STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515081	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery General Hospital	401 6th Avenue Montgomery, WV 25136

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and Staff interview the facility failed to ensure residents who room together were served lunch in a dignified manner, by not surveying meals at the same time. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents residing in the facility. Resident identifier: #2, #20 Facility Census: 28 Findings include: a) An observation during lunch tray pass on the hall on 05/28/25 at 4:21 PM revealed Resident #2 was served and had half his food eaten before Resident #20 was served. The residents were served approximately 15 minutes apart. During an interview on 05/28/25 with the Director of Nursing (DON) the DON stated, He (resident #20) gets his tray later because he requires staff to assist them. Confirming Resident #20 was not served and assisted when Resident #2 was given their lunch tray.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and staff interview, the facility failed to ensure privacy and confidentially during medication administration. Facility Census: 28. Findings Include: a) Computer on the Medication Cart On 05/28/25 at 4:34 PM, an observation of the medication cart sitting in the corridor by the elevators was unlocked and the computer screen was left unlocked. Licensed Practical Nurse (LPN) #34 was sitting in the employee lounge. There was no line of sight between LPN #34 and the medication cart. LPN #34 stated, I was just getting a drink. On 05/28/25 at 4:36 PM, the Director of Nursing (DON) was notified and stated, the medication cart and the computer should be locked.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview, the facility failed to notify the Medical Power of Attorney (MPOA) in writing of the transfer to the hospital, and did not provide the bed hold policy for Resident #28. Furthermore, the facility failed to notify the MPOA in writing of the transfer to the hospital, and did not provide the bed hold policy and no notification was sent to the ombudsman for Residents #18, and #10. This failed practice was found true for (3) three of (3) three residents reviewed for hospitalizations during the Long-Term Care Survey Process. Resident identifiers #28, #18, and #10. Facility census: 28. Findings include: a) Resident #28 A record review, on 05/29/25 at 12:00 PM, revealed that Resident #28 had been transferred to the hospital on [DATE]. Further record review found no transfer/discharge notifications, or the bed hold policy was sent to the MPOA. During an interview, on 05/29/25 at 12:38 AM, The Director of Nursing (DON), stated, I cannot find the transfer form, or the bed hold policy in the chart. The DON confirmed they were not sent. b) Resident 18 On 05/27/25 at 2:03 PM, a record review was completed for Resident #18. The review found the resident had been transferred to an acute care facility for a swollen knee on 04/23/25. The transfer form, bed hold policy and Ombudsman notification was requested from the facility. On 05/29/25 at 12:38 PM, the Director of Nursing (DON) was interviewed. The DON stated, I cannot find the transfer form, bed hold policy or the ombudsman notification.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on Record review and staff interview the facility failed to provide an accurate MDS diagnosis of Parkinsonism. This was found to be true for one (1) of 15 residents whose Minimum Data Set (MDS) was reviewed during the Long Term-Care Survey Process. Resident Identifier: #23 Facility census:28 Findings include: a) Resident #23 Record review completed on 05/27/25 03:42 PM revealed the following diagnosis Parkinsonism, unspecified Further record review of a consultation record completed by a neurologist on 12/14/23 revealed the neurologist had diagnosed Resident #23 to have Parkinsonism. Review of Resident #23's MDS section I (Active Diagnoses) that was completed on 03/14/24 revealed under the Neurological section that Parkinsonism was not marked. On 05/28/25 at 03:56 PM The Director of Nursing (DON) confirmed Parkinsonism was not identified in the MDS Completed on 3/14/24.