STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50551 Based on resident interview, record review and staff interview, the facility failed to ensure each resident was treated with dignity. This was a random opportunity for discovery. Resident identifier: #12. Facility Census: 63. Findings include: a) Resident #12 On 08/25/24 at 11:40 AM, during an interview with Resident #12, she reported when she pressed her call light it often took staff up to 20 minutes to answer. Resident #12 had a privately paid care giver in the room with her who agreed with the statement of the resident. Resident #12 reported, if she asked to go to the bathroom, she required the use of a lift to put her in the bed to use the bedpan, and staff would make her go to bed for the remainder of the day and would not let her get back up until the following day. On 08/27/24 at 2:00 PM, observed Nurse Aide (NA) #51 exit Resident #12's room with a lift. She reported she had just put the resident on the bedpan. She stated, Resident #12 has a private sitter due to blindness. She stated the resident gets up out of bed around 10:30 AM, will do her therapy and eat. She then calls to use the bedpan around approximately 1:30 PM- 2:00 PM. She stated Resident #12 had to be transferred to bed using a lift. After using the restroom, the resident normally likes to stay in bed the rest of the day. On 08/27/24 at 3:08 PM, an additional interview was conducted with the resident and private care giver, different from the initial care giver interviewed. Resident #12 reported there were times she felt like she was being punished for needing to use the bathroom. She stated, when she asked to use the bedpan, she was told Once you go to bed you cannot get back up. Resident #12 reported that sometimes she wanted to get back up but was told, That is against the rules. Resident's care giver reported she has heard a nurse aide suggest resident pee herself (use her brief so she does not have to go back to bed.) (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 3:38 PM, the information obtained from the interviews with the resident and the two (2) caregivers was reported to the Director of Nursing (DON) who stated, she was unaware of these issues and had never had a complaint from this resident but would report it to the proper channels and investigate. On 08/27/24 at 4:22 PM, review of Resident #12's care plan revealed the following: Resident at risk for falls. intervention: transfer assistance assist of 2 (two) total lift full body sling medium with purple binding. maximum physical activity to enhance general muscle tone, functioning of lower G.I. tract, and ability to mobilize to bathroom in response to urge to defecate. Encourage resident to attend activities that maximize their full potential while meeting their need to socialize.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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. 50551 Based on observation, staff interview and resident interview, the facility to ensure call light was placed in a position which would allow the resident to use it if she needed to call for help. This is true for one (1) of 22 sampled residents reviewed during the long term care survey process. Resident Identifier: Resident #35. Facility Census: 63. Findings include: a) On 08/26/24 at 10:55 AM, an observation found Resident #35 resting in her bed. Her call light button was clipped to the left side of her bed and was hanging down toward the floor. Resident #35 reported she was not able to use her left hand at all and was not able to use the call bell when it is clipped to the left side of her bed. On 08/26/24 at 11:00 AM, when Licensed Practical Nurse (LPN) #17 came into the room, she acknowledged the light was clipped to the non dominant side of the resident and moved it to the right side of the bed and placed it in HER dominant hand. She stated, resident had been working with physical therapy to try to strengthen the left hand. On 08/29/24 at 12:55 PM, The Director of Nursing (DON) #54 and Nurse Educator #34 acknowledged the resident's minimum data set (MDS) indicated the resident is dependent with upper extremities, physician believed maybe edema was causing the issue. No documentation on this from physician addressing Resident #35's use of her left hand could be found in the medical record. Both acknowledged the resident is not care planned nor does she have a diagnosis for inability to use her left hand but did acknowledge the resident was having difficulty using it. They reported therapy had been working with her with her use of the left hand. They stated they would change her call light to a flat device which could easily be used by the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49650 Based on observation, staff interview and the facility policy, the facility failed to ensure the residents had a comfortable, homelike environment. Meal tray service without removal of tray, and staff storing trash bags in residents room on residents hand towel rack. This was a random opportunity for discovery and had the ability to affect a limited number of residents. Resident identifier: Meal tray service without removal of tray and staff storing trash bags in residents room on residents hand towel rack. Facility census: 63. Findings include: a) Meal tray service without removal of tray. During an observation of the serving of the meal trays on 08/25/24 at approximately 11:50 AM the trays were being placed on the table for the residents and not being removed. During an interview with the Assistant Director of Nursing (ADON) on 08/25/24 at approximately 11:53 AM the ADON acknowledged the trays were not being removed from the table and agreed that the trays should have been removed. During an interview with the Administrator on 08/25/24 at approximately 12:00 PM, the administrator agreed that the trays should have been removed. The Administrator then provided the facility policy titled NSG270 Meal Service This policy states that when serving meals in a dining room with tray service, they staff is to deliver the food to the patient, remove the plate cover and remove the tray. b) B hall residential rooms During a tour of entire Unit B hall way on 08/25/24 at 9:58 AM all the residents rooms on Unit B was observed to have numerous trash bags stored on the hand towel rack with clean towels and wash clothes above the residents sinks. During an interview with Licensed Practical Nurse (LPN) #50 on 08/25/24 at approximately 10:00 AM LPN #50 stated the staff keep them stored there for the staff personal use and agreed it did not create a homelike environment for the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49467 Based on observation and resident and staff interview, the facility failed to ensure residents of the facility were free from abuse and neglect due to a Nurse Aide (NA) neglecting their duties, not serving Resident #2 lunch in a timely manner, and ensuring other residents were free from abuse by Resident #16. These were random opportunities for discovery. Resident identifiers: #2, #6, #24, #16. Facility census: 63. Findings include: a) Nurse Aide (NA) #39 At approximately 11:30 PM on 08/26/24, NA #39 was observed sitting in the area labeled Resident Sitting Area on her cell phone while a call light in her assigned area was ringing. NA #39 continued to look down at her phone and not answer the call light until approximately 11:38 PM. At approximately 11:42 PM, NA #39 returned from the room to the Resident Sitting Area, set back down in the chair, and resumed usage of her cell phone. At approximately 11:58 PM, a call light was pressed in room [ROOM NUMBER], another assigned room for NA #39. The call light rang for approximately three (3) minutes and was answered by Registered Nurse (RN) #21, who had left the medication cart to answer the light. Upon exiting room [ROOM NUMBER], NA #39 was observed still sitting in the chair in the Resident Sitting Area, on her phone, while RN #21 answered the call light for her room. At approximately 12:05 AM on 08/27/24, NA #39 stood up from the seat in the Resident Sitting Area and went out the back door for a smoke break. NA #39 re-entered the facility at approximately 12:15 AM and immediately returned to the chair and resumed usage of her cell phone. b) Resident #2 At approximately 1:55 PM on 08/27/24, Resident #2 asked Licensed Practical Nurse (LPN) #17 for some food due to her sleeping through lunch. Resident #2's lunch tray was observed sitting on her bedside table with the lid still on the plate, untouched. Resident #2 stated her food was cold and she would like to have a hot dog. LPN #17 stated, I'm not sure if they can make a hot dog but we can probably do a grilled cheese. Resident #2 stated that would be fine and LPN #17 stated she would let the kitchen staff know to make a grilled cheese. At approximately 2:35 PM an interview was conducted with Resident #2. At this time, Resident #2 states she was hungry due to her not getting her food from the kitchen. At this time, an interview was conducted with the Dietary Manager (DM) regarding food for Resident #2. The DM stated no one had come to the kitchen with a request for food for Resident #2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 3:05 PM, Resident #2 still had not received her food. At this time, another interview was conducted with the DM regarding food for Resident #2. The DM stated there still had not been anyone to come request food for Resident #2, but the kitchen would go ahead and make it and