STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515072	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Healthcare Center	300 Miller Road Kingwood, WV 26537

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 43340 Based on record reviw and staff interview, the facility failed to keep a resident's Health Care Surrogate / legal decision-maker informed of her health status and medical condition. The deficient practice prevented the legal decision-maker from being informed, in advance, of the care to be furnished. This was true for one (1) of 24 residents reviewed in the Long-Term Care Survey Process. Resident identifier: #74. Facility census: 117. Findings included: a) Resident #74 An electronic medical record review, conducted on 11/05/24 at 9:10 PM, revealed: -Resident #74 had been admitted to the hospital on 07/15/24. -During Resident #74's stay in the hospital, it was determined that the resident did not have the capacity to make medical decisions, and a Health Care Surrogate (HCS) was appointed to be the legal decision maker on Resident #74's behalf. -The hospital's 07/18/24 After Visit Summary stated that a surrogate decision-maker had been recorded during resident's hospitalization . Details of the After Visit Summary were scanned in Resident #74's electronic medical record. However, the HCS form appointing a legal decision maker on Resident #74's behalf was not part of medical record. -A nurses note, dated 07/24/24 at 9:21 AM, stated that the nurse practitioner had been made aware of lab results with no new orders at this time. It also stated, Resident aware. There was no evidence that resident's HCS had been notified. -An appointment note, dated 08/01/24 at 8:49 AM stated that resident had a follow-up neurology appointment on 08/23/24 at 1:00 PM. It also stated, MD (medical doctor) and resident aware. There was no evidence that resident's HCS had been notified. - An activities progress note, dated 07/31/24 at 10:15 AM, stated that the Activity Director issued resident a care conference letter on 07/31/24. There was no evidence that resident's HCS had been invited to attend the care plan meeting. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/06/24 at 3:10 PM, the Director of Nursing acknowledged the facility was unable to produce evidence that Resident #74's HCS had been properly identified following her 07/15/24 hospitalization . Furthermore, the DON acknowledged the facility could not provide evidence that the HCS had been kept informed of resident's health status.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 43340 Based on record review and staff interview, the facility failed to facilitate the inclusion of the resident representative in person-centered care planning. This was true for one (1) of 24 residents reviewed in the Long-Term Care Survey Process. Resident identifier: #74. Facility census: 117. Findings included: a) Resident #74 An electronic medical record review, conducted on 11/05/24 at 9:10 PM, revealed: -Resident #74 had been admitted to the hospital on 07/15/24 -During Resident #74's stay in the hospital, it was determined that the resident did not have the capacity to make medical decisions, and a Health Care Surrogate (HCS) was appointed to be the legal decision maker on Resident #74's behalf. -The hospital's 07/18/24 After Visit Summary clearly stated that a surrogate decision-maker had been recorded during resident's hospitalization . Details of the After Visit Summary were scanned in Resident #74's electronic medical record. However, the HCS form appointing a legal decision maker on Resident #74's behalf was not part of medical record. - An activities progress note, dated 07/31/24 at 10:15 AM, stated that the Activity Director issued resident a care conference letter on 07/31/24. There was no evidence that resident's HCS had been invited to attend the care plan meeting. During an interview, on 11/06/24 at 3:10 PM, the Director of Nursing acknowledged the facility was unable to produce evidence that Resident #74's HCS had been properly identified following her 07/15/24 hospitalization . Furthermore, the DON acknowledged that the facility could not provide evidence that the HCS had been invited to the above-mentioned care plan meeting.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43340 Based on record review and interview, the facility failed to notify the resident's legal representative of a change in health status and transfer to the hospital. This failed practice was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident identifier: #74. Facility census: 117. Findings included: a) Resident #74 An electronic medical record review, conducted on 11/05/24 at 9:10 PM, revealed: -A nurses note, dated 07/15/24 at 6:00 PM, stated, Resident transferred to [Name of a local hospital] as direct admit. Transported via facility staff and van. Left facility in stable condition. Resident with capacity. MD (medical doctor) aware. There was no evidence that resident's emergency contact/family member had been notified of the need for acute care or transfer to the hospital. -An eInteract Transfer form, dated 07/15/25 at 8:00 PM, indicated that Resident #74 was her own resident representative and that she was aware of the acute transfer and her clinical situation. During an interview on 11/06/24 at 3:10 PM, the Director of Nursing (DON) acknowledged the facility was unable to produce evidence that Resident #74's emergency contact/family member had been notified of the need for an acute care transfer to the hospital. The DON stated resident had capacity and was aware of the need to be sent to the hospital. Surveyor reviewed CMS [Centers for Medicare and Medicaid Services] guidance with the DON which indicated, even if a resident is competent, the resident representative should be notified of significant changes in health status because the resident may not be able to notify them themselves. The DON acknowledged the facility had failed to communicate with resident's emergency contact/family member.