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview, the facility failed to provide an accurate Pre-admission Screening and Resident Review (PASARR) containing all diagnoses for Resident #22 and #23. Resident identifiers: #22 and #23. Facility Census: 28. Findings include: a) Resident #22 On 05/27/25 at 3:17 PM, a record review was completed for Resident #22. The review found the PASARR dated 03/09/25 did not contain three (3) diagnoses. The following diagnoses were not included: Unspecified dementia, mild with anxiety, Bipolar disorder, in partial remission, most recent episode depressed and Depression, unspecified. On 05/28/25 at 3:06 PM, an interview was held with the Social Services Director (SSD). The SSD stated, thank you for letting me know. b) Resident #23 Review of PASARR on 05/27/25 at 1:42 PM revealed Bipolar disorder, Major depressive disorder was marked on the PASARR Further record review revealed the following Diagnoses: G20.C Parkinsonism, unspecified R45.851 Suicidal ideations (History of) F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features 05/28/25 2:56 PM DON confirmed Parkinsonism was not identified in the PASARR and Major Depressive disorder was identified on the PASARR when Resident #23 had no active diagnosis for Major Depressive Disorder.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, staff interview, and resident interview the facility failed to develop or implement a care plan related to nutrition and diagnoses. This failed practice was found true for toe (2) of 15 residents whose care plan were reviewed during the Long Term-Care Survey process. Resident identifiers: #23 and #26. Facility census: 28 Findings include: a) Resident #23 On 05/27/25 at 03:42 PM the following diagnoses was reviewed in Resident #23's medical record: Parkinsonism, unspecified Suicidal ideations (History of) Not marked on PASSR Further Record review of Resident #23's care plan showed neither diagnosis was identified in the resident person-centered care plan. 05/28/25 03:56 PM DON confirmed Parkinsonism and History of Suicidal Ideations was not identified in Resident #23's care plan. b) Resident #26 On 05/27/25 at 4:34 PM, an interview was held via telephone with Resident #26's representative. The representative stated, She is not eating well .I'm concerned. She dislikes eggs. On 05/28/25 at 7:56 PM, a record review was completed for Resident #26. The review found the care plan was not implemented under the focus area of potential for altered nutrition r/t (related to) no concentrated sweets diet. An intervention for the area of altered nutrition was for the facility to assess the residents likes/dislikes and provide diet as ordered with as many of resident's desired food choices. On 05/29/25 at 9:05 AM, an interview was held with the Director of Nursing (DON). The DON was asked, Will you provide a list of food likes/dislikes? The DON stated, We don't have the food likes and dislikes .the dietary manager does that with the nursing home next door .if someone doesn't like something we usually find out over time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and staff interview, the facility failed to maintain the environment of which it had control over to remain free of accident hazards due to the medication cart being unlocked. Facility Census: 28. Findings Include: a) Medication Cart On 05/28/25 at 4:34 PM, an observation of the medication cart sitting in the corridor by the elevators was unlocked and the computer screen was left unlocked. Licensed Practical Nurse (LPN) #34 was sitting in the employee lounge. There was no line of sight between LPN #34 and the medication cart. LPN #34 stated, I was just getting a drink. On 05/28/25 at 4:36 PM, the Director of Nursing (DON) was notified and stated, The medication cart and the computer should be locked.

