STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515103	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenville Health & Rehab	111 Fairground Road Glenville, WV 26351

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45171 Based on observation and staff interviews, the facility failed to provide each resident the right to be treated with dignity and respect when passing meal trays. This was true for four (4) of thirty-three (33) residents observed in the dining room. Resident identifiers: #9, #28, #31 and #61. Facility census: 63 Findings include: a) On 10/23/24 at 12:05 PM during observation of the noon meal tray pass in the dining room there were five (5) residents observed at one table. Resident #5 received her lunch at 12:05 PM. The remaining four (4) residents were not served their tray and staff members continued to serve residents at the other three (3) tables. At 12:08 PM Resident #31 asked, Can we have our food now? The staff member walking past responded, We are getting it. At 12:12 PM staff members began serving the remaining residents sitting at this table. The last meal was served to Resident #61 at 12:16 PM. This left the four (4) residents sitting at the table for seven to eleven (7-11) minutes with Resident #5 while she ate her meal. On 10/23/24 at 12:17 PM Licensed Practical Nurse #26, was asked if all residents at a table were to be served prior to serving the next table, she stated, She comes in late sometimes (speaking of Resident #5), I don't know why that happened. However Resident #5 was observed to be the first resident to arrive and sit at this table.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 42120 The facility failed to honor resident choices regarding the things that are important in her life regarding making her bed early in the morning. This is true for one (1) of (1) residents reviewed for choices. Resident Identifier #25. Facility census: 63. Findings included: a) Resident #25 During an observation with Resident #25, on 10/21/20 at 9:02 AM, she was upset about the staff not making her bed. On 10/22/24 at 08:57 AM during an interview, Resident #25 became upset and tearful about her bed not being made. She stated, They don't help me get my bed made in the mornings. She continued to say that she had to ask staff to come and make the bed all the time. On 10/22/24 at 3:36 PM during an interview the Social Services director revealed she was aware that Resident #25 liked her bed made early and got upset when it was not made. During an interview, on 10/23/24 at 1:15 PM, the Physical Therapy director stated that Resident #25 did get upset when staff did not make her bed and would refuse therapy treatment. No further information was provided prior to the end of the survey on 10/24/23 at 6:00 PM.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 20490 Based on observation and staff interview, the facility failed to ensure residents were able to examine the results of the most recent survey. This had the potential to affect more than an isolated number of residents. Facility census: 63. Findings included: a) An observation of the survey book in the facility revealed the last survey results that were in the survey book were from the annual inspection in November 2022. On 10/24/24 at 1:00 PM the administrator said one of the residents in the facility keeps getting papers out of the book. A review of the facility's survey history revealed complaints investigated in February 2023, September 2023 and February 2024 all had citations associated with them.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on observation and staff interview the facility failed to provide a home like environment. This was true for four (4) of nine (9) rooms observed. Room identifiers: #104, #108, #110, #213. Facility Census: 63 Findings included: a) room [ROOM NUMBER] On 10/23/24 at 1:30 PM observation of nine (9) rooms in the facility found that four (4) rooms did not have a homelike environment. room [ROOM NUMBER] had two (2) residents residing in the room and there were no comforters or chairs provided for them. On 10/23/24 at 2:45 PM during an interview with the resident in (B bed), she was asked if she felt like her room was like her home prior to coming to the facility. She said it was not. b) room [ROOM NUMBER] room [ROOM NUMBER] had two (2) residents residing in the room and there were no comforters or chairs provided for them. On 10/23/24 at 3:00 PM during an interview with the resident in (B bed) he was asked if he felt like his room was like his home prior to coming to the facility. He said it was not. c) room [ROOM NUMBER] room [ROOM NUMBER] had two (2) residents residing in the room and there were no comforters or chairs provided for them. There had been plaster repairs that were uneven and unfinished. There were no pictures in the room. There were paper signs taped to the wall listing mealtimes and there were no personal items in her room. On 10/23/24 at 3:30 PM during an interview with the resident in (B bed) she was asked if she felt like her room was like her home prior to coming to the facility. She said it was not. d) room [ROOM NUMBER] room [ROOM NUMBER] had one (1) resident residing in the room and there were no comforters, or a chair provided for her. On 10/24/24 at 9:10 AM during an interview with this resident she was asked if she felt like her room was like her home prior to coming to the facility. She said it was not. On 10/24/24 at 10:49 AM during observations of the rooms listed above and interview with the Administrator she agreed the furniture did not reflect a home-like environment.