| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515080 | A. Building<br>B. Wing | 02/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hampshire Memorial Hospital | 363 Sunrise Blvd<br>Romney, WV 26757 |

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|---|---|
| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22140<br><br>Based on record review and staff interview, the facility failed to inform the resident/responsible party of the risks and benefits of receiving an antipsychotic medication. This was found for one (1) of five (5) residents reviewed for unnecessary medications. Resident identifier: #13. Facility census: 27.<br><br>Findings included:<br><br>a) Resident #13<br><br>Resident #13 was admitted to the facility on [DATE]. On 10/17/23, a physician determined the Resident lacked capacity to make medical decisions due to a diagnosis of Dementia and his wife was appointed as his health care surrogate.<br><br>Record review found on 01/04/24, the Resident's physician prescribed a new antipsychotic medication Seroquel, oral Tablet, 25 milligrams (mg's) 1 tablet by mouth two (2) times a day for a diagnosis of depression. The Resident was already receiving Lexopro, an antidepressant for a diagnosis of depression.<br><br>Further review of the medical record found no evidence the responsible party, the Resident's wife, was notified of the risks and benefits of taking Seroquel, an antipsychotic medication.<br><br>On 02/21/24 at 2:24 PM, the Director of Nursing reviewed the resident's progress notes with the surveyor. The DON states, we really don't have any behaviors documented to add the Seroquel. I think I'll call the physician to address this and maybe he will discontinue the medication. The DON confirmed the physician and the nurse practitioner never addressed the use of Seroquel in their notes. The DON said this happens frequently, those nurses want to give medications for behaviors but they never document anything in their notes. This is an ongoing problem.<br><br>On 02/21/24 at 4:00 PM, the DON confirmed she could not find any evidence the risks and benefits of starting Seroquel were discussed with the responsible party. |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22140<br><br>39043<br><br>Based on record review and staff interview, the facility failed to notify the residents' representatives when Resident #20 had a significant change in status and when Resident #13 had a significant alteration in treatment. This deficient practice had the potential to affect two (2) of 14 residents reviewed in the long-term care survey sample. Resident identifiers: #20, #13. Facility census: 27.<br><br>Findings included:<br><br>a) Resident #20<br><br>Review of Resident #20's weights summary in the electronic health record showed the resident weighed 129. 6 pounds (lbs.) on 09/01/23. The weights summary identified the resident had lost 10% of weight in six (6) months when compared to the resident's weight of 144.6 lbs. on 04/05/23.<br><br>Further review of Resident #20's medical records showed a Physician Certification of Capacity/Incapacity dated 04/19/23 that showed the resident lacked sufficient mental capacity to make health care decisions. In 2021, the resident had chosen a family member to make health care decisions for her if she became incapacitated.<br><br>There was no documentation in Resident #20's medical record that the resident's representative had been notified when the resident had a significant weight loss on 09/01/23.<br><br>Resident #20 weighed 130.1 lbs. on 10/02/23 and 121.2 lbs. on 11/08/23. Although the weights summary did not identify this change as significant weight loss, the resident had lost 7% of weight in one (1) month.<br><br>There was no documentation in Resident #20's medical record that the resident's representative had been notified when the resident had a significant weight loss on 11/08/23.<br><br>The resident continued to lose weight, weighing 116 lbs. on 12/10/23 and 113 lbs. on 01/10/24. On 01/17/24, the resident's representative was notified regarding new orders instituted to address the resident's weight loss. There was no evidence the resident's representative was notified regarding weight loss before 01/17/24.<br><br>On 02/21/24 at 1:55 PM, Clinical Coordinator #6 confirmed Resident #20's medical records contained no documentation that the resident's representative had been notified of the resident's weight loss before 01/17/24.<br><br>No further information was provided through the completion of the survey process.<br><br>b) Resident #13<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #13 was admitted to the facility on [DATE]. On 10/17/23, a physician determined the Resident lacked capacity to make medical decisions due to a diagnosis of Dementia and his wife was appointed as his health care surrogate.<br><br>Record review found on 01/04/24, the Resident's physician prescribed a new medication Seroquel, oral Tablet, 25 milligrams (mg's) 1 tablet by mouth two (2) times a day for a diagnosis of depression.<br><br>Further review of the medical record found no evidence the responsible party, the Resident's wife, was notified of the physician's order for Seroquel, an antipsychotic medication.<br><br>On 02/21/24 at 4:00 PM, the Director of Nursing (DON) confirmed she could find no evidence the responsible party was contacted before starting the medication, Seroquel. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>22140<br><br>Based on record review and staff interview, the facility failed to ensure three (3) of three (3) residents reviewed for the care area of beneficiary notices received the required notices when the facility initiated a discharge from Medicare A and the three (3) residents elected to remain at the facility with benefit days remaining. Resident identifiers: #28, #13, and #17. Facility census: 27.<br><br>Findings included:<br><br>a) Beneficiary Notices<br><br>Review of the facility's entrance conference Worksheet indicated three (3) residents who were discharged from Medicare, Part A with benefit days remaining:<br><br>Resident #28 was discharged from Medicare Part A services on 11/15/23 and remained at the facility with benefit days remaining.<br><br>Resident #13 was discharged from Medicare Part A services on 11/04/23 and remained at the facility with benefit days remaining.<br><br>Resident #17 was discharged from Medicare Part A services on 10/29/23 and remained at the facility with benefit days remaining.<br><br>On 02/20/24 at 3:02 PM, the Director of Nursing (DON) and the Clinical Coordinator, Minimum Data Set (CCMDS) confirmed the facility did not issue a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) CMS 10055 to Residents #28, #13, #17 when they were discharged from Medicare Part A services. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>45171<br><br>Based on observation and staff interview the facility failed to provide residents the opportunity to file grievances anonymously by not making grievance forms accessible to residents. This has the potential to affect more than a limited number of residents. Facility Census: #27<br><br>Findings included:<br><br>a) Facility<br><br>On 02/20/24 at 11:10 AM observation found that there were no grievance forms accessible to residents to obtain on their own accord. Upon discussion with the Director of Nursing on 02/20/24 at 12:10 PM, she states the forms are kept in her office in a file cabinet. The Residents must go through a staff member to file a grievance. When asked how the Residents file an anonymous grievance, she states they do not.<br><br>According to the regulation: 483.10(j) Grievances.<br><br>. Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously;<br><br>During a Resident Council meeting on 02/21/24 residents present (14 residents) stated they can not file a grievance anonymously, they must go through a staff member and they might like to file an anonymous complaint sometime.<br><br>The above was confirmed with the Director of Nursing on 02/22/24 at 9:10 AM. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22140<br><br>39043<br><br>Based on record review and staff interview the facility failed to develop and/or implement the comprehensive care plan for seven (7) of fourteen (14) residents reviewed in the long term care survey sample. Resident Identifiers: #1, #27, #24, #11, #13, #20 and #3. Facility Census: #27.<br><br>Findings included:<br><br>a) Resident #1<br><br>On 02/20/24 at 03:10 PM record review show Resident #1 has a history of weight loss. Weights were documented as:<br><br>02/08/24 203.8<br><br>01/23/24 203.8<br><br>11/02/23 217.5<br><br>08/04/23 233.5<br><br>Further review of Resident #1's care plan found that there was no care plan developed for weight loss.<br><br>This was confirmed with the Director of Nursing on 02/20/24 at 03:58 PM who agreed that Resident #1 should be care planned for weight loss.<br><br>b) Resident #27<br><br>On 02/20/24 at 11:50 AM record review shows Resident #27 was admitted on [DATE] with contractures to the left shoulder and elbow. Review of the care plan in place found the contractures were not included on the care plan in place. This was confirmed with the Director of Nursing on 02/20/24 at 03:10 PM and she agreed the contractures should be care planned.<br><br>c) Resident #24<br><br>On 02/21/24 at 10:05 PM record review shows that Resident #24 has a Physicians order for:<br><br>Lasix Oral Tablet 20 milligrams (MG) (Furosemide) Give 1 tablet by mouth two times a day for edema related to essential (primary) hypertension.