STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515086	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49650 Based on observation and staff interview, the facility failed to ensure each resident was afforded the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. The call light system device was not accessible for a resident while in bed. This was a random opportunity for discovery and was true for Resident #109. Resident identifier: # 109. Facility Census: 191. Findings included: a) Resident #109 During a tour of the building, on 02/27/24 at approximately 09:39 AM, Resident #109 was observed to be hanging out of his bed sideways and banging his trash can on the floor. The resident's call light at this time was observed to be attached to the very top of the edge of the head of his bed and out of his reach. When asked if the resident needed assistance, he nodded his head yes. On 02/27/24 at approximately 9:45 AM, the Registered Nurse (RN) #129 stated Resident #109 has behaviors, and he (RN #129) has been back there several times already but would go back again. Upon entering the room, Resident #109 was repositioned in his bed and RN #129 agreed that on 02/27/24 at approximately 9:47 AM, the call light was so far above the resident's head that it was out of his reach. At this time RN #129 removed the call light from the head of the bed and moved it down to the waist area of Resident #109 within his reach.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49650 . Based on observation and staff interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment. A closet door was broken, and a Packaged Terminal Air Conditioner (PTAC) unit had several broken grids on top of the unit. This was a random opportunity for discovery. Room identifiers: #C11 and #G7. Facility Census: 191 Findings included: a) C 11 During a tour of the building, on 02/27/24 at 9:34 AM, Room #C11's closet door was observed to be broken and off track. During an interview with Registered Nurse (RN) #3 on 02/27/24 at approximately 9:35 AM, she agreed the closet door was broken. b) G 7 During a tour of the building on 02/28/24 at 11:00 AM, the PTAC unit in Room G7 was observed to have several broken and/or missing grids along the top of the protective covering. During an interview with Regional Admissions Director (RAM) #165 on 02/27/24 at approximately 11:01 AM, she acknowledged the cover had broken/missing areas.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40165 Based on policy review, staff interview, and record review, the facility failed to protect from neglect after a fire on 02/24/24 and after illegal drug activity was identified. Both situations created immediate jeopardy for more than a limited number of residents. Fire Local media reported a structure fire at the facility on 02/24/24. The facility also reported the fire by fax to the State Agency (SA) on 02/25/24. A total of 18 minutes elapsed from the time the fire alarm activated on the A-Wing, and the time the facility began to evacuate residents. The facility failed to identify the need to evacuate residents in a timely manner. They only began the evacuation of the residents after they were told to do so by emergency responders. The delay in evacuation and the failure to implement their fire plan placed all residents currently residing on the A- Hall at immediate risk for serious harm and/or death. The state agency determined this was an Immediate Jeopardy situation. Fentanyl The State Agency received a complaint alleging illegal drug activity involving residents at the facility. Record review at the facility revealed Resident #300 and Resident #301 were observed using illicit/illegal drugs at the facility in January 2024. Resident #300 was administered Narcan on 01/06/24. Resident #301 was administered Narcan on 01/05/24. Resident #300 was diagnosed by a local hospital with a Fentanyl overdose. According to facility documentation Resident #301 admitted to using Fentanyl. Fentanyl was not prescribed by the facility for either resident. Both residents were observed to be using a marijuana vaping device prior to the episode where Narcan was used. A mystery white powder was also observed on the dresser of Resident #300 on 01/02/24. No interventions were put in place to assess and protect other facility residents from possible exposure to drugs and risk of harm, including the roommates of Resident #300 and #301. These failures placed all residents currently residing in the facility at immediate risk of serious harm and/or death. Resident identifiers: #86, #87, #88, #88, #89, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #107, #108, #109, #110, #114, #116, #117, #118, #119, #120, #121, #122, #122, #300 and #301. Facility census: 191 Findings included: a) Fire Staff Interviews (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was completed with certified nurse aide (CNA) #62 on 02/26/24 at 1:20 PM. CAN #62 reported she was assigned to work on the D-Wing but was on the C-Wing helping another CNA with a resident when the fire alarm went off. Head counts were done on the C-Wing and the D-Wing and residents were placed in rooms and resident doors were shut. CNA #52 stated maybe 15-20 minutes went by before the decision was made by the Sheriff to evacuate the A-Wing. CNA #52 reported she assisted with the evacuation of the A-Wing. An interview was completed on 02/26/24 at 1:30 PM with CNA #137. CNA #137 was assigned to work on the E-Wing and at first thought it was just a drill when the fire alarm went off. As she walked over to the A-Hall to see what was happening, firemen were saying A-Wing needed to be evacuated and CNA #62 went to get more help. After residents were safely evacuated in the dining room the CNA went back to her assigned wing. An interview was completed with CNA #116 on 02/26/24 at 1:45 PM. CNA #116 was assigned to work on the C-Wing and recalled the fire doors closed at around 10:02. At first, staff thought it was just a fire drill because they had just had a fire drill on the nightshift. LPN #21 reported that it as a Code Red on the A-Wing. CNA #116 stated she remained on the C-Wing and assisted in getting residents up in their chairs in case there was a need to evacuate the entire building. CNA #116 stated she was told there were two (2) CNAs and a nurse on the A-Wing who witnessed smoke coming out of the vent and the alarm reportedly sounded around the same time. An interview was completed, on 02/26/24 at 1:58 PM, with CNA #53. CNA #53 was assigned to work on the A-Wing. She reported that as soon as the fire alarm sounded sheltering residents in place began. Staff on the floor got a complete head count and started shutting resident doors. CNA #53 believed it might have been the firemen who instructed the staff to evacuate the A-Wing. She recalled hearing, We need to evacuate but there was no specific plan that she was aware of. She stated she would have liked to have more training to know what her responsibilities would be if she heard the word evacuate. She reported residents, chairs and beds were taken to the dining room. An interview was completed with the ADON on 02/26/24 at 2:17 PM. The ADON reported she arrived at the facility at the same time the first emergency vehicle pulled into the facility's parking lot. Other emergency response vehicles began pulling into the parking lot as she was walking into the facility. The ADON reports she spoke to Minimum Data Set (MDS) Licensed Practical Nurse (LPN) Nurse who reported the fire panel showed there was a problem on the A-Wing. She reported she believed it was the firemen who said, we're evacuating A-Wing. The ADON reported the fireman also made the decision to evacuate the first four (4) rooms on the B-Wing as a precaution as well. An interview was completed on 02/26/24 at 2:33 PM with CNA #146. CNA reported she was assigned to work on the A-Wing. When the fire alarm first sounded the CNA was in a male resident's room providing care. After finishing in that room, she made her way to the hallway where the nurse was trying to comfort Resident #101 who always gets upset when the fire alarm goes off because she had a child perish in a fire. Another CNA walked by and stated, It might be real referring to the fire alarm. CNA #146 reported it was the Sheriff who made the decision to evacuate residents off the A-Wing. Resident Interview (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 02/26/24 at 3:30 PM, Resident #107 stated she heard the alarm go off and there was either a deputy or a firefighter that came sometime later and started to evacuate us at the end of the A-hall around the building to the dining room. Interview with Assistant Fire Marshal During an interview, on 02/26/24 at 12:55 PM, the Assistant Fire Marshall shared his insights on how the facility failed to move residents upon the sight of smoke. The Assistant Fire Marshal expressed concern that the facility did not evacuate their building properly per their Fire Safety Plan. He noted if it had been a real fire, it had potential to be a complete disaster. Review of Facility Video on 02/26/24 at 3:15 PM Review of the facility's video of the A-Wing on 02/24/24 revealed the fire alarm activated at 9:49 AM. MDS LPN #54 could be seen calling 911 at 9:50 AM. MDS LPN #54 could be seen looking at the fire panel and pointing to the A-Wing. At 10:04 AM, an employee from the Sheriff's office arrived. At 10:07 AM the facility began evacuating residents from the A-Hall. A total of 18 minutes elapsed from the time the fire alarm activated, and the time the facility began to evacuate residents. Interview with the nursing in charge During an Interview with MDS LPN #58, on 02/26/24 at 4:24 PM, she stated she was the nurse on the B-Wing and had just finished medication pass and sat down at the Nurses Station. When she saw smoke, she thought it was from where a resident had taken a shower and that perhaps the heater had gotten hot. She saw smoke on A-Wing and called, Code Red A Wing and repeated this three (3) times. This was about 9:51 AM - 9:52 AM. She stated that Maintenance turned off something and there was no more smoke. She stated that they did not evacuate any residents but did shut the doors to resident rooms. When the Sheriff and EMS arrived, they ordered the residents to be evacuated. When asked how they determined who they evacuated first (triage) she stated that they just started evacuating residents. She stated there were eight (8). The facility was notified of the Immediate Jeopardy (IJ) at 6:28 PM on 02/26/24. The The State Agency (SA) approved the facility's POC at 9:25 PM on 02/26/24. After observation, staff interview, review of facility documentation, and record review determining the implementation of the POC, the IJ was abated at 12:24 PM on 02/27/24. The IJ began on 02/24/24 at 9:49 AM when the fire alarm sounded, and the problem was identified as being on the A - Wing of the facility. The facility's approved abatement POC consisted of the following: 1. All residents were interviewed for potential post event trauma by the Director of Nursing and designees on 2/26/24. There were no negative findings with residents. All Responsible Parties were notified via a Caller Multiplier on 2/26/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	2. All residents have the potential to be affected by the deficient practice. All staff were educated on the facility Fire Safety/Evacuation Plans to include triage evacuation and Disaster Response Coordinator by the Maintenance Director and RN Staff Educator on next worked shift beginning 2/26/24. 