

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 04/04/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>42120</p> <p>Based on observation and staff interview the facility failed to treat each resident with respect and dignity regarding meal service. This was a random opportunity for discovery. Resident identifier: #69, #100 and #75. Facility census: 120.</p> <p>Findings included:</p> <p>a) Resident #69</p> <p>An observation of meal services, on 04/01/24 at 12:55 PM, revealed Resident #69's Roommate received her tray. Resident #69 was yelling, I want my (explicit language) tray. During the observation at 1:08 PM, Resident #69 received her tray after multiple trays were passed.</p> <p>During an interview at 1:15 PM with Nurse Aide (NA) #63, NA #63 stated that they just serve the trays from the cart as they come out, in no specific order. She also stated that Resident #69 should have received her tray when the roommate received a tray.</p> <p>b) Resident #100</p> <p>During an observation on 04/02/24 at 12:05 PM, of the noon time meal in the dining room, Resident #103 was served her lunch tray, along with 2 other residents seated at the same table.</p> <p>Further observation showed that Resident #100 was also seated at the same table. She was served her tray at 12:25 PM. The other residents seated at the table were almost done eating their noon meal.</p> <p>During an interview on 04/02/24 at 12:25 PM, with Nursing Assistant (NA) #60, she stated, The trays are supposed to come out in order by table, but the kitchen never sends them out that way.</p> <p>c) Resident #75</p> <p>During an observation on 04/02/24 at 1:00PM of the lunch meal being passed on hall 200, Resident # 23 was served her lunch tray in her room.</p> <p>Further observation showed that four (4) other rooms were served, before Resident #23's Roommate, which was Resident #75. Resident #75 received her lunch tray at 1:25 PM.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/02/24 at 1:25PM, the Dietary Manager stated, They are in order, the nurse aides just grab them wrong.</p> <p>An observation on 04/02/24 between 1:00 PM and 1:25 PM, revealed that Resident #23's tray was on the top row of the meal cart and Resident # 75's tray was three (3) rows from the bottom of the meal cart.</p> <p>During an interview on 04/02/24 at 2:30 PM, with the Administrator, she stated, The kitchen has had two different in-services about that exact same thing.</p> <p>49465</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>49467</p> <p>Based on observation, resident interview, and staff interview, the facility failed to provide accommodations for Resident #93, by failing to have a geriatric chair available for the resident for transportation to activities and other needs for the resident. This was true for one (1) of two (2) residents reviewed for accommodation of needs during the long-term care survey process. In addition, the facility failed to have the Ombudsman's contact information posted at a level easily accessible to residents in wheelchairs. This has the potential to affect more than a limited number of residents. Resident identifier: 93. Facility census: 120.</p> <p>Findings included:</p> <p>a) Resident #93</p> <p>At approximately 1:30 PM on 04/01/24, an interview was conducted with Resident #93. Resident #93 stated they had not been up out of bed in a long time because the sling used for the mechanical lift hurt them when the staff used it. Resident #93 stated they would like to get out of bed more, attend activities, and move around the facility.</p> <p>At approximately 3:00 PM on 04/01/24, Resident #93 was observed in their bed.</p> <p>At approximately 09:00 AM on 04/02/24, Resident #93 was observed still in bed.</p> <p>At approximately 02:30 AM 04/02/24, Resident #93 was observed still in bed.</p> <p>At approximately 03:10 PM on 04/02/24, an interview was conducted with Resident #93. Resident #93 was asked if they had been out of bed, or if facility staff had offered to get them out of bed since the interview on 04/01/24. Resident #93 stated they had not been up, nor had staff offered to get them up. Resident #93 stated I would like to get up and go to activities sometime, I love to play Bingo. Resident #93 then stated If I did get up, there would be no way for me to go anywhere, I don't even have a chair for them to put me in.</p> <p>At approximately 03:56 PM on 04/02/24, an interview was conducted with Registered Nurse (RN) #119 concerning a chair for Resident #93. RN #119 stated I don't think [they] have one. I have been here for quite a while and I've never seen one in the room, or known [them] to have one.</p> <p>At approximately 04:09 PM on 04/02/24, an interview was conducted with the Director of Rehabilitation (DOR) regarding a wheelchair for Resident #93. The DOR was asked if Resident #93 had a chair available to them, to which they stated, They had a bariatric geri-chair before, but they never got up, so it was pointless for them to have it, so we took it away. Why are we pursuing this? The DOR confirmed Resident #93 did not have a chair readily available to them for transportation to activities, or in the event of an emergency. The DOR stated We can get one. The Director of Nursing entered the room at the end of the interview and also confirmed there was no chair available for Resident #93.</p> <p>Record review showed Resident #93 had no orders for a wheelchair or geriatric chair.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b) Posted ombudsman information</p> <p>An observation on 04/03/24 at 10:30 AM, revealed the Ombudsman's information posted in the facility was not easily accessible to residents required to be in a wheelchair.</p> <p>On 04/03/24 at 10:38 AM, the Administrator confirmed the Ombudsman information posted is not eye level with residents in wheelchairs.</p> <p>Another observation on 04/04/24 at 8:30 AM showed the Ombudsman information posted in the facility remained not easily accessible for residents who are in wheelchairs.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>49467</p> <p>Based on record review, resident interview, and staff interview, the facility failed to honor the choices of Resident #82 by failing to schedule showers during the resident's preferred time of the day. This was true for one (1) of two (2) residents reviewed for choices during the long-term care survey process. Resident identifier: 82. Facility census: 120.