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review, family interview, and staff interview, the facility failed to provide appropriate notice of transfers or discharge for one (1) of two (2) residents reviewed for the care area of discharge. The facility failed to provide a facility-initiated discharge notice at least 30 days before the resident was discharged . For one (1) of five (5) residents reviewed for the care area of hospitalization s, the facility failed to notify the resident's representative of a hospital transfer and the reasons for the move in writing. Resident identifiers: #168, #47. Facility census: 63. Findings included: a) Resident #168 The Director of Nursing (DON) and Administrator were interviewed on 10/24/24 at 11:15 AM regarding an anonymous complaint regarding a resident elopement. The resident had not been identified in the complaint. The DON and Administrator identified Resident #168 as a resident who was exit seeking and walked around the facility's campus and surrounding area with staff, but never actually eloped. The DON stated Resident #168 was discharged home with his mother in a safe and orderly manner. The Administrator stated the resident's discharge was not a facility-initiated discharge. Review of Resident #168's medical records showed the resident was admitted on [DATE]. He displayed exit seeking behaviors and was deemed at risk for elopement. A Wanderguard bracelet was ordered and applied to prevent the resident from exiting the facility without staff knowledge. Resident #168's diagnoses included traumatic brain injury. The resident's admission Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 06/10/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. The physician's determination of capacity dated 06/12/24 determined the resident lacked ability to make medical decisions due to traumatic brain injury, cognitive loss, and inability to understand medical decisions. This was anticipated to be long-term in duration. The resident's mother was his Medical Power of Attorney (MPOA). Resident #168's comprehensive care plan stated, Resident is appropriate for LTC [long-term care] due to the need for 24/7 supervision secondary to MD [physician] DX [diagnosis]. An intervention was The need for LTC is understood by resident and/or POA [Power of Attorney]. D/C [discharge] plan to be discussed at comprehensive assessments. The progress notes documented that the resident refused physical therapy and refused medications at times. A change in condition note written on 06/04/24 at 8:10 AM stated, Resident went out the double doors to sit on front porch bench. Resident was able to be redirected without any issues. Wander guard in place. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A change in condition written on 06/06/24 at 8:00 AM stated, Nursing observations, evaluation, and recommendations are: The resident eloped out double doors with staff at side. The resident walked with staff and was not easily distracted. The resident was placed on one-on-one observation. A note written on 06/06/24 at 9:00 AM stated, The resident had another elopement episode at 0900 am. The resident escaped through double front doors with staff at side. Resident ended up setting [sic] in gazebo with staff at side. Resident eventually came back inside and ate lunch with staff member. A note written on 06/06/24 at 2:30 PM stated, The resident eloped for a third time today, resident made way with staff to parking lot of Foodland. Resident easily distracted and re-directed to front porch of SNF [skilled nursing] facility. Resident sitting peacefully on front porch with staff at side. After many attempts of redirection back into the facility, this nurse had to call sheriff department to help escort resident back into facility. A nursing note written on 06/07/24 at 5:54 AM, stated, In DR [dining room] wandering, sitting in other residents' chairs, when asked by another resident to move he yelled loudly F___ you, F___ you, F___ you! Noted to be agitated. A nursing note written on 06/07/24 at 6:30 AM, stated, Resident in DR and noted to cursing [sic] other resident, did draw back fist and attempt to strike other resident. Other resident removed from area. A nursing note written on 06/07/24 at 3:30 PM stated, Up wandering in the hallway. Wandering into other residents' rooms. Redirected unsuccessfully. A physician's note written on 06/08/24 stated, He has a severe dementia and it does not appear he will be able to go home unless there is someone to take care of him around-the-clock. A behavior note written on 06/17/24 at 11:15 PM stated the resident was incontinent and refused to wear incontinence products or have his soiled clothing taken to laundry. A nursing note written on 06/19/24 at 8:15 AM stated, Resident eloped from [facility] with staff at side. This nurse was able to easily redirect resident back to facility. A nursing note written on 06/19/24 at 10:00 AM stated, The resident was sitting on back porch with 1:1 sitter. The resident shoved through gate and 1:1 sitter and started walking toward Exxon station. Resident unable to be easily distracted. Resident escorted back to [facility] by state police vehicle. The next progress note was written on 06/19/24 at 2:00 PM and stated, Transported via facility van to resident home. Mother (POA) signed and understood discharge instructions. Medications called into pharmacy of POA choice for 30 days no refills. MD aware and voiced understanding with verbal readback for discharge order. (continued on next page)