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43340 Based on record review and staff interview, the facility failed to issue the required Notification of Medicare Non-Coverage (NOMNC) in a timely fashion for one (1) of three (3) residents reviewed for beneficiary protection notification. This failure had the potential to place the resident at risk of not being informed of her rights prior to the end of Medicare Part A covered services. Resident identifier: #269. Facility census: 117. Findings included: a) Beneficiary Notice Review On 11/05/24 at 7:25 PM, a review was completed regarding the beneficiary protection notification liability notice(s) given for Resident #269 who was discharged to home with a family member following his last covered day of Medicare Part A services. Resident #269's last covered day of Part A Services was on 09/05/24. There was no evidence in the electronic medical record that the required Notification of Medicare Non-Coverage (NOMNC) was issued. The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 state: The NOMNC must be delivered at least two calendar days before Medicare covered services end . The instructions also state: A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Further review of the electronic medical record revealed the following details: -An 08/22/24 summary of resident's discharge plans reflected that resident had capacity and that he desired to be discharged back to the community (to home with a family member) and with home health services. -An 08/23/24 Social Services note stated, Resident will be returning to the community. and He will be going back to live with his [family member] when he discharges. -An 08/26/24 Social Services note stated, Resident's plans to discharge back to the community and will be living with his [family member] when his inpatient treatment is complete. -An 08/29/24 MDS note stated, Plans to d/c (discharge) home with [family member] when able. -A 09/04/24 Clinical Meeting note stated, Resident plans to d/c home after therapy services completed. Review of therapy discharge summaries (physical therapy, speech therapy, and occupational therapy), completed on 11/06/24 at 9:40 revealed the following details: (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Physical Therapy Discharge Summary stated the discharge reason was Highest Practical Level Achieved. -The Speech Therapy Discharge Summary stated the discharge reason was Highest Practical Level Achieved. -The Occupational Therapy Discharge Summary stated the discharge reason was All Goals Met. During an interview on 11/06/24 at 10:10 AM, the Business Office Manager confirmed a NOMNC was not issued prior to Resident #269's last covered day of Medicare Part A skilled services and subsequent discharge to home.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 42120 Based on random observations and interviews, the facility failed to ensure a Resident's medical and health information was protected during MDS Interviews. Resident identifiers: #18 and #77. Facility census: 117. Findings included: a) Resident #18 A random observation on 11/04/24 at 1:33 PM, overheard the MDS Licensed Practical Nurse #16 Interviewing Resident #18 from the hallway. The Brief Interview for Mental Status was being assessed. Resident #18's door was open and MDS LPN was speaking loudly. This practice found resident's answers could be overheard by other residents, staff and visitors. b) Resident #77 A random observation on 11/05/24 at 2:38 PM, overheard MDS Licensed Practical Nurse #16 interviewing Resident #77 from the hallway. The Brief Interview for Mental Status was being assessed. Resident #77 was sitting in the MDS open doorway and MDS LPN was speaking loudly. This practice found resident's answers could be overheard by other residents, staff and visitors. On 11/05/24 at 2:40 PM, an interview with the Social Service Director confirmed the information could be overheard. The Social Service Director went at this time to close the MDS door.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795 Based on observation, and interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment, with housekeeping, and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This was a random opportunity for discovery. Bathroom identifiers: room [ROOM NUMBER], #114, #107, #112. Resident identifier: #94. Facility Census: 117 Findings include: a) room [ROOM NUMBER]: During an inspection of the bathroom in room [ROOM NUMBER] on 11/07/24 at approximately 10:17 AM, a brown substance was observed between the tiles near the commode. room [ROOM NUMBER]: During an inspection of the bathroom in room [ROOM NUMBER] at approximately 10:20 AM on November 7, 2024, a brown substance was observed on the tiles around the toilet. Additionally, sections of the baseboard under the sink were missing, and the drywall in that area needed repair and repainting. During an inspection on 11/07/24 at approximately 9:35 AM the following resident rooms were noted to have the following room [ROOM NUMBER] Gaps were observed in the floor tiles near commode room [ROOM NUMBER] Gaps were observed in floor tiles near commode Corporate Clinical Nurse (CCN) #200 was informed of the issues on 10/07/24 at approximately 10:55 AM and confirmed that the bathrooms were unsanitary. She subsequently notified housekeeping that the bathrooms needed to be cleaned. 50801 b) Resident#94 Observation of Resident # 94's bathroom, on 11/07/2024 at 3:30 pm revealed the facility failed to provide a clean, home like environment. A hole in the drywall was patched but not painted on the bathroom wall, above the sink. On 11/07/2024at approximately 9:00 AM The DON stated she had observed Resident # 94's bathroom wall had a drywall patch that had not been completed or painted. She did not provide any plans to complete the repairs.