</p> <p>a) Resident #82</p> <p>At approximately 02:26 PM on 04/01/24, an interview was conducted with Resident #82. During the interview, when asked if they felt if the facility honored their choices, Resident #82 stated No, I keep getting flipped back and forth between day showers and night showers, and I don't want night showers. I've told them every time they move me to night showers that I don't like them because I don't want to go to bed with my hair wet. They moved me back to day showers and a couple days later, moved me back to night, and that's where I am still. They won't tell me why I can't have a shower on day shift either.</p> <p>Upon record review the following progress notes were found, pertaining to Resident #82's showers, typed as written:</p> <p>3/21/2024 14:53 Nurses Note</p> <p>Note Text: pt (patient) did not refuse shower, pt is a afternoon shower now.</p> <p>3/23/2024 00:40 Nurses Note</p> <p>Note Text: pt refused scheduled shower tonight due to pt has requested to be a day turn shower. pt states I don't like having night shower because I do not like to go to bed with wet hair. pt states she had requested to be moved to a day turn shower and was unaware they had switched her back to nighttime and would like changed back to day turn.</p> <p>Further record review of the Nurse Aide bathing task sheet revealed Resident #82 had day showers on 03/06/24, 03/11/24, 03/13/24, 03/15/24, 03/18/24, and 03/25/24. Resident #82 then received night showers on 03/26/24, 03/28/24, 03/30/24, and 04/02/24.</p> <p>At approximately 10:56 AM on 04/03/24, interviews were conducted with Licensed Practical Nurse (LPN) #22 and Nurse Aide (NA) #31 regarding showers for Resident #82. LPN #22 stated Resident #22 had been a day shift shower, but then was moved to night shift. LPN #22 acknowledged Resident #82 had requested day shift showers again due to not wanting to have wet hair at night, however, Resident #82 remained a night shift shower at this time.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>NA #31 stated, regarding Resident #82's shower preferences, Resident #82 was a day shift shower, then night, then day, then night. Resident #82 wants day showers because they don't like going to bed with wet hair. They were moved from day shift to night shift, due to another resident that had a night shower, wanted to move to days. They made the switch so the amount of showers would not be uneven between shifts.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>49467</p> <p>Based on observation and staff interview, the facility failed to protect the confidentiality of resident records by leaving a computer screen on, unattended in the hallway. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Facility census: 120.</p> <p>a) Observation</p> <p>At approximately 04:01 PM on 04/02/24, while administering medication, Registered Nurse (RN) #80 left the screen on the computer on, while the computer was in the hallway, displaying resident information.</p> <p>Upon returning to the cart, RN #80 acknowledged leaving the computer screen on, stating I can't believe I did that, I have never done that before.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for one (1) of three (3) residents reviewed for the care area of falls. Resident identifier: #110. Facility census: 120.</p> <p>Findings included:</p> <p>a) Resident #110</p> <p>Review of Resident #110's medical records showed the resident had a fall on 02/04/24 and fractured her right hip.</p> <p>Review of Resident #110's Significant Change/Medicare Five (5) Day Minimum Data Set (MDS) Assessment with Assessment Reference Date (ARD) 02/16/24 showed No for the question if the resident had any falls since the prior assessment.</p> <p>On 04/04/24 at 8:46 AM, Minimum Data Set Registered Nurse #55 confirmed Resident #110's MDS with ARD 02/16/24 was incorrect and should have indicated the resident had a fall with major injury. She stated she submitted a corrected MDS after the surveyor identified the error.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465</p> <p>Based on observation, record review, staff interview, and resident interview the facility failed to develop and/or implement care plans related to communication, nutrition, pain management, and positioning devices. This failed practice was found true for (3) three of 30 residents reviewed for care plans during the Long-Term Care Survey Process. Resident identifiers #55, #75, and # 90. Facility census 120.</p> <p>Findings Include:</p> <p>a) Resident # 55 communication</p> <p>During the initial observation on 04/01/24 at 2:00 PM, it was discovered that Resident # 55 was hard of hearing and needed visitors/staff to write on a wipe off board to communicate with her.</p> <p>During an interview on 04/01/24 at 2:00 PM, Resident # 55 stated, I can't hear so you have to use the board to talk to me. Everybody uses the board.</p> <p>A record review on 04/03/24 at 10:00 AM, of Resident # 55's communication care plan revised on 09/21/23 reads as follows:</p> <p>FOCUS:</p> <p>-[NAME] has a communication problem related to being hard of hearing.</p> <p>[NAME] has a right hearing aid</p> <p>GOAL:</p> <p>-The resident will maintain / improve the current level of communication function through the review date.</p> <p>-Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Turn off TV/radio as needed to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues,</p> <p>-Anticipate and meet needs.</p> <p>-Be conscious of resident position when in groups, activities, and dining room to promote proper communication with others.</p> <p>-Ensure right hearing aide is in ear</p> <p>-Observe effectiveness of communication strategies and assistive devices</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Observe for declines in communication</p> <p>-Refer to speech therapy for evaluation and treatment as ordered</p> <p>-Speak into the patient's right ear, speak clearly and adjust tone as needed. Face the patient when speaking.</p> <p>No mention of the wipe off board for communication was in the care plan or the medical chart.</p> <p>During an interview on 04/04/24 at 11:00 AM, with the Administrator, she stated, It was not in there, but it is now.