3. The Maintenance Director or designee will facilitate Facility Fire Drills weekly times two weeks, bi-weekly times two weeks then monthly to cover all shifts within a quarter with any Corrective Actions immediately upon discovery. 4. Findings regarding the observations of Facility Fire Drills will be presented by the Director Nursing or designee in the Monthly Quality Assurance meeting for continued compliance as evidenced by meeting minutes. The facility's failure to follow their Fire Safety plan and begin IMMEDIATE evacuation upon discovery of a minor or major fire placed these residents at risk for serious bodily harm and/or death. Fire Safety Plan Review of the facility's Fire Safety plan revealed the following directives: -Upon discovery of a minor or major fire, Call Code Red or Fire to available staff members for assistance. -Immediately remove endangered residents or staff from affected area and adjacent rooms. -If resident is bedridden, evacuate the resident in his/her bed necessary. -Take residents/employees to safe area in the adjacent smoke compartment. Abuse, Neglect & Misappropriation Policy Review of the facility's Abuse, Neglect, and Misappropriation Policy revealed the following details: Neglect -Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. WV-Code 9-6-1 defines neglect as the unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult; or the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to, or for the benefit of, an incapacitated adult or resident. Fentanyl (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Facility policy Review of the facility policy entitled, Resident Substance Abuse in facility, found: A facility may admit a resident who has a history or diagnosis of substance abuse. However, residents may not possess, use or provide illicit drugs or abuse drugs in any manner, and may not have drug-related paraphernalia in their possession while a resident in the facility. Being under the influence of illicit or illegal drugs or alcohol places the resident at risk for overdose, falls and respiratory depression and places other residents at risk for injury by a resident under the influence of illicit or illegal drugs or alcohol. The facility will safeguard the resident under the influence of illicit or illegal drugs to the extent possible, as well as provide a safe environment for other residents, staff, and visitors. This may include up to discharge of the substance abusing resident. Management of Acute Episodes In the event a resident is found to be under the influence of abused substances: Wear proper PPE including gloves and mask when assessing a suspected drug overdose resident or when administering Naloxone to protect against unanticipated exposure to dangerous drugs. Clear the room of unnecessary personnel, visitors, or other residents to reduce risk of exposure to the illicit/illegal drug or as a safety precaution for erratic behavior . For residents receiving Naloxone Provide increased observation until the resident is transported or until the resident is no longer exhibiting signs and symptoms of being under the influence . Observation of other Residents Observe other residents for signs and symptoms of illicit drug use . Resident #300 Record review found Resident #300 was admitted to the facility on [DATE]. He was discharged from the facility on 01/12/24. On 12/28/23, the facility physician determined the resident had capacity to make medical decisions. The resident's care plan noted the resident wished to be discharged to home once his clinical and therapy goals were achieved. The resident was care planned on 01/02/24 for a substance use disorder related to opioid dependence and a history of methamphetamine abuse. The goal associated with this focus was, Will not use illegal drugs in facility. This care plan was initiated on 01/02/24, four (4) days after his admission. Interventions included: - Administer medications per medical provider's orders. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	- Observe for side effects and effectiveness. - Report abnormal findings to medical provider and resident. - Educate resident on following the prescribed treatment regime and leave of absence policy. - Encourage resident to express feelings regarding addiction. - Evaluate resident for stumbling, nodding off even when standing or in mid conversation, incoherent speech, slurred speech, rambling, sleepy, erratic behavior, hyperactive, threatening, hostile, blood shot eyes, pinpoint pupils, pale face, sweaty unruly appearance, fumbling, nervous, jerky movements. On 12/23/23, the facility physician prescribed an opioid medication, Oxycodone HCl 15 milligrams every 4 hours for pain. The following progress notes were found in the medical record: A note dated 12/28/23 at 6:35 PM revealed the resident was alert and oriented and signed out for visit and to go to get some supplies from store. The note stated the resident was educated to be back to facility by midnight. There was no documentation as to how the resident was going to get to the store to get supplies. The next progress note written at 8:04 PM on 12/28/23 noted the resident's medication could not be given because he was out of the facility. There was no documentation regarding what time the resident returned to the facility or his condition upon return. A note dated 01/02/24 at 12:50 PM revealed staff observed the resident snorting a white substance off his dresser in Room #E12a. BP (blood pressure) was 126/100 HR (heart rate) 72. Pupils were pinpoint. The medical director was notified and there was a new order to hold the12:00 PM dose of oxycodone. The registered nurse (RN) supervisor and administration were aware of the situation. (Room #E12 was occupied by Resident #301 which will be discussed under his medical record review below) The medical director ordered a urine drug screen. The results of this drug screen dated 01/02/24 found the Resident tested positive for THC (Tetrahydrocannabinol) and opiates. On 01/05/24 at 1:51 PM a medical record note revealed the resident signed out to leave the facility for a short time. The next note written on 01/5/24 at 5:53 PM revealed the resident was out of the facility. There were no notes indicating when the resident returned to the facility or his condition when he returned. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 01/06/2024 at 3:15 AM a note revealed a facility nurse was notified by a nurse aide that the resident was on the floor next to his bed. The note reflected that when the nurse entered the room the resident was sitting on the floor with his head against the dresser, not responding to verbal stimuli. The nurse was able to wake the resident up, but he was not answering questions appropriately, was nodding out, and there was a noted drop in his blood pressure, The note reflected the nurse contacted someone from a program who the resident was affiliated with. A worker from that program attempted to ask the resident questions. The resident was unable to answer. There was an order for the resident to be sent out to ER (emergency room) for evaluation. The nurse called 911 and as emergency medical services (EMS) were in route, the resident was nodding out and his blood pressure dropped to 77/43. An order was given to administer Narcan (Naloxone). The resident became more alert and able to answer questions. His blood pressure returned to normal. The resident transferred via EMS (emergency medical squad) to (Name of a local hospital) for evaluation. A note dated 01/06/24 at 6:29 AM revealed the resident returned to the facility at 6:30 AM via ambulance on stretcher. DX (diagnoses) fentanyl overdose. He was given clonidine 0.1mg for blood pressure. On 01/08/24 at 9:09 AM a note revealed the resident left the facility at this time via public transit. Resident stated he was going to an appointment. There was no indication an appointment was scheduled by the facility. There was no documentation as to where the resident was going. On 01/8/2024 at 1:59 PM (five (5) hours later) Nurses Note revealed the resident returned to facility at this time via public transit. (There was no indication the resident was assessed for his condition after his return.) An interdisciplinary team meeting note dated 01/09/24 at 3:45 PM revealed, Resident has used illegal, non-prescribed, controlled substances on at least two known occasions in the facility since admission on 12/22/23. Resident observed vaping a marijuana vape device and snorting a white powder on 01/02/24, physician was notified, and drug screen ordered, which was positive for THC. Drug abuse support offered and refused, he resigned the facility non-smoking and non-drug use policy and expressed clear understanding that he was not permitted to smoke, bring illegal substances in facility. On 01/06/24 he was sent out to the ER after the Licensed Nurse administered Narcan for a fentanyl overdose. He stated he obtained the drug from a friend outside of the facility. Police were notified and State Troopers came in and spoke to (Name of Resident.) (Resident) has been leaving the facility unattended, signing himself out. Therapy has issued a NOMNC (Medicare non-coverage) as he has reached his potential and the last day of treatment will be Thursday, 1/11/24. (Name of Resident) BIMs (Brief interview for mental status) is 15 and he has capacity. On 02/27/24 at 2:03 AM, the Administrator and the DON were interviewed. The DON stated the resident had capacity and there was no abuse or neglect suspected to report. He was free to leave the facility for outings. Both employees were asked about the risk to other residents and the roommate of this resident during his drug usage. They were asked how the facility ensured other residents and staff were not at risk when a white powder was found in Room #E12A on 01/02/24 noted to be used by Resident #300. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The DON said they had no reports of any other residents approaching the two (2) residents involved in illegal drug usage at the facility. The DON confirmed this resident did have a roommate at the time of both incidents. The administrator stated the facility called the police after Resident #300 received Narcan on 01/06/24 but were told there was nothing they could do. The DON confirmed the police were not called after the 01/02/24 incident. According to the DON, the State Police came and searched the room but found no drugs and said the Resident had capacity. The administrator said the police were asked for a report, but nothing was ever provided. In addition, they were asked if the resident was assessed after all his trips out of the facility. Both were asked to provide evidence of their investigation after the 01/02/24 incident of the white powder being found on the dresser and the IDT team noted the resident was using a marijuana vape pipe on 01/02/24. They were asked was the incident on 01/06/24, when the resident received Narcan and was sent to the hospital, investigated. Both staff confirmed the resident was diagnosed with a Fentanyl overdose on 01/06/24. They were asked where the resident got the Fentanyl. Both employees confirmed the Resident was not prescribed Fentanyl at the facility. The administrator and the DON said they believed Resident #301 was supplying the illegal drugs. During an interview, at 2:27 PM on 02/27/24, with Licensed Practical Nurse (LPN) #60, the author of the 01/02/24 note, (Staff observed resident snorting a white substance from dresser in E12a. BP (blood pressure) 126/100 HR (heart rate) 72. Pupils pinpoint. (Name of medical director) notified and new order to hold oxycodone 12 pm dose. RN supervisor and administration is aware of situation.) was asked about her role during the incident. LPN #60 said the staff person who observed the incident was a nurse aide (NA) who no longer works at the facility. LPN #60 said, I don't even remember her name. I wrote the note and reported this to my supervisor, that was my role in the situation. My supervisor said he was calling the administrator and the DON. I believe the administrator did come in to talk with the resident. I did not get any statement from the NA. On the afternoon of 02/27/24 around 3:30 PM, the DON provided an occurrence report that contained the same information as the progress note written on 01/06/24. A typed note on a separate piece of paper with this occurrence number noted the following: Resident #300 and Resident #301 were both placed on one-on-one observation in their respective rooms. The nurse phoned 911 to request an officer respond to the facility to have both residents' rooms searched for drugs. The officer stated he could only search if the Residents consented to the search. Each Resident consented to have their room and belongings searched. Officer (name) conducted the search. No drugs or paraphernalia were found. Both residents admitted to smoking, it. Neither resident would state what was contained in the aluminum foil they smoked. Resident #301 said a friend of his brought it in for him. Officer (Name) stated he would complete the report, but that it would be an informational report. The DON said the residents were placed on one (1) on one (1) supervision on 01/06/24 from when the police were called until the police arrived at the building. The DON said the resident was offered counseling but refused. The DON was unable to provide any further information regarding this incident and no information was provided noting how the other residents at the facility were protected from the illegal drug usage of Resident #300. c) Resident #301 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review found this Resident was admitted to the facility on [DATE] and was discharged on [DATE]. The resident was found to have capacity on 12/28/24. On 12/29/23 the resident was prescribed Percocet 7. 50325 milligrams, 1 tablet every 6 hours for pain. On 12/27/23 the Resident was prescribed Oxycodone 5 milligrams every 6 hours for pain. The Resident was care planned on12/27/23 with a revision date of 01/17/24. The care plan was for: Utilizing nicotine products and having used illegal drugs in facility since admission and has been observed vaping in his room. The goal associated with this problem was: Resident will utilize nicotine products in a safe manner. Interventions included completing a smoking evaluation on 12/27/23 and complete smoking evaluation - 12/27/23 Provide safe smoking devices, if required, such as smoke blankets, smoke aprons and cigarette extenders - 12/27/23. On 01/09/23 an intervention was added to observe for altered mental status and other signs that may indicate drug impairment. On 01/02/24 at 10:44 AM the resident was re-educated resident on facility smoking policy that was signed upon admission to facility. The resident was educated resident that this was a non-smoking facility and that a vaping fell under that. Risks and benefits discussed with the resident. Resident stated that his son brought the vape to him. Educated resident that his son should not bring anymore vapes to him. Resident has capacity and he stated that he understood. Resident denied wanting nicotine patch at this time. (This resident's nursing notes did not include any information about Resident #300 being in Resident #301's room snorting a white substance off his dresser. Resident #300's progress note on 01/02/24 noted he was observed snorting a white substance off dresser in Room #E12a. Resident #301 was residing in Room #E12A on 01/02/24. On 01/03/24 a nursing note written at 12:45 PM, revealed the resident left the facility via taxi service. This nurse educated the resident on the importance of staying in the facility to participate in therapy and receive treatment. Resident verbalized understanding. 01/03/24 at 5:28 PM a nursing note revealed the resident returned to the facility at this time. There were no notes to indicate the Resident was assessed upon his return. A late entry note dated 01/05/24 at 9:00 PM revealed the resident was found on the toilet in bathroom of Room #E12, lethargic, diaphoretic, and disoriented. The resident's vitals were taken, the resident was unable to answer questions appropriately, notified (name of on-call physician services,) ordered Narcan for patient. Narcan was given per order, resident answering questions appropriately, vitals within normal limits. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	There were no notes indicating the resident was ever assessed again after the Narcan was administered. An interdisciplinary team note dated at 2:50 PM on 01/09/24 was a follow up to illicit drug use in the facility on 01/01/24 and 01/05/24. The administrator, DON and vice president of risk management were all involved in the meeting. According to this note the resident was observed vaping marijuana on 01/01/24 and was provided with the opportunity for substance abuse support and declined. The resident re-signed the facility policies on smoking and illegal drug use and stated understanding. On 01/05/24 nursing staff found him unresponsive, contacted the physician, and administered Narcan. He responded and was able to disclose that he had used fentanyl that he got from another individual. Police were involved and came to the facility; State Troopers were the response team and addressed the resident. The resident allowed nursing staff to search the room and they removed drug residue and paraphernalia. On 02/27/24 at 2:03 AM, the Administrator and the DON were interviewed. The DON stated the resident had capacity and there was no abuse or neglect suspected. He was free to leave the facility for outings. Both employees were asked about the risk to other residents and the roommate of this resident during his drug usage. The DON confirmed this resident did have a roommate at the time of the incident. Staff were asked how the facility ensured other residents or even staff were not at risk when a white powder was found in Room #E12A on 01/02/24. They were asked who cleaned the room after the white powder was found and how was the room cleaned. They were also asked if anyone investigate or confirm what the white powder was. The DON stated Resident #301 was involved in the incident in his room on 01/02/24 with Resident #300 even though his progress note stated he had a vape pen. She said both residents were using a marijuana vape pen . Resident #301 received Narcan on 01/05/23 but the DON said since this resident had a positive reaction to the Narcan, he was not sent to the hospital. No drug testing was ordered for Resident #301 to determine what substances he had used that resulted in the use of Narcan. The DON confirmed Resident #301 admitted to using Fentanyl himself. The DON confirmed the police were not called until 01/06/24 after the incident with Resident #300. The DON said the staff felt Resident #301 was getting the drugs for himself and Resident #300. That was why the police were asked to search both Resident rooms on 01/06/24. On the afternoon of 02/27/24 around 3:30 PM, the DON provided an occurrence report noting the following: (Name of Resident #301) was found on the toilet in his bathroom unresponsive. Narcan was given per order. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The DON provided the same statement for this resident's occurrence as provided for the occurrence report with Resident #300. Resident #300 and Resident #301 were both placed on one (1) on one (1) observation in their respective rooms. The nurse phoned 911 to request an officer respond to the facility to have both residents' rooms searched for drugs. The officer stated he could only search if the residents consented to the search. Each Resident consented to have their room and belongings searched. Officer (name) conducted the search. No drugs or paraphernalia were found. Both residents admitted to smoking, IT. Neither resident would state what was contained in the aluminum foil they smoked. Resident #301 said a friend of his brought IT in for him. Officer (Name) stated he would complete a report, but that it would be an informational report. The DON was unable to provide any documentation, other than calling the State Police and filling out an occurrence report to show how the other residents were protected during Resident #301's drug usage. No information was provided to conclude an investigation was conducted to determine the source of the white powder on the dresser in this resident's room seen on 01/02/24. No information was provided to include how the room was cleaned or if the condition of the resident's roommate was assessed or if any other residents were assessed for possible drug usage or exposure to the drugs used by Resident's #301. According to the Centers for Disease Control (CDC) Fentanyl even in small doses can be deadly. It is among the most common drugs involved in overdose. Fentanyl can be absorbed into the body via inhalation, oral exposure or ingestion, or skin contact. When coming into contact with Fentanyl, the CDC recommends wearing nitrile gloves; respiratory protection if powdered illicit drugs are visible or suspected; avoid performing tasks or operations that may cause illicit drugs to become airborne; do not touch eyes, nose or mouth after touching any surface that may become contaminated; wash hands with soap and water, do not use hand sanitizer or bleach The facility was notified of the Immediate Jeopardy (IJ) at 4:47 PM on 02/27/24. The State Agency (SA) approved the facility's Plan of Correction (POC) at 6:45 PM on 02/27/24. The IJ was abated at 12:18 PM on 02/28/24. The facility's approved abatement POC consisted of the following: 1. All residents with a diagnosis of illicit drug use were reviewed and assessed for signs and symptoms with no findings. 2. All residents who have the potential to come into contact with illicit drug use while in the facility have the potential to be affected. DON/Designee will initiate all staff education on 02/27/24 on observing for signs and symptoms of being under the influence of drugs. In the event of occurrence, order will be on MAR to observe all residents for being under the influence of drugs. Residents will be monitored every 12 hours for 72 hours unless additional monitoring is deemed necessary. If staff visually notice any drugs or patients impaired this will be reported immediately to their supervisor. Staff educated not to touch drugs and for residents receiving Narcan will have increased observation until the resident is transported to an acute care facility. The facility will request a toxicology report prior to the resident returning to facility. Facility will notify local law enforcement and initiate an internal investigation. Resident will be educated on substance [NAME][TRUNCATED]