<br><br>A review of the care plan shows there are no care plans in place for hypertension, edema or the use of Lasix for these two diagnosis.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | This was confirmed with the Director of Nursing on 02/21/24 at 11:01 AM who confirmed the care plan was not correct.<br><br>d) Resident #11<br><br>Review of the current physician's orders found an order written on 4/20/23 for a Cockup brace to right wrist, every eight (8) hours as needed for comfort or support range of motion (ROM) as tolerated. There was no diagnosis for the use of the brace.<br><br>Review of the current care plan found no mention of a brace to the right wrist.<br><br>An interview, with the resident's Licensed Practical Nurse (LPN) #10 on 02/21/24 at 8:06 AM, revealed LPN #10 thought the brace was ordered by an orthopedic physician after the Resident broke her wrist. LPN #10 searched the medical record and found a consult dated 04/03/23 which states, cast removed today patient may use cockup brace as needed. Range of motion as tolerated. This order was signed on 04/06/23.<br><br>On 04/10/23 the physician wrote a new order for, Resident may use cockup brace as needed. ROM as tolerated, every shift.<br><br>A second order for the brace was written on 04/20/23.<br><br>Review of the Medication Administration Record (MAR) found the resident wore the brace from 04/10/23 through 04/20/23.<br><br>Review of the past 3 months of MAR'S for December, 2023, January 2024, and February 2024 found no indication the resident wore the brace, yet the order remained on the MAR.<br><br>On 02/21/24 at 9:00 AM, the author of the care plan, Registered Nurse (RN) #6 the Clinical Coordinator, Minimum Data Set confirmed the care plan did not mention the use of the brace. RN #6 stated she wasn't sure what the brace was for.<br><br>e) Resident #13<br><br>Resident #13 was admitted to the facility on [DATE]. On 10/17/23, a physician determined the Resident lacked capacity to make medical decisions due to a diagnosis of Dementia and his wife was appointed as his health care surrogate.<br><br>The Resident was admitted without any psychotropic medications.<br><br>On 11/05/23, Lexapro 20 milligrams (mg's) daily was ordered for a diagnosis of depression. The Resident was having difficulty adjusting to the facility. He would frequently talk of wanting to go home and would wander around the facility asking for his wife.<br><br>Record review found on 01/04/24, the Resident's physician prescribed a new antipsychotic medication Seroquel, oral Tablet, 25 milligrams (mg's) 1 tablet by mouth two (2) times a day for a diagnosis of depression. The Resident was already receiving Lexapro, an antidepressant for a diagnosis of depression.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the current care plan found no mention of the Resident receiving Seroquel, an antipsychotic medication, for the use of depression.<br><br>In addition the Resident was diagnosed with Dementia and the care plan did not address a diagnosis of dementia utilizing individualized, non-pharmacological approaches to care with purposeful and meaningful activities to address the resident's well-being.<br><br>Interviews with the Resident's caregivers found the Resident exhibited the following signs of distress:<br><br>On 02/21/24 at 11:58 AM, Licensed Practical Nurse (LPN) #10 said the Resident seems more anxious in the evenings. He gets mad when we have to tell him he can't walk alone without our help. He will ball up his fist but he doesn't hit you. Then he will cry and get upset because he threatened to hit us. He says he's sorry. He misses his wife and gets upset because he can't go home. He will say, I have to get home, I can walk home. He hasn't left the facility. I think the Lexapro really helped him. He can be distracted by watching something on the computer. LPN #10 said the resident likes to be out by the nurses station in the evenings. He likes to stay up late and be around other people. We use a geri-chair so he can prop his feet up and sometimes he will doze off and on.<br><br>On 02/21/24 at 12:05 PM, Registered Nurse (RN) #36 stated, sometimes I call his house when he wants his wife. A step daughter will talk to him. She says his wife is too sick to talk. Watching something on the computer or youtube helps distract him. I have tried food and drinks but that doesn't help at all. A couple of months ago he was on an antibiotic for a urinary tract infection and he had more problems then. He wants to go home and he misses his wife.<br><br>On 02/21/24 at 12:35 PM, the Residents nurse aide (NA) #3 said he gets upset when family visits. He begs them to take him home, says please don't leave me here I have to get home to my wife. He also gets upset because he can't walk alone anymore. I use coffee and snacks to distract him. He also likes to watch shows about horses and rodeo shows. We turn on youtube for him and he likes to sit here across from the nurses station and watch horse shows. He has never hit me or anyone else that I know about. He really likes to talk about the days when he delivered milk. That was what he worked at and he can really talk about work.<br><br>02/21/24 at 12:40 the activity aide #39 said the Resident likes to watch television and shows on you tube. She said he also likes to listen to his faith based programs on the internet. She said members from his congregation visited and told her how to access the religious programs on line. She said this seems to calm him, he just wants to go home at times. He misses his wife. His wife is sick herself and can't visit often.<br><br>All the above staff denied the Resident had any conflict with any other residents at the facility.<br><br>Examples of progress notes written by licensed nursing staff indicated the following concerns with the Resident's psychosocial well being:<br><br>11/1/23 at 4:56 PM<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Note Text: (Resident) has made multiple remarks about wanting to go home. He has been looking for a way out. Resident wanders around the facility asking for his wife and when will he be able to go home. New order for Safe Guard bracelet to be applied to his right ankle. Bracelet applied with no problems noted.<br><br>11/4/23 at 3:27 AM<br><br>Note Text: (Resident) has been pacing on occasion this shift. Very forgetful with short term memory. (Resident) has asked for his wife several times and is redirected by staff as needed.<br><br>11/5/2023 at 10:40 AM<br><br>Note Text: (Resident) up ambulating in halls with his walker and looking for his wife. Tearful @ (at) times. (Resident) doesn't understand why his wife is not here now. Appetite has been poor, although he's drinking well.<br><br>11/5/2023 at 2:21 PM<br><br>Note Text: (Resident) continues to pace the halls and asking staff if his wife has been in and where she is at. Tearful at times. Staff try to redirect him and use distraction without success. Resident has a poor appetite and isn't sleeping well. Wife was called and stated to CNA (Certified Nurse Aide) that she wasn't well and that she wanted the staff to try to distract him. The wife stated that it upset her when he called because all he wanted to talk about was coming home.<br><br>On 02/21/24 at 2:24 PM, the Director of Nursing reviewed the resident's progress notes with the surveyor. The DON states, we really don't have any behaviors documented to add the Seroquel. I think I'll call the physician to address this and maybe he will discontinue the medication. The DON confirmed the physician and the nurse practitioner never addressed the use of Seroquel in their notes. The DON said this happens frequently, those nurses want to give medications for behaviors but they never document anything in their notes. This is an ongoing problem.<br><br>At 8:00 AM on 2/22/24, Registered Nurse (RN) #6 the Clinical Coordinator, Minimum Data Set confirmed the resident had never been care planned for the use of Seroquel or his diagnosis of Dementia. There was no mention of any behaviors/signs of distress in the care plan and no interventions as to how to address the Residents verbalization of missing his wife and wanting to go home.<br><br>f) Resident #20<br><br>Review of Resident #20's comprehensive care plan showed the following focus, [Resident's name] is at risk for wt (weight) loss, dehydration, due to NPO (nothing by mouth) status with peg (percutaneous endoscopic gastrostomy) tube placement.<br><br>An intervention was Check for residual prior to feedings and record. The residual is the volume of fluid remaining in the resident's stomach. Nurses withdraw this fluid by attaching a large syringe to the PEG tube and pulling back on the plunger. This is done to make sure the stomach is emptying properly and to prevent complications such as vomiting and aspiration.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #20 was receiving a tube feeding infusion for 12 hours one (1) time a day. The medical records contained no documentation that tube feeding residuals were being checked before the feeding was started.<br><br>During an interview on 02/21/24 at 10:03 AM, Clinical Coordinator #6 stated residuals had not been documented in the resident's medical records prior to initiating daily tube feedings.<br><br>No further information was provided through the completion of the survey process.<br><br>g) Resident #3<br><br>Review of Resident #3's comprehensive care plan showed the following focus, Psychotropic meds: use of Buspar for anxiety.