being rough, she stated some staff members pulled on her leg a little too hard when changing her diaper and removing bed linen. She further stated, the staff members who were 'rough' were no longer employed at the facility. Record review of resident's care plan revealed the following notes: FOCUS: [Resident] requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, toileting related to: Limited mobility. [Resident] refuses lift transfers 2/2 acute pain, prompting resident to refuse weights and showers, only permits bed baths. [Resident] prefers her husband to move her legs while receiving care at times. Date Initiated: 07/27/2022 Created on: 07/27/2022 Created by: RN #93 Revision on: 01/28/2025 (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS: Provide resident/patient with extensive assist of one for personal hygiene (grooming). Date Initiated: 07/27/2022 Created on: 07/27/2022 Revision on: 07/27/2022 During interviews with Nursing Aides (NA) # 50 and #134, on 01/29/25 at approximately 2:25 PM, they stated the resident's husband was not always present when the resident needed care. They further stated incontinence care frequently involved completely changing the bed linen too. A review of the investigative documents revealed the facility had interviewed and obtained statements from Residents #28, #32, #78, #89, and #108. Residents had stated the staff were not impatient or rough when providing care. The facility indicated in the FRI they would follow up with education for staff on issues which impacted resident care. A record review on 01/29/25 at 9:45 AM revealed no follow-up for staff education. The Director of Nursing (DON) on 01/29/25 at approximately 3:15 PM, confirmed she did not have any staff education records.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, investigation, and interview, the facility failed to provide sufficient preparation and orientation and take steps under its control to ensure one of one resident discharge was safe and orderly. Resident #111 was taken to a local homeless shelter who was not equpieed to meet her needs to her physical limitations. Resident identifier: #111. Facility Census: 110. Findings included: a) Resident #111 A record review revealed, the facility notified the resident of a pending discharge on [DATE] at 9:12 AM. The resident was discharged from the facility on 03/13/24 at 9:39 AM. In addition the facility made the referral to a homeless shelter without adequate planning to ensure the shelter could meet the needs of the resident. When the homeless shelter declined to accept the resident, the facility kept the resident in the transport vehicle, while searching for other shelters that would be able to accept the resident. A record review revealed the following notes in resident's medical record: A nursing note dated 3/13/24 at 7:21 AM by RN #141 stated: This nurse and another nurse asked [Resident] if she was okay if we were able to search her room. [Resident] stated Yeah, that's fine. [Resident] was present sitting in her chair and her bed while said nurses searched her belongings/room. When checking the nightstand, [Resident] voluntarily unlocked her lock box to allow this nurse to see inside. While checking the nightstand there was a single credit card laying on night stand, white residue noted to one side of the card. This nurse obtained white particles of a pill off the floor. There were smaller white particles on the floor by the night stand. While searching [Resident's] bed, her Teddy bear that was sitting on the bed was searched as well. This nurse noted a hole in the neck of the teddy bear, upon further investigation there was a white oblong tablet scored with the letters M365 wrapped up in tissues stuffed inside a ziplocked baggy. This nurse asked [Resident] what the contents of the baggy were she stated Oh, those are just Tylenol 'resident 102644' gave me. Educated [Resident] that she is prescribed Tylenol and is able to ask the nurse for medicine as the needs arise, that we are unable to keep medications at bedside. [Resident] verbalized understanding. Items searched were placed back in the way they were prior to search. Ziplocked baggy and white pill particle confiscated. Pill was identified as Hydrocodone-Acetaminophen 5-325 mg Tablet. This resident is not currently prescribed this medication. 9:12 am - This nurse, another nurse, and sheriff spoke with [Resident] regarding her need to discharge due to finding the narcotic in her room, per facility Administrator. [Resident] stated, That's fine, I will go, I just need to gather a couple of things. Resident gathered the belongings she wanted to take with her, presented to the 500 hall, discharge paperwork reviewed. [Resident] verbalized understanding of her discharge instructions. