STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515077	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weirton Medical Center	601 Colliers Way Weirton, WV 26062

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 50795 Based on interview and investigation, the facility failed to ensure Resident #2's preferred sleeping and waking times were honored. This failed practice had the potential to affect more than a limited number of residents who reside at the facility. This was a random opportunity for discovery. Resident Identifier #2. Facility Census: 24 Findings included: a) Resident #2 During an interview with Resident #2, she stated she was woken up at around 4:30 AM on 06/26/24 by three (3) Nursing Assistants (NAs). Resident #2 stated they set about getting her things packed. She said that they stated that they were getting her ready for discharge. She stated that she was unable to identify the NAs because it was dark, and she had just woken up. Resident stated, I paid for this room, and I will decide when to wake up, and when to get ready. An interview with the resident's daughter at 1:08 PM on 06/26/24, revealed she had made a complaint to RN #17. She stated the RN said that staff had probably, attempted to get a jump on things. During an Interview with RN #17 at 1:17 PM on 06/26/24 she stated she had received a complaint from the resident, and the resident's daughter. She further stated she had forwarded the complaint to Director of Nursing (DON) #23. While being interviewed, on 06/26/24 at 1:38 PM, (DON) #23 stated she would review the previous night's staffing schedule and investigate the complaint. The DON agreed that residents had the right to choose their schedules, consistent with their interests, assessments, and care plans. This included, but was not limited to, choices about the schedules that were important to the resident, such as waking, eating, bathing, and going to bed at night.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 43340 Based on observation and staff interview, the facility failed to post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. This deficient practice had the ability to affect more than a limited number of residents and/or family members. This was a random opportunity for discovery. Facility census: 24. Findings included: a) Survey Results During an observation, completed on 06/26/24 at 10:19 AM, it was determined the facility had signage by the elevator indicating that survey results were available in the three-ring binder kept in a clear, wall mounted bin by the signage. Further observation revealed the three-ring binder did not have the results of the most recent Long-Term Care Survey Process. During an interview on 06/26/24 10:25 AM, the current Director of Nursing (DON) confirmed the binder did not have the most recent Long-term Care Survey Process survey. At that time, the DON spoke to the former DON who was working on the floor in a different capacity. The former DON stated, It was there. Maybe it was taken and not replaced.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on medical record review and staff interview, the facility failed to ensure Advance Directive paperwork was part of the resident's medical record. This was true for one (1) of 13 residents reviewed in the Long-Term Care Survey Process. Resident identifier: #139. Facility census: 24. Findings included: a) Resident #139 A medical record review, completed on 06/25/24 at 8:27 AM, indicated that Resident #139 was admitted to the facility on [DATE]. It also identified the following details: -Resident #139's profile page identified the fact that one of resident's family members was appointed as Medical Power of Attorney (MPOA). -A Advance Directive Acknowledgement form on file and indicated Resident #139 been informed of his right under the law to use an Advance Directive while at the facility. Resident #139 indicated that he did have an Advance Directive and wanted it included in his medical record. -There was no copy of the Advance Directive paperwork scanned into the electronic record. -There was no copy of the Advance Directive paperwork on Resident #139's hard chart at the nurses' station. During an interview, on 06/26/24 at 10:50 AM, the MDS Coordinator reported the facility could not produce resident's Advance Directive paperwork which meant there was no way of knowing if a Living Will was part of it and what the resident's wishes would be in a true medical emergency where he was very sick and unable to communicate his wishes for himself.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795 Based on record review and staff interview, the facility failed to develop accurate written abuse and neglect policies and failed to implement procedures for reporting to prevent all types of abuse. The facility failed to report an incident of neglect/mistreatment with Resident #2. This practice affected one (1) of two residents reviewed using the abuse pathway in the survey process. This failed practice had the potential to affect more than a limited number of residents who reside at the facility. Resident identifier: #2. Facility census: 24. Findings included: a) Based on an interview of Resident #2 on 06/24/24 at 1:05 PM, resident stated that she had needed to use her bedside commode on 06/23/24 at around 6:00 AM. Resident stated that no one had responded to her call light for over two (2) hours. She further stated that she was sitting at the edge of her bed and could feel herself sliding off, so she had begun to shout out loudly for assistance. Her calls were responded to by a Nursing Assistant (NA) #15, who told her to stop shouting so loudly. Resident's family member, who was present, stated