</p> <p>b) Resident # 75 (weight loss)</p> <p>A record review on 04/01/24 at 4:23 PM it was discovered that Resident # 75 had the following weights:</p> <p>On 02/7/24 she weighed 132.7 Pounds (lbs) using the Hoyer Scale.</p> <p>On 03/6/24 she weighed 112.9 lbs using the Hoyer Scale.</p> <p>This calculated out to be a 14.92% weight loss in one month.</p> <p>A review on 04/02/24 at 10:00 AM, of Resident #75's nutrition care plan revised on 01/15/24 read as follows:</p> <p>Focus:</p> <p>Resident with potential for altered nutritional status/nutrition related problems d/t: disease progression of dementia, lactose intolerance, and need for altered texture diet with insulin and diuretic use</p> <p>Goal:</p> <p>-Resident to maintain weight without significant change</p> <p>Interventions:</p> <p>-Identify resident food / beverage preferences.</p> <p>-Monitor meal intake</p> <p>-Notify medical provider and resident representative of unplanned weight changes.</p> <p>-Nutritional consult on admission, quarterly, and PRN.</p> <p>-Observe for s/sx of aspiration / dysphagia i.e. choking, coughing, pocketing food, loss of liquids / solids from mouth when eating / drinking, difficulty / pain when swallowing.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Provide meals per diet order.</p> <p>CCD diet, dysphagia pureed texture, nectar thick liquids nose cups</p> <p>-Provide supplements per medical provider's orders.</p> <p>house shake qd</p> <p>Further review of Resident # 75's medical record revealed there were no notes in the current medical chart to indicate that the physician or her representative had been notified of the significant weight loss as indicated in the care plan.</p> <p>During and interview on 04/03/24 at 1:00 PM, with the Director of Nursing (DON), she confirmed that she did not see notes in the chart where the physician or the representative was notified.</p> <p>b1) Resident # 75 (Pain)</p> <p>During the initial interview on 04/01/24 at 1:40 PM, with Resident # 75 she stated, I hurt all in my legs and my hand. She then rubbed her left hand.</p> <p>A record review on 04/02/24 at 1:45 PM, of Resident #75's care plan, revised on 04/14/23 reads as follows:</p> <p>Focus:</p> <p>(Resident #75 name) is at risk for pain related to limited range of motion due to left sided flaccid</p> <p>Goal:</p> <ul style="list-style-type: none"> - Resident will be able to verbalize relief of pain, through the target date. Target date of 03/19/24 - Resident will not exhibit non-verbal s/sx of pain (grimacing, groaning, agitation, yelling, moaning, resisting care, crying, refusal to eat), through the target date. Target date of 03/19/24. <p>Interventions:</p> <ul style="list-style-type: none"> -Administer non-pharmacological interventions (repositioning, diversion activities, snacks and fluids, ice / heat, music therapy, relaxation techniques, imagery) - Complete pain assessment on admission / readmission, quarterly, significant change, and PRN. - Notify medical provider, resident representative if interventions are unsuccessful, or if current complaint is a significant change from residents past experience of pain. - Observe for pain every shift. <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Provide medication per orders. Monitor for s/sx of side effects. Evaluate effectiveness of medication.</p> <p>- PT / OT eval and treat, per orders.</p> <p>Further record review of Resident # 75's medical chart revealed that there were no pain assessments in the current medical chart, as indicated in the care plan. Resident # 75 was admitted to the facility on [DATE].</p> <p>During an interview on 04/03/24 at 1:00 PM, with the Director of Nursing (DON), she confirmed that she did not see any pain assessments in Resident # 75's medical chart.</p> <p>c) Resident #90</p> <p>At approximately 02:50 PM on 04/01/24, Resident #90 was observed with a pommel cushion in their geriatric chair.</p> <p>At approximately 03:00 PM on 04/01/24, record review of Resident #90's orders and care plan was conducted. It was noted during the record review Resident #90 did not have an order for the pommel cushion, nor were they care planned for the pommel cushion.</p> <p>At approximately 03:46 PM on 04/02/24, an interview was conducted with Registered Nurse (RN) #119 concerning the pommel cushion. RN #119 stated, Resident #90 has had the cushion for about a month, we didn't want them to fall out of their chair.</p> <p>At approximately 10:00 Am on 04/03/24, the Administrator acknowledged there was no order for the pommel cushion, nor was the resident care planned to have the pommel cushion.</p> <p>49467</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>49751</p> <p>Based on observation, staff interview, family interview, and record review, the facility failed to ensure the resident and/or resident representative is invited to the care plan conference. This was a random opportunity for discovery during the Long-Term Care Process. Resident identifier: 51. Facility census: 120.</p> <p>Findings included:</p> <p>a) Resident #51</p> <p>On 04/02/24 at 1:20 PM, Resident #51's Representative states in the past year she has only been to one care plan conference and that was after Resident #51 was admitted to the facility a year ago.</p> <p>On 04/03/24 at 11:39 AM, the Director of Social Services #24 (DSS) states, the Assistant Director of Nursing (ADON) took care of the invitations sent out to representatives for the care plan conference; however, when she left that kind of fell off to the side. The DSS confirmed Resident #51's representative has not been getting invited to care plan conferences.</p> <p>On 04/03/24 at 12:07 PM, the Minimum Data Set Registered Nurse (MDS RN) provided six (6) Care Plan Conference signature sheets for Resident #51.</p> <p>A record review on 04/03/24 at 12:10 PM, of Resident #51 care conference meeting sign in sheets revealed the representative has attended one (1) of six (6) care plan conferences in the past year.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>49465</p> <p>Based on record review, resident interview, and staff interview the facility failed to provide a program of activities to meet the physical, mental, and psychosocial well being of each resident. This failed practice was found true for (2) two of (5) five residents reviewed for activities during the Long-Term Care Survey Process. Resident identifiers #23 and #93. Facility census 120.