deliver it. The DM delivered food to Resident #2 at approximately 3:15 PM, one (1) hour and twenty (20) minutes after the resident initially requested food. c) Resident #16 On 08/27/24 at approximately 12:00 PM, a record review was conducted for Resident #16. During the record review, Resident #16 was noted to have the following diagnoses: Anxiety disorder, unspecified, date 02/10/17 Insomnia, unspecified, date 03/25/17 Major depressive disorder, unspecified, date 02/10/17 Schizoaffective disorder, bipolar type, date 05/17/24 Psychotic disorder with hallucinations, date 12/15/23 Unspecified dementia, unspecified severity, date 02/10/27 Alzheimer's disease, unspecified, date 12/31.20 Vascular dementia with behavioral disturbance, date 12/31/20 Resident #16 was also noted to be receiving the following medications: Clonazepam 0.5 milligram (MG) 1 (one) tablet by mouth three times a day Cymbalta 60 MG 1 (one) capsule by mouth one time a day Nuplaid 34 MG 1 (one) capsule by mouth one time a day Remeron 15 MG 1 (one) tablet by mouth at bedtime In addition the following care plans related to behavioral patterns: Focus: (First Name of Resident #16) has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium. Resident becomes agitated and aggressive at times. verbally cursing: Dementia (other than Alzheimer's disease), Parkinson's disease, Short/long term memory loss, Impaired decision making. Her spouse serves as MPOA assisting with decision making Goal: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(First name of Resident #16) will make daily decisions/choices about activities of daily living when provided with appropriate level cues and supervision by the next review date. Interventions: Observe and evaluate types of changes in cognitive status, e.g., confusion, orientation, forgetfulness, decision making ability, ability to express self, ability to understand others, impulsivity, mental status and notify physician as needed. Monitor for pain. Attempt non-pharmacological interventions to alleviate pain and document effectiveness. Administer pain medication as ordered by physician and document effectiveness/side effects. Evaluate responses from Brief Interview for Mental Status (BIMS) or Staff Assessment for Mental Status and address as indicated. Redirect resident/patient using external cues (e.g., calendar, date book, radio, television etc.), as needed. Provide consistent, trusted caregiver and structured daily routine, when possible. Personalize the resident's/patient's room with familiar items to assist him/her in identifying the room Explain all care, including procedures (one step at a time.), and the reason for performing the care before initiating. Call resident/patient by his/her preferred name for self identity. Focus: Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to : Anxiety/fear caused by move into/within Center and/or inability to return home, coping with acute/chronic illnesses, dx of anxiety and depressive disorder as evidenced by (AEB) she will verbalize her anxiousness, crying/tearful and verbalizing sadness, agitation AEB cursing hitting staff. Goal: Resident/Patient will express anxieties/fears to staff regarding coping with acute/chronic illnesses, care at facility, therapy services by next review. Interventions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident frequently asks for a cigarette to calm her nerves as this was her coping mechanism at home. Facility to provide resident with an imitation cigarette that she can hold when she becomes agitated or anxious. Resident has a cigarette pouch that the imitation cigarettes are kept in to mimic her previous smoking habits. An ashtray has been provided for resident to dispose of her imitation cigarette. Observe laboratory test results and report abnormal results to physician/advanced practice provider. Observe for pain and effectiveness of current interventions. Attempt non-pharmacologic interventions. Observe for signs of delirium, including delusions/hallucinations; notify physician/advanced practice practitioner as needed. Observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation. Determine the psychosocial cause for the residents/patients sadness/depression, anxiety/fear or persistent anger/agitation. Encourage resident/patient to seek staff support for distressed mood. Refocus resident/patient to something positive. Allow time for expression of feelings, voice her concerns and talk through the problems; provide empathy, encouragement and reassurance. Encourage resident/patient participation in activity preference. Provide resident/patient with opportunities for choice during care/activities to provide a sense of control. Social Service visits to provide support, as needed. Furthermore, during the record review, Resident #16 had several progress notes documented related to aggressive behavior towards staff and other residents. The following documentation is typed as written: eInteract Summary for providers 02/16/24 at 2:16 PM Resident #6 reported that Resident #16 approached her from behind in the dining room and pulled Resident #6's hair to the extent that Resident #6's head went backwards. When Resident #16 was asked, Resident #16 stated, yes, I pulled her hair, she is stealing all my stuff. Nursing documentation note 02/19/24 at 11:40 PM: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident was cussing and try to hit another resident but was intervened and she missed. Resident trying exit doors. She was removed from situation and try to listen and offer food. Resident has delusions other residents are after husband. She threatened to hit staff because we removed her from other residents because she was verbally cussing along with staff. Was unsuccessful in interventions. Nursing documentation note 02/22/24 at 12:03 AM: Physical behaviors directed towards others occurs up to 5 (five) days a week. Verbal behaviors, directed towards others, occur up to 5 (five) days a week. Assessment 03/18/24 at 10:52 PM: Since the last evaluation there has been no change in behavior symptoms. Accusing others x5, cursing others x6, screaming at others x4, threaten 6, disruptive 1, enters others room [ROOM NUMBER], exit seeking 1, refusal 1, depression. eMAR (electronic medication administration record) for 05/29/24 at 07:41 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 6/27/24 at 08:42 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 07/23/24 at 08:18 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 08/04/24 at 08:53 AM: Was behavior observed? Yes On 08/28/24 at approximately 12:00 PM, the policy and procedure entitled, Abuse Prohibition was reviewed. This policy states that if suspected abuse is patient-to-patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. That the Center will provide adequate supervision when the risk of patient to patient altercation is suspected. The Center is responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. The patient representative and physician will be notified and any follow up recommended will be completed. Furthermore, the policy states that allegations involving abuse (physician, verbal, sexual or mental) shall be reported not later than 2 (two) hours after the allegation is made to the appropriate state authorities. In addition, the policy states the investigation shall focus on the causative factors and interventions to prevent further injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 12:30 PM on 08/27/24, while a fell ow Surveyor was observing tray pass for lunch, Resident #16 was observed hitting her roommate, Resident #24, in the face during an altercation in their room. Two nurse aides were assisting Resident #16 out of her room at the time and were attempting to break up the altercation. Nurse Aide (NA) #13 was pushing Resident #16's chair out of the room and NA #36 was trying to place a pillow between the two residents to keep Resident #16 from striking Resident #24 again. At approximately 12:40 PM, an interview was conducted with NA #13 who stated Resident #16 pulled Resident #6's hair for an unknown reason and Resident #16 started swinging at her. NA #13 stated, I thought someone was going to get hurt bad this time. At approximately 1:00 PM, an interview was conducted with NA #36 who stated, I did not see Resident #16 pull Resident #6's hair, but I did see Resident #16 slap Resident #24, causing me to grab a pillow and hold it up between them. I thought someone was going to get hurt. NA #36 then stated, This is not the first altercation Resident #16 has been in with other residents. On 08/28/24 at approximately 1:05 PM, an interview was conducted with the Director of Nursing(DON). During the interview, the DON stated, Resident #16 and Resident #24 had in fact had multiple altercations, however no intervention had been put into place, such as a room move, because the family did not wish them to be separated. At that time, this Surveyor requested the documentation. The DON was unable to provide documentation related to this. The DON was able to provide the reporting documentation, investigation and intervention put into place for the occurrence from 02/16/24, however acknowledged there was none for the occurrence from 02/19/24. Also, the DON was unable to identify the other resident mentioned in the documentation from 02/19/24, with the DON stating, There was no investigation, there was no physician intervention required for the occurrence from 02/19/24, I didn't have to report it. At that time, this Surveyor supplied the DON with the document entitled, Office of Health Care Facilities Licensure and Certification Long Term Care Reporting Requirement dated 12/04/19 which states that an allegation of abuse must be reported within 2 (two) hours. After reviewing the DON acknowledged this had not been done. Furthermore, the DON acknowledged, she was unable to say what the behavior and non-pharmacological intervention was documented for the eMAR notes dated 05/29/24, 6/27/24, 07/23/24 and 08/04/24. On 08/28/24 at approximately 2:20 PM, an interview was conducted with the facility Social Worker (SW) with the SW acknowledging she had not performed an investigation or reported the occurrence dated 02/19/24. On 08/29/24 at approximately 12:30 PM, an additional interview was conducted with the DON who acknowledged the facility policy entitled, Abuse Prohibition had not been followed. 50552