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 43340 Based on record review and staff interview, the facility failed to ensure the appropriate information was communicated to the receiving health care institution when the facility transferred Resident #167 to the hospital. This deficient practice was true for one (1) of five (5) residents reviewed under the hospitalization pathway. Resident identifier: #167. Facility census: 117. Findings included: a) Resident #167 An electronic medical record review, completed on 11/05/24 at 8:42 PM, reflected that resident was transferred to the hospital on 10/28/24. There was no evidence that an eInteract Transfer form had been completed or that the following items had been sent with the resident upon his transfer to the hospital: -Contact information of the practitioner responsible for the care of the resident -Resident representative information including contact information -Advance Directive information -All special instructions or precautions for ongoing care, as appropriate -Comprehensive care plan goals -All other necessary information and any other documentation, as applicable, to ensure a safe and effective transition of care During an interview on 11/07/24 at approximately 9:40 AM, the Director of Nursing reported the facility could not produce evidence the appropriate discharge paperwork had been sent with Resident #167 when he was transferred to the hospital.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 43340 Based on medical record review and staff interview, the facility failed to ensure a written Notice of Transfer / Discharge was provided to residents/resident representatives for four (4) of five (5) residents reviewed for hospitalization s during the long-term care survey process. This had the potential to affect all residents being transferred or discharged . Resident identifier: #167, #74, and #28. Facility census: 117. Findings included: a) Resident #167 A medical record review was completed on 11/05/24 at 8:42 PM. The record review revealed Resident #167 was transferred to the hospital on 10/28/24. The record did not reflect the resident/resident's representative was provided with a written Notice of Transfer/Discharge indicating the reason for transfer, the effective date of transfer, the location to which the resident was being transferred, and a statement of the resident's appeal rights. During an interview on 11/07/24 at 9:05 AM, the Director of Nursing (DON) reported the facility could produce no evidence that resident/resident's representative was provided a Notice of Transfer/Discharge. b) Resident #74 A medical record review was completed on 11/05/24 at 7:02 PM. The record review revealed Resident #74 was transferred to the hospital on 07/15/24. The record did not reflect the resident/resident's representative was provided with a written Notice of Transfer/Discharge indicating the reason for transfer, the effective date of transfer, the location to which the resident was being transferred, and a statement of the resident's appeal rights. During an interview on 11/07/24 at 9:06 AM, the Director of Nursing (DON) reported the facility could produce no evidence that resident/resident's representative was provided a Notice of Transfer/Discharge. c) Resident #28 Review of Resident #28's medical records revealed the resident was transferred to the hospital due to decreased levels of consciousness on 07/06/24, returning to the facility on [DATE], and on 07/21/24, returning to the facility on [DATE]. For these dates, the resident's electronic health record did not contain notices of transfer or discharge giving the reason for the transfer and information regarding appeal rights. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/24 at 11:30 AM, the Director of Nursing confirmed notices of transfer or discharge were not given for Resident #28's hospital transfers on 07/06/24 and 07/21/24. No further information was provided through the completion of the survey process. 50801

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review, outside agency interview, and staff interview, the facility failed to allow a resident to return to the facility following a brief hospitalization . When the facility did not allow the resident to return, the facility failed to initiate a discharge and did not comply with transfer and discharge requirements at 42 CFR 483.15(c). This was true for one (1) of two (2) residents reviewed under the discharge pathway throughout the survey process. Resident identifier #167. Facility census: 117. Findings included: a) Resident #167 Resident #167 was admitted to the facility on [DATE] as a skilled patient (receiving physical and occupational therapy to help resident regain strength, maximize his independence with activities of daily living, and improve his quality of life following an acute hospitalization .) Resident #167 had the following diagnoses: - Schizoaffective disorder, depressive type. The 2025 edition of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) states symptoms of schizoaffective disorder include: *Unusual or bizarre behavior *Depression symptoms, such as feeling empty, sad, or worthless *Manic periods, with more energy and less need for sleep over several days *Difficulty functioning at work, school, or in social situations -Borderline Intellectual Functioning. The National Institute on Health states, The term borderline intellectual functioning describes a group of people who function on the border between normal intellectual functioning and intellectual disability, between 1 and 2 standard deviations below the mean on the normal curve of the distribution of intelligence, roughly an IQ between 70 and 85. -Cognitive Communication Deficit -Encephalopathy -Type 2 Diabetes with Neuropathy -Chronic kidney disease, stage 3 -Insomnia (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Glaucoma in diseases classified elsewhere -Chronic Obstructive Pulmonary Disease (COPD) -Generalized muscle weakness A physician statement of capacity reflected that Resident #167 had the ability to make his own medical decisions. A Discharge Plans form, dated 10/04/24, indicated that resident had capacity and had expressed a desire to remain at the facility long term. A Social Services note, dated 10/7/2024 at 8:47 AM, stated that resident desired to stay at the facility as a long-term care patient. A Social Service note, dated 10/8/2024 at 8:29 AM, stated that Resident #167 planned to remain in the facility for long term care. Resident did not wish to be asked about returning to the community. An Activities Progress note, dated 10/9/2024 at 9:55 AM, stated resident enjoyed activities like cards, bingo, some games, walking, music, some television, trips, car rides, community outings, spiritual, outside, talking, being around others, and groups. It went on to state that resident had participated in scheduled activities such as bingo, bible study, resident council, and a group activity called busy bodies. Resident reportedly accepted cookie cart and ice cream cart. He had conversations with staff. He also watched television while in his room. Resident liked to walk in the hallway with walker. Resident received mail. A Minimum Data Set (MDS) note, dated 10/11/2024 at 1:48PM, stated that resident reported that he planned to remain in the facility for long-term care after skilled services were completed. Page 11 of Resident's care plan listed the following Focus Area, I have no plans for discharge due to care needs being unable to be met in the community. The date the focus area was initiated was listed as 10/11/24. A Social Services Note, dated 10/15/2024 at 10:08 AM, documented, Resident with capacity and requested that both his brother and sister be removed from his emergency contacts. Resident is aware that if he is deemed as incapacitated a HCS (Health Care Surrogate) would be completed making DHHR as his representative and he stated understanding of above. When LSW (Licensed Social Worker) asked resident why he wanted his siblings removed he said that they had requested being removed with their own lives they could no longer assume the role of Emergency Contacts for him. A nurses note, dated 10/28/2024 at 6:05 PM, stated that 911 had telephoned the facility to report Resident #167 had called them twice to go to the hospital. The nurse informed the 911 operator that resident had capacity to make his own medical decisions and that if he wanted to go to the hospital, he could go. A second nurses note, dated 10/28/2024 at 6:20 PM, indicated that resident had left the facility via Emergency Medical Services (EMS) transport to go to the hospital. There was no evidence in the electronic medical record that Resident #167 had been given a bed hold notice. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 11:30 AM, Resident #56 reported hearing Resident #167 shouting over and over again, You guys are getting what you want! to the facility staff as he was being transported out the door to go to the hospital. The discharge MDS, dated [DATE], indicated Discharge assessment - return not anticipated. During a telephone interview on 11/06/24, at 10:43 AM, the following details were obtained from the hospital's RN/Health Care Quality and Management (HCQM) #170: -On 10/29/24 at 8:09 AM, the hospital's RN/HCQM #170 received a report from the emergency department nurse stating that the nursing home had called and reported resident no longer had a bed at their facility anymore. -On 10/29/24 at 8:54 AM, the hospital's RN/HCQM #170 spoke to the Director of Nursing at the nursing home and was told that the facility did not hold resident's bed. -On 10/29/24 at 9:20 AM, the hospital's RN/HCQM #170 spoke with the nursing home's Hospital Referral Manager and was told, This individual has been problematic since arrival a month ago and corporate has stated he could not return. -It was necessary for Resident #167 to remain in the hospital emergency department until 11/01/24 at 3:38 PM, a total of four (4) days, until an alternate long-term care placement was secured. During an interview on 11/07/24 at 10:45 AM, the Director of Nursing (DON) acknowledged Resident #167's medical record did not include any evidence as to why resident did not return to the facility. She reported that the facility did not have a bed for Resident #167 to come back to when she spoke to the hospital staff on 10/29/24 at 8:54 AM. When asked why the facility's Hospital Referral Manager would have reported to the hospital staff that resident had been problematic since his arrival and that corporate had stated he could not return, neither the DON nor the Administrator voiced an answer. Additionally, the facility could produce no evidence Resident #167 and the long-term care Ombudsman were given a written Notice of Discharge including the right to appeal the decision of him not being permitted to return to the facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43340 Based on record review, and staff interview, the facility failed to follow physician orders related to insulin. This was true for one (1) of five (5) residents reviewed for the unnecessary medication review during the annual long-term care survey process. Resident identifier: #56. Facility census: 117. Findings included: a) Resident #56 A record review was completed on 11/05/24 at 6:15 PM. The record review demonstrated that Resident #56 had a diagnosis of diabetes mellitus and had a sliding scale order for insulin. The term sliding scale refers to the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges. Sliding scale insulin regimens approximate daily insulin requirements. The order stated to call the physician if the resident's blood glucose level went above 400. There was no evidence in the electronic medical record that the physician had been notified of a blood glucose