<br><br>The interventions were as follows:<br><br>- Consult with pharmacy. Physician to consider dosage reduction when clinically appropriate, per protocol.<br><br>- Discuss with physician, family re: ongoing need for use of medication.<br><br>- Monitor/record occurrence for target behavior symptoms (tearfulness) and document per facility protocol.<br><br>- Monitor/record/report to physician prn [as needed] side effects and adverse reactions of psychoactive medications: unsteady gait, frequent falls, refusal to eat, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting.<br><br>Resident #3's comprehensive care plan contained no other focus related to the resident's anxiety. The comprehensive care plan did not include any information regarding situations that caused or exacerbated the resident's anxiety. The comprehensive care plan did not include any non-pharmacological interventions to attempt to relieve the resident's anxiety.<br><br>During an interview on 02/22/24 at 8:29 AM, Licensed Practical Nurse [LPN] #10 stated Resident #3 is anxious about her health status and exertional activities, such as showers, can also cause her to be anxious. LPN #10 stated non-pharmacological interventions for anxiety that help Resident #3 are talking with her, reassuring her about her medical conditions, and encouraging her to attend activities that she enjoys, such as Bingo.<br><br>During an interview on 2/22/24 at 8:35 AM, Clinical Coordinator #6 confirmed Resident #3's comprehensive care plan did not contain any information regarding triggers for the resident's anxiety or any non-pharmacological interventions to relieve the resident's anxiety.<br><br>No further information was provided through the completion of the survey process.<br><br>45171 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>22140<br><br>Based on record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. The facility failed to document vital signs when medications were held for Resident #13 and Resident #7. The facility failed to follow the physician's orders for side rails for Resident #11. This deficient practice had the potential to affect three (3) of 14 residents reviewed in the long-term care survey sample. Resident identifiers: #13, #7, #11. Facility census: 27.<br><br>Findings included:<br><br>a) Resident #13<br><br>Review of Resident #13's physician's orders showed the following order written on 10/06/23, Lisinopril, oral tablet, 5 mg [milligrams], one time a day related to essential (primary) hypertension. Hold for SBP [systolic blood pressure] < [less than] 100.<br><br>On 12/13/24 at 8:00 AM, Resident #13's Medication Administration Record (MAR) was marked 5 for Lisinopril administration. According to the MAR code, 5 means hold/see nurse notes. However, there was no nurse note in the progress notes. The area on the MAR to record the resident's blood pressure was marked with an X. The blood pressure was not recorded in the vital signs summary in the resident's medical record.<br><br>Resident #13 also had the following physician's order written on 10/06/23, Metoprolol, give 25 mg by mouth one time a day related to essential (primary) hypertension. Hold for SBP <100. Hold for pulse <60.<br><br>On 12/13/23 at 8:00 AM and on 02/19/24 at 8:00 AM, Resident #13's Medication Administration Records were marked 4 for Metoprolol administration. According to the MAR code, 4 means pulse below 60/min [60 beats per minute]. The areas on the MARs to record the resident's pulse rate were marked with an X The pulse rates were not recorded in the vital signs summary in the resident's medical record.<br><br>During an interview on 02/21/24 at 1:54 PM, Clinical Coordinator #6 confirmed Resident #13's blood pressure and pulse rates had not been documented when medication was held.<br><br>No further information was provided through the completion of the survey process.<br><br>39043<br><br>b) Resident #7<br><br>On 02/21/24 at 09:23 AM, record review shows Resident #7 has a Physicians order for a blood pressure medication with parameters as to when to hold the medication.<br><br>The order reads:<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hampshire Memorial Hospital | 363 Sunrise Blvd<br>Romney, WV 26757 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Metoprolol Tartrate Tablet 25 MG<br><br>Give 0.5 tablet by mouth two times a day for HTN (hypertension) give 1/2 tab to equal 12.5 milligram (mg) hold if SBP (systolic blood pressure) <100 or HR <60<br><br>A review of the Medication Administration Record (MAR) for 02/01/24 through 02/19/24 shows the medication was held fourteen (14) times. Eight (8) of the fourteen (14) times do not have a documented reason for with holding the medication (heart rate or systolic blood pressure reading).<br><br>02/01/24 AM held for a documented heart rate of 52<br><br>02/01/24 PM held with no documentation of heart rate or blood pressure<br><br>02/02/24 PM held with no documentation of heart rate or blood pressure<br><br>02/03/24 PM held for a documented heart rate of 55<br><br>02/05/24 AM held for a documented heart rate of 57<br><br>02/06/24 PM held with no documentation of heart rate or blood pressure<br><br>02/07/24 PM held with no documentation of heart rate or blood pressure<br><br>02/10/24 AM held for a documented heart rate of 53<br><br>02/11/24 AM held for a documented heart rate of 54<br><br>02/11/24 PM held with no documentation of heart rate or blood pressure<br><br>02/13/24 PM held with no documentation of heart rate or blood pressure<br><br>02/14/24 AM held with no documentation of heart rate or blood pressure<br><br>02/15/24 AM held for a documented heart rate of 54<br><br>02/19/24 PM held with no documentation of heart rate or blood pressure<br><br>This was confirmed with the Director of Nursing on 02/21/24 at 12:15 PM.<br><br>c) Resident #11<br><br>Review of the facility's resident matrix (802) on 02/19/24 PM shows the resident has a restraint.<br><br>Observation on 02/19/24 at 3:01 PM, found Resident #11 was in bed resting. Side rails were present on the right and left side of the bed.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the current physician's orders on 02/20/24 found an order for: Side Rails 1/4 rail to the right side of the bed to assist with turning/positioning while in bed. There was no order for a side rail to be in place on the left side of the bed.<br><br>On 02/20/24 at 4:13 PM, record review found a Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/30/23 which shows the side rails were coded as a restraint.<br><br>On 1/30/24 a correction MDS was submitted noting the Resident was incorrectly coded as having a restraint.<br><br>On 02/20/24 at 4:30 PM, observation with Registered Nurse (RN) #50 the staff development coordinator found Resident #11 in bed with both the right and left side quarter rails up on the bed. RN #50 asked the Resident if she used the side rails for turning and repositioning. Resident #11 replied, yes and side she wanted both side rails up on her bed. RN #50 reviewed the current physician's orders for only a quarter rail on the right side to be in place. RN #50 said, we will call the physician and get a new order.<br><br>Observation on 02/21/24 at 9:47 AM, with Licensed Practical Nurse (LPN) #10 found the resident was again in bed with both the right and left quarter rails in place. Review of the new order, dated 02/20/24, found an order was written for a quarter rail to the right side of the bed to assist in turning and repositioning. The new order dated 02/20/24 is as follows: Side Rails 2/4 to the right side of the bed to assist with turning/positioning while in bed. LPN #10 said, I don't know why that order was written, Resident #11 does use both rails to turn and reposition. I'm getting this fixed right now.<br><br>45171 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043<br><br>45171<br><br>Based on record review and staff interview the facility failed to assess, monitor and provide timely interventions for residents experiencing weight loss. This was true for two (2) of three (3) residents reviewed for nutrition. Resident Identifiers: #17 and #20. Facility Census: #27<br><br>Findings included:<br><br>a) Policy Review<br><br>On 02/21/24 at 09:20 AM review of the facility Policy for Resident Weights, revised 05/2023 found the following:<br><br>Purpose: . that residents maintain acceptable parameters of nutritional status, such as body weight. Weights can be a useful indicator of nutritional status when evaluated within the context of the individuals personal history and overall conditions. A standard protocol is needed to reduce errors.<br><br>Policy: A. Nursing facility residents will be weighed on admission and weekly (at minimum) for the next consecutive 4 weeks. Thereafter, they will be weighed monthly unless otherwise ordered to help identify any trends such as insidious weight loss.<br><br>B. Weight loss can be avoidable (resident did not maintain a good nutritional status and the facility did not address it), or unavoidable (resident did not maintain good nutritional status due to clinical condition<br><br>C. Weighing may also be pertinent if there is significant change in condition, food intake has declined or there is other evidence of altered nutritional status or a fluid/electrolyte imbalance<br><br>Procedure: . B. Residents will be reweighed for all weight changes of plus or minus 5 pounds, per physician order or at the request of the registered dietician/nurse.