</p> <p>Findings Include:</p> <p>a) Resident # 23</p> <p>During an interview on 04/01/24 at 1:02 PM, Resident #23, stated, I can't go out to the activity programs, because they never get me up to my wheelchair.</p> <p>A record review on 04/02/24 at 1:00 PM, of Resident #23's care plan read as follows:</p> <p>Focus:</p> <p>Resident enjoys group activities such as, special events, Bingo, card games, likes working puzzles, likes visits with her husband, being outdoors and socializing.</p> <p>Goal:</p> <ul style="list-style-type: none"> - Resident will participate in activities of choice through review date. <p>Interventions:</p> <ul style="list-style-type: none"> -Assist with transport to activities as needed -Encouraging attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities. -Interview and determine resident activity preferences. -Invite resident to scheduled activities. -Offer technology of interest i.e. laptop, internet access, tablets, etc -Provide a schedule of activities available. -Provide activity materials of interest, i.e. library books, word puzzles, magazine <p>Further record review of the Activity Participation Records revealed that Resident #23 had no group activity participation for the months of January 2024, February 2024, and March 2024.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review on 04/02/24 at 1:15 PM, of Section F of the Minimum Data Set (MDS), with an assessment reference date (ARD) of 02/09/24, section FO800, question Q is marked as resident enjoys participating in her favorite activities.</p> <p>Further record review revealed that no activity preference interviews were in Resident #23's current medical chart.</p> <p>During an interview on 04/03/24 with the Administrator, she stated, The Activity Preference interview for her, is more than likely in the old system. I have a call in to get access to that. The administrator further confirmed that it did not look like there was group participation on the record.</p> <p>No further documentation was provided by the end of the survey.</p> <p>49467</p> <p>b) Resident #93</p> <p>At approximately 01:30 PM on 04/01/24, an interview was conducted with Resident #93 as part of the survey process. Resident #93 stated they had not been up out of bed in a long time because the sling used for the mechanical lift hurt them when the staff used it. Resident #93 stated they would like to get out of bed more, attend activities, and move around the facility.</p> <p>At approximately 3:00 PM on 04/01/24, Resident #93 was observed in their bed.</p> <p>At approximately 09:00 AM on 04/02/24, Resident #93 was observed still in bed.</p> <p>At approximately 02:30 AM 04/02/24, Resident #93 was observed still in bed.</p> <p>At approximately 03:10 PM on 04/02/24, an interview was conducted with Resident #93. Resident #93 was asked if they had been out of bed, or if facility staff had offered to get them out of bed since the interview on 04/01/24. Resident #93 stated they had not been up, nor had staff offered to get them up. Resident #93 stated I would like to get up and go to activities sometime, I love to play Bingo. Resident #93 then stated If I did get up, there would be no way for me to go anywhere, I don ' t even have a chair for them to put me in.</p> <p>At approximately 03:56 PM on 04/02/24, an interview was conducted with Registered Nurse (RN) #119 concerning a chair for Resident #93. RN #119 stated I don ' t think [they] have one. I have been here for quite a while and I ' ve never seen one in the room, or known [them] to have one.</p> <p>Record review showed Resident #93 had no orders for a wheelchair or geriatric chair.</p> <p>Record review of Resident #93 ' s activity participation record indicated, within the past 30 days, from 03/05/24 through 04/02/24, Resident #93 participated in Relaxation/Self directed activities and Watching TV, with the exception of 03/11/24, the resident participated in exercise and sensory activities, all taking place in the resident ' s room.</p> <p>Record review of the MDS for Resident #93 indicated it is somewhat important for Resident #93 to participate in group activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At approximately 04:09 PM on 04/02/24, an interview was conducted with the Director of Rehabilitation (DOR) regarding a wheelchair for Resident #93. The DOR was asked if Resident #93 had a chair available to them, to which they stated, They had a bariatric geri-chair before, but they never got up, so it was pointless for them to have it, so we took it away. Why are we pursuing this? The DOR confirmed Resident #93 did not have a chair readily available to them for transportation to activities, or in the event of an emergency. The DOR stated We can get one. The Director of Nursing entered the room at the end of the interview and also confirmed there was no chair available for Resident #93.</p> <p>At approximately 01:00 PM on 04/03/24, an interview was conducted with Activities Leader (AL) #41 regarding activities for Resident #93. AL #41 stated they offer Resident #93 activities in their room but no one gets the resident up for activities in the activities room.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49467</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review, resident interview, and staff interview, the facility failed to provide care within acceptable standards of care, by administering medications without a physician's order. This was true for one (1) of 30 residents reviewed during the long-term care survey process. Resident identifier: 318. Facility census: 120.</p> <p>Findings include:</p> <p>a) Resident #318</p> <p>At approximately 02:32 PM on 04/01/24, an interview was conducted with Resident #318. During the interview, Resident #318 stated they were in severe pain, and had been since they arrived at the facility on 03/11/24. The resident reported they suffered a broken shoulder that had not healed in two and a half months. Resident #318 stated the facility would not give them anything other than Tylenol to manage their pain.</p> <p>Record review was conducted for Resident #318's orders. Orders indicated there were no orders for non-pharmacological interventions, Tylenol, or any other pain medication to manage Resident #318's pain.