level above 400 on the following dates: -05/07/24 at 8:00 PM, Blood Sugar (BS) of 449 -05/08/24 at 8:00 PM, BS of 402 -05/13/24 at 8:00 PM, BS of 404 -06/02/24 at 8:00 PM, BS of 415 -06/06/24 at 8:00 PM, BS of 435 -06/14/24 at 4:30 PM, BS of 417 -06/15/24 at 4:30 PM, BS 0f 402 -06/16/24 at 4:30 PM, BS of 445 -07/06/24 at 8:00 PM, BS 0f 403 -07/08/24 at 4:30 PM, BS of 440 -07/11/24 at 4:30 PM, BS of 417 -07/12/24 at 8:00 PM, BS of 450 -07/13/24 at 8:00 PM, BS of 445 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-07/14/24 at 8:00 PM, BS of 430 -07/16/24 at 8:00 PM, BS of 426 -07/17/24 at 8:00 PM, BS of 439 -07/22/24 at 8:00 PM, BS of 414 -07/26/24 at 8:00 PM, BS of 421 -07/27/24 at 8:00 PM, BS of 449 -08/11/24 at 8:00 PM, BS of 481 -08/26/24 at 7:30 AM, BS of 440 -09/14/24 at 4:30 PM, BS of 416 -09/23/24 at 7:30 AM, BS of 426 -09/31/24 at 8:00 PM, BS of 428 During an interview on 11/06/24 at 3:40 PM, the Assistant Director of Nursing reported the facility could produce no evidence the physician had been contacted on the above-mentioned dates.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review, and staff interview, the facility failed to provide physician-ordered treatment and services to a resident admitted with limited range of motion. This deficient practice affected potential one (1) of one (1) residents reviewed for position/mobility. Resident identifier: #1. Facility census: 117. a) Resident #1 Review of Resident #1's progress notes showed a therapy note from 09/30/24 at 5:59 PM that stated, Patient given [NAME] air short opponens orthosis this date to gradually lift flexed digits in R [right] hand. Nurse and aide instructed to keep it on for an hour and then to remove d/t [due to] newness. Patient to wear as tolerated. Review of Resident #1's physicians' orders showed the following order written on 10/01/24, [NAME] air short opponens orthosis to right hand on for an hour and the remove, to wear as tolerated. On 11/06/24 at 9:45 AM Licensed Practical Nurse (LPN) #10 stated she didn't know if Resident #1 had any devices ordered for his hand. LPN #10 looked at the resident's treatment administration record (TAR) and stated no orthosis was ordered. Upon entering Resident #1's room on 11/06/24 at 9:48 AM, LPN #10 located the orthosis in the top drawer of the resident's bedside table. She stated she would review the resident's order and apply the device. LPN #10 stated the orthosis order should have been on the resident's TAR so she would have known that it needed applied. On 11/06/24 at 10:25 AM, the Director of Nursing (DON) stated the order had not been transferred to the TAR for nursing implementation because the order was entered in a manner to transfer to the order to the therapy TAR and not the nurses' TAR. She stated she would revise the order and audit other orders for errors. On 11/06/24 at 4:07 PM, the DON stated Resident #1 had refused to wear the splint, so the order was discontinued.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50801 Based on record review and staff interviews, the facility failed to ensure the environment remained as free of accident hazards as is possible and assistance devices to prevent accidents for Resident #101. This was true for one (1) of five (5) residents reviewed for accident hazards. Resident identifier: #101. Facility census: 47. Findings included: a) Resident #101 Review of the nurse's progress notes dated 08/20/24, Resident #101 was sitting in a nonfunctioning scoop chair, in the up position, which caused her to fall into the floor in the hallway. During an interview with Director of Nursing(DON) # 68, on 11/06/24 at approximately 4:30 AM, she stated she would look into it. On 11/07/24, the DON returned with copies of the Nursing Progress notes from the date of fall (08/20/24), and acknowledged the faulty scoop chair was the cause of Resident #101's fall on 08/20/24. On 8/20/24 at 5:08 PM Note Text: CNA alert this nurse resident was laying on floor on 300 hallway. Resident was sitting up in scoop chair prior to fall. Resident assessed for injury, denies hitting head, ROM performed. Neuros initiated, VSS. Resident's scoop chair was noted in the up position and not functioning. Work order placed at this time for maintenance to fix and resident was taken to lay in bed to rest. Message left for daughter (name) to call facility back. NP (name) present and aware of fall.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 50795 Following record review and interviews, the facility failed to obtain an order to utilize a pain scale for the administration of pain medication. Additionally, facility staff did not assess residents after administering pain medication, to ensure effective pain management, as per professional standards of practice. This failed practice had the potential to affect more than a limited number of residents. Resident identifiers: #103 and #319. Facility census: 117. Findings included: a) Resident #103: Record review, and interview, revealed that Resident #103 had been prescribed the following medication: Tylenol Oral Tablet 325 MG X2 every 6 hours as needed for pain. Order date 08/11/24 at 11:13 AM. Record review conducted on 11/05/24, at approximately 10:00 AM revealed that a pain scale had not been prescribed for the administration of medication. Staff administered medication even when the resident's pain level was recorded as zero (0). Additionally, there were no documented assessments of post-administration pain levels available for review, to evaluate the effectiveness of pain management. The following random sampling revealed dates, administered medication, and resident's stated pre-medication pain levels: 08/11/24 11:25 AM Pain Level: 5 Medication Administered: Tylenol Oral Tablet 325 MG X2 08/11/24 9:21 PM Pain Level: 5 Medication Administered: Tylenol Oral Tablet 325 MG X2 08/13/24 9:00 PM Pain Level: 10 Medication Administered: Tylenol Oral Tablet 325 MG X2 