<br><br>C. Residents who experience a weight loss or weight gain of more than 5% in a month are to be evaluated by the registered dietitian<br><br>b) Resident #17<br><br>On 02/20/24 at 02:10 PM record review for Resident #17 shows the following:<br><br>Medical history:<br><br>Urinary tract infection<br><br>Idiopathic peripheral autonomic neuropathy<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Heart failure<br><br>Weakness<br><br>Other specified symptoms and signs involving the circulatory and respiratory systems.<br><br>Other pulmonary embolism<br><br>Pneumonia<br><br>Edema<br><br>Hypokalemia<br><br>Hypotension<br><br>Vitamin B12 deficiency anemia due to intrinsic factor deficiency<br><br>Resident #17 was admitted on [DATE] weighing 161 pounds<br><br>Resident #17 was sent out to the hospital on 12/12/23 and returned on 12/17/23 with no re admission weight obtained.<br><br>On 12/01/23 Resident #17 weighed 171.5 pounds, a weight gain of 10 pounds, (prior to hospitalization on [DATE])<br><br>On 01/01/24 Resident #17 weighed 153.4 pounds, a weight loss of 18.1 pounds with no re-weigh. This represents a 10.55% weight loss.<br><br>On 02/08/24 Resident #17 weighed 138 pounds, a weight loss of 15.4 pounds with no re-weigh. This represents a 10.04% weight loss.<br><br>Resident #17 lost 19.53% of his weight from 12/01/23 until 02/08/24 with no new interventions in place.<br><br>Further record review shows Resident #17 is on a no added salt diet, soft and bite sized texture, thin liquids consistency. Heart Healthy. There are no supplements ordered.<br><br>The care plan in place has interventions to refer to Registered Dietitian as needed and Resident to be weighed weekly X 4 weeks to monitor weight loss or gain and then as needed.<br><br>Review of Nutrition Progress notes finds two progress notes, one dated 10/12/23 and the other 01/08/24. There is one Nutritional Assessment completed on 10/09/23.<br><br>There are no nutritional notes or assessments completed since the time the weight loss began on 12/01/23. There are no progress notes indicating the Physician has been notified.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The above information was confirmed with the Director of Nursing on 02/21/24 at 09:45 AM at which time she stated Resident #17 has a status of Do Not Resuscitate, comfort focused treatments: maximize comfort through symptom management; allow natural death. The DON added, the Resident should not have been weighted; however, the DON was unable to find an order directing no weights. The DON said the Resident's daughter was a nurse practitioner who visits frequently and she has no issues with the Resident's care at the facility. The DON said since the staff did weigh the Resident he should have been reweighted on 1/1/24 and 2/8/24 after the 5 pound weight fluctuation.<br><br>She agreed that the Physician and Dietitian should have been notified and assessments and/or progress notes maintained concerning the nutritional status of the resident in order to provide professional standards of practice for this resident experiencing weight loss.<br><br>c) Resident #20<br><br>Review of Resident #20's medical records showed a Nutritional Assessment had been performed by the Registered Dietician (RD) on 05/30/23. The resident weighed 137.6 pounds (lbs.). At that time, the resident was receiving tube feeding boluses, 237 milliliters (ml), three (3) times a day, via a percutaneous endoscopic gastrostomy (PEG) tube. The resident received no nutrition by mouth. The RD recommended the resident's tube feeding be changed to infusions to increase the resident's tolerance to feeding. An order was written on 06/05/23 for Glucerna 55 ml an hour for 12 hours via PEG tube daily.<br><br>Review of Resident #20's weights summary in the electronic health record showed the resident weighed 129. 6 lbs. on 09/01/23. The weights summary identified the resident had lost 10% of weight in six (6) months when compared to the resident's weight of 144.6 lbs. on 04/05/23. There was no indication in the medical records that a nutritional assessment had been performed or that any interventions for weight loss had been implemented.<br><br>Resident #20 weighed 130.1 lbs. on 10/02/23 and 121.2 lbs. on 11/08/23. Although the weights summary did not identify this change as significant weight loss, the resident had lost 7% of weight in one (1) month. There was no indication in the medical records that a nutritional assessment had been performed or that any interventions for weight loss had been implemented. There was no documentation the resident had been reweighed as specified in the facility's policy.<br><br>The resident continued to lose weight, weighing 116 lbs. on 12/10/23 and 113 lbs. on 01/10/24. On 01/17/24, the RD performed a Nutritional Assessment. The RD recommended the resident's tube feeding amount be increased. On 01/17/24, an order was written for Glucerna 75 ml an hour for 12 hours via PEG tube.<br><br>On 02/21/24 at 1:55 PM, Clinical Coordinator #6 confirmed Resident #20's medical records contained no documentation that the resident's weight loss had been addressed prior to 01/17/24. Clinical Coordinator #6 confirmed there was no documentation that the RD had been consulted when the resident first experienced significant weight loss on 09/01/23 or that any interventions for weight loss had been implemented. Additionally, Clinical Coordination #6 confirmed there was no documentation the resident had been reweighed as specified in the facility's policy.<br><br>No further information was provided through the completion of the survey process. |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.<br><br>39043<br><br>Based on record review and staff interview, the facility failed to ensure residents' care after significant weight loss was supervised by the physician. This deficient practice had the potential to affect two (2) of three (3) residents reviewed for the care area of nutrition. Resident identifier: #20, #1. Facility census: 27.<br><br>Findings included:<br><br>a) Resident #20<br><br>Review of Resident #20's weights summary in the electronic health record showed the resident weighed 129. 6 pounds (lbs.) on 09/01/23. The weights summary identified the resident had lost 10% of weight in six (6) months when compared to the resident's weight of 144.6 lbs. on 04/05/23. The resident was receiving feeding via a percutaneous endoscopic gastrostomy (PEG) tube. The resident received no nutrition by mouth. There was no indication in the medical records that the physician had been notified of the resident's weight loss.<br><br>Resident #20 weighed 130.1 lbs. on 10/02/23 and 121.2 lbs. on 11/08/23. Although the weights summary did not identify this change as significant weight loss, the resident had lost 7% of weight in one (1) month. Again, there was no indication in the medical records that the physician had been notified of the resident's weight loss.<br><br>The resident continued to lose weight, weighing 116 lbs. on 12/10/23 and 113 lbs. on 01/10/24. On 01/17/24, the physician was notified of the resident's weight loss and a physician's order to increase the resident's tube feeding infusion amount was written.<br><br>On 02/21/24 at 1:55 PM, Clinical Coordinator #6 confirmed Resident #20's medical records contained no documentation that the physician had been notified of the resident's weight loss prior to 01/17/24.<br><br>45171<br><br>b) Resident #1<br><br>On 02/20/24 at 9:35 AM record review shows Resident #1 had a significant weight loss of greater than 5% in one (1) month two (2) times in five (5) months.<br><br>According to the facility Resident Weights Policy revised 05/2023 .Procedure: B. Residents will be reweighed for all weight changes of plus or minus 5 pounds, per physician order .<br><br>Documented weights are as follows with no re-weights when there was a plus or minus of five (5) pounds.<br><br>2/8/2024 16:09 203.8 Lbs Mechanical Lift<br><br>(continued on next page) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1/23/2024 16:23 203.8 Lbs Sitting<br><br>12/1/2023 09:47 215.4 Lbs Bath<br><br>11/2/2023 16:51 217.5 Lbs Bath<br><br>10/1/2023 15:57 220.3 Lbs Bath<br><br>9/29/2023 11:14 221.5 Lbs Bath<br><br>9/22/2023 10:26 224.6 Lbs Mechanical Lift<br><br>9/15/2023 14:42 222.8 Lbs Mechanical Lift<br><br>9/8/2023 09:26 219.4 Lbs Mechanical Lift<br><br>9/7/2023 09:53 220.0 Lbs Bath (Manual)<br><br>8/4/2023 12:11 233.5 Lbs Mechanical Lift (Manual)<br><br>Record review shows Resident #1 had the following weights recorded:<br><br>08/04/23 233.5 pounds and on 09/07/23 220 pounds for a weight loss of -5.78% and<br><br>12/01/23 215.4 pounds and on 01/23/24 203.8 pounds for a weight loss of -5.85%<br><br>This reflects a 12.72% weight loss from 08/04/23 until 01/23/24.<br><br>According to record review, the Physician was not informed of residents' weight loss to evaluate and address medical and nutritional issues. The Physician was not notified of the weight loss on 09/07/23 and the weight loss on 01/23/24 was not reported to the Physician until 02/18/24.<br><br>A significant weight loss is described as:<br><br>5% change in weight in 1 month (30 days)<br><br>7.5% change in weight in 3 months (90 days)<br><br>10% change in weight in 6 months (180 days)<br><br>This was confirmed with the Director of Nursing on 02/21/24 at 2:10 PM. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>22140<br><br>Based on observation and staff interview, the facility failed to ensure the daily staff posting included the actual amount of hours worked per each shift for Nurse Aides, Licensed Practical Nurses and Registered Nurses. This had the potential to affect all residents at the facility. Facility census: 27.<br><br>Findings included:<br><br>a) Staff posting<br><br>Observation of the staff posting for 02/19/24 found the facility failed to record the actual number of hours worked per each shift by Nurse Aides, Licensed Practical Nurses and Registered Nurses.<br><br>At 1:43 PM on 02/20/24, the Director Of Nursing (DON) said she didn't realize the hours had to be recorded for each shift, she thought the hours just needed to be recorded for the day. Review of the daily posted staffing sheets with the DON from 02/06/24 until present found the facility only recorded the hours worked by each discipline for the day, not for each shift. |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22140<br><br>Based on record review and staff interview the facility failed to ensure a resident who is diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. The facility failed to identify and address the needs of a resident diagnosed with dementia and develop a person-centered care plan that included individual non-pharmacological approaches to care using meaningful activities to address the resident's customary routines, interests, preferences and choices to enhance the resident's well-being. This was found for one (1) of two (2) residents reviewed for dementia care. Resident identifier: #13. Facility census: 27.<br><br>Findings include:<br><br>a) Resident #13<br><br>Resident #13 was admitted to the facility on [DATE]. On 10/17/23, a physician determined the Resident lacked capacity to make medical decisions due to a diagnosis of Dementia and his wife was appointed as his health care surrogate.<br><br>The Resident was admitted to the facility without any psychotropic medications.<br><br>On 11/05/23, Lexapro 20 milligrams (mg's) daily was ordered for a diagnosis of depression. Progress notes indicated the Resident was having difficulty adjusting to the facility. He would frequently talk of wanting to go home and would wander around the facility asking for his wife.<br><br>Record review found on 01/04/24, the Resident's physician prescribed a new antipsychotic medication Seroquel, oral Tablet, 25 milligrams (mg's) 1 tablet by mouth two (2) times a day for a diagnosis of depression. The Resident was already receiving Lexapro, an antidepressant for a diagnosis of depression.<br><br>Review of the Resident's care plan found the facility did not address a diagnosis of dementia and utilizing individualized, non-pharmacological approaches to care with purposeful and meaningful activities to address the resident's well-being.<br><br>On the morning of 02/21/24 around 11:00 AM, the Resident was observed sitting across from the nurses station watching a show about a rodeo on the computer. Interaction with the Resident found he likes watching rodeo's. He said, those rodeo's are on there (pointing to the computer screen) all the time. Sometimes they go off but they come back on.<br><br>On 02/21/24 several staff members were interviewed and asked about the Resident's behaviors and how staff interact with him:<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 02/21/24 at 11:58 AM, Licensed Practical Nurse (LPN) #10 said the Resident seems more anxious in the evenings. He gets mad when we have to tell him he can't walk alone without our help. He will ball up his fist but he doesn't hit you. Then he will cry and get upset because he threatened to hit us. He says he's sorry. He misses his wife and gets upset because he can't go home. He will say, I have to get home, I can walk home. He hasn't left the facility. I think the Lexapro really helped him. He can be distracted by watching something on the computer. LPN #10 said the resident likes to be out by the nurses station in the evenings. He likes to stay up late and be around other people. We use a geri-chair so he can prop his feet up and sometimes he will doze off and on.<br><br>On 02/21/24 at 12:05 PM, Registered Nurse (RN) #36 stated, sometimes I call his house when he wants his wife. A step daughter will talk to him. She says his wife is too sick to talk. Watching something on the computer or youtube helps distract him. I have tried food and drinks but that doesn't help at all. A couple of months ago he was on an antibiotic for a urinary tract infection and he had more problems then. He wants to go home and he misses his wife.<br><br>On 02/21/24 at 12:35 PM, the Residents nurse aide (NA) #3 said he gets upset when family visits. He begs them to take him home, says please don't leave me here I have to get home to my wife. He also gets upset because he can't walk alone anymore. I use coffee and snacks to distract him. He also likes to watch shows about horses and rodeo shows. We turn on youtube for him and he likes to sit here across from the nurses station and watch horse shows. He has never hit me or anyone else that I know about. He really likes to talk about the days when he delivered milk. That was what he worked at and he can really talk about work.<br><br>02/21/24 at 12:40 the activity aide #39 said the Resident likes to watch television and shows on you tube. She said he also likes to listen to his faith based programs on the internet. She said members from his congregation visited and told her how to access the religious programs on line. She said this seems to calm him, he just wants to go home at times. He misses his wife. His wife is sick herself and can't visit often.<br><br>All the above staff denied the Resident had any conflict with any other residents at the facility and all staff confirmed the Resident just wants to go home and he misses his wife.<br><br>On 02/21/24 at 2:24 PM, the above interviews were shared with the Director of Nursing (DON.) The DON reviewed the progress notes with the surveyor and states, we really don't have any behaviors documented to add the Seroquel. I think I'll call the physician to address this and maybe he will discontinue the medication. The DON confirmed the physician and the nurse practitioner never addressed the use of Seroquel in their notes. The DON said this happens frequently, those nurses want to give medications for behaviors but they never document anything in their notes. This is an ongoing problem. The DON was unable to provide documentation of any non-pharmacological interventions implemented prior to starting Seroquel. The DON was aware the Resident frequently wants to go home and he wanders around the facility looking for a way to get home.<br><br>At 8:00 AM on 2/22/24, Registered Nurse (RN) #6 the Clinical Coordinator, Minimum Data Set along with the DON present confirmed the resident had never been care planned for a diagnosis of dementia including services to meet the Resident's needs. RN #6 confirmed the non-pharmacological interventions used by staff for distraction when the Resident is missing his wife were never care planned. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515080 | A. Building<br>B. Wing | 02/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hampshire Memorial Hospital | 363 Sunrise Blvd<br>Romney, WV 26757 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22140<br><br>Based on record review and staff interview, the facility failed to ensure each resident's drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Resident's #13, #24, #7 and #3 received psychotropic medications without adequate indication for use. Nonpharmacological interventions were not provided prior to starting the medication and the facility failed to monitor medications for side effects and efficacy. This was true for four (4) of five residents reviewed for unnecessary medications. Resident identifiers: #13, #24, #7, and #3. Facility census: 27.<br><br>Findings included:<br><br>a) Resident #13<br><br>Resident #13 was admitted to the facility on [DATE]. On 10/17/23, a physician determined the Resident lacked capacity to make medical decisions due to a diagnosis of Dementia and his wife was appointed as his health care surrogate.<br><br>The Resident was admitted without any psychotropic medications.<br><br>On 11/05/23, Lexapro 20 milligrams (mg's) daily was ordered for a diagnosis of depression. The Resident was having difficulty adjusting to the facility. He would frequently talk of wanting to go home and would wander around the facility asking for his wife.<br><br>Record review found on 01/04/24, the Resident's physician prescribed a new antipsychotic medication Seroquel, oral Tablet, 25 milligrams (mg's) 1 tablet by mouth two (2) times a day for a diagnosis of depression. The Resident was already receiving Lexapro, an antidepressant for a diagnosis of depression.<br><br>The medical record contained no documentation of any behaviors five (5) days prior to starting the antipsychotic medication, Seroquel.<br><br>The last progress note indicating any concerns with the Resident's psychosocial well being was written on 12/30/2023 at 11:02 PM.<br><br>Note text: Resident rested for short intervals throughout the evening in his bed. Resident is currently in chair awake in hallway. Talkative with staff. Talking and asking for how to get a ride home to his house. Resident became agitated at times with redirection. Resident continues to be confused as to time, place, and situation. Resident continues to have poor safety awareness. Gait continues to be unsteady. Refused snacks when offered. Fluids consumed as Resident desires. Denies any pain or discomfort when asked.<br><br>On 02/21/24 at 10:37 AM, the Director of Nursing was asked why Seroquel was started?<br><br>(continued on next page) |