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review and staff interview the facility failed to implement the policy and procedure entitled, Abuse Prohibition. This was a random opportunity for discovery. Resident identifiers: Resident #16, #6 and #24. Facility census 63. Findings include: c) Resident #16 On 08/27/24 at approximately 12:00 PM, a record review was conducted for Resident #16. During the record review, Resident #16 was noted to have the following diagnoses: Anxiety disorder, unspecified, date 02/10/17 Insomnia, unspecified, date 03/25/17 Major depressive disorder, unspecified, date 02/10/17 Schizoaffective disorder, bipolar type, date 05/17/24 Psychotic disorder with hallucinations, date 12/15/23 Unspecified dementia, unspecified severity, date 02/10/27 Alzheimer's disease, unspecified, date 12/31.20 Vascular dementia with behavioral disturbance, date 12/31/20 Resident #16 was also noted to be receiving the following medications: Clonazepam 0.5 milligram (MG) 1 (one) tablet by mouth three times a day Cymbalta 60 MG 1 (one) capsule by mouth one time a day Nuplaid 34 MG 1 (one) capsule by mouth one time a day Remeron 15 MG 1 (one) tablet by mouth at bedtime In addition the following care plans related to behavioral patterns: Focus: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(First Name of Resident #16) has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium. Resident becomes agitated and aggressive at times. verbally cursing: Dementia (other than Alzheimer's disease), Parkinson's disease, Short/long term memory loss, Impaired decision making. Her spouse serves as MPOA assisting with decision making Goal: (First name of Resident #16) will make daily decisions/choices about activities of daily living when provided with appropriate level cues and supervision by the next review date. Interventions: Observe and evaluate types of changes in cognitive status, e.g., confusion, orientation, forgetfulness, decision making ability, ability to express self, ability to understand others, impulsivity, mental status and notify physician as needed. Monitor for pain. Attempt non-pharmacological interventions to alleviate pain and document effectiveness. Administer pain medication as ordered by physician and document effectiveness/side effects. Evaluate responses from Brief Interview for Mental Status (BIMS) or Staff Assessment for Mental Status and address as indicated. Redirect resident/patient using external cues (e.g., calendar, date book, radio, television etc.), as needed. Provide consistent, trusted caregiver and structured daily routine, when possible. Personalize the resident's/patient's room with familiar items to assist him/her in identifying the room Explain all care, including procedures (one step at a time.), and the reason for performing the care before initiating. Call resident/patient by his/her preferred name for self identity. Focus: Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to : Anxiety/fear caused by move into/within Center and/or inability to return home, coping with acute/chronic illnesses, dx of anxiety and depressive disorder as evidenced by (AEB) she will verbalize her anxiousness, crying/tearful and verbalizing sadness, agitation AEB cursing hitting staff. Goal: Resident/Patient will express anxieties/fears to staff regarding coping with acute/chronic illnesses, care at facility, therapy services by next review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Resident frequently asks for a cigarette to calm her nerves as this was her coping mechanism at home. Facility to provide resident with an imitation cigarette that she can hold when she becomes agitated or anxious. Resident has a cigarette pouch that the imitation cigarettes are kept in to mimic her previous smoking habits. An ashtray has been provided for resident to dispose of her imitation cigarette. Observe laboratory test results and report abnormal results to physician/advanced practice provider. Observe for pain and effectiveness of current interventions. Attempt non-pharmacologic interventions. Observe for signs of delirium, including delusions/hallucinations; notify physician/advanced practice practitioner as needed. Observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation. Determine the psychosocial cause for the residents/patients sadness/depression, anxiety/fear or persistent anger/agitation. Encourage resident/patient to seek staff support for distressed mood. Refocus resident/patient to something positive. Allow time for expression of feelings, voice her concerns and talk through the problems; provide empathy, encouragement and reassurance. Encourage resident/patient participation in activity preference. Provide resident/patient with opportunities for choice during care/activities to provide a sense of control. Social Service visits to provide support, as needed. Furthermore, during the record review, Resident #16 had several progress notes documented related to aggressive behavior towards staff and other residents. The following documentation is typed as written: eInteract Summary for providers 02/16/24 at 2:06 PM Resident #6 reported that Resident #16 approached her from behind in the dining room and pulled Resident #6's hair to the extent that Resident #6's head went backwards. When Resident #16 was asked, Resident #16 stated, yes, I pulled her hair, she is stealing all my stuff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was cussing and try to hit another resident but was intervened and she missed. Resident trying exit doors. She was removed from situation and try to listen and offer food. Resident has delusions other residents are after husband. She threatened to hit staff because we removed her from other residents because she was verbally cussing along with staff. Was unsuccessful in interventions. Nursing documentation note 02/22/24 at 12:03 AM: Physical behaviors directed towards others occurs up to 5 (five) days a week. Verbal behaviors, directed towards others, occur up to 5 (five) days a week. Assessment 03/18/24 at 10:52 PM: Since the last evaluation there has been no change in behavior symptoms. Accusing others x5, cursing others x6, screaming at others x4, threaten 6, disruptive 1, enters others room [ROOM NUMBER], exit seeking 1, refusal 1, depression. eMAR (electronic medication administration record) for 05/29/24 at 07:41 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 6/27/24 at 08:42 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 07/23/24 at 08:18 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 08/04/24 at 08:53 AM: Was behavior observed? Yes On 08/28/24 at approximately 12:00 PM, the policy and procedure entitled, Abuse Prohibition was reviewed. This policy states that if suspected abuse is patient-to-patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. That the Center will provide adequate supervision when the risk of patient to patient altercation is suspected. The Center is responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. The patient representative and physician will be notified and any follow up recommended will be completed. Furthermore, the policy states that allegations involving abuse (physician, verbal, sexual or mental) shall be reported not later than 2 (two) hours after the allegation is made to the appropriate state authorities. In addition, the policy states the investigation shall focus on the causative factors and interventions to prevent further injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 12:30 PM on 08/27/24, while a fell ow Surveyor was observing tray pass for lunch, Resident #16 was observed hitting her roommate, Resident #24, in the face during an altercation in their room. Two nurse aides were assisting Resident #16 out of her room at the time and were attempting to break up the altercation. Nurse Aide (NA) #13 was pushing Resident #16's chair out of the room and NA #36 ws trying to place a pillow between the two residents to keep Resident #16 from striking Resident #24 again. At approximately 12:40 PM, an interview was conducted with NA #13 who stated Resident #16 pulled Resident #6's hair for an unknown reason and Resident #16 started swinging at her. NA #13 stated, I thought someone was going to get hurt bad this time. At approximately 1:00 PM, an interview was conducted with NA #36 who stated, I did not see Resident #16 pull Resident #6's hair, but I did see Resident #16 slap Resident #24, causing me to grab a pillow and hold it up between them. I thought someone was going to get hurt. NA #36 then stated, This is not the first altercation Resident #16 has been in with other residents. On 08/28/24 at approximately 1:05 PM, an