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F 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 06/21/24, the attending physician wrote a discharge note which stated in part, [Resident #168] is a [AGE] year-old white male who is a resident of this facility for short time. He has a severe dementia and had severe behavioral problems while he was here. He tried to elope from the facility. It was decided that the facility could no longer handle him, and he was discharged .Facility Course: He was here a few days but had severe behavioral difficulties, and it was decided he could not be taking [sic] care of at this facility.

Resident #168's Notice of Transfer or discharge date d 06/19/24 stated the basis of the discharge was The transfer or discharge is appropriate because your health has improved sufficiently that you no longer need the services provided by this facility and The transfer or discharge is necessary for your welfare and your needs cannot be met in this facility.

The discharge planning review dated 06/19/24 indicated the facility initiated discharged . The reason for discharge was safety reason for discharge. The recap of the resident's stay was The resident has had multiple elopement attempts, the resident is a safety risk for resident safety. Resident refuses therapy.

On 10/24/24 at 12:30 PM, Resident #168's mother was interviewed by telephone. She stated she had not planned on taking the resident home. She stated she had not expressed to the facility a willingness or ability to take the resident home. She stated the facility called on the day of the discharge to tell her that the resident was being sent home that day because the facility could not take care of him anymore. She stated she could not think of anything she needed the facility to arrange before they sent him home. The resident was in the hospital once since discharge, but she could not provide details. She stated her son was doing okay. She stated she was happy that the resident had a new physician who was adjusting his medication.

On 10/24/24 at 3:31 PM, the Director of Nursing and the Administrator were re-interviewed. The DON stated the facility had decided to send Resident #168 out of the facility for a psychological evaluation. When they contacted the resident's mother to inform her, she stated she wanted the resident to come home instead. The DON acknowledged this was not documented in the resident's record. The Administrator and DON acknowledged Resident #168's Discharge Planning Review stated the discharge was facility initiated, but stated this was a documentation error. The Administrator acknowledged a 30-day notice of discharge was not given to the resident's Medical Power of Attorney but stated this was because the resident's mother had requested the resident be sent to her home instead of for psychiatric evaluation.

No further information was provided through the completion of the survey.