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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. 45171 Based on record review and staff interview the facility failed to implement the individualized comprehensive care plan. This was true for two (2) of four (4) resident care plans reviewed for wound care. Resident Identifier: #30 and #201. Facility Census: #191 Findings included: a) Resident #30 On 02/27/24 at 9:30 AM, a review of Reisdent #30's medical record found an active order to cleanse stage 3 to left gluteal fold with in house wound cleanser (IHWC), pat dry, apply bordered dressing every Monday/Wednesday/Friday and PRN as needed and cleanse stage 4 to the sacrum with IHWC, pat dry, apply Hydrofera blue, and cover with border dressing every Monday, Wednesday, Friday and PRN as needed. The facility Skin Care and Wound Management Policy #NS 1400-00 states: Policy: The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds . Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. During an interview with the Director of Nursing on 02/27/24 at 3:35 PM, she stated if a new skin wound is identified, the nurse does a Skin Grid Sheet. This is usually identified during a shower or bath. They do Weekly Skin Check Sheet if the resident has a wound identified. Wounds are accessed weekly with measurements and treated as ordered by the Physician. They consult an outside source, Healing Partners, to assist with wound treatment recommendations, measurements and staging if needed. The Wound Nurse Practioner comes four (4) days a week. The also have in house wound nurses and all nurses in house can do wound care treatment orders. Review of Resident #30's records show he was admitted with these wounds on 12/18/23. There is no order in place for Weekly Skin Checks and there has been none completed since 12/19/23. Review of the Residents individualized care plan for impaired skin integrity shows there is an intervention in place to complete Weekly Skin Checks. The above information was confirmed with the Director of Nursing on 02/28/24 at 11:50 AM at which time, she agreed there should have been doing Weekly Skin Checks being completed as they are on the care plan. b) Resident #201 On 02/27/24 at 9:30 AM record review for Resident #201 found an active order at the time of discharge to cleanse unstageable to sacrum with in house wound cleanser (IHWC), pat dry, apply calcium alginate and bordered dressing every other day and PRN as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Skin Care and Wound Management Policy #NS 1400-00 states: Policy: The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds . Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. During an interview with the Director of Nursing on 02/27/24 at 3:35 PM, she stated if a new skin wound is identified, the nurse does a Skin Grid Sheet. This was usually identified during a shower or bath. They did Weekly Skin Check Sheet if the resident had a wound identified. Wounds are accessed weekly with measurements and treated as ordered by the Physician. They consult an outside source, Healing Partners, to assist with wound treatment recommendations, measurements and staging if needed. The Wound Nurse Practioner comes four (4) days a week. The also have in house wound nurses and all nurses in house can do wound care treatment orders. Review of Resident #201's records show she was admitted from a local hospital with these wounds on 01/20/24. There was no active order in place for Weekly Skin Checks and there has been none completed since 01/21/24. Review of the Bed Mobility Task sheet shows Resident #201 was unable to turn and reposition alone. Review of the Skin and Wound Progress Note shows the resident has poor bed mobility with new recommendations to .Recommend ongoing pressure reduction and turning/repositioning precautions per protocol . recommend placement of air mattress. Review of the January and February 2024 Bed Mobility Task documentation shows the resident was extensive assistance to total dependence with one (1) to two (2) person physical assist. According to documentation, she was not being turned or repositioned according to standard practice of care (every two (2) hours). There was an order for pressure reducing/relieving mattress on 01/20/24 at 09:36 PM, and revised and deleted on 01/21/24 at 04:55 AM. There was no evidence that Resident #201 had a pressure reducing/relieving mattress ordered as it was not on the Treatment Administration Record during the time prior to her discharge on 02/09/24. Review of the Residents individualized care plan for impaired skin integrity showed interventions were in place to complete Weekly Skin Checks, educate resident/resident representative on need for turning and repositioning, Encourage resident to turn and reposition or assist as needed as resident allows, ensure residents are turned and repositioned, provide appropriate off-loading mattress & off loading cushion if applicable. There were no orders for Weekly Skin Checks, turning and repositioning or off loading mattress or cushion. The above information was confirmed with the Director of Nursing on 02/28/24 at 11:50 AM at which time, she agreed there should have been Weekly Skin Checks being completed. She also agreed that Resident #201 should have had orders for a pressure reducing mattress, turning and repositioning and Weekly Skin Checks, which were on the individualized care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45171 Based on record review and staff interview the facility failed to revise the individualized comprehensive care plan. This was true for one (1) of four (4) resident care plans reviewed for wound care. Resident identifier: #65. Facility Census: #191 a) Resident #65 On 02/27/24 at 9:30 AM, a record review for Resident #65 found an active order to cleanse stage 4 to sacrum with in house wound cleanser (IHWC), pat dry, apply santyl, mupirocin, Hydrofera blue, and cover with border dressing every Tuesday, Thursday, Saturday and PRN as needed. The facility Skin Care and Wound Management Policy #NS 1400-00 stated: The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds . Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition During an interview with the Director of Nursing, on 02/27/24 at 3:35 PM, she stated if a new skin wound was identified, the nurse did a Skin Grid Sheet. This was usually identified during a shower or bath. They did a Weekly Skin Check Sheet if the resident has a wound identified. Wounds were accessed weekly with measurements and treated as ordered by the physician. They consult an outside source, Healing Partners, to assist with wound treatment recommendations, measurements and staging if needed. The Wound Nurse Practitioner came four (4) days a week. They also have in-house wound nurses and all nurses in house can do wound care treatment orders. Review of Resident #65's records showed she was readmitted from a local hospital with these wounds on 01/23/24. There was no order in place for Weekly Skin Checks. The facility staff ordered the weekly skin checks during the survey on 02/27/24 at 7:02 PM but failed to revise the individualized care plan. The above information was confirmed with the Director of Nursing on 02/28/24 at 11:50 AM at which time, she agreed Weekly Skin Checks should be completed and should have been added to the resident's care plan at the time of the order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45171 Based on record review and staff interview the facility failed to provide treatment and services to prevent or heal pressure ulcers in accordance with professional standards of care. This was true for three (3) of four (4) residents reviewed for wound care. Resident identifiers: #30, #65 and #201. Facility Census: #191 Findings included: a) Resident #30 On 02/27/24 at 9:30 AM, a record review for Resident #30 found an active order to cleanse stage 3 to left gluteal fold with in house wound cleanser (IHWC), pat dry, apply bordered dressing every Monday/Wednesday/Friday and PRN as needed and cleanse stage 4 to the sacrum with IHWC, pat dry, apply Hydrofera blue, and cover with border dressing every Monday, Wednesday, Friday and PRN as needed. There are orders for a wound care consult, air mattress to bed, and an overhead bed trapeze of which all are present. The facility Skin Care and Wound Management Policy #NS 1400-00 states: Policy: The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds . Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. During an interview with the Director of Nursing on 02/27/24 at 3:35 PM, she stated if a new skin wound was identified, the nurse did a Skin Grid Sheet. This is usually identified during a shower or bath. They do a Weekly Skin Check Sheet if the resident has a wound identified. Wounds are accessed weekly with measurements and treated as ordered by the Physician. They consult an outside source, Healing Partners, to assist with wound treatment recommendations, measurements and staging if needed. The Wound Nurse Practitioner comes four (4) days a week. They also have in house wound nurses and all nurses in house can do wound care treatment orders. Review of Resident #30's records show he was admitted with these wounds on 12/18/23. There is no order in place for Weekly Skin Checks and there has been none completed since 12/19/23. Review of the Bed Mobility Task sheet and observation of the resident himself, he is able to turn and reposition himself by utilizing the over bed trapeze at times. This was confirmed with the Resident on 02/28/24 at 11:05 AM during an interview and observation of the dressing change. Observation of wound care notes and measurements showed the wounds were improving since admission. Review of the Treatment Administration Records showed the treatments were being completed as per Physicians orders. Review of the Residents individualized care plan for impaired skin integrity shows there was an intervention in place to complete Weekly Skin Checks as well as ensure residents are turned and repositioned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above information was confirmed with the Director of Nursing on 02/28/24 at 11:50 AM at which time, she agreed there should have been Weekly Skin Checks being completed. b) Resident #65 On 02/27/24 at 9:30 AM, a record review for Resident #65 found an active order to cleanse stage 4 to sacrum with in house wound cleanser (IHWC), pat dry, apply santyl, mupirocin, Hydrofera blue, and cover with border dressing every Tuesday, Thursday, Saturday and PRN as needed. There is an order for a wound care consult. The facility Skin Care and Wound Management Policy #NS 1400-00 states: Policy: The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds . Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. During an interview with the Director of Nursing on 02/27/24 at 3:35 PM, she stated if a new skin wound is identified, the nurse does a Skin Grid Sheet. This is usually identified during a shower or bath. They do Weekly Skin Check Sheet if the resident has a wound identified. Wounds are accessed weekly with measurements and treated as ordered by the Physician. They consult an outside source, Healing Partners, to assist with wound treatment recommendations, measurements and staging if needed. The Wound Nurse Practitioner comes four (4) days a week. The also have in house wound nurses and all nurses in house can do wound care treatment orders. Review of Resident #65's records show she was readmitted from a local hospital with these wounds on 01/23/24. There was no order in place for Weekly Skin Checks and there has been none completed since 01/24/24. Review of the Bed Mobility Task sheet and observation of the resident shows she is able to turn and reposition alone. This was confirmed with the Resident on 02/28/24 at 11:25 during an interview. Observation of wound care notes and measurements show the wound is improving since admission. Review of the Treatment Administration Records show the treatments are being completed as per Physicians orders. Review of the Residents individualized care plan for impaired skin integrity shows no intervention in place to complete Weekly Skin Checks. The above information was confirmed with the Director of Nursing on 02/28/24 at 11:50 AM at which time, she agreed there should be Weekly Skin Checks being completed and should be on the resident's care plan. c) Resident #201 On 02/27/24 at 9:30 AM record review for Resident #201 shows there was an active order to cleanse unstageable to sacrum with inhouse wound cleanser (IHWC), pat dry, apply calcium alginate and bordered dressing every other day and PRN as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There is an order for a wound care consult. The facility Skin Care and Wound Management Policy #NS 1400-00 states: Policy: The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds . Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition During an interview with the Director of Nursing on 02/27/24 at 3:35 PM, she stated if a new skin wound is identified, the nurse does a Skin Grid Sheet. This is usually identified during a shower or bath. They do a Weekly Skin Check Sheet if the resident has a wound identified. Wounds are accessed weekly with measurements and treated as ordered by the Physician. They consult an outside source, Healing Partners, to assist with wound treatment recommendations, measurements and staging if needed. The Wound Nurse Practitioner comes four (4) days a week. They also have in house wound nurses and all nurses in house can do wound care treatment orders. Review of Resident #201's records show she was admitted from a local hospital with these wounds on 01/20/24. There was no active order in place for Weekly Skin Checks and there has been none completed since 01/21/24. There was, however, an order placed on 01/20/24 at 09:36 PM for Weekly Skin assessment to be completed. Documentation to be completed on Weekly Skin Assessment. This order was revised/deleted on 01/21/24 at 04:55 AM. Review of the Bed Mobility Task sheet shows Resident #201 was unable to turn and reposition alone. Review of the Skin and Wound Progress Note shows the resident has poor bed mobility with new recommendations to .Recommend ongoing pressure reduction and turning/repositioning precautions per protocol . recommend placement of air mattress. Review of the January and February 2024 Bed Mobility Task documentation shows the resident had extensive assistance to total dependence with one (1) to two (2) person physical assistance. Documentation shows Resident #201 was not turned or repositioned on the following dates/shifts: 01/24/24 night shift 01/25/24 day shift 01/25/24 night shift 01/26/24 night shift 01/29/24 night shift 01/30/24 night shift 01/31/24 night shift 02/02/24 night shift (continued on next page)

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	515086	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/04/24 day shift 02/05/24 night shift 02/07/24 night shift Further review shows the resident was not turned or repositioned according to standard practice of care (turn every two (2) hours) on the following dates: 01/26/24 turned one (1) time on day shift 01/28/24 turned one (1) time on day shift 01/31/24 turned one (1) time on day shift There was an order for pressure reducing/relieving mattress on 01/20/24 at 9:36 PM and revised and deleted on 01/21/24 at 4:55 AM. There was no evidence that Resident #201 had a pressure reducing/relieving mattress ordered as it was not on the Treatment Administration Record during the time prior to her discharge on 02/09/24. Observation of wound care notes and measurements show the wound was improving since admission. Review of the Treatment Administration Records show the treatments were being completed as per Physicians orders. Review of the Residents individualized care plan for impaired skin integrity shows interventions were to be complete Weekly Skin Checks, educate resident/resident representative on need for turning and repositioning, encourage resident to turn and reposition or assist as needed as resident allows, ensure residents are turned and repositioned, provide appropriate off-loading mattress & offloading cushion if applicable. There were no orders for Weekly Skin Checks, turning and repositioning or offloading mattress or cushion. The above information was confirmed with the Director of Nursing, on 02/28/24 at 11:50 AM, at which time, she agreed there should be Weekly Skin Checks being completed. She also agreed that Resident #201 should have had orders for a pressure reducing mattress, turning, and repositioning.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40165 Based on policy review, staff interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as is possible and that each resident received adequate supervision and assistance to prevent accidents. A structure fire resulted in the activation of the facility fire alarm system. The facility staff did not begin evacuation after seeing smoke and hearing the fire alarm system. Two (2) residents were using illegal substances inside the facility. These substances include opiates that were not prescribed. The residents required Narcan due to overdose. Fire A total of 18 minutes elapsed from the time the fire alarm activated on the A-Wing, and the time the facility began to evacuate. The facility did not begin to evacuate until told to do so by emergency responders. The facility's failure to follow their Fire Safety plan and begin immediate evacuation upon discovery of a minor or major fire placed all residents currently residing in the facility at risk for serious bodily harm and/or death. These failures were determined to place all residents in an immediate jeopardy (IJ) situation. Fentanyl Residents #300 and #301 were using illegal drugs at the facility exposing other residents to potential hazards. The facility failed to take steps to protect other residents from the illegal drugs. This failure placed all residents currently residing at the facility at an immediate risk for serious harm and or death. Resident identifiers: #86, #87, #88, #88, #89, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #122. #300 and #301. Facility census: 191 Findings included: a) Fire Safety Plan Review of the facility's Fire Safety plan revealed the following directives: -Upon discovery of a minor or major fire, Call Code Red or Fire to available staff members for assistance. -Immediately remove endangered residents or staff from affected area and adjacent rooms. -If resident is bedridden, evacuate the resident in his/her bed as necessary. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	-Take residents/employees to safe area in the adjacent smoke compartment. b) Staff Interviews An interview was completed with Nurse Aide (NA) #62 on 02/26/24 at 1:20 PM. NA #62 reported she was assigned to work on the D-Wing but was on the C-Wing helping another NA with a resident when the fire alarm went off. Head counts were done on the C-Wing and the D-Wing and residents were placed in rooms and resident doors were shut. NA #52 stated maybe 15-20 minutes went by before the decision was made by the Sheriff to evacuate the A-Wing. NA #52 reported she assisted with the evacuation of the A-Wing. An interview was completed on 02/26/24 at 1:30 PM with NA #137. NA #137 was assigned to work on the E-Wing and at first thought it was just a drill when the fire alarm went off. As she walked over to the A-Hall to see what was happening, firemen were saying A-Wing needed to be evacuated and NA #62 went to get more help. After residents were safely evacuated in the dining room the NA went back to her assigned wing. An interview was completed with NA #116 on 02/26/24 at 1:45 PM. NA #116 was assigned to work on the C-Wing and recalled the fire doors closed at around 10:02. At first, staff thought it was just a fire drill because they had just had a fire drill on the nightshift. LPN #21 reported that it as a Code Red on the A- Wing. NA #116 stated she remained on the C-Wing and assisted in getting residents up in their chairs in case there was a need to evacuate the entire building. NA #116 stated she was told there were two (2) NAs and a nurse on the A-Wing who witnessed smoke coming out of the vent and the alarm reportedly sounded around the same time. An interview was completed on 02/26/24 at 1:58 PM with NA #53. NA #53 was assigned