</p> <p>At approximately 11:55 AM on 04/03/24, another interview was conducted with Resident #318 regarding their pain. Resident #318 stated they were given Tylenol that morning after returning from therapy, but it did not relieve the pain. Resident #318 states they request more Tylenol but is told it is unavailable for 4 more hours.</p> <p>At approximately 12:16 PM on 04/03/24, an interview was conducted with Licensed Practical Nurse (LPN) #22 regarding Resident #318's complaints of pain, and receiving Tylenol without orders from a physician. LPN #22 stated I gave Resident #318 a Tylenol this morning when they got back from therapy. LPN #22 confirmed there was no order for Resident #318 to receive Tylenol by saying I need get an order in for PRN Tylenol.</p> <p>At approximately 12:40 PM on 04/03/24, the Director of Nursing (DON) and the Administrator were notified of Resident #318 receiving medication without a physician's order.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>49465</p> <p>Based on observation, record review and staff interview the facility failed to ensure Resident #8 had a palm guard in place as ordered by the physician to prevent further decrease in range of motion. This failed practice was found true for (1) one of (1) residents reviewed for Range of Motion (ROM) during the Long-Term Care Survey Process. Resident identifier #8. Facility Census 120.</p> <p>Findings include:</p> <p>a) Resident #8</p> <p>During an observation on 04/01/24 at 1:00 PM, it was discovered that Resident # 8 had a contracture of her left hand.</p> <p>A record review on 04/02/24 at 9:30 AM revealed that Resident # 8 is ordered a Palm guard to Left hand as tolerated. May remove for hygiene.</p> <p>Further record review of Resident #8's care plan revised on 02/26/24 reads as follows:</p> <p>Focus:</p> <p>(Resident #8 name) has muscle pain to her left hand and left shoulder areas.</p> <p>(Resident #8 name) uses a palm guard on her left hand.</p> <p>Goal:</p> <p>- She will be without pain through her review.</p> <p>Interventions:</p> <p>-Observe for pain and report to MD if noted.</p> <p>- Treatment as ordered by MD</p> <p>- Remove Left hand Palm guard for hygiene QD and PRN</p> <p>An observation on 04/02/24 at 9:40 AM, showed that Resident # 8 was in bed and did not have on her left hand palm guard.</p> <p>An observation on 04/02/24 at 2:02PM, showed that Resident # 8 was in bed and did not have on her left hand palm guard.</p> <p>,</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 04/03/24 at 9:10 AM, showed that Resident # 8 was in bed and did not have on her left hand palm guard.</p> <p>During an observation on 04/03/24 at 9:11 AM, with the interim Director of Nursing (DON), she attempted to open Resident # 8's left hand in front of surveyor and Resident screamed ouch. DON then stated, I don't know if she refuses or what. Let me get with therapy and I will let you know.</p> <p>A record review on 04/03/24 at 9:20 AM, shows that there are no indications in Resident # 8's medical record that she refuses to wear the palm guard.</p> <p>During an interview on 04/03/24 at 9:35 AM, with the interim DON, she stated, I talked to staff about that brace and they said it is in the laundry. I am still investigating it.</p> <p>A record review on 04/03/24 at 10:00 AM, revealed that the Treatment Administration Record (TAR) was marked for 04/01/24 and 04/02/24 as if the splint was put on Resident # 8.</p> <p>During an interview on 04/03/24 at 11:02 AM, with Licensed Practical Nurse (LPN) # 137 she stated, Her hand brace was in the laundry. I don't know why they didn't bring it back for two days. I went and got it and she has it on now.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to follow professional standards of practice for tube feeding. The tube feeding documentation for Resident #102 did not include whether she required tube feeding for oral intake less than 50% of the meal. This deficient practice had the potential to affect one (1) of one (1) resident reviewed for the care area of tube feeding. Resident identifier: #102. Facility census: 120.</p> <p>Findings included:</p> <p>a) Resident #102</p> <p>Review of Resident #102's physician orders showed an order written on 03/05/24 to give a tube feeding bolus of 240 milliliters (ml) of Jevity 1.5 with 100 ml of water three (3) times a day if the resident ate less than 50% of the meal.</p> <p>Review of Resident #102's Medication Administration Record (MAR) for March 2024:</p> <p>Breakfast</p> <p>The MAR showed the tube feeding bolus was marked with a check mark for breakfast on 03/06/24 through 03/08/24, 03/11/24 through 03/15/24, 03/18/24 through 03/22/24, 03/24/24 through 03/28/24, and 03/30/24 through 03/31/24.</p> <p>Review of Resident #102's MAR for March 2024 showed the tube feeding bolus was marked with a 9 for breakfast on 03/09/24, 03/10/24, 03/16/24, 03/17/24, 03/23/24, and 03/29/24.</p> <p>Lunch</p> <p>The MAR showed the tube feeding bolus was marked with a check mark for lunch on 03/06/24 through 03/08/24, 03/12/24, and 03/16/24 through 03/31/24.</p> <p>The MAR showed the tube feeding bolus was marked with a 9 for lunch on 03/10/24, 03/11/24, and 03/13/24 through 03/15/24. According to the MAR chart code, 9 meant see progress notes.</p> <p>On 03/09/24 at 4:24 PM, a medication administration note in the progress notes indicated the resident ate 50% of the meal but did not specify whether the tube feeding bolus was given or not given.</p> <p>On 03/10/24 at 9:10 AM, a medication administration note indicated the resident ate 50% or greater.</p> <p>On 03/10/24 at 9:22 PM, a medication administration note indicated the tube feeding bolus was not given because the resident ate 100% of dinner.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/11/24 at 10:16 PM, a medication administration note indicated the resident ate 75% of dinner.</p> <p>On 03/13/24 at 11:38 PM, a medication administration note indicated the tube feeding bolus was not given because the resident ate 100% of dinner.</p> <p>On 03/14/24 at 10:50 PM, a medication administration note indicated the resident ate 75%.</p> <p>On 03/16/24 at 4:58 AM, a medication administration note indicated the resident ate over 50%.</p> <p>On 03/16/24 at 9:16 AM, a medication administration note indicated the resident ate over 50%.