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| | 515080 | A. Building<br>B. Wing | 02/22/2024 |

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| Hampshire Memorial Hospital | 363 Sunrise Blvd<br>Romney, WV 26757 |

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|---|---|
| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Again on 02/21/24 at 11:52 AM, the DON was asked about the medication and what non-pharmacological interventions were used before starting the Seroquel?<br><br>Interviews with the Resident's caregivers found the following:<br><br>On 02/21/24 at 11:58 AM, Licensed Practical Nurse (LPN) #10 said the Resident seems more anxious in the evenings. He gets mad when we have to tell him he can't walk alone without our help. He will ball up his fist but he doesn't hit you. Then he will cry and get upset because he threatened to hit us. He says he's sorry. He misses his wife and gets upset because he can't go home. He will say, I have to get home, I can walk home. He hasn't left the facility. I think the Lexapro really helped him. He can be distracted by watching something on the computer. LPN #10 said the resident likes to be out by the nurses station in the evenings. He likes to stay up late and be around other people. We use a geri-chair so he can prop his feet up and sometimes he will doze off and on.<br><br>On 02/21/24 at 12:05 PM, Registered Nurse (RN) #36 stated, sometimes I call his house when he wants his wife. A step daughter will talk to him. She says his wife is too sick to talk. Watching something on the computer or youtube helps distract him. I have tried food and drinks but that doesn't help at all. A couple of months ago he was on an antibiotic for a urinary tract infection and he had more problems then. He wants to go home and he misses his wife.<br><br>On 02/21/24 at 12:35 PM, the Residents nurse aide (NA) #3 said he gets upset when family visits. He begs them to take him home, says please don't leave me here I have to get home to my wife. He also gets upset because he can't walk alone anymore. I use coffee and snacks to distract him. He also likes to watch shows about horses and rodeo shows. We turn on youtube for him and he likes to sit here across from the nurses station and watch horse shows. He has never hit me or anyone else that I know about. He really likes to talk about the days when he delivered milk. That was what he worked at and he can really talk about work.<br><br>02/21/24 at 12:40 the activity aide #39 said the Resident likes to watch television and shows on you tube. She said he also likes to listen to his faith based programs on the internet. She said members from his congregation visited and told her how to access the religious programs on line. She said this seems to calm him, he just wants to go home at times. He misses his wife. His wife is sick herself and can't visit often.<br><br>All the above staff denied the Resident had any conflict with any other residents at the facility.<br><br>Review of the current care plan found no mention of adding Seroquel, an antipsychotic medication. The care plan addressed the resident did receive an antidepressant. The goal was for the resident to be free from discomfort or adverse reactions related to antidepressant use and he will not exhibit indicators of depression anxiety or sad mood less than daily.<br><br>The interventions included:<br><br>Reporting signs and symptoms of depression to the physician<br><br>Give antidepressants as ordered<br><br>Consult the pharmacist<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | There was no indication of any specific behaviors exhibited by the resident on the care plan or any interventions to use if the resident exhibited any behaviors. The care plan did not list any side effects of the medication.<br><br>On 02/21/24 at 2:24 PM, the Director of Nursing reviewed the resident's progress notes with the surveyor. The DON states, we really don't have any behaviors documented to add the Seroquel. I think I'll call the physician to address this and maybe he will discontinue the medication. The DON confirmed the physician and the nurse practitioner never addressed the use of Seroquel in their notes. The DON said this happens frequently, those nurses want to give medications for behaviors but they never document anything in their notes. This is an ongoing problem. The DON was unable to provide documentation of any non-pharmacological interventions implemented prior to starting Seroquel. In addition the DON confirmed the facility was not monitoring for any side effects associated with the use of Seroquel.<br><br>At 8:00 AM on 2/22/24, Registered Nurse (RN) #6 the Clinical Coordinator, Minimum Data Set confirmed the resident had never been care planned for the use of Seroquel including any behaviors exhibited by the Resident to warrent the use of an antipsychotic.<br><br>b) Resident #24<br><br>On 02/20/24 at 01:50 PM, record review shows Resident #24 has a medical diagnosis of neurocognitive disorder with Lewy Bodies, auditory hallucinations, anxiety disorder, and unspecified hallucinations.<br><br>This resident has current Physician orders for:<br><br>Seroquel Oral Tablet 50 milligrams (MG) (Quetiapine Fumarate)<br><br>Give 1 tablet by mouth two times (BID) a day for behaviors with hallucinations related to auditory hallucinations<br><br>and<br><br>Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium)<br><br>Give 4 capsule by mouth two times a day for behaviors with hallucinations related to neurocognitive disorder with Lewy Bodies (Give 4 125 mg capsules to equal 500 mg BID)<br><br>Upon review of the orders, care plan and progress notes for Resident #24, there is no documentation to monitor side-effects of the anti-psychotropic medication.<br><br>According to regulation S483.45(e) Psychotropic Drugs:<br><br>.Anticholinergic side effect is an effect of a medication that opposes or inhibits the activity of the parasympathetic (cholinergic) nervous system to the point of causing symptoms such as dry mouth, blurred vision, tachycardia, urinary retention, constipation, confusion, delirium, hallucinations, flushing, and increased blood pressure. Types of medications that may produce anticholinergic side effects include:<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Antihistamines, antidepressants, anti-psychotics, antiemetics, muscle relaxants; and<br><br>Certain medications used to treat cardiovascular conditions, Parkinson's disease, urinary incontinence, gastrointestinal issues and vertigo .<br><br>This was confirmed with the Director of Nursing on 02/21/24 at 11:01 AM who agreed that there are no monitoring systems in effect for the side effects of anti-psychotic medications.<br><br>c) Resident #7<br><br>On 02/20/24 at 04:00 PM, record review shows resident #7 has a diagnosis of generalized anxiety disorder and recurrent major depressive disorder and is prescribed Zoloft Oral Tablet 150 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to major depressive disorder, recurrent and Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug*Give 1 tablet by mouth every 8 hours as needed for anxiousness related to end stage process for 14 Days.<br><br>Upon review of the care plan and progress notes, there are no systems or documentation in place to monitor side effects of the antidepressant, nor are there any behaviors monitored or documented.<br><br>This was confirmed with the Director of Nursing on 02/21/24 at 03:10 PM who agreed that there were no behavioral or side effect monitoring systems in place for this resident.<br><br>39043<br><br>d) Resident #3<br><br>The facility's policy titled Psychotropic Drugs with effective date 07/2022 stated, Nursing and Pharmacy will monitor and document usage through daily (nursing) and monthly (pharmacy) review of individual patient regimes.<br><br>Review of Resident #3's medical records showed the resident had a diagnosis of anxiety disorder. On 11/03/23, the resident was prescribed Buspar (buspirone) 5 mg, twice a day, for anxiety.<br><br>The resident's comprehensive care plan contained the focus, Psychotropic meds: use of Buspar for anxiety. An intervention was the following, Monitor/record occurrence of targeted behavior symptoms (tearfulness) and document per facility protocol.<br><br>Resident #3's medical records contained no documentation as to whether the resident was experiencing tearfulness.<br><br>During an interview on 02/21/24 at 2:40 PM, the Director of Nursing confirmed the occurrence of tearfulness episodes for Resident #3 had not been documented and the efficacy of the resident's anti-anxiety medication had not been monitored.<br><br>No further information was provided through the completion of the survey.<br><br>45171 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043<br><br>Based on observation and staff interview, the facility failed to ensure medications were stored in accordance with currently accepted professional principles of practice. This was a random opportunity for discovery that had the potential to affect more than a limited number of residents. Facility census: 27.<br><br>Findings included:<br><br>a) Expired intravenous fluids<br><br>On [DATE] at 8:30 AM, observation of the medication room was made with Registered Nurse (RN) #36 in attendance.