interview was conducted with the Director of Nursing(DON). During the interview, the DON stated, Resident #16 and Resident #24 had in fact had multiple altercations, however no intervention had been put into place, such as a room move, because the family did not wish them to be separated. At that time, this Surveyor requested the documentation. The DON was unable to provide documentation related to this. The DON was able to provide the reporting documentation, investigation and intervention put into place for the occurrence from 02/16/24, however acknowledged there was none for the occurrence from 02/19/24. Also, the DON was unable to identify the other resident mentioned in the documentation from 02/19/24, with the DON stating, There was no investigation, there was no physician intervention required for the occurrence from 02/19/24, I didn't have to report it. At that time, this Surveyor supplied the DON with the document entitled, Office of Health Care Facilities Licensure and Certification Long Term Care Reporting Requirement dated 12/04/19 which states that an allegation of abuse must be reported within 2 (two) hours. After reviewing the DON acknowledged this had not been done. Furthermore, the DON acknowledged, she was unable to say what the behavior and non-pharmacological intervention was documented for the eMAR notes dated 05/29/24, 6/27/24, 07/23/24 and 08/04/24. On 08/28/24 at approximately 2:20 PM, an interview was conducted with the facility Social Worker (SW) with the SW acknowledging she had not performed an investigation or reported the occurrence dated 02/19/24. On 08/29/24 at approximately 12:30 PM, an additional interview was conducted with the DON who acknowledged the facility policy entitled, Abuse Prohibition had not been followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review and staff interview the facility failed to report an allegation of abuse. This was a random opportunity for discovery. Resident identifiers: #16, #6, #24. Facility census: 63. Findings included: a) Resident #16 On 08/27/24 at approximately 12:00 PM, a record review was conducted for Resident #16. During the record review, Resident #16 was noted to have the following diagnoses: Anxiety disorder, unspecified, date 02/10/17 Insomnia, unspecified, date 03/25/17 Major depressive disorder, unspecified, date 02/10/17 Schizoaffective disorder, bipolar type, date 05/17/24 Psychotic disorder with hallucinations, date 12/15/23 Unspecified dementia, unspecified severity, date 02/10/17 Alzheimer's disease, unspecified, date 12/31/20 Vascular dementia with behavioral disturbance, date 12/31/20 Resident #16 was also noted to be receiving the following medications: Clonazepam 0.5 milligram (MG) 1 (one) tablet by mouth three times a day Cymbalta 60 MG 1 (one) capsule by mouth one time a day Nuplaid 34 MG 1 (one) capsule by mouth one time a day Remeron 15 MG 1 (one) tablet by mouth at bedtime In addition the following care plans related to behavioral patterns: Focus: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(First Name of Resident #16) has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium. Resident becomes agitated and aggressive at times. verbally cursing: Dementia (other than Alzheimer's disease), Parkinson's disease, Short/long term memory loss, Impaired decision making. Her spouse serves as MPOA assisting with decision making Goal: (First name of Resident #16) will make daily decisions/choices about activities of daily living when provided with appropriate level cues and supervision by the next review date. Interventions: Observe and evaluate types of changes in cognitive status, e.g., confusion, orientation, forgetfulness, decision making ability, ability to express self, ability to understand others, impulsivity, mental status and notify physician as needed. Monitor for pain. Attempt non-pharmacological interventions to alleviate pain and document effectiveness. Administer pain medication as ordered by physician and document effectiveness/side effects. Evaluate responses from Brief Interview for Mental Status (BIMS) or Staff Assessment for Mental Status and address as indicated. Redirect resident/patient using external cues (e.g., calendar, date book, radio, television etc.), as needed. Provide consistent, trusted caregiver and structured daily routine, when possible. Personalize the resident's/patient's room with familiar items to assist him/her in identifying the room Explain all care, including procedures (one step at a time.), and the reason for performing the care before initiating. Call resident/patient by his/her preferred name for self identity. Focus: Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to : Anxiety/fear caused by move into/within Center and/or inability to return home, coping with acute/chronic illnesses, dx of anxiety and depressive disorder as evidenced by (AEB) she will verbalize her anxiousness, crying/tearful and verbalizing sadness, agitation AEB cursing hitting staff. Goal: Resident/Patient will express anxieties/fears to staff regarding coping with acute/chronic illnesses, care at facility, therapy services by next review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Resident frequently asks for a cigarette to calm her nerves as this was her coping mechanism at home. Facility to provide resident with an imitation cigarette that she can hold when she becomes agitated or anxious. Resident has a cigarette pouch that the imitation cigarettes are kept in to mimic her previous smoking habits. An ashtray has been provided for resident to dispose of her imitation cigarette. Observe laboratory test results and report abnormal results to physician/advanced practice provider. Observe for pain and effectiveness of current interventions. Attempt non-pharmacologic interventions. Observe for signs of delirium, including delusions/hallucinations; notify physician/advanced practice practitioner as needed. Observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation. Determine the psychosocial cause for the residents/patients sadness/depression, anxiety/fear or persistent anger/agitation. Encourage resident/patient to seek staff support for distressed mood. Refocus resident/patient to something positive. Allow time for expression of feelings, voice her concerns and talk through the problems; provide empathy, encouragement and reassurance. Encourage resident/patient participation in activity preference. Provide resident/patient with opportunities for choice during care/activities to provide a sense of control. Social Service visits to provide support, as needed. Furthermore, during the record review, Resident #16 had several progress notes documented related to aggressive behavior towards staff and other residents. The following documentation is typed as written: eInteract Summary for providers dated 02/16/24 at 2:16 PM Resident #6 reported that Resident #16 approached her from behind in the dining room and pulled Resident #6's hair to the extent that Resident #16's head went backwards. When Resident #16 was asked, Resident #16 stated, yes, I pulled her hair, she is stealing all my stuff. Nursing documentation note 02/19/24 at 11:40 PM: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was cussing and try to hit another resident but was intervened and she missed. Resident trying exit doors. She was removed from situation and try to listen and offer food. Resident has delusions other residents are after husband. She threatened to hit staff because we removed her from other residents because she was verbally cussing along with staff. Was unsuccessful in interventions. Nursing documentation note 02/22/24 at 12:03 AM: Physical behaviors directed towards others occurs up to 5 (five) days a week. Verbal behaviors, directed towards others, occur up to 5 (five) days a week. Assessment 03/18/24 at 10:52 PM: Since the last evaluation there has been no change in behavior symptoms. Accusing others x5, cursing others x6, screaming at others x4, threaten 6, disruptive 1, enters others room [ROOM NUMBER], exit seeking 1, refusal 1, depression. eMAR (electronic medication administration record) for 05/29/24 at 07:41 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 6/27/24 at 08:42 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 07/23/24 at 08:18 AM: Was behavior observed? Yes eMAR (electronic medication administration record) for 08/04/24 at 08:53 AM: Was behavior observed? Yes On 08/28/24 at approximately 12:00 PM, the policy and procedure entitled, Abuse Prohibition was reviewed. This policy stated that if suspected abuse is patient-to-patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. That the Center will provide adequate supervision when the risk of patient to patient altercation is suspected. The Center is responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. The patient representative and physician will be notified and any follow up recommended will be completed. Furthermore, the policy stated that allegations involving abuse (physician, verbal, sexual or mental) shall be reported not later than 2 (two) hours after the allegation is made to the appropriate state authorities. In addition, the policy states the investigation shall focus on the causative factors and interventions to prevent further injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 12:30 PM on 08/27/24, while a fell ow Surveyor was observing tray pass for lunch, Resident #16 was observed hitting her roommate, Resident #24, in the face during an altercation in their room. Two