</p> <p>On 03/17/24 at 10:15 AM, a medication administration note indicated the tube feeding bolus was not given because the resident ate 75% of breakfast.</p> <p>On 03/23/24 at 9:45 AM, , a medication administration note indicated the resident ate 75%.</p> <p>On 03/29/24 at 9:49 AM, , a medication administration note stated, Give Bolus of 240 cc TID [three (3) times a day] via Peg Tube of Jevity 1.5 with 100 ml free water after each bolus if resident eats less than 50% of meals every shift for decreased PO [oral] intake. However, the note did not say how much the resident ate or whether the bolus was given.</p> <p>For dinner, the tube feeding bolus was marked with a check mark on 03/13/24. For all other dates, dinner was marked with an X.</p> <p>Review of Resident #102's meal percentages showed the resident ate 50% or less of the following meals, indicating tube feeding bolus should have been given:</p> <ul style="list-style-type: none"> - 03/06/24: the resident refused breakfast and ate 25%-50% for lunch and dinner - 03/07/24: the resident ate 0%-25% for breakfast and ate 25%-50% for dinner - 03/08/24: the resident ate 25%-50% for breakfast, ate 0%-25% for lunch, and refused dinner - 03/09/24: the resident ate 0%-25% for lunch; additionally, lunch was not documented - 03/10/24: the resident ate 25%-50% for breakfast and lunch - 03/18/24: the resident ate 25%-50% for lunch - 03/19/24: the resident ate 25%-50% for breakfast and refused lunch - 03/20/24: the resident ate 25%-50% for breakfast - 03/26/24: the resident ate 25%-50% for lunch <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/03/24 at 2:09 PM, Licensed Practical Nurse (LPN) #152 clarified the resident should have received tube feeding bolus when the meal intake indicated the resident ate 0%-25% or 25%-50% of meals or refused the meal. LPN #152 stated the check marks on the MAR indicated the nurse obtained the meal intake percentage and administered tube feeding bolus if intake was less than 50%. She stated the check marks did not indicate whether or not the resident received tube feeding bolus and clarified this information was not contained anywhere else in the resident's records. LPN #152 also stated the dinner documentation should not have been an x. She confirmed there was no documentation of the amount of tube feeding Resident #120 received each day. She stated she would change the MAR documentation to indicate the amount of meal consumed and whether tube feeding bolus was administered.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>49465</p> <p>Based on resident interview, record review and staff interview, the facility failed to provide pain management to Resident #318. Harm occurred when the facility failed to address the resident's complaints of continued pain resulting from a right humerus fracture. There were no orders for non-pharmacological interventions, or any pain medications prescribed for 21 days. In addition, Resident #75's pain management was not addressed. Resident identifiers: #318 and #75. Facility census: 120.</p> <p>Findings included:</p> <p>a) Resident #318</p> <p>At approximately 2:32 PM on 04/01/24, an interview was conducted with Resident #318. During the interview, Resident #318 stated they were in severe pain, and had been since they arrived at the facility on 03/11/24. The resident reported they suffered a broken shoulder which had not healed in two and a half months. Resident #318 stated the facility would not give them anything other than Tylenol to manage their pain. Resident teary eyed and losing breath during interview when shoulder is moved.</p> <p>Record review was conducted for Resident #318's orders. Orders indicated there were no orders for non-pharmacological interventions, Tylenol, or any other pain medication to manage Resident #318's pain.</p> <p>At approximately 11:55 AM on 04/03/24, another interview was conducted with Resident #318 regarding their pain. Resident #318 stated they were given Tylenol that morning after returning from therapy, but it did not relieve the pain. Resident #318 states they requested more Tylenol but was told it was unavailable for 4 more hours. The resident stated their pain is 8/10 at the time of interview.</p> <p>At approximately 12:16 PM on 04/03/24, an interview was conducted with Licensed Practical Nurse (LPN) #22 regarding Resident #318's complaints of pain. LPN #22 stated We were told you were going to be asking questions about this, because the resident came here with a prescription of percocet and they didn't have it once they were admitted . LPN #22 stated, I gave Resident #318 a Tylenol this morning when they got back from therapy. LPN #22 confirmed there was no order for Resident #318 to receive Tylenol by saying I need to get an order in for PRN (as needed) Tylenol.</p> <p>A review of an encounter note from 03/27/24 at 1:00 PM, in which Resident #318 saw a Nurse Practitioner typed as written:</p> <p>Patient seen at nurses station, complaining of right shoulder pain. Patient has a history of a right surgical neck fracture in January of this year. States they saw Dr who put them in a shoulder sling but the fracture was non operable. Patient came to us without a sling and is now complaining of worsening pain. Right shoulder pain was entered on the encounter note.</p> <p>Progress note from 04/01/24 typed as written:</p> <p>Pt (patient) lying in bed with sling off. Encouraged to put sling on. States it hurts when it's on and off. I don't know what to do. Counseled without success.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Progress note from 04/02/24 typed as written:</p> <p>Report called from ER (emergency room) at 1830 (6:30 PM) stating resident was on way back to facility via EMS (emergency medical squad.) ER reports resident was placed in sling and orthopedic referral was made with Dr for right humerus fracture. Resident also Dx with pneumonia and UTI at ER, new order for doxycycline 100mg BID x 10 days. ER also reports resident was given 1 liter fluids and Dilaudid 0.5mg x 1. Resident returned to facility at 1840 (6:40 PM.) No complaints of pain or discomfort at this time. Will continue to monitor.