<br><br>Two (2) of three (3) bags of intravenous fluids locked in a cart in the medication room were found to have expiration dates of [DATE]. Both of these intravenous fluids bags contained 5% dextrose and 0.45% sodium chloride.<br><br>RN #36 confirmed the two (2) bags of 5% dextrose and 0.45% sodium chloride were expired.<br><br>No further information was provided through the completion of the survey.<br><br>b) Narcotic emergency box<br><br>During the medication room observation on [DATE] at 8:30 AM, Registered Nurse (RN) #36 opened a locked cabinet. The locked cabinet contained a suitcase-shaped box sealed with zip ties. RN #36 stated the box was a narcotic emergency box, and stated the box contained the items listed on a paper affixed to the box. The box was not affixed to the cabinet and could be removed by anyone who obtained the keys to unlock the medication room and the cabinet containing the narcotic emergency box.<br><br>According to the label, the box contained as follows: Duragesic (Fentanyl) patches, Morphine for injection, rectal insertion, and oral ingestion, oral methadone, oral hydrocodone and acetaminophen, oral hydromorphone, and oral oxycodone.<br><br>During an interview on [DATE] at 8:44 AM, the Director of Nursing confirmed the narcotic emergency box was not affixed to the cabinet. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>45171<br><br>Based on staff interview and record review the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service when one (1) of eight (8) dietary staff members did not have their Food Handlers/SafeServ certification. Facility Identifier: Facility Facility Census: 27<br><br>Findings Included:<br><br>a) Facility<br><br>On 02/19/24 at 01:17 PM, the Dietary Manager #49 failed to provide the required Food Handler or Safe/Serve certification for one (1) of the eight (8) staff members on the dietary staff.<br><br>On 02/20/24 at 09:30 AM a telephone interview with the County Sanitarian at the Hampshire County Health Department states they must have the Food Handlers or Safe/Serve certification in order to work in any food area in this county.<br><br>This was confirmed with the Director of Nursing on 02/20/24 at 02:45 PM. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>39043<br><br>Based on observation, record review, resident interview, and staff interview, the facility failed to ensure dietary preferences were honored. Two (2) of six (6) residents reviewed for the care area of food did not receive the food items indicated on their tray ticket. Resident identifiers: #3, #10. Facility census: 27.<br><br>Findings included:<br><br>a) Resident #3<br><br>On 02/19/24 at 12:15 PM, Resident #3 was observed eating in her room. Her lunch tray consisted of grilled cheese, tomato soup, and peaches. Resident #3 stated, I can't stand tomato soup. She stated the staff was going to get chicken soup for her.<br><br>Review of Resident #3's tray ticket indicated she was to receive double noodle chicken soup for that meal. Resident #3 stated she often did not receive the food items she wanted.<br><br>On 02/19/24 at 12:20 PM, Clinical Coordinator #6 confirmed Resident #3 had received tomato soup when her tray ticket indicated she was supposed to have received chicken noodle soup.<br><br>No further information was provided through the completion of the survey process.<br><br>b) Resident #10<br><br>On 02/19/24 at 12:12 PM, Resident #10 was observed eating in her room. Her lunch tray consisted of French fries and peaches. She stated her tray had just been delivered and she did not receive a sandwich. She stated the staff was going to get a sandwich for her.<br><br>Review of Resident #10's tray ticket indicated she was supposed to have received a turkey salad sandwich that meal. Resident #10 stated she often did not receive the food items she wanted.<br><br>On 02/19/24 at 12:20 PM, Clinical Coordinator #6 confirmed Resident #10 had not received a sandwich for lunch when her meal tray was delivered.<br><br>No further information was provided through the completion of the survey process. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>45171<br><br>Based on record review and staff interview the facility failed to ensure complete and accurate medical records were available pertaining to Physicians Order for Scope of Treatment (POST). Resident Identifier: #17 and #27 Facility Census: #27<br><br>Findings Included:<br><br>a) Resident #17<br><br>On 02/19/24 at 03:10 PM, record review shows that the POST form for Resident #17 was not completed in its entirety. The patient information on page one (1) did not have identifying information for a middle initial, last four (4) numbers of the social security number and an address. Section D for Medically Assisted Nutrition was not addressed. Page two (2) of the POST only provided a resident name and the Medical Power of Attorney name. The Primary Care Provider Name or telephone number was provided.<br><br>This was confirmed with the Director of Nursing on 02/20/24 at 10:40 AM, who agreed that Section D should have been addressed and Resident identification information on page one (1) should be completed in its entirety.<br><br>b) Resident #27<br><br>On 02/19/24 at 03:15 PM, record review shows that the POST form for Resident #27 was not completed in its entirety. Page two (2) of the POST was blank.<br><br>This was confirmed with the Director of Nursing on 02/20/24 at 10:40 AM, who agreed that at a minimum it should include the residents name, Medical Power of Attorney and Primary Care provider name and telephone number. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043<br><br>Based on record review and staff interview, the facility failed to identify and correct quality deficiencies of which it should have been aware. The facility's Quality Assessment and Assurance Committee failed to identify and correct deficiencies regarding psychotropic medications. This deficient practice had the potential to affect four (4) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifiers: #13, #24, #7, #3. Facility census: 27.<br><br>Findings included:<br><br>a) Quality Assessment and Assurance (QAA) Committee Interview<br><br>During an interview on 02/22/24 at 9:20 AM, the Director of Nursing (DON) stated the QAA Committee had not known about deficiencies related to prescribing and monitoring psychotropic medications before the survey began. The DON stated the committee had not been aware of antipsychotic medication being prescribed without adequate documented indications. The DON stated the committee was unaware of the failure to address non-pharmacological interventions prior to starting psychotropic medications. The DON also stated the QAA Committee was not aware of the failure to monitor for medication side-effects and for medication efficacy. The DON stated the facility would begin to work on issues related to psychotropic medications now that the issues had been identified during the survey process.<br><br>The following are examples of the QAA committees failure to monitor psychotropic medications:<br><br>b) Resident #13<br><br>Resident #13 was admitted to the facility on [DATE]. On 10/17/23, a physician determined the Resident lacked capacity to make medical decisions due to a diagnosis of Dementia and his wife was appointed as his health care surrogate.<br><br>The Resident was admitted without any psychotropic medications.<br><br>On 11/05/23, Lexapro 20 milligrams (mg's) daily was ordered for a diagnosis of depression. The Resident was having difficulty adjusting to the facility. He would frequently talk of wanting to go home and would wander around the facility asking for his wife.<br><br>Record review found on 01/04/24, the Resident's physician prescribed a new antipsychotic medication Seroquel, oral Tablet, 25 milligrams (mg's) 1 tablet by mouth two (2) times a day for a diagnosis of depression. The Resident was already receiving Lexapro, an antidepressant for a diagnosis of depression.<br><br>The medical record contained no documentation of any behaviors five (5) days prior to starting the antipsychotic medication, Seroquel.<br><br>The last progress note indicating any concerns with the Resident's psychosocial well being was written on 12/30/2023 at 11:02 PM.<br><br>(continued on next page) |

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| | 515080 | A. Building<br>B. Wing | 02/22/2024 |