b) Resident #47

Review of Resident #47's medical records showed the resident was transferred to the hospital on 03/24/24 due to fever and increased secretions. The resident did not have capacity to make medical decisions. The transfer form provided to the receiving hospital documented the resident's Medical Power of Attorney (MPOA) was notified of the hospital transfer. The resident returned to the facility 04/14/24.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #47's medical records showed a Notice of Transfer or discharge date d 03/24/24. The areas on the form to indicate the date of verbal notification and the date of written notification were left blank. On 10/23/24 at 4:25 PM, the Director of Nursing (DON) stated Resident #47's MPOA was notified of the hospital transfer before the transfer occurred. The DON stated the Notice of Transfer or Discharge was sent to the hospital with the resident. The DON confirmed the MPOA had not received a written Notice of Transfer or Discharge with appeal instructions unless she went to the hospital to get the form that was sent to the hospital. She confirmed the facility's usual practice did not include mailing Notices of Transfers or Discharges to residents' representatives. No further information was provided through the completion of the survey.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 39043 Based on record review, family interview, and staff interview, the facility failed to provide a written bed hold notice to the Medical Power of Attorney (MPOA) for one (1) of five (5) residents reviewed for the care area of hospitalization s. Resident identifier: #47. Facility census: 63. Findings included: a) Resident #47 Review of Resident #47's medical records showed the resident was transferred to the hospital on 03/24/24 due to fever and increased secretions. The resident did not have capacity to make medical decisions. The resident returned to the facility 04/14/24. Further review of Resident #47's medical records showed a Bed Hold Notice of Policy and Authorization. The notice had been signed by a Licensed Practical Nurse, as the representative for the Center. However, the notice was not signed by the Resident Representative. On 10/23/24 at 4:25 PM, the Director of Nursing (DON) stated Resident #47's representative was called and informed of the bed hold policy. She stated the Bed Hold Notice of Policy and Authorization would not have been mailed to the representative, unless the representative expressed interest in guaranteeing a bed hold. She stated the facility's usual practice was to not provide a written copy of the bed hold notice after verbal explanation unless the family expresses interest in the bed hold. No further information was provided through the completion of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42120 Based on medical record review and interview, the facility failed to develop person-centered comprehensive care plans. The facility failed to develop care plans for a lap tray, dental issues, specialty mattress and failed to develop a resident centered care plan. This practice affected four (4) of (24) resident's care plans reviewed during the Long-Term Care Survey Process (LTCSP). Resident identifiers: #2, #61, and #64. Facility census: 63. Findings included: a) Resident #2 An observation on 10/21/24 12:45 PM Resident #2 had a lap tray in place in the dining room while eating lunch. A second observation on 10/22/24 at 845 AM Resident #2 had a lap tray in place when eating breakfast. A review of the current care plan showed there was no care plan addressing a lap tray during meals with interventions and goals. This showed it was not updated to reflect the residents' current status. A third observation on10/22/24 at 12:03 PM found the lap tray in place during lunch. On 10/22/24 at 12:14 PM during an interview the Administrator stated the tray was used for a table to eat only. During an interview on 10/24/22 at 11:29 AM the Administrator confirmed there was no care plan addressing Resident #2's lap tray until surveyor intervention. 45171 b) Resident # 61 On 10/21/24 at 12:10 PM during the initial long term care survey process interview, Resident #61 stated he had a dentist appointment later today as he was having some issues. Record review found the following Progress notes: -10/18/24 12:49 PM Resident POA (power of attorney) notified of appt (appointment) date and time at (name) family dentistry. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/21/24 2:26 PM Resident returned to facility from dentist appointment. Resident has multiple teeth that are non-restorable. Resident elects to have no treatment done at this time and has no pain. Physician Orders: October 21, 2024, at 1300 (1:00) pm with (name of dentist). Facility to transport. Please have the resident ready no later than 1200 pm. one time only for dentist appointment for 1 Day Other Completed 10/20/24 23:00 (11:00 pm). On 10/22/24 at 3:25 PM during a follow up interview with Resident #61, he stated he was not sure when his dental problems started. He did not want a bunch of dental work done. He said that if his teeth that were bad started to bother him he would just have them pulled. Record review of the care plan found there was no focus, goals or interventions initiated in his care plan for dental. This was confirmed with the Administrator on 10/23/24 at 9:00 AM. c) Resident #61 On 10/21/24 at 12:10 PM during the initial long term care survey process interview it was observed that Resident #61 was on a specialty mattress. On 10/22/24 at 9:05 AM during record review it was noted that Resident #61 has pressure ulcers with treatments ordered. There was no order or care plan initiated for the specialty mattress. This was confirmed with the Administrator on 10/23/24 at 9:00 AM. 39043 d) Resident #64 Resident #64's Five (5) Day Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 09/27/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Review of Resident #64's comprehensive care plan showed the following focus initiated on 08/30/24, The resident has impaired cognitive function/dementia or impaired thought processes AEB (as evidenced by). The as evidenced by portion had not been completed. The goal initiated 08/30/24 stated, The resident will remain oriented to (SPECIFY: person, place, situation, time) through the review date. The target date was 12/22/24. No review or revision dates were documented for the focus or goal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 1:13 PM, the Administrator confirmed for the resident to be oriented to person, place, situation, and time was not a realistic goal for Resident #64. No further information was provided through the completion of the survey. e) Resident #64 Review of Resident #64's medical records showed the resident experienced a fall on 09/03/24 and received a skin tear on his left elbow. Further review of Resident #64's medical records showed the resident experienced another fall on 09/08/24 and received a skin tear to right outer forearm. Review of Resident #64's comprehensive care plan showed the following focus initiated on 09/03/24 and revised on 09/08/24, [Resident's name] has had actual falls with minor injury and is at risk for further falls related to cognitive deficits, poor safety awareness, hx [history] of falls, impaired mobility. The goal initiated 08/30/24 stated, The resident's (Specify: injured areas) will resolve without complication by review date. The target date was 12/22/24. On 10/23/24 at 1:13 PM, the administrator confirmed the resident's injured areas were not specified in the goal. No further information was provided through the completion of the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 20490 Based on resident interview, medical record review and staff interview the facility failed to ensure they facilitated a resident's involvement and invited him in advance to his care plan meeting. Resident identifier: #54. Facility census: 63. Findings included: a) Resident #54 During an interview with Resident #54 on 10/22/24 at 11:59 AM he commented that he did not know anything about care plan meetings. Review of the medical record did not reveal any documentation regarding the facility's invitation to Resident #54 for care plan meetings or their facilitation to involve him in these meetings. During an interview with the social worker on 10/23/24 at 9:00 AM she said she goes around the day of the care plan and talks to the resident and asks him if he wants to attend the meeting. The medical record review revealed an invitation to the care conference scheduled for 10/24/24. The social worker said this invitation was mailed to the legal representative. Care plan conference sign in sheets for meetings held on 05/09/24, 02/08/24, 11/08/23, and 08/16/23 did not reveal the resident had attended any of these meetings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on record review, observation, resident interview, and staff interview the facility failed to implement an ongoing activity program designed to meet the interests of and support the well-being of each resident. This had the potential to affect a limited number of residents residing at the facility. Resident identifiers: #34 and #12. Facility census: 63. Findings included: a) Resident #34 During multiple observations of Resident #34 on 10/21/24, 10/22/24 and 10/23/24, the resident was lying in bed with no activities being provided. Record review