</p> <p>Review of Resident #318's physical, occupational, and speech therapy evaluations on 03/12/24 noted the following:</p> <p>Pain at rest- Intensity= 4/10; Frequency/Duration= Constant; Location RUE (right upper extremities)</p> <p>Pain with movement- Intensity= 8/10; Frequency/Duration= Constant; Location RUE</p> <p>Pain Assessment- Patient verbalized pain level;Does pain limit patient ' s functional activities: yes.</p> <p>At approximately 12:40 PM on 04/03/24, the Director of Nursing (DON) and the Administrator were notified of Resident #318's complaints of pain, along with no orders for pain medication or non-pharmacological interventions to manage pain.</p> <p>b) Resident #75</p> <p>During the initial interview on 04/01/24 at 1:40 PM, with Resident # 75 she stated, I hurt all in my legs and my hand. She then rubbed her left hand.</p> <p>A record review on 04/02/24 at 1:45 PM, of Resident #75's care plan, revised on 04/14/23 reads as follows:</p> <p>Focus:</p> <p>(Resident #75 name) is at risk for pain related to limited range of motion due to left sided flaccid</p> <p>Goal:</p> <ul style="list-style-type: none"> - Resident will be able to verbalize relief of pain, through the target date. Target date of 03/19/24 - Resident will not exhibit non-verbal s/sx of pain (grimacing, groaning, agitation, yelling, moaning, resisting care, crying, refusal to eat), through the target date. Target date of 03/19/24. <p>Interventions:</p> <p>-Administer non-pharmacological interventions (repositioning, diversion activities, snacks and fluids, ice / heat, music therapy, relaxation techniques, imagery)</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Moundsville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Floral Street Moundsville, WV 26041	
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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Complete pain assessment on admission / readmission, quarterly, significant change, and PRN. - Notify medical provider, resident representative if interventions are unsuccessful, or if current complaint is a significant change from residents past experience of pain. - Observe for pain every shift. - Provide medication per orders. Monitor for s/sx of side effects. Evaluate effectiveness of medication. - PT / OT eval and treat, per orders. <p>During an interview on 04/02/24 at 2:15 PM, with Licensed Practical Nurse (LPN) # 137, she stated, She has never indicated to me that she was in pain, and I am on this hall most of the time. No, we do not ask her daily if she is in pain.</p> <p>During an interview on 04/02/24 at 2:20 PM, with Resident #75, she stated, with LPN #137 present, No, I am not in pain today, but I was yesterday. I hurt all down in my legs and my hand. When asked by the surveyor if she hurt at other times Resident # 75 stated, Yes, sometimes.</p> <p>LPN # 137 then stated, I will see if I can get her an order for Tylenol.</p> <p>A record review on 04/02/24 at 2:20 PM, showed that Resident # 75 was ordered Acetaminophen on 03/02/22 650 milligrams (mg) to be given every 6 hours as needed for Generalized pain.</p> <p>Further record review revealed that there are no Pain Assessments in Resident # 75's current medical chart.</p> <p>The record review also revealed, according to the Medication Administration Record (MAR), during the months of February 2023, and March 2023 that Resident # 75 was not given any Tylenol, nor was she assessed for pain.</p> <p>During a record review on 04/02/24 at 3:14 PM, of Resident #75's Occupational Therapy (OT) notes dated 03/07/24 reads as follows:</p> <p>Typed as written</p> <p>Reason for Skilled Services: Continued OT services are necessary in order to maximize Activities of Daily Living (ADL's) increase safety awareness, minimize safety hazards/barriers, maximize rehab potential, decrease painful condition of UE (upper extremities,) provision of pain management techniques and provision of modalities and strengthening in order to enhance patient's quality of life by improving ability to be able to return to prior living level.</p> <p>During an interview on 04/02/24 at 4:00 PM, with the Administrator, she stated, I did not see any pain assessments in her chart, and no it does not look like Tylenol was given during those months according to this.</p> <p>49467</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>39043</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure meds were stored in accordance with professional standards of practice. Two (2) of three (3) medication carts observed had vials of insulin that had been opened more than 28 days ago. Resident identifiers: #65, #51. Facility census: 120.</p> <p>Findings included:</p> <p>a) Resident #65</p> <p>On 04/02/24 at 8:52 AM, the 600 hallway medication cart was inspected with Registered Nurse (RN) #119 in attendance. An opened vial of Lantus (glargine) insulin for Resident #65 was in the cart. The insulin vial had an opening date of 02/28/24 written on the vial in marker. The vial also had an expiration date of 03/25 written on the insulin box in marker. RN #116 confirmed the insulin vial for Resident #65 had been opened more than 28 days ago.</p> <p>Review of Resident #65's physician's orders showed an order for insulin glargine (Lantus), 8 units every day for diabetes.</p> <p>b) Resident #51</p> <p>On 04/02/24 at 9:08 AM, the 300 hallway medication cart was inspected with Licensed Practical Nurse (LPN) #89 in attendance. An opened vial of Lantus (glargine) insulin for Resident #51 was in the cart. The insulin vial had an opening date of 02/25/24 written on the vial in marker. LPN #89 confirmed the insulin vial for Resident #51 had been opened more than 28 days ago.</p> <p>Review of Resident #51's physician's orders showed an order for insulin glargine (Lantus), 12 units every day for diabetes.</p> <p>c) Product Information Review</p> <p>Lantus insulin product information, revised 2023, available on-line at www.lantus.com, stated an opened vial of Lantus (glargine) insulin could be used for 28 days.</p> <p>No further information was provided through the completion of the survey.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49465</p> <p>Based on observation, staff interview and policy review the facility failed to store food in a safe, sanitary manner to prevent food borne illness. This failed practice had the potential to affect more than a limited number of residents. Facility census 120.