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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. Based on record review, resident representative interview and staff interview, the facility failed to document all meal intake percentages for Resident #26, who was identified with weight loss. This was true for one (1) of two (2) residents reviewed under the care area of nutrition. Resident identifier: #26. Facility Census: 28. Findings Include: a) Resident 26 On 05/27/25 at 4:34 PM, an interview was held via telephone with Resident #26's representative. The representative stated, She is not eating well .I'm concerned. She dislikes eggs. On 05/28/25 at 7:56 PM, a record review was completed for Resident #26. The review of meal percentages from 04/08/25 through 05/28/25 found no documentation for the following dates: --04/17/25 dinner --04/19/25 dinner --04/20/25 breakfast --04/20/25 lunch --04/20/25 dinner --04/28/25 lunch --05/06/25 dinner A further review of the resident's weights found a 5.1% of weight loss from 04/08/25 through 05/08/25. The following is a list of the resident's weights: --04/08/25 163.60 --04/10/25 162.70 --04/17/25 159.00 --04/24/25 157.40 --05/01/25 157.80 --05/04/25 156.80 --05/08/25 155.30 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No documentation from the facility physician or the registered dietician was found. On 05/29/25 at 9:05 AM, the Director of Nursing (DON) was notified of the weight loss of 5.1%. The DON stated, We don't have the food likes and dislikes .the dietary manager does that with the nursing home next door .if someone doesn't like something we usually find out over time.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, record review and staff interview, the facility failed to use appropriate alternatives prior to installing bed rails and failed to assess each resident for the risk of entrapment from bed rails prior to installation. This failed practice was a random opportunity for discovery and had the potential to affect all residents currently residing in the facility during the Long-Term Care Survey Process. Facility Census: 28. Findings Include: a) Facility Bed Rails An observation on 05/29/25 at 10:00 AM, revealed that all empty beds in the Long-Term Care Unit, and all 28 beds currently occupied by a resident had bed rails installed. The observation revealed that throughout the unit, 4 types of bed rails were being used. During an interview on 05/29/25 at 10:45 AM, The Maintenance Director (MD), stated, Prior to getting a new admit, we do not inspect the beds or anything. We just work on them if we have a work order for them. We do not have any policy that I know of, about inspecting the bed rails. During an interview and observation on 05/29/25 at 11:05 AM, of bed rails throughout the facility, the Director of Nursing (DON), stated, Everybody has bed rails the control to the beds is on them. These beds are so old. I have no idea where to find the manufacturer's guideline. As you can see, we have different types of beds and 3 or 4 different types of bed rails. A record review on 05/29/25 at 11:30 AM, revealed that all residents residing in the facility had a side rail assessment and consent completed and signed by the resident or Medical Power of Attorney (MPOA) upon admission. No side rail assessments had been completed since the admission of the resident. The side rail assessment and consent had no indication that the side rails were assessed for entrapment risk. During an interview on 05/29/25 at 12:30 PM, The Minimum Data Set Registered Nurse (MDSRN), stated, I do the assessments. I only do the one on admission. I did not know we were required to do anything different. The MDSRN further confirmed that nowhere on the side rail assessment does it mention checking for risk of entrapment. During an interview on 05/29/25 at 12:45 PM, The DON stated, I will look for the manufacturer's guideline and ask if we have that, but the beds are so old I doubt they are here. No further information was provided by the end of the survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and Staff interview the facility failed to ensure foods were probably labelled and discarded when out of date. This failed practice had the potential to affect more than a limited number of residents residing in the facility. Facility Census: 28 Findings include a) On 05/27/25 at approximately 12:00 PM initial tour of the facility kitchen found the following; Two (2) salads were in the walk-in cooler with no dates/labels. One (1) carton of pasteurized eggs in the walk-in cooler with no dated/labels One (1) carton of heavy whipping cream in the walk-in cooler with no dates/labels One (1) carton of cream of wheat in the walk-in cooler with no dates/labels One bag of flour in the dry stock room with no open date One bag of cheesecake mix in dry stock with no open date One bag of Tostito corn chips in dry stock room with no open date An interview with the Dietary Manager (DM) on 05/27/25 at 12:10 PM regarding items not being labeled was completed. The DM stated, We will get this fixed, the staff should know better than this. confirming the items were not labeled correctly. Further observations during the initial tour of the kitchen on 05/27/25 revealed one (1) carton of milk with a use by date of 05/22/25. 