that her sister, had made a complaint to the nurse in charge on 06/23/24 at 10:35 AM. She stated that no one had responded to the complaint. Investigation, and record review, revealed that the nurse in charge, RN #16, had submitted an email to the Director of Nursing (DON) #23 on 06/23/24 at 11:32 AM. The email stated: room [ROOM NUMBER] Resident #12's daughter is very upset. She said that her mother was on the call light for over two (2) hours from 4am - 6am. She said that a girl came in the room and asked her if she needed help and left her without helping and acted like she didn't know what a bedside commode was and left her. Family is upset and would like to talk to you. b) Review on 06/26/24 at 11:33 AM, of the facility's policy Abuse, Neglect and Exploitation, with an initial date of September 1990, and review, and revision dates from 08/91 through 03/22, revealed that the purpose of the policy is to assure that patients are free from mistreatment, neglect or abuse, including injuries of unknown source. The facility prohibits abuse, neglect, and exploitation of resident property. A review of the policy definitions revealed the following: Willfil - means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Verbral Abuse - means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Physical Abuse - includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Mental Abuse - is non-consensual sexual contact of any type with a resident. Further review of the policy revealed that the policy states that: Suspicion of abuse/neglect/exploitation, or reports of abuse/neglect/exploitation are to be responded to immediately. 1. The licensed Registered Nurse will: a. Respond to the needs of the resident and protect him/ her from further incident. b. Remove the accused employee from the resident care areas. c. Notify the Director of Nursing Service and Administrator d. Notify the attending physician, resident's family/legal representative, and Medical Director. e. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. f. Document actions taken in the medical record. g. Protect the individual from further injury or mental anguish. h. Complete an incident report and initiate an investigation. 2. The Director of Nursing Services, Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than twenty- four (24) hours after discovery of the incident. b. Obtain statements from direct care staff. c. Suspend the accused employee pending completion of the investigation. d. Follow up with the appropriate agencies . to confirm the report was received. e. Report to the state nurse aide registry or nursing board any knowledge of any actions which would indicate an employee is unfit for service. Further record review, and interviews, with DON #23 revealed that none of the actions mandated in the policy had been initiated or acted upon. A review of the facility reportables, on 06/25/24 at 11:45 AM, did not find a corresponding reportable to the appropriate state agencies. During an interview with the DON on 06/25/24 at 2:28 PM, she stated that she had pulled the call log response time, but she had not yet had the opportunity to talk to the resident's daughter, due to surveyors entering the facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795 Based on record review, resident interview, and staff interviews, the facility failed to report allegations of neglect and verbal abuse for Resident #2. This was a random opportunity for discovery. This failed practice has the potential to affect more than a limited number of residents at the facility. Resident Identifier #2. Facility census:24 Findings: a) Resident #2 During an interview of Resident #2 on 06/24/24 at 1:05 PM, resident stated that she had needed to use her bedside commode on 06/23/24 at around 6:00 AM. Resident stated that no one had responded to her call light for over two (2) hours. She further stated that she was sitting on the edge of her bed and could feel herself sliding off, so she had begun to shout out loudly for assistance. Her calls were responded to by Nursing Assistant (NA) #15, who told her to stop shouting so loudly. Resident's family member, who was present, stated that her sister had made a complaint to the nurse in charge on 06/23/24 at 10:35 AM. She stated that no one had responded to the complaint. Investigation, and record review, revealed that the nurse in charge, RN #16, had submitted an email to the Director of Nursing (DON) #23 on 06/23/24 at 11:32 AM. The email stated: room [ROOM NUMBER] Resident #12's daughter is very upset. She said that her mother was on the call light for over two (2) hours from 4am - 6am. She said that a girl came in the room and asked her if she needed help and left her without helping and acted like she didn't know what a bedside commode was and left her. Family is upset and would like to talk to you. A review of the facility reportables, on 06/25/24 at 11:45 AM, did not find a corresponding reportable to the appropriate state agencies. During an interview with the DON on 06/25/24 at 2:28 PM, she stated that she had pulled the call log response time, but she had not yet had the opportunity to talk to the resident's daughter, due to surveyors entering the facility