</p> <p>Findings included:</p> <p>a) Dietary walk-in refrigerator and freezer</p> <p>During the initial tour of the facilities kitchen on 04/01/24 at 12:06 PM found that the following items were out of date in the walk-in refrigerator:</p> <ul style="list-style-type: none"> - Chicken noodle soup in a clear plastic container with a use by date of 03/25/23. - Sliced cheese in a clear plastic container with a use by date of 03/23/24. - Parmesan cheese in a clear plastic container with a use by date of 03/30/23. <p>Further observation found the following items out of date in the walk-in freezer:</p> <ul style="list-style-type: none"> - Pepperoni that was brown in color in a clear plastic container with a use by date of 06/04/23. -Tomato sauce in a clear plastic container with a use by of 12/31/23. <p>During an interview on 04/01/24 at 12:20 PM, with the Dietary Manager, he confirmed all of the items were out of date.</p> <p>A review on 04/01/24 at 1:30 PM, of the facilities policy titled: {Food Storage: Cold Foods} under References: number (2) two, it references F-812, which reads under interpretative guidelines as follows:</p> <p>Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>39043</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure medical records were complete and accurate for two (2) of 30 residents reviewed in the long-term care survey sample. Refusals of heel protectors were not documented for Resident #13. A diagnosis of Post-traumatic Stress Disorder (PTSD) was not documented in the diagnoses list for Resident #81. Resident identifiers: #13, #81. Facility census: 120.</p> <p>Findings included:</p> <p>a) Resident #13</p> <p>Review of Resident #13's physician's orders showed an order written on 10/31/23 which stated, Prevention: Apply Heel Protectors WIB (while in bed) and at rest, QS (every shift) and PRN (as needed) for Pressure Relief.</p> <p>Observation of Resident #13's room on 04/01/24 at 2:59 PM, showed the resident's heel protectors were laying on the floor in the corner of the room.</p> <p>During an observation on 04/02/24 at 12:15 PM, Resident #13 was noted to be up in a Geri-chair, which was leaned back. She did not have heel protectors on, but she had on thick socks and her heels were resting on a pillow on the Geri-chair footrest.</p> <p>During an observation on 04/02/24 at 4:13 PM, Resident #13 was noted to be in the same location with socks and a pillow, but no heel protectors. Certified Nursing Assistant (CNA) #60 stated Resident #13 won't wear heel protectors. She stated Resident #13 will yell until someone takes off the heel protectors.</p> <p>During observation, on 04/03/24 at 3:10 PM, Resident #13 was noted to be sitting in a Geri-chair in the hallway. She had on thick socks and her legs were elevated on a wedge pillow. She did not have on heel protectors. CNA #99 stated Resident #13 refused heel protectors. She stated the resident would yell and attempt to kick off the heel protectors. CNA #99 stated sometimes Resident #13 will allow a pillow under her heels and sometimes she won't allow a pillow.</p> <p>Review of Resident #13's Treatment Administration Record (TAR) for 04/01/24, 04/02/24, and 04/03/24 indicated the resident wore her heel protectors every shift.</p> <p>On 04/03/24 at 3:15 PM, the Administrator stated Resident #13's refusals to wear heel protectors should be documented. She stated the intervention to wear heel protectors would be changed to an intervention agreeable to the resident.</p> <p>49467</p> <p>b) Resident #81</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At approximately 3:30 PM on 04/01/24 a record review was conducted for Resident #81. During record review, it was noted Resident #81 was care planned for PTSD. Upon review of the diagnoses for Resident #81, it was noted there was not a current or prior diagnosis of PTSD.</p> <p>At approximately 08:58 AM on 04/03/24, an interview was conducted with the Administrator. The Administrator acknowledged the missing diagnosis, as well as the care plan included PTSD. The Administrator stated, The diagnosis should definitely be there. I'm not sure why it isn't.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120</p> <p>Based on observation, policy review, medical record review, and staff interview the facility failed to establish and maintain an infection prevention program to help prevent the development and transmission of communicable diseases, to help prevent cross-contamination and infections including Covid-19 in regard to, laundry services, water management, and meal services. This failed practice had the potential to affect every resident currently residing in the facility. Facility Census: 120.</p> <p>Findings included:</p> <p>a) Water Management</p> <p>During facility record review of the water management revealed, the documentation was not maintained to prevent growth of water borne pathogens including description of the building water system. The flow diagram did not identify the building's water systems for which Legionella control measures are needed.</p> <p>No documentation was provided describing the building water systems using text or testing protocols or dead leg water flushes.</p> <p>On 03/05/24 at 2:20 PM the Maintenance Director verified the facility did not maintain the water management program.</p> <p>b) Laundry Services</p> <p>An observation during the laundry tour on 04/04/24 at 9:32 AM found, the laundry room did not have a sealed separation from the soiled laundry area to the clean laundry area. There was also no negative air flow pulling from the clean area to the soiled area, failing to maintain a functional and safe laundry area to avoid contamination. The laundry was in progress in both areas.</p> <p>An interview with the Laundry Supervisor, on 04/04/24 at 9:43 AM, confirmed there was no sealed separation from the soiled laundry area to the clean laundry area and the vent was not on. He at this time turned the air flow vent on.</p> <p>49467</p> <p>c) Tray Cart</p> <p>At approximately 12:31 PM on 04/02/24, Nurse Aide (NA) #122 was observed taking a tray into room [ROOM NUMBER]. NA #122 placed the tray on the table, removed the lid, and the resident stated, I don't want that. NA #122 then removed the tray from the room and placed it back on the clean cart with other trays.</p> <p>NA #122 stated, I didn't know I couldn't do that.</p>		