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note by SW #142 on 3/13/24 at 9:05 AM which stated: Late Entry: 3/13/2024 10:56 Informed this resident is agreeable to discharge today following situation regarding narcotics found in room. She did allow staff to search her room and found some narcotics hidden in some of her belongings. Called (Name of local Homeless shelter) to make referral. A note on 03/13/24 at 9:07 AM by RN #93 stated: Discharge Plan Documentation was completed, The Resident Discharge Summary and Transition Plan can be found in the Document tab of the resident's chart. A nursing note on 3/13/24 at 9:39 AM by RN #93 stated: All discharge paperwork reviewed with resident, education provided for all medications with verbal understanding voiced, resident taking all medications and was notified that MD discontinued oxycodone, resident took 25 Lyrica 50mg, resident chooses to not allow staff to make appt with MD for follow up at this time and will do on her own. Resident took all belongings that she wanted and left several boxes. Resident is being transferred by facility van to (name of local homeless shelter), resident left with facility wheelchair that facility allowed her to keep. A note by SW # 142 on 3/13/24 at 10:00 AM which stated: Called by staff transporting resident to (Name of local homeless shelter). They are unable to accommodate [Resident] at this time as she is unable to complete the stairs to the sleeping quarters and dining area. No other available accommodations in the area at this time. Message left for (Name of neighboring county shelter). Another note by SW #142 on 03/13/24 at 10:35 AM which stated: [Resident] requested to be taken to the area of McDonald's/[NAME] on Fairmont Avenue. APS referral made. Intake number 3976939 A Note by SW #144 on 03/14/24 at 10:45 AM which stated: Received a call from yesterday morning. CED (center executive director) was attempting to assist the facility social services department on creating & facilitating the most successful/safe discharge available. [Resident] was agreeable to be transferred to a homeless shelter and was accepted by one arranged by #142, facility social worker. However, it was determined upon arrival to the shelter, [Resident] was unable to climb stairs, which was necessary to safely ambulate throughout that facility. MSW #145 contacted many additional homeless shelters throughout the state and the (Name of shelter in a town 1 an 1/2 hours away fromwere resident was) accepted [Resident] for placement. Resident was informed and stated that she would rather be transported to McDonalds where there is Wi-Fi and she would figure it out. Facility explained this was her decision and they would be more than willing to transport her to (Name of town where accepting shelter was locate) - resident declined. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at approximately 10:30 AM during an interview with the Interim Administrator #29, The Director of Nursing (DON) #111, and the Corporate Resource Nurse #137, it was confirmed that the facility did not ensure that resident was discharged safely and appropriately.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review and staff interview the facility failed to develop and implement a comprehensive person-centered care plan for a venous access device. This was true for one (1) of one (1) residents reviewed. Resident identifier: #113. Facility Census: 110. Findings Include: a) Resident #113 On 01/29/25 at 11:30 AM a record review found Resident #113 had a central line while a resident at the facility from 10/20/23 through 01/10/24. He was transferred to the facility from a local hospital with a central ([NAME]) Intravenous line in his right chest. On 01/29/25 at 3:30 PM a record review of the comprehensive care plan for Resident #133 found there was no care plan implemented for care of the central line. According to documentation and an interview provided by the Director of Nursing (DON) on 01/29/25 at 1:10 PM, they follow their pharmacy (PharMerica) recommendations for venous access devices which is also stated in their policy. The document provided from the pharmacy, Catheter Care and Flush Protocols states tunneled venous access device will have a transparent dressing changed every seven (7) days and as needed (PRN). The facility Infection Control Infection Prevention Measures for IV Catheter Dressings policy states: A sterile dressing is utilized as an infection control measures. Transparent, semi-permeable membrane (TSM) dressings are changed a minimum of every seven (7) days and PRN whenever the dressing integrity becomes disrupted, becomes wet, loose, or soiled or if skin integrity is compromised under the dressing On 01/29/25 at 3:30 PM it was confirmed with the Administrator that the central line was not addressed on the 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review and staff interview the facility failed to provide proper care for a venous access device according to their Infection Prevention Measures Policy and standard practice of care. This was true for one (1) of one (1) resident reviewed. Resident identifier: #113 Facility Census: 110. Findings Include: a) Resident #113 On 01/29/25 at 11:30 AM a record review found Resident #113 had a central line while a resident at the facility