revealed an activities participation sheet. The activities assessments revealed one (1) on one (1) activities were required. During an interview on 10/23/22 at 12:48 PM with the facility Activities Director (AD) she stated that there was not any documentation of one (1) on one (1) activities being provided. She stated she only had one other staff member to provide activities seven (7) days a week. 45171 b) Resident #12 On 10/21/24 at 3:19 PM Resident #12 stated she liked to listen to gospel music. She stated she did not do much because she was blind and cannot see to do much but she loved gospel music. The following observations of Resident #12 were as follows: 10/22/24 8:10 AM the resident was observed sitting in her wheelchair in her room looking out the window. The television was not on. 10/22/24 12:15 PM the resident was observed sitting in her wheelchair in her room, looking out the window , waiting for lunch. The television was not on. 10/22/24 2:45 PM the resident was observed in her wheelchair rolling in the hallway 10/23/24 10:10 AM the resident was observed in her wheelchair rolling in the hallway 10/23/24 4:15 PM the resident was observed sitting in her wheelchair in her room, looking out her window. The television was not on. 10/24/24 10:00 AM the resident was observed sitting in her wheelchair in her room, looking out her window. The television was not on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/24/24 2:15 PM Resident observed sitting in her wheelchair in her room looking out the window. Administrator observed as well. No TV on. On 10/23/24 at 2:41 PM the activity calendar and activity logs were reviewed for July-October 2024 with findings as follows:. The activity calendar for July 2024 had ten (10) opportunities for gospel music provided by the activities team. The activity log documentation for July 2024 under Spiritual/Emotional Activities showed twenty-two (22) out of thirty-one (31) days were marked as N/A for Not applicable. The additional nine (9) days were blank. The activity calendar for August 2024 had eleven (11) opportunities for gospel music provided by the activities team. The activity log documentation for August 2024 under Spiritual/Emotional Activities showed twenty-four (24) out of thirty-one (31) days were marked as N/A for Not applicable. The additional seven (7) days were blank. The activity calendar for September 2024 had twelve (12) opportunities for gospel music provided by the activities team. The activity log documentation for September 2024 under Spiritual/Emotional Activities showed twenty (20) out of thirty (30) days were marked as N/A for Not applicable. The additional ten (10) days were blank. The activity calendar reviewed for October through 10/22/24 has had nine (9) opportunities for gospel music provided by the activities team. The activity log documentation thus far for October 2024 under Spiritual/Emotional Activities showed sixteen (16) out of twenty-two (22) days were marked as N/A for Not applicable. The additional six (6) days were blank. During an interview with the Director of Activities #49, on 10/23/24 at 2:54 PM, she explained the coding system on the activity logs. She explained that gospel music would fall under Spiritual/Emotional Activities. That was when a church or individual pastor comes in, has Bible study and a sing a long hymn session or they turn on church on the television which usually has gospel music. She explained the code for N/A meant not applicable. This meant the resident was not taken to the activity and would probably not be interested in it. When asked if the resident was invited, the Director stated, no, probably not. Resident #16's care plan initiated on 04/17/24 was reviewed and the intervention was: Focus: (Residents name) exhibits limited engagement related to Alzheimer. Goal: (Residents name) will demonstrate engagement of interest as evidenced by socialization, specify limited and focus attention for a period of 15 minutes or less during activities by next review. Interventions: Encourage (residents name) participation in activity preferences of TV, special events, visiting family and friends, 1:1, music, sensory, being read to. Invite residents to activities. The quarterly activity assessment dated [DATE] described the resident's favorite activities, special accomplishments, and/or new interests. They were identified as bingo, church, tv, music, drawing, tactile, visits, mail, outings, special events, cooking groups. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above findings were confirmed on 10/23/24 04:30 PM with the Director of Activities and the Administrator. They both agreed Resident #12 did not have enough activities to keep her involved in something.