nurse aides were assisting Resident #16 out of her room at the time and were attempting to break up the altercation. Nurse Aide (NA) #13 was pushing Resident #16's chair out of the room and NA #36 ws trying to place a pillow between the two residents to keep Resident #16 from striking Resident #24 again. At approximately 12:40 PM, an interview was conducted with NA #13 who stated Resident #16 pulled Resident #6's hair for an unknown reason and Resident #16 started swinging at her. NA #13 stated, I thought someone was going to get hurt bad this time. At approximately 1:00 PM, an interview was conducted with NA #36 who stated, I did not see Resident #16 pull Resident #6's hair, but I did see Resident #16 slap Resident #24, causing me to grab a pillow and hold it up between them. I thought someone was going to get hurt. NA #36 then stated, This is not the first altercation Resident #16 has been in with other residents. On 08/28/24 at approximately 1:05 PM, an interview was conducted with the Director of Nursing(DON). During the interview, the DON stated, Resident #16 and Resident #24 had in fact had multiple altercations, however no intervention had been put into place, such as a room move, because the family did not wish them to be separated. At that time, this Surveyor requested the documentation. The DON was unable to provide documentation related to this. The DON was able to provide the reporting documentation, investigation and intervention put into place for the occurrence from 02/16/24, however acknowledged there was none for the occurrence from 02/19/24. Also, the DON was unable to identify the other resident mentioned in the documentation from 02/19/24, with the DON stating, There was no investigation, there was no physician intervention required for the occurrence from 02/19/24, I didn't have to report it. At that time, this Surveyor supplied the DON with the document entitled, Office of Health Care Facilities Licensure and Certification Long Term Care Reporting Requirement dated 12/04/19 which stated that an allegation of abuse must be reported within 2 (two) hours. After reviewing the DON acknowledged this had not been done. Furthermore, the DON acknowledged, she was unable to say what the behavior and non-pharmacological intervention was documented for the eMAR notes dated 05/29/24, 6/27/24, 07/23/24 and 08/04/24. On 08/28/24 at approximately 2:20 PM, an interview was conducted with the facility Social Worker (SW) with the SW acknowledging she had not performed an investigation or reported the occurrence dated 02/19/24. On 08/29/24 at approximately 12:30 PM, an additional interview was conducted with the DON who acknowledged the facility policy entitled, Abuse Prohibition had not been followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49650 Based on record review, staff interview and the facility policy and procedure review, the facility failed to provide evidence that all alleged violations were thoroughly investigated, and that corrective action was taken. Residents level of care was not reviewed for possible discrepancies and statements were not obtain from all relevant staff members. This was true for one (1) of five (5) residents reviewed for abuse during the long terms survey process. Resident identifier: #4. Facility census: 63. Findings Include: a) Resident #4 On 08/29/24 at approximately 2:40 PM during the review of the facility investigation completed for the incident which occurred on 06/01/24 it was identified that statements from all staff who had cared for the resident during this time had not been obtained. It was further identified Resident #4's radiology report results states Resident #4 had a moderately displaced impaction fracture of the distal femur metaphysis. The facility did follow up with the medical treatment for the resident. The facility was not able to identify the origin of the injury. During a further review of the resident's medical record, the individual comprehensive care plan identified the level of care to be provided for bed mobility and toileting to be extensive assist of two persons assist. A review of the facility Documentation Survey Report for the assisted daily living task performed revealed documentation for the bed mobility and or toileting was completed for the resident prior to and the day of the incident. This documentation identified the staff was using one person assistance and not two people as the individual care plan required. This inaccurate level of care occurred on the following days and shifts; * 05/14/24 Day, Evening and Night shift was one-person physical assist. * 05/15/24 Evening was one-person physical assist. * 05/16/24 Evening and Night (times two) shift was one-person physical assist. * 05/18/24 Day, Evening and Night shift was one-person physical assist. * 05/19/24 Day, Evening and Night shift was one-person physical assist. * 05/20/24 Day, Evening and Night shift was one-person physical assist. * 05/21/24 Day, Evening and Night shift was one-person physical assist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 05/22/24 Day, Evening and Night shift was one-person physical assist. * 05/23/24 Day, Evening and Night shift was one-person physical assist. * 05/24/24 Evening shift was one-person physical assist. * 05/25/24 Night shift was one-person physical assist. * 05/26/24 Night shift (two times) was one-person physical assist. * 05/27/24 Day and Night shift (two times) was one-person physical assist. * 05/29/24 Day, Evening and Night shift was one-person physical assist. * 05/30/24 Day, Evening and Night shift was one-person physical assist. * 05/31/24 Day, Evening and Night shift was one-person physical assist. * 06/01/24 Night shift (two times) was one-person physical assist. In reviewing the task list referenced above, Nursing Assistant (NA) #63 was identified to have assisted with an inaccurate level of care for Resident #4's toileting and bed mobility on 05/29/24 and 05/30/24. A statement for NA #63 was not identified in the statements obtained by the facility during their investigation. During an interview with Director of Nursing (DON), Nurse Practice Educator (NPE) #34 and Social Worker (SW) #61 on 08/29/24 at approximately 3:52 PM, SW #61 stated she had assisted NPE #34 with completing the Facility Reported Incident (FRI) for Resident #4 and she did not recall if the facility Documentation Survey Report for the assisted daily living task performed documentation was pulled. SW #61 stated she had reviewed the care plan, and it was extensive assist with the activities of daily living (ADL) care. The DON further stated, the certified nursing assistants would identify their residents ADL care by the Kardex, and that information pulls from the care plan. NPE #34 and SW #61 stated they had not considered reviewing facility Documentation Survey Report v2 for the assisted daily living task performed documentation to identify the risk for accidents. The DON, NPE #34 and SW #61 agreed this could have been helpful to have completed during their investigation. In review of NA #63, was identified to have assisted with toileting and bed mobility on 05/29/24 and 05/30/24 prior to the injury being identified. NPE #34 stated that they do call staff for interviews if they are not on schedule but stated they did not obtain a statement from NA #63. The NPE further identified NA #63 had been in contact with the facility during this time regarding babysitting issues and she had informed them she would return as an as needed only employee at that time. NA #63 is noted to have not returned to the facility since. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NPE acknowledged the interview with NA #63 who had assisted with toileting and bed mobility incorrectly on 05/29/24 and 05/30/24 should have been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on medical record review and staff interview the facility failed to accurately complete a Minimum Data Set (MDS) when Resident #61 was discharged home. This was true for one (1) of 22 residents reviewed during the long term care survey process. Resident Identifier: Resident #61. Facility census: 63. Findings include: a) Resident #61 During a medical record review on 08/26/24 at 1:49 PM a review of a nursing note revealed the following [typed as written] Resident discharging home, discharge transition packet and medications discussed. Belongings packed up and sent with resident. All questions answered satisfactorily, medications called in to (Name of Local Pharmacy). Son at bedside to transport. During a further review the facility discharge plan documentation's also identified the resident discharged to home. During a medical record review of the MDS dated [DATE] it is identified in Section A. 2105 that the resident discharged to a short-term General Hospital. During an interview with the Director of Nursing (DON) on 08/26/24, the DON agreed that MDS was not coded correctly as the resident had discharged home and not to the short-term General Hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 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. 