

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Moundsville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Floral Street Moundsville, WV 26041	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>49466</p> <p>Based on record review, and staff interview, the facility failed to thoroughly investigate the elopement of Resident #101. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents in the facility. Resident identifier: #101. Facility census: 117.</p> <p>Findings included:</p> <p>a) Resident #101</p> <p>A facility reported incident (FRI) dated 07/15/24 stated, Resident (#101) exited the center at 7:03 PM through the front door via emergency exit and at 7:35 PM staff was alerted that resident was seen by an off duty staff member RN who stayed until center showed up. Resident did not want to be at the center.</p> <p>At approximately 2:00 PM on 08/14/24 an interview was conducted with the Administrator (NHA). When asked why no one heard the alarm to address the resident elopement within 30 minutes. The NHA stated that they could not confirm if the doors were alarmed on that specific instance, nor could comment on why no one heard or responded to the alarm. The NHA could only comment that upon testing after the event the alarms were functioning fine.</p> <p>The NHA stated that Resident #101 eloped at exactly 7:03 PM. The NHA said this was verified by review of the video to confirm the time of exit and return to the facility. The NHA stated that the video evidence was no longer available due to the video's are only retained for two (2) weeks.</p> <p>At approximately 2:00 PM on 08/14/24 surveyors interviewed the administrator. When asked why no one heard the alarm to address the resident elopement within 30 minutes. The administrator stated they could not confirm if the doors were alarmed on that specific instance, nor could they comment on why no one heard or responded to the alarm. The administrator could only comment that upon testing after the event the alarms were functioning fine. Surveyors then asked how the administrator knew that resident #101 eloped at exactly 7:03 PM, and they stated that they had pulled video from the time of the event to confirm the time of exit and reentry into the facility. They stated that they could not provide this video evidence to surveyors because it is only retained for two (2) weeks.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 515067
		If continuation sheet Page 1 of 6

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 3:30 PM on 08/14/24 two (2) surveyors went to administration to request live testing of the alarms. The administrator demonstrated the emergency delayed egress on the door, and the alarm sounded as designed. The alarm was shrill and audible around the proximity of the door. Another surveyor ventured back to the nurse's station in the central hallway of the building surrounded by four wings of the building. At this location, a repeater alarm sounded. It was audible enough that all hallways were within hearing range around the station.</p> <p>The surveyor observed through the doorway, walking from the main lobby to the nurse's station. The repeater alarm had a second number pad by which to disable the alarm. At the time of the demonstration, a gentleman was rushing over to disable the alarm. Due to the sheltered location of the pad, it was not clearly within the eyesight of the door. By appearance, the gentleman took a moment to identify that the administrator was testing the door as he was already punching in the code to disable it.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49751</p> <p>Based on record review, observations and staff interview, the facility failed to ensure one (1) resident was provided with a safe environment to prevent elopement. This resulted in Resident #101 leaving the facility and being found outside the facility, two (2) blocks away. The facility's failure to ensure the resident did not exit the facility unattended on 07/09/24 placed him at risk and in an Immediate Jeopardy (IJ) situation. This will be cited as past noncompliance because the facility corrected the failure as of 07/29/24, prior to this survey. Resident identifier: #101. Facility census: 117.</p> <p>Findings included:</p> <p>a) Resident #101</p> <p>A record review revealed the following regarding Resident #101's activities.</p> <p>06/19/24 at 8:59 PM</p> <p>Behavior Note Text: Resident attempting to exit building, calling staff names and cursing. Threw heart monitor at nurse from across nurse's station. Keeps screaming, 'call the fucking cops, call the cops' and getting up into this nurse's face and stated, Call doctor [NAME], you fucking fat ass bitch.</p> <p>06/22/24 at 2:40 PM</p> <p>Nurses Note Text: Resident wondering about facility this afternoon telling staff he is breaking out tonight. Redirected resident that he has to be discharged by Dr. [NAME]. He wasn't happy with the answer.</p> <p>07/09/24 at 5:35 PM</p> <p>Nurses Note Text: An off-duty staff member phoned the facility and notified of this resident being seen on 4th and Grant street. This staff member stayed with resident while he continued to sixth street to his sons house. I sent 3 staff members to pick resident up from son's house and notified ED of incident who then informed the DON, ADON, and resident family member.</p> <p>On 07/09/24 7:00 PM</p> <p>Resident #101 was found by an off-duty staff member two blocks away from the facility after 7:00 PM. Upon returning to the building at 7:35 PM, resident was assessed head to toe, neuros checked, and a WanderGuard was ordered.</p> <p>07/09/24 8:20 PM</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Nurses Note Text: Resident returned to facility with staff members. Head-to-toe attempted and no injuries noted. Resident refusing neuros at this time.</p> <p>7/9/2024 8:36 PM</p> <p>Nurses Note Text: MD notified of situation. New order given for trazodone 50 mg q12hr PRN for agitation.</p> <p>07/09/24 at 11:00 PM</p> <p>Nurses Note Text: Resident's son at facility and meeting with resident. Residents demeanor is okay at this time as they walk throughout facility.</p> <p>07/09/24 10:47 PM</p> <p>Behavior Note Text: Resident continues exit seeking, becomes agitated and combative with staff int. Attempts to hit and kick staff, calling names, such as lying bitch, asshole, etc. Difficult to redirect and refuses medications at this time. Resident does allow some CNAs to interact.</p> <p>07/09/24 11:49 PM</p> <p>The patient has been fairly agitated tonight. He managed to leave the facility and walk to his son's house. PCP was made aware and trazodone ordered. Wander guard bracelet applied. Monitor for further behaviors.</p> <p>07/09/24 11:54 PM</p> <p>Behavior Note Text: Resident kicked front door exit open and ran out front door into parking lot, Staff intervened and followed resident, attempting to get him to return to facility. At this point resident physically threatened staff, spit on a staff member, and getting into the faces of staff. Staff convinced resident to return to facility. Once inside resident kicked the front door again, causing damage to the door. Resident is now sitting in lobby; staff members are in lobby with resident as well.</p> <p>07/10/24</p> <p>Resident #101 had increased agitation and an acute transfer to the local emergency department (ED) took place. Resident #101 was transported to the local ED by his son due to his refusal to go with emergency medical services. The facility wanted the resident evaluated by psychiatry.</p> <p>At approximately 2:00 PM on 08/14/24 surveyors interviewed the administrator. When asked why no one heard the alarm to address the resident elopement within 30 minutes. The administrator stated they could not confirm if the doors were alarmed on that specific instance, nor could they comment on why no one heard or responded to the alarm. The administrator could only comment that upon testing after the event the alarms were functioning fine. Surveyors then asked how the administrator knew that resident #101 eloped at exactly 7:03 PM, and they stated that they had pulled video from the time of the event to confirm the time of exit and reentry into the facility. They stated that they could not provide this video evidence to surveyors because it is only retained for two (2) weeks.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. True/False: By working together as a team and reporting increased behaviors the safest environment possible for our residents.</p> <p>3. Is it my responsibility to investigate an alarm sounding</p> <p>A. Yes, everyone should investigate an alarm sounding</p> <p>B. No, that is the nurses and CNA ' s responsibility.</p>		