to work on the A-Wing. She reported that as soon as the fire alarm sounded sheltering residents in place began. Staff on the floor got a complete head count and started shutting resident doors. NA #53 believed it might have been the firemen who instructed the staff to evacuate the A-Wing. She recalled hearing, We need to evacuate but there was no specific plan that she was aware of. She stated she would have liked to have more training to know what her responsibilities would be if she heard the word evacuate. She reported residents, chairs and beds were taken to the dining room. An interview was completed with the ADON on 02/26/24 at 2:17 PM. The ADON reported she arrived at the facility at the same time the first emergency vehicle pulled into the facility's parking lot. Other emergency response vehicles began pulling into the parking lot as she was walking into the facility. The ADON reports she spoke to MDS LPN Nurse who reported the fire panel showed there was a problem on the A-Wing. She reported she believed it was the firemen who said, we're evacuating A-Wing. The ADON reported the fireman also made the decision to evacuate the first four (4) rooms on the B-Wing as a precaution as well. An interview was completed on 02/26/24 at 2:33 PM with NA #146. NA reported she was assigned to work on the A-Wing. When the fire alarm first sounded the NA was in a male resident's room providing care. After finishing in that room, she made her way to the hallway where the nurse was trying to comfort Resident #101 who always gets upset when the fire alarm goes off because she had a child perish in a fire. Another NA walked by and stated, It might be real referring to the fire alarm. NA #146 reported it was the Sheriff who made the decision to evacuate residents off the A-Wing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	c) Resident Interview During an interview on 02/26/24 at 3:30 PM, Resident #107 stated she heard the alarm go off and there was either a deputy or a firefighter that came sometime later and started to evacuate us at the end of the A-hall around the building to the dining room. d) Interview with Assistant Fire Marshall During an interview, on 02/26/24 at 12:55 PM, the Assistant Fire Marshall shared his insights on how the facility failed to move residents upon the sight of smoke. Expressed concern that the facility did not evacuate their building properly per their Fire Safety Plan. He noted if it had been a real fire it had potential to be a complete disaster. e) Review of Facility Video on 02/26/24 at 3:15 PM Review of the facility's video of the A-Wing on 02/24/24 revealed the fire alarm activated at 9:49 AM. MDS LPN #54 could be seen calling 911 at 9:50 AM. MDS LPN #54 could be seen looking at the fire panel and pointing to the A-Wing. At 10:04 AM, an employee from the Sheriff's office arrived. At 10:07 AM the facility began evacuating residents from the A-Hall. A total of 18 minutes elapsed from the time the fire alarm activated, and the time the facility began to evacuate residents. f) Interview with the Nurse in Charge During an Interview with MDS LPN #58, on 02/26/24 at 4:24 PM, she stated she was the nurse on the B-Wing and had just finished medication pass and sat down at the Nurses Station. When she saw smoke, she thought it was from where a resident had taken a shower and that perhaps the heater had gotten hot. She saw smoke on A-Wing and called, Code Red A Wing and repeated this three (3) times. This was about 9:51 AM - 9:52 AM. She stated that Maintenance turned off something and there was no more smoke. She stated that they did not evacuate any residents but did shut the doors to resident rooms. When the Sheriff and EMS arrived, they ordered the residents to be evacuated. When asked how they determined who they evacuated first (triage) she stated that they just started evacuating residents. She stated that there were eight (8) residents in beds. The facility was notified of the Immediate Jeopardy (IJ) at 6:28PM on 02/26/24. The State Office approved the facility's POC at 9:25 PM on 02/26/24. After observation, staff interview, review of facility documentation, and record review determining the implementation of the POC, the IJ was abated at 12:24 PM on 02/27/24. The IJ started on 02/24/24 at 9:49 AM and ended on 02/27/24 at 12:24 PM. The facility's approved abatement POC consisted of the following: 1. All residents were interviewed for potential post event trauma by the Director of Nursing and designees on 2/26/24. There were no negative findings with residents. All Responsible Parties were notified via a Caller Multiplier on 2/26/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review found Resident #300 was admitted to the facility on [DATE]. He was discharged from the facility on 01/12/24. On 12/28/23, the facility physician determined the resident had capacity to make medical decisions. The resident's care plan noted the resident wished to be discharged to home once his clinical and therapy goals were achieved. The resident was care planned on 01/02/24 for a substance use disorder related to opioid dependence and a history of methamphetamine abuse. The goal associated with this focus was, Will not use illegal drugs in facility. This care plan was initiated on 01/02/24, four (4) days after his admission. Interventions included: - Administer medications per medical provider's orders. - Observe for side effects and effectiveness. - Report abnormal findings to medical provider and resident. - Educate resident on following the prescribed treatment regime and leave of absence policy. - Encourage resident to express feelings regarding addiction. - Evaluate resident for stumbling, nodding off even when standing or in mid conversation, incoherent speech, slurred speech, rambling, sleepy, erratic behavior, hyperactive, threatening, hostile, blood shot eyes, pinpoint pupils, pale face, sweaty unruly appearance, fumbling, nervous, jerky movements. On 12/23/23, the facility physician prescribed an opioid medication, Oxycodone HCl 15 milligrams every 4 hours for pain. The following progress notes were found in the medical record: A note dated 12/28/23 at 6:35 PM revealed the resident was alert and oriented and signed out for visit and to go to get some supplies from store. The note stated the resident was educated to be back to facility by midnight. There was no documentation as to how the resident was going to get to the store to get supplies. The next progress note written at 8:04 PM on 12/28/23 noted the resident's medication could not be given because he was out of the facility. There was no documentation regarding what time the resident returned to the facility or his condition upon return. A note dated 01/02/24 at 12:50 PM revealed staff observed the resident snorting a white substance off his dresser in Room #E12a. BP (blood pressure) was 126/100 HR (heart rate) 72. Pupils were pinpoint. The medical director was notified and there was a new order to hold the12:00 PM dose of oxycodone. The registered nurse (RN) supervisor and administration were aware of the situation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	(Room #E12 was occupied by Resident #301 which will be discussed under his medical record review below) The medical director ordered a urine drug screen. The results of this drug screen dated 01/02/24 found the Resident tested positive for THC (Tetrahydrocannabinol) and opiates. On 01/05/24 at 1:51 PM a medical record note revealed the resident signed out to leave the facility for a short time. The next note written on 01/5/24 at 5:53 PM revealed the resident was out of the facility. There were no notes indicating when the resident returned to the facility or his condition when he returned. On 01/06/2024 at 3:15 AM a note revealed a facility nurse was notified by a nurse aide that the resident was on the floor next to his bed. The note reflected that when the nurse entered the room the resident was sitting on the floor with his head against the dresser, not responding to verbal stimuli. The nurse was able to wake the resident up, but he was not answering questions appropriately, was nodding out, and there was a noted drop in his blood pressure, The note reflected the nurse contacted someone from a program who the resident was affiliated with. A worker from that program attempted to ask the resident questions. The resident was unable to answer. There was an order for the resident to be sent out to ER (emergency room) for evaluation. The nurse called 911 and as emergency medical services (EMS) were in route, the resident was nodding out and his blood pressure dropped to 77/43. An order was given to administer Narcan (Naloxone). The resident became more alert and able to answer questions. His blood pressure returned to normal. The resident transferred via EMS (emergency medical squad) to (Name of a local hospital) for evaluation. A note dated 01/06/24 at 6:29 AM revealed the resident returned to the facility at 6:30 AM via ambulance on stretcher. DX (diagnoses) fentanyl overdose. He was given clonidine 0.1mg for blood pressure. On 01/08/24 at 9:09 AM a note revealed the resident left the facility at this time via public transit. Resident stated he was going to an appointment. There was no indication an appointment was scheduled by the facility. There was no documentation as to where the resident was going. On 01/8/2024 at 1:59 PM (five (5) hours later) Nurses Note revealed the resident returned to facility at this time via public transit. (There was no indication the resident was assessed for his condition after his return.) An interdisciplinary team meeting note dated 01/09/24 at 3:45 PM revealed, Resident has used illegal, non-prescribed, controlled substances on at least two known occasions in the facility since admission on 12/22/23. Resident observed vaping a marijuana vape device and snorting a white powder on 01/02/24, physician was notified, and drug screen ordered, which was positive for THC. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Drug abuse support offered and refused, he resigned the facility non-smoking and non-drug use policy and expressed clear understanding that he was not permitted to smoke, bring illegal substances in facility. On 01/06/24 he was sent out to the ER after the Licensed Nurse administered Narcan for a fentanyl overdose. He stated he obtained the drug from a friend outside of the facility. Police were notified and State Troopers came in and spoke to (Name of Resident.) (Resident) has been leaving the facility unattended, signing himself out. Therapy has issued a NOMNC (Medicare non-coverage) as he has reached his potential and the last day of treatment will be Thursday, 1/11/24. (Name of Resident) BIMs (Brief interview for mental status) is 15 and he has capacity. On 02/27/24 at 2:03 AM, the Administrator and the DON were interviewed. The DON stated the resident had capacity and there was no abuse or neglect suspected to report. He was free to leave the facility for outings. Both employees were asked about the risk to other residents and the roommate of this resident during his drug usage. They were asked how the facility ensured other residents and staff were not at risk when a white powder was found in Room #E12A on 01/02/24 noted to be used by Resident #300. The DON said they had no reports of any other residents approaching the two (2) residents involved in illegal drug usage at the facility. The DON confirmed this resident did have a roommate at the time of both incidents. The administrator stated the facility called the police after Resident #300 received Narcan on 01/06/24 but were told there was nothing they could do. The DON confirmed the police were not called after the 01/02/24 incident. According to the DON, the State Police came and searched the room but found no drugs and said the Resident had capacity. The administrator said the police were asked for a report, but nothing was ever provided. In addition, they were asked if the resident was assessed after all his trips out of the facility. Both were asked to provide evidence of their investigation after the 01/02/24 incident of the white powder being found on the dresser and the IDT team noted the resident was using a marijuana vape pipe on 01/02/24. They were asked was the incident on 01/06/24, when the resident received Narcan and was sent to the hospital, investigated. Both staff confirmed the resident was diagnosed with a Fentanyl overdose on 01/06/24. They were asked where the resident got the Fentanyl. Both employees confirmed the Resident was not prescribed Fentanyl at the facility. The administrator and the DON said they believed Resident #301 was supplying the illegal drugs. During an interview, at 2:27 PM on 02/27/24, with Licensed Practical Nurse (LPN) #60, the author of the 01/02/24 note, (Staff observed resident snorting a white substance from dresser in E12a. BP (blood pressure) 126/100 HR (heart rate) 72. Pupils pinpoint. (Name of medical director) notified and new order to hold oxycodone 12 pm dose. RN supervisor and administration is aware of situation.) was asked about her role during the incident. LPN #60 said the staff person who observed the incident was a nurse aide (NA) who no longer works at the facility. LPN #60 said, I don't even remember her name. I wrote the note and reported this to my supervisor, that was my role in the situation. My supervisor said he was calling the administrator and the DON. I believe the administrator did come in to talk with the resident. I did not get any statement from the NA. On the afternoon of 02/27/24 around 3:30 PM, the DON provided an occurrence report that contained the same information as the progress note written on 01/06/24. A typed note on a separate piece of paper with this occurrence number noted the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Resident #300 and Resident #301 were both placed on one-on-one observation in their respective rooms. The nurse phoned 911 to request an officer respond to the facility to have both residents' rooms searched for drugs. The officer stated he could only search if the Residents consented to the search. Each Resident consented to have their room and belongings searched. Officer (name) conducted the search. No drugs or paraphernalia were found. Both residents admitted to smoking, it. Neither resident would state what was contained in the aluminum foil they smoked. Resident #301 said a friend of his brought it in for him. Officer (Name) stated he would complete the report, but that it would be an informational report. The DON said the residents were placed on one (1) on one (1) supervision on 01/06/24 from when the police were called until the police arrived at the building. The DON said the resident was offered counseling but refused. The DON was unable to provide any further information regarding this incident and no information was provided noting how the other residents at the facility were protected from the illegal drug usage of Resident #300. c) Resident #301 Record review found this Resident was admitted to the facility on [DATE] and was discharged on [DATE]. The resident was found to have capacity on 12/28/24. On 12/29/23 the resident was prescribed Percocet 7. 50325 milligrams, 1 tablet every 6 hours for pain. On 12/27/23 the Resident was prescribed Oxycodone 5 milligrams every 6 hours for pain. The Resident was care planned on12/27/23 with a revision date of 01/17/24. The care plan was for: Utilizing nicotine products and having used illegal drugs in facility since admission and has been observed vaping in his room. The goal associated with this problem was: Resident will utilize nicotine products in a safe manner. Interventions included completing a smoking evaluation on 12/27/23 and complete smoking evaluation - 12/27/23 Provide safe smoking devices, if required, such as smoke blankets, smoke aprons and cigarette extenders - 12/27/23. On 01/09/23 an intervention was added to observe for altered mental status and other signs that may indicate drug impairment. On 01/02/24 at 10:44 AM the resident was re-educated resident on facility smoking policy that was signed upon admission to facility. The resident was educated resident that this was a non-smoking facility and that a vaping fell under that. Risks and benefits discussed with the resident. Resident stated that his son brought the vape to him. Educated resident that his son should not bring anymore vapes to him. Resident has capacity and he stated that he understood. Resident denied wanting nicotine patch at this time. (continued on next page)

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	515086	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	(This resident's nursing notes did not include any information about Resident #300 being in Resident #301's room snorting a white substance off his dresser. Resident #300's progress note on 01/02/24 noted he was observed snorting a white substance off dresser in Room #E12a. Resident #301 was residing in Room #E12A on 01/02/24. On 01/03/24 a nursing note written at 12:45 PM, revealed the resident left the facility via taxi service. This nurse educated the resident on the importance of staying in the facility to participate in therapy and receive treatment. Resident verbalized understanding. 01/03/24 at 5:28 PM a nursing note revealed the resident returned to the facility at this time. There were no notes to indicate the Resident was assessed upon his return. A late entry note dated 01/05/24 at 9:00 PM revealed the resident was found on the toilet in bathroom of Room #E12, lethargic, diaphoretic, and disoriented. The resident's vitals were taken, the resident was unable to answer questions appropriately, notified (name of on-call physician services,) ordered Narcan for patient. Narcan was given per order, resident answering questions appropriately, vitals within normal limits. There were no notes indicating the resident was ever assessed again after the Narcan was administered. An interdisciplinary team note dated at 2:50 PM on 01/09/24 was a follow up to illicit drug use in the facility on 01/01/24 and 01/05/24. The administrator, DON and vice president of risk management were all involved in the meeting. According to this note the resident was observed vaping marijuana on 01/01/24 and was provided with the opportunity for substance abuse support and declined. The resident re-signed the facility policies on smoking and illegal drug use and stated understanding. On 01/05/24 nursing staff found him unresponsive, contacted the physician, and administered Narcan. He responded and was able to disclose that he had used fentanyl that he got from another individual. Police were involved and came to the facility; State Troopers were the response team and addressed the resident. The resident allowed nursing staff to search the room and they removed drug residue and paraphernalia. Yesterday he walked out of the facility and headed to the local gas station after refusing to sign himself out. Earlier today while he was in his room a staff member observed him release what appeared to be a puff of smoke. When questioned about the incident he first denied smoking, then stated he had smoked/vaped on a vape pen he got at gas station but threw the pen away, and then when asked again to hand over the device he handed it to this author. It was concealed in his glove. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The medical record revealed a meeting held with the resident to discuss the two (2) instances of illegal drug use in facility since his admission on 12/27/24. Explained that it was not allowed and that police would be involved if it happened again. Also, addressed today's vaping episode. The resident stated understanding. Therapy had issued Notice of Medicare Non-Coverage (NOMNC) because he had reached his maximum potential in therapy and (Name of Resident) will be discharging either Thursday afternoon or Friday morning. During the meeting he gave permission, and we contacted his son (Name of son) by phone. The facility staff explained to the resident that they were concerned about the safety of other residents and staff and that if there was another incident of drug use or any indication of activity that the police would be notified. The resident stated understanding. The resident was again offered referral for substance use support and he declined stating that he did not need it. On 02/27/24 at 2:03 AM, the Administrator and the DON were interviewed. The DON stated the resident had capacity and there was no abuse or neglect suspected. He was free to leave the facility for outings. Both employees were asked about the risk to other residents and the roommate of this resident during his drug usage. The DON confirmed this resident did have a roommate at the time of the incident. Staff were asked how the facility ensured other residents or even staff were not at risk when a white powder was found in Room #E12A on 01/02/24. They were asked who cleaned the room after the white powder was found and how was the room cleaned. They were also asked if anyone investigate or confirm what the white powder was. The DON stated Resident #301 was involved in the incident in his room on 01/02/24 with Resident #300 even though his progress note stated he had a vape pen. She said both residents were using a marijuana vape pen . Resident #301 received Narcan on 01/05/23 but the DON said since this resident had a positive reaction to the Narcan, he was not sent to the hospital. No drug testing was ordered for Resident #301 to determine what substances he had used that resulted in the use of Narcan. The DON confirmed Resident #301 admitted to using Fentanyl himself. The DON confirmed the police were not called until 01/06/24 after the incident with Resident #300. The DON said the staff felt Resident #301 was getting the drugs for himself and Resident #300. That was why the police were asked to search both Resident rooms on 01/06/24. On the afternoon of 02/27/24 around 3:30 PM, the DON provided an occurrence report noting the following: (Name of Resident #301) was found on the toilet in his bathroom unresponsive. Narcan was given per order. The DON provided the same statement for this resident's occurrence as provided for the occurrence report with Resident #300. Resident #300 and Resident #301 were both placed on one (1) on one (1) observation in their respective rooms. The nurse phoned 911 to request an officer respond to the facility to have both residents' rooms searched for drugs. The officer stated he could only search if the residents consented to the search. Each Resident consented to have their room and belongings searched. Officer (name) conducted the search. No drugs or paraphernalia were found. Both residents admitted to smoking, IT. Neither resident would state what was contained in the aluminum foil they smoked. Resident #301 said a friend of his brought IT in for him. Officer (Name) stated he would complete a report, but that it would be an informational report. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The DON was unable to provide any documentation, other than calling the State Police and filling out an occurrence report to show how the other residents were protected during Resident #301's drug usage. No information was provided to conclude an investigation was conducted to determine the source of the white powder on the dresser in this resident's room seen on 01/02/24. No information was provided to include how the room was cleaned or if the condition of the resident's roommate was assessed or if any other residents were assessed for possible drug usage or exposure to the drugs used by Resident's #301. According to the Centers for Disease Control (CDC) Fentanyl even in small doses can be deadly. It is among the most common drugs involved in overdose. Fentanyl can be absorbed into the body via inhalation, oral exposure or ingestion, or skin contact. When coming into contact with Fentanyl, the CDC recommends wearing nitrile gloves; respiratory protection if powdered illicit drugs are visible or suspected; avoid performing tasks or operations that may cause illicit drugs to become airborne; do not touch eyes, nose or mouth after touching any surface that may become contaminated; wash hands with soap and water, do not use hand sanitizer or bleach. The facility was notified of the Immediate Jeopardy (IJ) at 4:47 PM on 02/27/24. The State Agency (SA) approved the facility's Plan of Correction (POC) at 6:45 PM on 02/27/24. The IJ was abated at 12:18 PM on 02/28/24. The facility's approved abatement POC consisted of the following: 1. All residents with a diagnosis of illicit drug use were reviewed and assessed for signs and symptoms with no findings. 2. All residents who have the potential to come into contact with illicit drug use while in the facility have the potential to be affected. DON/Designee will initiate all staff education on 2/27/24 on observing for signs and symptoms of being under the influence of drugs. In the event of occurrence, order will be on MAR to observe all residents for being under the influence of drugs. Residents will be monitored every 12 hours for 72 hours unless additional monitoring is deemed necessary. If staff visually notice any drugs or patients impaired this will be reported immediately to their supervisor. Staff educated not to touch drugs and for residents receiving Narcan will have increased observation until the resident is transported to an acute care facility. The facility will request a toxicology report prior to the resident returning to facility. Facility will notify local law enforcement and initiate an internal investigation. Resident will be educated on substance abuse and staff will attempt to provide substance abuse counseling. Center will update CP and educate the resident if found to be a repeat offender will be subjec[TRUNCATED]

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 30153 Based on staff interviews and medical record review, the facility administration (Administrator and Director of Nursing) who knew illegal drugs were being used and brought into the facility, failed to administer the facility in such a manner as to protect other residents and promote their highest practicable level of mental and physical well-being. In addition, two (2) residents had to be administered Narcan and sent to the local hospital after using illegal drugs. Resident identifiers: #300 and #301. Facility census: 191. Findings include: a) Resident #300 and #301 Residents #300 and #301 were observed using illicit/illegal drugs at the facility. Both Residents received Naloxone for a suspected drug overdose. Resident #300 was diagnosed with a Fentanyl overdose. According to facility documentation Resident #301 admitted to using Fentanyl. Fentanyl was not prescribed by the facility for either resident. In addition, both residents were observed to be using a marijuana vaping device. No interventions were put in place to assess and protect other facility residents and staff from possible exposure and risk of harm, including the roommates of Resident #300 and #301. b) Interdisciplinary Team (IDT) On 01/9/24 at 3:45 PM, an IDT Follow Up note was written: Resident #301 Date of review: 1/9/24 Type of incident: Resident has used illegal, non-prescribed, controlled substances on at least two known occasions in the facility since admission on 12/22/23. What was happening at the time: Resident observed vaping a marijuana vape device and snorting a white powder on 01/02/24, physician was notified, and drug screen ordered, which was positive for THC. Drug abuse support offered and refused, he resigned the facility non-smoking and non-drug use policy and expressed clear understanding that he was not permitted to smoke, bring illegal substances in facility. On 01/06/24 he was sent out to the ER after the Licensed Nurse administered Narcan for a Fentanyl overdose. He stated he obtained the drug from a friend outside of the facility. Police were notified and State Troopers came in and spoke to Resident #301. Therapy has issued a Notice of Medicare Non-Coverage as he had reached his potential and the last day of treatment will be Thursday, 1/11/24. Resident #301 had BIMS (Brief interview for mental status) of 15 and he had capacity. Root cause of incident: Illegal substance abuse (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Intervention(s) put into place: Observe for altered mental status or non-prescribed substances, notify Administrator and physician immediately if present. Care plan updated: Yes Other essential information: This IDT team met with (Resident) today to discuss his discharge plans and the illegal drug activity that has occurred since admission. Explained the concern about placing other residents and staff at risk. He acknowledged the risk to others. He is planning to discharge to his apartment in (Name of local town,) his niece (Name of Niece) was contacted during the meeting, and she agrees that she is providing transportation for him to the apartment on Friday, 1/12/24 and will be here at 11:00. We explained during that call that per (Name of Resident) request his medications/prescriptions will be called into (Name of pharmacy) and they will be ready for pick up when he leaves. We explained that if there is any indication of drug activity for the remainder of his stay that we will notify the police and will press charges for creating a hazard to others. (Name of Resident) expressed understanding. He stated that he does not have any more appointments or reason to leave the facility again between now and his discharge and plans to remain onsite until that time. He stated that he does not need any equipment in his apartment on discharge, that he is using his leg without issue and getting around fine. We offered to connect him with resources to assist in addressing substance dependency and he stated he was not interested. (Name of Resident) agreed that he will not participate in any more drug activity during his stay. Physician is being contacted for discharge orders and instructions. IDT members involved in this follow up: Name of Administrator, Name of Director of Nursing (DON) and name of a vice president of risk management. On 02/27/24 at 2:03 PM, the Administrator and the DON were interviewed. The DON stated the resident had capacity and there was no abuse or neglect suspected to report. He was free to leave the facility for outings. Both employees were asked about the risk to other residents and the roommate of this resident during his drug usage .How did the facility ensure other residents or even staff were not at risk when a white powder was found in Room #E12 A on 01/02/24 noted to be used by Resident #300? DON said, We had no reports of any other residents approaching the two (2) residents involved in the illegal drug usage at the facility. The DON confirmed this Resident did have a roommate at the time of both incidents. The Administrator stated the facility called the police after Resident #300 received Narcan on 01/06/24 but were told there was nothing they could do. The DON confirmed the police were not called after the 01/02/24 incident. According to the DON, the State Police came and searched the room but found no drugs and said the Resident had capacity. The Administrator said the police were asked for a report, but nothing was ever provided. In addition, they were asked if the resident was assessed after all his trips out of the facility. Both were asked to provide evidence of their investigation after the 01/02/24 incident of the white powder being found on the dresser and the IDT team noted the Resident was using a marijuana vape pipe on 01/02/24. The Administrator and DON confirmed the resident was diagnosed with a Fentanyl overdose on 01/06/24. The Administrator and DON confirmed the resident was not prescribed Fentanyl at the facility. The Administrator and the DON said they believed Resident #301 was supplying the illegal drugs.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 22140 Based on observation and staff interview, the facility failed to ensure the resident call system was operable. This was a random opportunity for discovery. Resident identifier: #125. Facility census: 191. Findings included: a) Resident #125 While obtaining the water temperatures in Room B-5 with the maintenance director (MD) #124. Resident #125 was asking to be pulled up in bed and stated, I can't do it myself. The surveyor asked if she had turned on her call light to ask for help. Observation revealed the call ligh was broken and could not be used to summon help from staff. The resident was unable to say how long the call light had not been working. MD #124 stated he would fix this immediately. At 12:23 PM on 2/28/24, the administrator was advised of the above observations.