49650 Based on medical record review and staff interview the facility failed to develop and implement the individualized comprehensive care plan for depression. This was true for one (1) of 22 residents reviewed during the long term care survey process. Resident identifier: #26. Facility census: 63. Findings include: a) Resident #26 During a medical record review for Resident #26 on 08/27/24 at 12:40 PM it was identified the Resident had a physician order for Escitalopram Oxalate Tablet 20 MG to be given one (1) tablet by mouth for a diagnosis of depression. A review of Resident #26's care plan found it did not include a individualized comprehensive care plan that addressed the diagnosis of depression. During an interview with the Director of Nursing (DON), on 08/27/24 at 1:54 PM, the DON agreed the individual comprehensive care plan for the diagnosis of depression had not be developed for Resident #26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50551 Based on observation, record review and staff interview the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice by failing to provide care according to physicians orders. This was a random opportunity for discovery during the Long Term Care Survey Process. Resident identifiers: Resident #15 and Resident #25. Facility census: 63. Findings include: a) Resident #15 On 08/26/24 at approximately 9:00 AM, a record review was conducted for Resident #15 revealing the following diagnoses: Hemiplegia and heiparesis following unspecified cardiovascular disease affecting non-dominate side dated as admitting diagnosis. Epilepsy, unspecified, date 05/18/18 Cerebral palsy, date 05/07/18 Nontraumatic subdural hemorrhage, unspecified, date 05/07/18 Personal history of traumatic brain injury, date 05/07/18 Unspecified convulsions, date 05/07/18 In addition, Resident #15 had a physicians order to wear a helmet when out of bed and an optifoam to head for breakdown prevention. At that time, the following care plan was noted in reference to the above mentioned orders: Focus: Resident is at risk for falls: impaired mobility, cerebral palsy, cognitive loss, lack of safety awareness and traumatic brain injury. Goal: Resident will have no falls with injury throughout next review. Intervention: Protective helmet when restless or out of bed every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/24 at the following times, observations were made of Resident #15, at which times Resident #15 was noted to be up out of bed, in the geri-chair without the helmet in place: 11:12 AM 11:45 AM 12:15 AM 12:45 AM 1:35 PM 2:30 PM On 08/27/24 at 9:40 AM, this Surveyor and LPN #17 went into make an observation of Resident #15, at which time Resident #15 did not have his helmet on and was out of bed in the geri-chair. At this time, LPN #17 acknowledged Resident #15 had an order for the helmet when out of bed and that the helmet and dressing to the head was due to where he had brain surgery, the screws have worked their way out and through his skin before. I thought the order for the helmet had been discontinued, but it hasn't. It is active, he should have it on. b) Resident #25 During an interview on 08/25/24 at 3:00 PM, Resident #25 stated he does not get his medications on time. He stated, he has a diagnosis of bipolar and that if he does not get his evening medications by 9:00 PM, he cannot sleep. He reports sometimes his medications are up to three (3) hours late. On 08/27/24 at 10:52 AM, a record review of Medication Admin Audit Report revealed the following late medications: -07/19/2024 Tamsulosin HCl Oral Capsule 0.4 MG, give one (1) capsule by mouth one time a day. Scheduled 8:00 PM and administered at 10:55 PM Licensed Practical #5 (five). -08/25/2024 Depakote Tablet Delayed Release 250 MG. Give one (1) tablet by mouth two times a day for targeted behaviors: cursing staff, throwing items at staff, ensure environment safety and allow to decompress alone. Scheduled 9:00 PM and administered 11:04 PM by Registered Nurse #21. On 08/28/24 at 2:25 PM an interview with Director of Nursing (DON) #54, DON acknowledged the Tamsulosin and Depakote were administered late on 7/19/24 and 08/25/24. 50552

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49650 Based on observation, resident interview and staff interview the facility failed to ensure the environment was free of accident hazards. Residents fall mats were preventing a resident to safely make it to his bed in his wheelchair, oxygen was stored in resident sitting area with no signage, and medications were not stored in a safe manner. These were random opportunities for discovery during the long term care survey process and had the ability to affect a more than a limited number of residents currently resding in the facility. Identifier: Resident #26. Facility Census.: 63. Findings include: a) Resident #26 fall mats. During a tour of the facility on 08/25/24 at approximately 2:15 PM, Resident #26 was observed attempting to wheel himself in his wheelchair to his side of the room by the window. The resident stated, he was unable to safely go to his side because he can't get over the fall mats with his wheelchair. During this observation, fall mats were identified on the left and right side of the first bed entering the room and this resident was sitting in his wheel chair to the side of his bed on top of a fall mat. Resident #26 also had a fall mat to the front side of his bed with the left side of the bed placed against the wall. On 08/25/24 at approximately 2:20 PM, Licensed Practical Nurse (LPN) #50 was asked about Resident #26 not being able to safely wheel himself in his room. LPN #50 stated, we normally remove the floor mats when the residents are up out of the bed. LPN #50 assisted Resident #26 and the fall mats were removed off the floor. b) Oxygen stored in resident sitting area with no signage. During a tour of the facility on 08/26/24 at 10:51 PM there were three (3) oxygen tanks identified to be sitting unattended on the back of wheel chairs in the residents sitting area. All residents were in bed and the oxygen was not in use. Upon further review it is identified this room is not marked with signage which identifies it to be an area the oxygen is located and or stored. During an interview with the Registered Nurse (RN) #30 at 12:05 AM on 08/26/24, RN #30 stated they do not normally leave the oxygen stored in this room when the residents are not using them. She stated they are normally returned to the oxygen holder outside of the facility. RN #30 removed the oxygen tanks at this time. RN #30 agreed the room is not identified with signage for oxygen in use or oxygen stored. c) Medication Storage (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/25/24 at 09:48 AM, a facility tour was conducted revealing the treatment cart unlocked with the key in the lock, with resident medications stored on top of it. At that time, RN #21 acknowledged the treatment cart should have been locked with the keys and medications securely stored out of resident reach. On 08/26/24 at 11:35 PM, an additional tour of the facility was conducted revealing A Hall medication cart unlocked with key in lock with the top drawer open. No nurse was present at the time. At 11:40 PM, RN #30 came out of a resident room and walked to the cart. At that time, RN #30 acknowledged this was her cart for the shift and the cart should have been locked with the keys securely stored out of resident reach. In addition, at 11:38 PM, B Hall medication cart was noted to have medications sitting on top of the cart with a white oblong pill in a pill cup, a bottle of Lactulose and a bottle of Melatonin. Again, no nurse was present at the time. LPN # 52 returned to the cart at 11: 43 PM stating the white oblong pill was a Norco, however LPN #52 was unable to tell me which resident this medication belonged too. In addition, LPN #52 stated, We just got a new admission to the facility I was working on. LPN #52 acknowledged the medications should not have been sitting on top of the cart unattended and should have been securely stored out of residents reach. On 08/27/24 at approximately 12:00 PM, a review of the policy and procedure entitled, Medication Storage was conducted which revealed that in order to limit access to prescription medications, only licensed nurses, pharmacy staff and those lawfully authorized to administer medications are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access. On 08/27/24 at approximately 02:30 PM, an interview was conducted with the Director of Nursing who acknowledged the medication carts should have been locked when unattended and the medications should not have been left unsecured on top of the medication carts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50552 Based on record review and staff interview the facility failed to timely act upon a Medication Regimen Review (MRR) of a high-risk medication. This was true for 1 (one) of 5 (five) residents reviewed for the care area of unnecessary medications during the Long-Term Care Survey Process. Resident identifier: Resident #16. Facility census 63. Findings include: a) Resident #16 On 08/27/24 at approximately 12:00 PM, a record review was conducted for Resident #16. During the record review, Resident #16 was noted to have the following diagnoses: Anxiety disorder, unspecified, date 02/10/17 Insomnia, unspecified, date 03/25/17 Major depressive disorder, unspecified, date 02/10/17 Schizoaffective disorder, bipolar type, date 05/17/24 Psychotic disorder with hallucinations, date 12/15/23 Unspecified dementia, unspecified severity, date 02/10/17 Alzheimer ' s disease, unspecified, date 12/31/20 Vascular dementia with behavioral disturbance, date 12/31/20 Resident #16 was also noted to be receiving the following medications: Clonazepam 0.5 milligram (MG) 1 (one) tablet by mouth three times a day Cymbalta 60 MG 1 (one) capsule by mouth one time a day Nuplaid 34 MG 1 (one) capsule by mouth one time