08/16/24 10:06 AM Pain Level: 5 Medication Administered: Tylenol Oral Tablet 325 MG X2 08/16/24 9:20 PM Pain Level: 10 Medication Administered: Tylenol Oral Tablet 325 MG X2 08/26/24 11:01 AM Pain Level: 0 Medication Administered: Tylenol Oral Tablet 325 MG X2 08/26/24 8:57 PM Pain Level: 4 Medication Administered: Tylenol Oral Tablet 325 MG X2 09/10/24 11:51 AM Pain Level: 0 Medication Administered: Tylenol Oral Tablet 325 MG X2 09/11/24 7:28 AM Pain Level: 4 Medication Administered: Tylenol Oral Tablet 325 MG X2 09/14/24 8:14 PM Pain Level: 3 Medication Administered: Tylenol Oral Tablet 325 MG X2 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/18/24 8:00 PM Pain Level: 10 Medication Administered: Tylenol Oral Tablet 325 MG X2 09/26/24 9:19 AM Pain Level: 1 Medication Administered: Tylenol Oral Tablet 325 MG X2 10/04/24 9:10 AM Pain Level: 2 Medication Administered: Tylenol Oral Tablet 325 MG X2 10/06/24 8:36 PM Pain Level: 9 Medication Administered: Tylenol Oral Tablet 325 MG X2 10/07/24 7:52 AM Pain Level: 0 Medication Administered: Tylenol Oral Tablet 325 MG X2 10/15/24 7:25 AM Pain Level: 2 Medication Administered: Tylenol Oral Tablet 325 MG X2 10/16/24 8:35 AM Pain Level: 1 Medication Administered: Tylenol Oral Tablet 325 MG X2 10/29/24 12:15 AM Pain Level: 3 Medication Administered: Tylenol Oral Tablet 325 MG X2 10/30/24 9:00 PM Pain Level: 10 Medication Administered: Tylenol Oral Tablet 325 MG X2 11/04/24 8:12 AM Pain Level: 5 Medication Administered: Tylenol Oral Tablet 325 MG X2 b) Resident #319: Record review, and interview on 11/05/24 at 9:09 AM, revealed that Resident #319 had been prescribed the following medication: Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) 1 tablet by mouth every 8 hours as needed for pain. PRN pain medication. Order date 10/29/2024 at 4:45 PM. Further review indicated that no pain assessment scale was specified for the administration of the medication. During an interview with Licensed Practical Nurse (LPN) #133 on 11/06/24 at approximately 9:05 AM, she stated that there was no pain scale for the administration of pain medication, and no assessments were conducted after administration. At approximately 9:08 AM on 11/06/24, during an interview with LPN #15, she stated that pain levels were not assessed or documented after medication administration. On 11/06/24, at approximately 10:00 AM, during an interview with the Director of Nursing (DON), this surveyor requested documentation on pain scales used for administering the medications, Acetaminophen or Oxycodone, for Residents # 117 and #319. The DON confirmed that no pain scales had been prescribed. Additionally, the DON acknowledged that there were no documented post-medication pain levels to ensure that the residents were receiving adequate pain management. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 2:51 PM on 11/06/24, the Corporate Clinical Nurse (CCN) #200 reported that she had requested pain scales for the administration of pain medication. She also mentioned that she implemented teaching sessions, and in-services for the nursing staff, to ensure that residents were properly assessed and adequately medicated for pain.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 42120 Based on record review and staff interview, the facility failed to complete annual performance reviews for Nurse Aides (NA). This was true for five (5) of five (5) reviewed for staffing during the Long-Term Survey Process (LTCSP). Facility census: 117. Findings included: a) Facility NA's Annual Evaluations A facility record review revealed NA #29, NA #34, NA #60, NA #14, and NA #18 did not receive their 12-month evaluation. During an interview, on 11/06/24 at 4:04 PM, the Human Resource Manager confirmed there were no annual evaluations completed for NA #29, NA #34, NA #60, NA #14, and NA #18. She stated that NA evaluations were something the facility was working on getting completed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42120 Based on record review, and staff interview, the facility failed to ensure the physician documented the actions or rational if no action taken to monthly drug regimen reviews. This was true for four (4) of five (5) reviewed for unnecessary medications and the pharmacist failed to identify clinically significant risks associated with concurrent use of a Benzodiazepines and opioids. Resident identifiers: #22, #77, #101 and #17. Facility census: 117. Findings included: a) Resident #22 Record review of the facility's policy titled, Medication Regimen Review, showed: -Attending Physician Responsibilities: 1. The resident's attending physician must document in the medical record that the identified irregularity has been reviewed, and what if any action has been taken to address it. 2. If there is to be no change in the medications, the attending physician must document his/her rationale in the resident's medical record. A medical record review for Resident #22 revealed monthly drug regimen reviews response without actions or rational if no action taken by the physician. --06/27/24 Recommendation -Psychotropic (Non-Antipsychotic) on as needed (PRN) basis Hydroxyzine Pamoate 25 mg. Per regulatory guidelines, the duration of treatment with such medications on PRN basis should be limited to 14 days. --07/23/24 Recommendation Resident currently has order to obtain Vitamin D, TSH and FLP every 6 months. The last results are 11/14/23. During an interview on 11/06/24 at 11:02 AM the Director of Nursing verified that the physician did not document the action or rational. b) Resident #77 A medical record review for Resident #77 revealed monthly drug regimen reviews response without actions or rational if no action taken by the physician. --05/28/24 Recommendation - Resident is currently taking Divalproex 500 MG BID. There is no standing order to have a divalproex level checked routinely. Please consider adding an order to monitor Divalproex level every 6 months. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--08/27/24 Recommendation this resident receives Vitamin D 50,000 units once weekly. No vitamin D level in resident chart. Please consider monitoring a Vitamin D level every 3 months. During an interview on 11/06/24 at 11:02 AM the Director of Nursing verified that the physician did not document the action or rational. c) Resident #17 A review of Resident #17's records on 11/06/24, at approximately 12:45 PM, revealed that the resident was currently prescribed the following medications: 1. Ativan Oral Tablet 0.5 MG (Lorazepam) - Controlled Drug Administer 1 tablet by mouth three times a day for generalized anxiety due to yelling, cursing, and combativeness. Order date: August 23, 2023, at 10:30 AM. 2. Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Administer 1 tablet by mouth three times a day for moderate to severe chronic pain, not to exceed 3 g of acetaminophen in 24 hours. Order date: July 18, 2023, at 9:00 PM. 3. Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) - *Controlled Drug Administer 0.25 ml by mouth every 2 hours as needed for severe pain. Order date: January 17, 2023, at 2:49 PM. A review of the guidance by the Centers for Disease Control, dated November 4, 2022, titled: CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022 showed the following under Recommendation 11. Clinicians should check the Prescription Drug Monitoring Program (PDMP) for concurrent controlled medications prescribed by other clinicians .and should consider involving pharmacists as part of the management team when opioids are co-prescribed with other central nervous system depressants. In patients receiving opioids and Benzodiazepines long term, clinicians should carefully weigh the benefits and risks of continuing therapy with opioids and Benzodiazepines and discuss with patients and other members of the patient's care team. Clinicians should communicate with other clinicians managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent Benzodiazepines and opioid exposure, and coordinate care. Benzodiazepines and opioids both cause central nervous system depression, and Benzodiazepines can potentiate opioid-induced decreases in respiratory drive. Epidemiologic studies find concurrent Benzodiazepines use in large proportions of opioid-related overdose deaths. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review and staff interview conducted on October 7, 2024, at approximately 8:30 AM revealed that the consulting pharmacist did not identify, or notify the physician about clinically significant risks and potential adverse consequences associated with the concurrent use of Benzodiazepines and opioids. Furthermore, the attending physician failed to provide the nursing staff with instructions for properly assessing and monitoring the effectiveness of the medications, as well as for detecting adverse consequences such as depressed respiration or sedation. This includes a lack of guidance on how, and when, to monitor the resident's symptoms to ensure their safety while on this medication regimen. During an interview with Licensed Practical Nurse (LPN) #133 on 11/06/24 at approximately 9:05 AM, she stated that there was no pain scale for the administration of pain medication, and no assessments were conducted after administration. At approximately 9:08 AM on 11/06/24, during an interview with LPN #15, she stated that pain levels were not assessed or documented after medication administration. During an interview with the Director of Nursing (DON) on 11/07/24 at approximately 9:18 AM, she confirmed that the physician prescribed no assessment guidelines and that the nurses do not monitor residents' respirations. d) Resident #101 The facility failed to provide signed and written documentation in the medical record that the identified irregularity has been reviewed and what, if any, action had been taken to address it. Pharmacists consults dated 02/26/24, and 6/25/24, 06/29/24 revealed the pharmacist found Irregularities noted and/or recommendation(s) made. 02/26/24 Resident's current order of Lorazepam PRN. There are no instruction on frequency of administration on the order. The discharge medication list has TID (three times a day) PRN (as needed). Please confirm and update the order for patient safety and concern. Nicotine and Melotonin were not entered. Anxiolytic behavior monitoring are not complete. On 06/20/24 the Resident admission medication regimen was assessed issues and concerns: This resident is currently receiving Heparin TID after a recent hospital visit. Recommendation for stop date for Heparin. There was no signed and written documentation in the medical record that the identified irregularity has been reviewed and what, if any, action had been taken to address it. 50795 50801

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42120 Based on observation and staff interviews, the facility failed to keep unit refrigerators free from medical supplies that could contaminate food and store food and supplies in accordance with professional standards for food service safety. This has the ability to affect more than a limited number of Residents. Facility census: 117. Findings included: a) Unit Pantry's During the initial tour of pantries with the Dietary Manager on 11/04/24 at 11:30 AM an observation of the south pantry found five (5) used resident cold gel Icepacks for injury or surgical procedures stored in the Resident freezer. The continued tour of the north pantry on 11/04/24 at 11:44 AM found five (5) used resident cold gel Icepacks for injury or surgical procedures stored in the Resident freezer and the ice scoop stored in the ice cooler. On 11/04/24 at 12:00 PM during an interview with the Dietary Manager (DM) verified that medical supplies should not be stored in Resident refrigerators or freezers and the ice scoop should be placed in the scoop holder, not in the ice chest.