from 10/20/23 through 01/10/24. He was transferred to the facility from a local hospital with a central ([NAME]) Intravenous line in his right chest. According to documentation and an interview provided by the Director of Nursing (DON) on 01/29/25 at 1:10 PM, they follow their pharmacy (PharMerica) recommendations for venous access devices which is also stated in their policy. The document provided, Catheter Care and Flush Protocols stated that tunneled venous access device will have a transparent dressing changed every seven (7) days and as needed (PRN). The facility Infection Control Infection Prevention Measures for IV Catheter Dressings policy states: A sterile dressing is utilized as an infection control measures. Transparent, semi-permeable membrane (TSM) dressings are changed a minimum of every seven (7) days and PRN whenever the dressing integrity becomes disrupted, becomes wet, loose, or soiled or if skin integrity is compromised under the dressing Review of the Medication Administration Record (MAR) for October 2023 through January 2024, at which time he was discharged , the intravenous central line dressing in his right chest was never changed. Review of progress notes and the Treatment Administration Record (TAR) found no evidence that the dressing had been changed. According to the Director of Nursing the central line was never used. The resident had IV antibiotics, but the facility placed a peripheral IV and then later a midline IV for administration of these antibiotics. This was confirmed by review of the progress notes. This was confirmed with the Director of Nursing and the Administrator on 01/29/25 at 3:30 PM. No additional documentation was received prior to exiting the facility on 01/30/25.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, and resident and staff interviews, the facility failed to ensure Resident # 90 was transferred in a safe manner to prevent physical injury. This resulted in actual harm for Resident #90 who sustained a laceration to her lower extremity requiring16 stitches. After the incident with Resident #90 the facility identified the failures and took appropriate action to correct the failures prior to the state agency entering the facility to conduct this complaint investigation. Therefore this will be cited as past non compliance. This was true for one (1) of three (3) sampled residents. Resident Identifier: #90. Facility Census: 110. Findings Include: A) Resident #90 On 04/09/24 Nurse Aide (NA) # 136 was transferring Resident #90 from the wheelchair to the bed when the resident sustained a laceration to her right lower extremity. Resident #90 was taken to the emergency room requiring 16 stitches. The facility reported the incident as required to all state agencies and began an investigation into what happened. A review of the facility's investigation found a statement written by NA #136, in this statement she confirmed she did not use the appropriate procedure when lifting Resident #90. Based on the Care Plan, Resident #90 was a lift sit to stand transfer. NA #136 used a gait belt to transfer resident # 90 from the wheelchair to her bed and discovered the resident's laceration to her right lower extremity. The facility substantiated neglect and reported NA #136 to the state registry and terminated her employment on 04/10/24. During the course of the investigation the facility discovered other NA's caring for Resident #90 may not have been transferring her appropriately. The facility then completed a whole house audit finding incorrect transfer procedures to be isolated to Resident #90. Staff inservices and education on resident transfers and lifts using the kardex started 04/10/24 and was completed 04/17/24 with scheduled future staff monitoring. During an interview with Resident #90, on 1/29/25 at 9:18 AM, she was up and sitting in her wheelchair down the hall from her room. She stated staff used a lift to transfer her to her wheel chair. She stated she did not have to wait for long periods of time for transfers when she requested to be up. She stated she hasn't missed meals or activities due to waiting to be transferred to the chair. She stated her call lights were answered timely. She did not remember being hurt during her transfer from the bed to the chair. She stated she hasn't had any falls lately. Resident room observation: at 9:24 Am 01/29/24 found Resident #90's bed is at wheelchair level and against the wall and bedside table at bed level with a longreach appliance tool. Grip strips fall prevention on the floor and call light clipped to bed within resident's reach while in the room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the DON, Nurse Administrator, and Corporate Resource Nurse, on 01/29/24 at approx 2:30 PM, the facility provided verification of employment termination of NA #136, staff transfers/lift education and inservices/monitoring(pre and post incident), and whole house transfer/lifts audits. No further incidents related to improper transferring were identified during course of the survey.