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795 This was a random opportunity for discovery. Based on record review and resident and staff interview, the facility failed to initiate an investigation of an alleged violation of neglect and verbal abuse for Resident #2. This failed practice had the potential to affect more than a limited number of residents at the facility. Resident Identifier #2. Facility Census:24. a) Resident #2 Based on an interview of Resident #2 on 06/24/24 at 1:05 PM, resident stated that she had needed to use her bedside commode on 06/23/24 at around 6:00 AM. Resident stated that no one had responded to her call light for over two (2) hours. She further stated that she was sitting on the edge of her bed and could feel herself sliding off, so she had begun to shout out loudly. Her calls were responded to by a Nursing Assistant (NA) #15, who told her to stop shouting so loudly. Resident's family member, who was present, stated that her sister had made a complaint to the nurse in charge on 06/23/24 at 10:35 AM. She stated that no one had responded to the complaint. Investigation, and record review, revealed that the nurse in charge, RN #16, had submitted an email to the Director of Nursing (DON) #23 on 06/23/24 at 11:32 AM. The email stated: room [ROOM NUMBER] Resident #12's daughter is very upset. She said that her mother was on the call light for over two (2) hours from 4am - 6am. She said that a girl came in the room and asked her if she needed help and left her without helping and acted like she didn't know what a bedside commode was and left her. Family is upset and would like to talk to you. During an interview with the DON on 06/25/24 at 2:28 PM, she stated that she had pulled the call log response time, but she had not had the opportunity to talk to the resident's daughter as yet, due to surveyors entering the facility. b) Facility Policy on Abuse, Neglect and Exploitation A review of the policy revealed that the policy states that: Suspicion of abuse/neglect/exploitation, or reports of abuse/neglect/exploitation are to be responded to immediately. The Director of Nursing Services, Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than twenty-four (24) hours after discovery of the incident. b. Obtain statements from direct care staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Suspend the accused employee pending completion of the investigation. d. Follow up with the appropriate agencies . to confirm the report was received. e. Report to the state nurse aide registry or nursing board any knowledge of any actions which would indicate an employee is unfit for service. A review of the facility reportables, on 06/25/24 at 11:45 AM, did not find a corresponding reportable to the appropriate state agencies. Further record review, and interview with DON #23 on 06/25/24 at 2:28 PM revealed that none of the actions mandated in the policy had been initiated or acted upon.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 The facility failed to provide an environment that was free from accident hazards over which the facility had control. Water temperatures were found to be above 120 degrees Fahrenheit (F). This deficient practice had the potential to affect more than a limited number of residents. Facility census: 24. Findings included: a) State Operations Manual Appendix PP Review of the State Operations Manual Appendix PP found in the interpretive guidelines for F689 the following concern regarding water temperatures: - Water temperature of 124 degrees Fahrenheit will cause a 3rd degree burn in 3 minutes. - Water temperature of 120 degrees Fahrenheit will cause a 3rd degree burn in 5 minutes. - Burns can occur even at water temperatures below those identified, depending on an individual's condition and the length of exposure. -Third-degree burns penetrate the entire thickness of the skin and permanently destroy tissue. These present as loss of skin layers, often painless (pain may be caused by patches of first- and second-degree burns surrounding third-degree burns), and dry, leathery skin. Skin may appear charred or have patches that appear white, brown, or black. b) Water Temperatures On 06/24/24 at 2:30 PM, the water temperature of the sink in room [ROOM NUMBER] was tested by Maintenance Worker #26 under observation of the surveyor. The water temperature was tested by inserting the stem of the thermometer into the stream of running water, so that the sensor was fully immersed. A water temperature of 120.5 degrees Fahrenheit was reached. Maintenance Worker #26 stated he knew it was undesirable to have a water temperature at or above 120.0 degrees Fahrenheit. The following areas of the facility were also tested by Maintenance Worker #26 under observation of the surveyor and had temperatures greater than 110 degrees Fahrenheit. - The shower room sink had a water temperature of 124.0 degrees Fahrenheit. - The sink in room [ROOM NUMBER] had a water temperature of 123.2 degrees Fahrenheit. During an interview, on 06/24/24 at 3:55 PM, the Director of Nursing confirmed that plant maintenance staff would ensure all water temperatures were immediately addressed to ensure resident safety.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42120 Based on staff interview and medical record review the facility failed to ensure resident #92 received an adequate amount of nutrition. This was true for one (1) of (1) residents reviewed for nutrition. Resident identifier #92. Facility census 24. Findings included: a) Resident #92 An observation on 06/24/24 at 1:14 PM the lunch tray was sitting in front of resident, she was not eating, no assistance was offered or observed during meal. A second observation on 06/25/24 at 1:32 PM her lunch meal was not consumed and just sitting in front of resident. A medical record review revealed a physician's order for a diabetic regular diet. No weights or nutritional assessments were documented during her admission to the skilled unit. A subsequent review of meal intakes revealed the resident's percentages were 0-25 eaten during meals. During an interview on 06/26/24 at 12:23 PM the Director verified that no weight was obtained on admission or 7 days later. She also verified Resident #92 should have been assessed within the first week of admission for nutritional status.