a day Remeron 15 MG 1 (one) tablet by mouth at bedtime On 08/28/24 at approximately 1:05 PM, a review of Resident #16's Psychiatrist progress note dated 05/17/24 and an MRR dated 01/17/24, for Resident #16 was conducted revealing the following recommendation: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Please review the current dose of Buspar as per CMS regulations due for a gradual dose reduction at this time. At this time, it was noted Resident #16's Psychiatrist progress note addressed the recommendation from the MRR dated 01/17/24. On 08/28/24 at approximately 1:05 PM, an interview was conducted with the Director of Nursing and facility Infection Preventionist (IP). The IP stated the facility had 90 days as per policy to review and act upon any recommendations made. On 08/28/24 at 2:00 PM, a review of the policy and procedure entitled, Medication Regimen Review and Reporting was conducted which revealed the facility was to act upon pharmacy recommendations within 30 calendar days. On 08/29/24 at 10:15 AM, an interview was conducted with the IP who acknowledged, the MRR dated 01/17/24 had not been acted upon until the Psychiatrist visit on 05/17/24 and the facility failed to address the recommendation in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 49467 Based on observation, record review, and staff interview, the facility failed to ensure Resident #24 and #28 were served the correct diet to meet their needs. This was a random opportunity for discovery. Resident identifiers: #24, #28. Facility census: 63. Findings included: a) Nourishment Room At approximately 10:15 AM on 08/25/24, during a tour of the nourishment room at the facility, two (2) bologna sandwiches, with labels for snacks from the previous night shift, were discovered with the names of Resident #24 and #28 on them. Upon further inspection, the labels for both sandwiches read Peanut Butter and Jelly and listed both residents' diets as advanced. At approximately 10:45 AM, an interview was conducted with the Dietary District Manager (DDM) concerning the diets listed on the sandwiches, the type of sandwich indicated by the labels, and the actual sandwich that was served. The DDM confirmed the labels for both Residents #24 and #28 stated Peanut Butter and Jelly and listed both diets as advanced. The DDM stated neither Resident #24 nor #28 should have received a bologna sandwich unless the meat was chopped. The DDM confirmed at this time both sandwiches were bologna sandwiches that did not contain chopped meat. At approximately 11:00 AM, the DDM printed off meal tickets and confirmed the wrong diets were served to Resident #24 and #28. The meal ticket for Resident #24 reads Regular/Liberalized-Advanced and calls for ground meat. The meal ticket for Resident #28 reads Consistent Carbohydrate- Advanced and calls for ground meat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49467 Based on observation and resident and staff interviews, the facility failed to offer snacks to residents who wished to revieve a snack at night time, and failed to ensure all ordered snacks were delivered to residents at night time. This was a random opportunity for discovery. Resident identifiers: #24, #28, #33, #51, #52, #22, #58. Facility census: 63. Findings included: a) Resident #24 At approximately 10:15 AM on 08/25/24, during a tour of the nourishment room at the facility, a sandwich was found in the refrigerator with a label dated 08/24/24 S3 (third shift, night shift), with the resident's name on it. A review of the task sheet for snacks offered for Resident #24 indicated Not Applicable was selected under question 2, titled Snack Accepted. At approximately 10:45 AM, an interview with the District Dietary Manager (DDM) confirmed the resident was ordered the snack, the S3 on the label meant third shift, or night shift, and they were not passed. At approximately 11:00 AM on 08/25/24, an interview was conducted with the Dietary Manager (DM) regarding snacks. The DM stated the last dietary employee leaves the facility at approximately 7:00 PM each evening and the snacks are delivered to the nurses station at that time. The DM stated They never deliver the snacks. I have pictures on my phone of the snacks still sitting there the next day. It happens all the time. At approximately 11:38 PM on 08/26/24, a sandwich labeled for third shift on 08/26/24 was found on the nurses station. At approximately 11:40 PM in interview was conducted with Nurse Aides (NA) #15 and #33. NA #15 and #33 confirmed they had not offered the snacks to residents during the shift. NA #15 stated, I haven't offered one to anyone and if they are still sitting there, no one from evening shift did either. NA #33 stated the employees were getting ready to throw the snacks in the trash because they have been sitting here all night. b) Resident #28 At approximately 10:15 AM on 08/25/24, during a tour of the nourishment room at the facility, a sandwich was found in the refrigerator with a label dated 08/24/24 S3 (third shift, night shift), with the resident's name on it. A review of the task sheet for snacks offered for Resident #28 indicated Not Applicable was selected under question 2, titled Snack Accepted. At approximately 10:45 AM, an interview with the District Dietary Manager (DDM) confirmed the resident was ordered the snack, the S3 on the label meant third shift, or night shift, and they were not passed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 11:00 AM on 08/25/24, an interview was conducted with the Dietary Manager (DM) regarding snacks. The DM stated the last dietary employee left the facility at approximately 7:00 PM each evening and the snacks weree delivered to the nurses station at that time. The DM stated, They never deliver the snacks. I have pictures on my phone of the snacks still sitting there the next day. It happens all the time. At approximately 11:38 PM on 08/26/24, a sandwich labeled for third shift on 08/26/24 was found on the nurses station. At approximately 11:40 PM an interview with Nurse Aides (NA) #15 and #33. NA #15 and #33 confirmed they had not offered the snacks to residents during the shift. NA #15 stated, I haven't offered one to anyone and if they are still sitting there, no one from evening shift did either. NA #33 stated the employees were getting ready to throw the snacks in the trash because they have been sitting here all night. At approximately 11:45 PM, an interview was conducted with Resident #28. During the interview, Resident #28 stated no one had brought or offered her the snack that evening. Resident #28 stated, I would have liked to have had it. I didn't even know it was there. c) Resident #33 At approximately 10:15 AM on 08/25/24, during a tour of the nourishment room at the facility, a house supplement shake was found in the refrigerator with a label dated 08/24/24 S3 (third shift, night shift), with the resident's name on it. A review of the task sheet for snacks offered for Resident #33 indicated Not Applicable was selected under question 2, titled Snack Accepted. At approximately 10:45 AM, an interview with the District Dietary Manager (DDM) confirmed the resident was ordered the snack, the S3 on the label meant third shift, or night shift, and they were not passed. At approximately 11:00 AM on 08/25/24, an interview was conducted with the Dietary Manager (DM) regarding snacks. The DM stated the last dietary employee leaves the facility at approximately 7:00 PM each evening and the snacks are delivered to the nurses station at that time. The DM stated They never deliver the snacks. I have pictures on my phone of the snacks still sitting there the next day. It happens all the time. At approximately 11:38 PM on 08/26/24, a melted cup of ice cream labeled for third shift on 08/26/24 was found on the nurses station. At approximately 11:40 PM in interview was conducted with Nurse Aides (NA) #15 and #33. NA #15 and #33 confirmed they had not offered the snacks to residents during the shift. NA #15 stated I haven't offered one to anyone and if they are still sitting there, no one from evening shift did either. NA #33 stated the employees were getting ready to throw the snacks in the trash because they have been sitting here all night. d) Resident #51 At approximately 10:15 AM on 08/25/24, during a tour of the nourishment room at the facility, a house supplement shake was found in the refrigerator with a label dated 08/24/24 S3 (third shift, night shift), with the resident's name on it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the task sheet for snacks offered for Resident #51 indicated Not Applicable was selected under question 2, titled Snack Accepted. At approximately 10:45 AM, an interview with the District Dietary Manager (DDM) confirmed the resident was ordered the snack, the S3 on the label meant third shift, or night shift, and they were not passed. At approximately 11:00 AM on 08/25/24, an interview was conducted with the Dietary Manager (DM) regarding snacks. The DM stated the last dietary employee leaves the facility at approximately 7:00 PM each evening and the snacks are delivered to the nurses station at that time. The DM stated They never deliver the snacks. I have pictures on my phone of the snacks still sitting there the next day. It happens all the time. At approximately 11:38 PM on 08/26/24, a melted cup of ice cream labeled for third shift on 08/26/2028 was found on the nurses station. At approximately 11:40 PM in interview was conducted with Nurse Aides (NA) #15 and #33. NA #15 and #33 