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 42120 Based on observation and staff interviews, the facility failed to store garbage and refuse in a proper manner to prevent rodents, vermin and pests. The dumpsters were in disrepair. This had the potential to affect all residents that reside in the facility. Facility census: 117. Findings included: a) Dumpsters On 10/05/24 at 1:47 PM an observation of the dumpsters found one (1) dumpster with a rusty hole in the bottom front with debris hanging out. Dumpster two (2) was in disrepair as the middle doors were unable to close properly do to damage. On 10/05/24 at 1:50 PM during an Interview the Maintenance Director stated that he was aware of the issues with the dumpsters. He continued to say that he has got quotes for new dumpsters, but the facility has not purchased them at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515072	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Healthcare Center	300 Miller Road Kingwood, WV 26537

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43340 Based on record review and staff interview, the facility failed to maintain accurate records on four (4) out of 24 sampled residents in the Long-Term Care Survey Process. Resident identifiers: #71, #68, #110, and #93. Facility census: 117. Findings included: a) Resident #71 A record review, on 11/04/24 at 12:44 PM, revealed a Physician Orders for Scope of Treatment (POST) form in Resident #71's electronic medical record. The POST form was dated 07/30/22. Section E of the POST form, entitled Signature: Patient or Patient Representative/Surrogate/Guardian was unsigned and undated. On 11/05/24 at 2:45 PM, a review of resident's paper chart at nurses' station revealed the original POST was also not signed by resident/resident representative. The directions for completing the POST form, compiled by the [NAME] Virginia Center for End of Life, state, The signature section provides a declaration on behalf of the patient (or incapacitated patient's Medical Power of Attorney representative or health care surrogate) related to their voluntary participation in the completion of the POST form and agreement with the orders on the form. 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 11/05/24 at 3:15 PM, the Director of Social Services acknowledged the POST form was not completed according to guidance and could not be considered legally valid. b) Resident #68 A record review, on 11/04/24 at 1:38 PM, revealed a POST form in Resident #68's electronic medical record. The POST form was dated 10/17/23. Section F of the POST form, entitled Signature: Health Care Provider was undated. On 11/05/24 at 2:47 PM, a review of resident's paper chart at nurses' station revealed the original POST also had no date with the physician's signature under Section F. The directions for completing the POST form, compiled by the [NAME] Virginia Center for End of Life, state, The health care provider completing this form must print their name, sign, and date this section for the form to be legally valid. During an interview, on 11/05/24 at 3:17 PM, the Director of Social Services acknowledged the POST form was not completed according to guidance and could not be considered legally valid. c) Resident #110 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515072	A. Building B. Wing	11/07/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #110's medical records showed a POST form. A POST form is completed by the resident or resident's representative to indicate end-of-life wishes. Resident #110 did not have capacity to make medical decisions. A POST form had been completed and signed by the resident's representative. However, the resident's representative's signature had been dated. The physician had signed the POST form and dated the form on 08/09/24. However, the physician did not print his or her full name on the form. The signature was illegible. The POST form guidance titled, Using the POST Form: Guidance for Health Care Professionals, available on-line, stated as follows: - The patient (or incapacitated patient's MPOA [medical power of attorney] representative or health care surrogate) must sign and date this section for the form to be legally valid. - The health care provider completing this form . must print their name, sign, and date this section for the form to be legally valid. On 11/06/24 at 10:40 AM, the Assistant Director of Nursing (ADON) confirmed Resident #110's POST form had not been fully completed. d) Resident #93 Record review on 11/05/24 at 9:25 AM revealed a physician determination of capacity form dated 08/23/24, that stated that the resident suffered from: Disorientation Inability to Process Information Delirium Encephalopathy However, the physician inaccurately documented that Resident #93 had capacity by checking off the box that stated: Demonstrates CAPACITY to make decisions. Record review revealed a Brief Interview for Mental Status (BIMS) for Resident #93, dated 08/29/24 that showed a BIMS score of 15. Further investigation and record review revealed a State Of [NAME] Virginia Checklist for Surrogate Selection dated 08/23/24 that had designated the resident's daughter-in-law as the surrogate. During an interview with the Director of Social Services (DSS) on 11/05/24 at approximately 2:30 PM to discuss the discrepancies, the DSS stated that the resident responded appropriately to the questions and was having a good day when the BIMS assessment was done. On 08/29/24. DSS further stated that Resident #93 has good days and bad days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 11/05/24 at approximately 2:45 PM, and the DON confirmed that the physicians' determination of the resident's capacity was inaccurate. The DON returned at approximately 3:45 PM with an updated form dated 11/05/24, signed by the physician's designee, which stated that Resident #93 did not have capacity. 39043 50795