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice. Pain medication was not administered appropriately per the physician's order. This was true for one (1) of two (2) residents who were reviewed under the pain pathway in the Long-Term Care Survey Process. Resident #139. Facility census: 24 Findings included: a) Resident #139 During an interview, on 06/24/24 at 1:33 PM, Resident #139 mentioned he received medication for pain in his back and had arthritis in hand which necessitated pain medication as well. Resident #139 went on the say that he had requested for his doctor visit him today because his pain levels were not always under control. A record review, completed on 06/26/24 at 8:35 AM, revealed the resident was admitted to the facility on [DATE]. The following two (2) orders were for pain management: -A 06/06/24 Physician Order prescribing: Oxycodone 5 mg oral tablet every 6 hr., -A 06/22/24 Physician Order prescribing: Acetaminophen (Tylenol) - 650 mg =2 oral tablets, every 6 hours, PRN, mild - Pain 1-3. Review of the Medication Administration Record revealed the following dates that Acetaminophen/Tylenol was given to resident despite his pain being higher than three (3): -Acetaminophen/Tylenol was given on 06/22/24 at 11:14 AM for a pain of ten (10) -Acetaminophen/Tylenol was given on 06/24/24 at 5:43 PM for a pain of four (4) -Acetaminophen/Tylenol was given on 06/25/24 at 8:12 AM for a pain of six (6) During an interview on 06/26/24 at 11:34 AM, the Director of Nursing acknowledged the above-mentioned dates where pain levels where at the level that Oxycodone should have been administered instead of Acetaminophen/Tylenol.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50795 Based on record review and staff interview, the facility failed to ensure the attending physician documented in the resident's medical record, that the pharmacist's monthly medication review with recommendations had been reviewed and what, if any, action has been taken to address it. This was true for one (1) of five (5) unnecessary medication reviews throughout the long-term care survey process. Resident identifier: #2. Facility census: 24. Findings include: a) Resident #2 Record review on 06/25/24 at 3:38 PM for Unnecessary Meds, and Med Regimen Review, revealed that drug regimen reviews were performed by the pharmacist on 05/29/24 at 8:57AM, and on 06/25/24 at 9:53 AM. The pharmacist had notified physician that there were no depression, anxiety, or other mental health diagnoses for the prescribed drugs Duloxetine, Mirtazapine, and Lorazepam. Record review 0n 06/26/24 at 10:17 AM revealed that physician had not acknowledged or responded to the consultant pharmacist's recommendation. Record review on 06/26/24 at 10:23 AM revealed the facility's Drug review policy stated: Recommendations of the consulting pharmacist are acted upon and documented by the attending physician. The attending physician must document in the resident's chart that the identified irregularity has been reviewed and what, if any, action has been taken to address it within seven (7) days (48 hours if urgent action is required) During an interview with the DON, on 06/26/24 at 10:50 AM, she confirmed the physician had not acted upon the pharmacist's recommendations dated 05/29/24.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50795 Based on observation, and staff interview, the facility failed to ensure the safe storage of medications in the medication room. The facility had made no provision to install the appropriate environmental controls, and monitoring devices, to preserve the integrity of the medications stored in the medication room. This was a random opportunity for discovery. This failed practice had the potential for more than minimal harm. Facility census: 24. Findings included: a) Medication Room During an inspection of the medication room on 06/25/24 at 08:11 AM, this surveyor noted that there was no temperature monitoring device in the medication room. Interview of LPN #12 at 08:14 AM revealed that the medication room temperature was not monitored or documented. The Director of Nursing (DON) # 23, on 06/26/24 at 11:38 AM, confirmed that the medication room temperature was not monitored. She stated she would have to consult with the pharmacy. The DON acknowledged that she did not have any knowledge of the need for the medication room to be temperature monitored. Manufacturers' recommendations specify the storage temperature range for medications, because many medications can be altered by exposure to improper temperature, light, or humidity, it is important the facility implement procedures that address and monitor the safe storage and handling of medications in accordance these recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515077	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weirton Medical Center	601 Colliers Way Weirton, WV 26062

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42120 Based on facility documentation and staff interview the facility failed to have required members sign in at the Quality Assessment and Assurance (QAA) meetings. This failed practice had the potential to affect all residents residing at the facility. Facility Census: 24. Findings included: a) QAA Record review of the facility's documentation of QAA Meeting Agenda and Minutes revealed no meeting was conducted in the first quarter of 2024. During an Interview 06/26/24, at 2:23 PM the Director verified the first quarter required quarterly QAA meeting was not conducted. No other information was provided prior to the end of the survey on 06/26/24.