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| Hampshire Memorial Hospital | 363 Sunrise Blvd<br>Romney, WV 26757 |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Note text: Resident rested for short intervals throughout the evening in his bed. Resident is currently in chair awake in hallway. Talkative with staff. Talking and asking for how to get a ride home to his house. Resident became agitated at times with redirection. Resident continues to be confused as to time, place, and situation. Resident continues to have poor safety awareness. Gait continues to be unsteady. Refused snacks when offered. Fluids consumed as Resident desires. Denies any pain or discomfort when asked.<br><br>On 02/21/24 at 10:37 AM, the Director of Nursing was asked why Seroquel was started?<br><br>Again on 02/21/24 at 11:52 AM, the DON was asked about the medication and what non-pharmacological interventions were used before starting the Seroquel?<br><br>Interviews with the Resident's caregivers found the following:<br><br>On 02/21/24 at 11:58 AM, Licensed Practical Nurse (LPN) #10 said the Resident seems more anxious in the evenings. He gets mad when we have to tell him he can't walk alone without our help. He will ball up his fist but he doesn't hit you. Then he will cry and get upset because he threatened to hit us. He says he's sorry. He misses his wife and gets upset because he can't go home. He will say, I have to get home, I can walk home. He hasn't left the facility. I think the Lexapro really helped him. He can be distracted by watching something on the computer. LPN #10 said the resident likes to be out by the nurses station in the evenings. He likes to stay up late and be around other people. We use a geri-chair so he can prop his feet up and sometimes he will doze off and on.<br><br>On 02/21/24 at 12:05 PM, Registered Nurse (RN) #36 stated, sometimes I call his house when he wants his wife. A step daughter will talk to him. She says his wife is too sick to talk. Watching something on the computer or youtube helps distract him. I have tried food and drinks but that doesn't help at all. A couple of months ago he was on an antibiotic for a urinary tract infection and he had more problems then. He wants to go home and he misses his wife.<br><br>On 02/21/24 at 12:35 PM, the Residents nurse aide (NA) #3 said he gets upset when family visits. He begs them to take him home, says please don't leave me here I have to get home to my wife. He also gets upset because he can't walk alone anymore. I use coffee and snacks to distract him. He also likes to watch shows about horses and rodeo shows. We turn on youtube for him and he likes to sit here across from the nurses station and watch horse shows. He has never hit me or anyone else that I know about. He really likes to talk about the days when he delivered milk. That was what he worked at and he can really talk about work.<br><br>02/21/24 at 12:40 the activity aide #39 said the Resident likes to watch television and shows on you tube. She said he also likes to listen to his faith based programs on the internet. She said members from his congregation visited and told her how to access the religious programs on line. She said this seems to calm him, he just wants to go home at times. He misses his wife. His wife is sick herself and can't visit often.<br><br>All the above staff denied the Resident had any conflict with any other residents at the facility.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the current care plan found no mention of adding Seroquel, an antipsychotic medication. The care plan addressed the resident did receive an antidepressant. The goal was for the resident to be free from discomfort or adverse reactions related to antidepressant use and he will not exhibit indicators of depression anxiety or sad mood less than daily.<br><br>The interventions included:<br><br>Reporting signs and symptoms of depression to the physician<br><br>Give antidepressants as ordered<br><br>Consult the pharmacist<br><br>There was no indication of any specific behaviors exhibited by the resident on the care plan or any interventions to use if the resident exhibited any behaviors. The care plan did not list any side effects of the medication.<br><br>On 02/21/24 at 2:24 PM, the Director of Nursing reviewed the resident's progress notes with the surveyor. The DON states, we really don't have any behaviors documented to add the Seroquel. I think I'll call the physician to address this and maybe he will discontinue the medication. The DON confirmed the physician and the nurse practitioner never addressed the use of Seroquel in their notes. The DON said this happens frequently, those nurses want to give medications for behaviors but they never document anything in their notes. This is an ongoing problem. The DON was unable to provide documentation of any non-pharmacological interventions implemented prior to starting Seroquel. In addition the DON confirmed the facility was not monitoring for any side effects associated with the use of Seroquel.<br><br>At 8:00 AM on 2/22/24, Registered Nurse (RN) #6 the Clinical Coordinator, Minimum Data Set confirmed the resident had never been care planned for the use of Seroquel including any behaviors exhibited by the Resident to warrent the use of an antipsychotic.<br><br>c) Resident #24<br><br>On 02/20/24 at 01:50 PM, record review shows Resident #24 has a medical diagnosis of neurocognitive disorder with Lewy Bodies, auditory hallucinations, anxiety disorder, and unspecified hallucinations.<br><br>This resident has current Physician orders for:<br><br>Seroquel Oral Tablet 50 milligrams (MG) (Quetiapine Fumarate)<br><br>Give 1 tablet by mouth two times (BID) a day for behaviors with hallucinations related to auditory hallucinations<br><br>and<br><br>Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium)<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Give 4 capsule by mouth two times a day for behaviors with hallucinations related to neurocognitive disorder with Lewy Bodies (Give 4 125 mg capsules to equal 500 mg BID)<br><br>Upon review of the orders, care plan and progress notes for Resident #24, there is no documentation to monitor side-effects of the anti-psychotropic medication.<br><br>According to regulation S483.45(e) Psychotropic Drugs:<br><br>.Anticholinergic side effect is an effect of a medication that opposes or inhibits the activity of the parasympathetic (cholinergic) nervous system to the point of causing symptoms such as dry mouth, blurred vision, tachycardia, urinary retention, constipation, confusion, delirium, hallucinations, flushing, and increased blood pressure. Types of medications that may produce anticholinergic side effects include:<br><br>Antihistamines, antidepressants, anti-psychotics, antiemetics, muscle relaxants; and<br><br>Certain medications used to treat cardiovascular conditions, Parkinson's disease, urinary incontinence, gastrointestinal issues and vertigo .<br><br>This was confirmed with the Director of Nursing on 02/21/24 at 11:01 AM who agreed that there are no monitoring systems in effect for the side effects of anti-psychotic medications.<br><br>d) Resident #7<br><br>On 02/20/24 at 04:00 PM, record review shows resident #7 has a diagnosis of generalized anxiety disorder and recurrent major depressive disorder and is prescribed Zoloft Oral Tablet 150 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to major depressive disorder, recurrent and Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug*Give 1 tablet by mouth every 8 hours as needed for anxiousness related to end stage process for 14 Days.<br><br>Upon review of the care plan and progress notes, there are no systems or documentation in place to monitor side effects of the antidepressant, nor are there any behaviors monitored or documented.<br><br>This was confirmed with the Director of Nursing on 02/21/24 at 03:10 PM who agreed that there were no behavioral or side effect monitoring systems in place for this resident.<br><br>e) Resident #3<br><br>The facility's policy titled Psychotropic Drugs with effective date 07/2022 stated, Nursing and Pharmacy will monitor and document usage through daily (nursing) and monthly (pharmacy) review of individual patient regimes.<br><br>Review of Resident #3's medical records showed the resident had a diagnosis of anxiety disorder. On 11/03/23, the resident was prescribed Buspar (buspirone) 5 mg, twice a day, for anxiety.<br><br>The resident's comprehensive care plan contained the focus, Psychotropic meds: use of Buspar for anxiety. An intervention was the following, Monitor/record occurrence of targeted behavior symptoms (tearfulness) and document per facility protocol.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #3's medical records contained no documentation as to whether the resident was experiencing tearfulness.<br><br>During an interview on 02/21/24 at 2:40 PM, the Director of Nursing confirmed the occurrence of tearfulness episodes for Resident #3 had not been documented and the efficacy of the resident's anti-anxiety medication had not been monitored.<br><br>No further information was provided through the completion of the survey. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>39043<br><br>Based on record review and staff interview, the Quality Assessment Performance Improvement meetings did not include all required members for two (2) of four (4) meetings. This deficient practice had the potential to affect all residents residing in the facility. Facility census: 27.<br><br>Findings included:<br><br>a) Review of Quality Assessment Performance Improvement (QAPI) meeting sign-in sheets<br><br>On 02/22/24 at 9:04 AM, the Quality Assessment Performance Improvement (QAPI) meeting sign-in sheets were reviewed for the past four (4) quarters.<br><br>The sign-in sheet for 05/31/23 indicated neither the Medical Director nor a designee for the Medical Director had attended the QAPI meeting.<br><br>The sign-in sheet for 09/01/23 indicated the Medical Director, the Director of Nursing, the facility vice-president, and the Infection Preventionist had attended the meeting. The meeting was also attended by a member of the therapy/rehabilitation staff. However, another member of staff did not attend the meeting as required.<br><br>During an interview on 02/22/24 at 9:20 AM, the Director of Nursing confirmed the Medical Director had not attended the QAPI meeting on 05/31/23 and another staff member had not attended the meeting on 09/01/23.<br><br>No further information was provided through the completion of the survey. |