confirmed they had not offered the snacks to residents during the shift. NA #15 stated I haven't offered one to anyone and if they are still sitting there, no one from evening shift did either. NA #33 stated the employees were getting ready to throw the snacks in the trash because they have been sitting here all night. e) Resident #52 On 08/26/24 at 3:42 PM, an interview was conducted with Resident #52. At tist time, Resident #52 stated, I don't always get snacks before I go to bed. I would like them but they usually don't offer them. Its less than once every 2 (two) weeks I would say they even offer me something before bed. On 08/27/24 at 10:45 AM, a record review was conducted for Resident #52's Nurse Aide (NA) task list documentation related to provision of snacks which revealed Resident #52 was not offered a snack on the following dates: 07/28/24 07/29/24 07/31/24 08/01/24 08/02/24 08/03/24 08/04/24 08/05/24 08/06/24 08/07/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/09/24 08/10/24 08/11/24 08/12/24 08/13/24 08/14/24 08/15/24 08/16/24 08/17/24 08/18/24 08/19/24 08/20/24 08/21/24 08/23/24 08/24/24 08/25/24 08/27/24 On 08/27/24 at 2:55 PM, an interview was conducted with the Director of Nursing (DON) who stated, we offer snacks every evening, if the resident is not on the list for an ordered snack they can ask for it. On 08/28/24 at 10:22 AM, review of facility policy for meal/snacks revealed evening snack was planned as part of the menu. Food and Nutrition Services delivers snacks to nursing stations at specified times. Nursing or designated staff offer an evening snack to every resident. Snacks are passed within 15 minutes of delivery to the unit or are properly stored at the nursing station and offered at a later time. On 08/28/24 at approximately 1:30 PM, the DON acknowledged the facility had not been following the procedures as outlined in the policy and procedure for meal and snacks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F) Resident Council, Residents #22 and #58 On 08/26/24 at 12:00 PM, review of six (6) month's of resident council meeting minutes with no addressed concerns. On 08/26/24 at 1:10 PM, during resident council, Resident #22 and Resident #58 reported they were not offered snacks at bedtime. They reported staff lay the snacks down at the nurses station and do not pass them out in the evening. Maybe one day per week staff will go around from room to room and offer a snack was stated by Resident #58. On 08/28/24 at 1:13 PM a review of records task form for Resident #22 revealed residents were not offered a bedtime snack on the following evenings between 07/30/24 and 08/27/24: -7/31/24 -08/01/24 -08/2/24 -08/3/24 -08/4/24 -08/06/24 -08/08/24 -08/09/24 -08/10/24 -08/11/24 -08/12/24 -08/13/24 -08/15/24 -08/16/24 -08/17/24 -08/18/24 -08/19/24 -08/20/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-08/21/24 -08/22/24 -08/23/24 -08/24/24 -08/25/24 -08/26/24 -08/27/24 On 08/27/24 review of recorded task form revealed, Resident #58 was not offered bedtime snacks on the following days between 07/30/24 and 08/27/24: -07/30/24 -08/1/24 -08/2/24 -08/4/24 -08/5/24 -08/07/24 -08/08/24 -08/09/24 -08/10/24 -08/11/24 -08/12/24 -08/13/24 -08/17/24 -08/18/24 -08/19/24 -08/20/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-08/21/24 -08/24/24 -08/25/24 -08/26/24 -08/27/24 On 08/28/24 at 10:22 AM, review of facility policy for meal/snacks revealed evening snack was planned as part of the menu. Food and Nutrition Services delivers snacks to nursing stations at specified times. Nursing or designated staff offer an evening snack to every resident. Snacks are passed within 15 minutes of delivery to the unit or are properly stored at the nursing station and offered at a later time. 50551 50552

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49467 Based on observation and staff interview, the facility failed to ensure food was stored, prepared, and served in a sanitary manner. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents residing in the facility. Facility census: 63. Findings include: a) Kitchen Tour At approximately 9:45 AM on 08/25/24, during the initial tour of the kitchen, a jar of apple sauce was discovered in the reach-in refrigerator. The apple sauce had a discard date of 7/19/24 on it and was still in use. [NAME] #82 acknowledged the apple sauce, discard date, and that it was still in use. At approximately 11:00 AM, an interview was conducted with the Dietary Manager (DM) regarding the apple sauce. During the interview, the apple sauce was still in the refrigerator and acknowledged by the DM. b) Dining Observation On 08/25/24 at 12:00 PM, the Assistant Director of Nursing (ADON) #55 was observed assisting a resident with her fork, food and drink while the resident was eating. The ADON then turned and picked up a clean tray to serve another resident without sanitizing her hands. On 08/25/24 at 12:01 PM, ADON #55 was made aware she was observed assisting a resident with her food and didn't sanitize before continuing to pass trays and putting others at risk for cross contamination. ADON #55 acknowledged and stated I'm messing up, I am not usually in here. c) Placement of soiled tray. During a dining room observation on 08/25/24 at approximately 11:47 AM the Assistant Director of Nursing (ADON) was observed to taking a resident meal tray from the enclosed food delivery cart and placed the tray on the table in front of the resident. The resident was observed to refuse the tray and the ADON was observed to take the tray and place it back into the enclosed food delivery cart with other residents trays which had not yet been served. During an interview with the ADON on 08/25/24 at 11:50 AM the ADON agreed the tray being placed back in the food delivery cart after it was sat at the table does increase the potential of cross contamination and she knew she should not have done that but doesn't normally work in the dining room. She further stated the tray should have been taken to the kitchen. During an interview with the Administrator on 08/25/24 at approximately 12:00 PM, the Administrator stated the ADON should not have placed the tray back into the food delivery cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49650 50551

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49467 Based on observation and staff interview, the facility failed to ensure garbage and refuse was disposed of properly. This was a random opportunity for discovery. This had the potential to affect more than a limited number of residents residing in the facility. Facility census: 63. Findings included: a) At approximately 10:00 AM on 08/25/24, during a tour of the facility, the dumpster was observed with the lid and door open with debris (food particles and trash) laying all around it, on the ground. Gloves and masks were observed laying on the ground around the dumpster as well. Housekeeper #88 acknowledged the state of the dumpster and the ground around it. The Director of Nursing (DON) arrived at the facility during this time and also acknowledged the dumpster.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49467 According to record review and resident and staff interviews, the facility failed to accurately complete medical records pertaining to blood pressures for Resident #45 and a diagnosis of depression for Resident #26. This was a random opportunity for discovery. Resident identifiers: #45, #26. Facility 63. Findings include: A) Resident #45 At approximately 10:30 AM on 08/29/24, during record review pertaining to Resident #45's dialysis, it was discovered the facility was documenting blood pressures in the resident's left arm, which she has orders not to, due to having a fistula in her left arm. The following dates were documented as times the resident's blood pressure was taken in her left arm: 10/07/2023- Three (3) times 10/10/2023 10/14/2023 10/28/2023 11/22/2023- Three (3) times 11/29/2023 11/30/2023 12/06/2023 12/09/2023 12/12/2023 12/20/2023 01/18/2024 01/25/2024 02/08/2024 02/18/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/21/2024 03/13/2024 05/13/2024 05/14/2024 05/20/2024 05/22/2024 06/17/2024 06/27/2024 06/29/2024 At approximately 10:45 AM an interview was conducted with the Director of Nursing (DON) regarding the blood pressures. The DON stated it was documentation errors and the facility was already auditing the notes and documentation. The DON stated Resident #45 has capacity and will not let staff take blood pressure in her left arm. At approximately 11:00 AM, an interview was conducted with Resident #45. Resident #45 stated, I absolutely will not let them take my blood pressure in my left arm. My doctor told me they couldn't do it or it would cause bad problems, and I won't allow them to touch it. Resident has capacity and a Brief Interview for Mental Status (BIMS) Score of 15, indicating the resident was cognitively intact. b) Resident #26 During a medical record review 08/27/24 at 1:46 PM for Resident #26 it was noted the physician had an order for the resident to receive medication for a diagnosis of depression. Further review of the the physician diagnosis it was identified the resident does not have a depression diagnosis listed. During an interview with the Director of Nursing (DON), on 08/27/24 at 1:53 PM, the DON agreed Resident #26 was receiving medication for a diagnosis of depression and also agreed that there was not a physician diagnosis for depression listed. The DON further stated she would make sure this was corrected. 49650