05/27/25 at approximately 12:30 PM the DM stated, They must have missed that carton of milk when rotating the milk. On 05/27/25 at approximately 11:30 PM initial tour of the kitchen revealed a cooler that had a seal damaged causing a gap and making the cooler not seal correctly. Further observations of the cooler and milk that was being held inside showed the milk did not feel very cold to touch. An interview with DM on 05 /27/25 at 11:40 AM who stated, I did not know the seal on the tray line milk cooler was like that. An observation reveled the DM taking the temperature of the milk. The milk was 41.4 degrees Farenheit. The cranberry juice was 57.6 degrees Farenheit and the temperature inside the cooler was 51 degrees Farenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM at this time confirmed the cooler was not properly holding temperatures due to the broken seal on the cooler. When asked what the temperature of the milk and juice should be the DM stated, It (milk and juice) should be under 40 degrees Fahrenheit, but i think they just put that juice back in the cooler(but was not sure the juice were placed back in the cooler). confirming the milk and juice were above holding temperature.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, resident interviews, and documentation review, the facility failed to maintain a proper infection prevention and control in the environment. Facility census 28. Findings include: a) On 05/28/25 at approximately 3:05 p.m., reviewed the facility's water management plan documentation. Upon review of the water management plan discovered that there was no water flow diagram readily available. Interview with employee #48 verified this at the time of discovery. The finding was also acknowledged by the Administrator that the facility does not have a water flow diagram. This finding was also acknowledged by the Administrator upon the exit on 05/29/25. b) Resident #15 On 05/27/25 at 1:14 PM, a soiled pink bath basin was observed sitting on floor under the sink in Resident #15's room. On 05/27/25 at 1:17 PM, Registered Nurse (RN) #9 was notified and stated, I thought maybe the sink was leaking but it's not. At this time, RN #9 removed the bath basin from the room. On 05/28/25 at 9:35 AM, the Director of Nursing (DON) was notified and confirmed the bath basin should not have been sitting under the sink in the floor. c) Resident #26 On 05/27/25 at 3:40 PM, an observation of oxygen tubing and cannula was found laying on the table and hanging into the floor. RN #9 was notified. RN #9 was asked, does the resident use oxygen? RN #9 confirmed the oxygen tubing and cannula did not belong to the resident. On 05/28/25 at 9:35 AM, the Director of Nursing (DON) was notified and confirmed the oxygen tubing and cannula should be stored properly; it should not be in the room if the resident does not use oxygen. d) Resident #11 On 05/27/25 at 1:10 PM, a urinal was observed hanging on the commode handle without being in an appropriate storage container. On 05/27/25 at 1:13 PM, Nurse Aide (NA) #16 removed the urinal from the commode handle. NA #16 stated, let me get this. On 05/28/25 at 9:35 AM, the Director of Nursing (DON) was notified and confirmed the urinal should be stored properly.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, record review and staff interview, the facility failed to offer a pneumococcal vaccination to Resident #18. This was true for one (1) of five (5) residents reviewed under the care area of infection control. Resident Identifier: #18. Facility Census: 28. Findings Include: a) Resident #18 On 05/27/25 at 1:30 PM, Resident #18 asked, are you here to bring me my pneumonia shot? The resident was admitted to the facility on [DATE] and no documentation was found listing any immunizations the resident had received. On 05/29/25 at 11:25 AM, the Director of Nursing (DON) was interviewed regarding the pneumococcal vaccination for Resident #18. The DON stated, we have ordered them .but they haven't came in yet .the resident was not offered a pneumococcal vaccination since she has been here.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and staff interview, the facility failed to ensure the tray line milk cooler had proper seals to maintain safe temperatures for the milk/juice by holding it under 40 degrees Fahrenheit. This was a random opportunity for discovery and had the potential to affect a limited number of residents residing in the facility. Facility census: 28 Findings include: On 05/27/25 at approximately 11:30 PM the initial tour of the kitchen revealed a cooler that had a seal damaged causing a gap and making the cooler not seal correctly. Further observations of the cooler and milk that was being held inside showed the milk did not feel very cold to touch. An interview with Dietary Manager (DM) 05/27/25 at 11:40 AM who stated, I did not know the seal on the tray line milk cooler was like that. The DM took the temperature o placed a thermometer in the cooler and took the temperature of the milk. This temperature reading revealed the milk was 41.4 Fahrenheit and the cranberry juice was 57.6 Fahrenheit. When the DM checked the temperature of the inside of the cooler it was 51.0 degree Fahrenheit. The DM at this time confirmed the cooler was not properly holding temperatures due to the broken seal.