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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.

20490

Based on observation, staff interview, and record review the facility failed to ensure two (2) residents had received care and treatment in accordance with professional standards of practice, and the comprehensive care plan. For Resident #61 they failed to follow a physician's order for wound care and failed to provide. For Resident #33 they failed to follow the care plan for the use of a palm protector. Resident identifiers: #61, #33. Facility census: 63.

Findings included:

a) Resident #33

An observation on 10/21/24 at 2:57 PM revealed Resident #33 had a contracture to his left hand. The resident said she had suffered a stroke. The resident's medical record revealed she had a left hand contracture.

Observations throughout the day on 10/21/24 and 10/22/24 revealed the resident's palm protector was not in place.

On 10/24/24 at 11:15 AM during an interview with Certified Occupational Therapy Assistant (COTA) #66 he stated he had recommended the palm protector when he worked with Resident #33.

A palm protector can help with hand contractures by preventing skin breakdown and keeping fingers from digging into the palm.

On 10/24/24 at 11:30 AM during observations in Resident #33's room it was noted that a palm protector was lying on the resident's over bed table.

The resident was asked about the palm protector and at that time she tried to put it on her right hand.

A review of the kardex for Resident #33 revealed an intervention which stated, Palm protector in left hand.

A review of the resident's care plan revealed a focus area which stated the resident was at risk for skin breakdown related to limited mobility. One of the interventions for this focus area was Clean left hand with wound cleanser, gently dry, apply maxorb Mon., Wed., and Friday.

45171

b) Resident #61

On 10/22/24 at 1:15 PM record review shows the following orders:

Order Summary:

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cleanse right heel with wound cleanser, pat dry, apply Santyl to wound bed, cover with opti-foam heels then wrap with kling every day shift for wound Order Summary: Clean left heel with wound cleanser, pat dry, apply Hydrogel, cover with opti-foam heel protector, wrap with kerlix. every day shift for wound to left heel On 10/23/24 at 11:03 AM observation of wound care with Licensed Practical Nurse (LPN) #18 found that wound care on 10/22/24 was not performed as according to the physicians orders. On 10/23/24 at 11:03 AM when LPN #18 removed the previous days dressing it did not have the opti-foam feel protector in place on either heel. This was confirmed immediately with LPN #18 who agreed the treatment on 10/22/24 was not performed according to the physicians order. c) Resident #61 - Specialty mattress On 10/21/24 at 12:10 PM during the initial long term care survey process interview it was observed that Resident #61 was on a specialty mattress. On 10/22/24 at 9:05 AM during record review it was noted that Resident #61 has pressure ulcers with treatments ordered. There is no Physicians order or care plan initiated for the specialty mattress. This was confirmed with the Administrator on 10/23/24 at 9:00 AM. d) Resident #61 - heel boots On 10/22/24 at 10:10 AM during record review it was noted that Resident #61 has a physicians order as follows: 07/09/24 Order Summary: Apply protective heel boots every day (QD) to prevent skin breakdown. The following observations found Resident #61 out of bed and not have heel boots on as ordered. He currently has pressure ulcers to bilateral heels. 10/22/24 at 10:10 AM No heel boots on 10/22/24 at 2:05 PM No heel boots on 10/22/24 at 3:20 PM No heel boots on 10/23/24 at 8:30 AM No heel boots on 10/23/24 at 10:22 AM No heel boots on 10/23/24 at 3:15 PM No heel boots on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/24/24 at 9:05 AM No heel boots on 10/24/24 at 1:15 PM No heel boots on 10/24/24 at 4:35 PM No heel boots on The care plan was reviewed and found an intervention under skin integrity which states heel protectors to be worn when out of bed and as needed (prn). This was confirmed with the Administrator on 10/24/24 at 4:45 PM.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on observation, record review and staff interviews, the facility failed to provide treatment or services to prevent and heal pressure ulcers for one (1) of three (3) residents reviewed for pressure ulcers. The resident suffered actual physical harm when further avoidable facility acquired pressure ulcers developed. Resident identifier: #61 Facility Census: 63. Findings included: a) Resident #61 Resident #61 was admitted on [DATE] with the following identified skin issues noted on the Nursing Admission Evaluation dated 07/03/24: Resident #61 had a deep tissue injury measuring 5 centimeters (cm) X 4.5 cm to the left heel. Resident #61 had a pressure ulcer measuring 1 cm X 1.5 cm to the right side of the coccyx. A wound was also noted on the left-hand middle finger. On 08/24/24 a note identified a left heel pressure ulcer/injury or suspected deep tissue injury. This was identified as a new facility acquired unstageable. No size was documented. No description was identified. This area appeared to be the same that was present upon admission but no prior documentation could be found before 08/24/24. On 09/05/24 according to the weekly skin observation sheets a new open area was identified to the right buttock. This was identified as a new skin condition. This wound was not evaluated on any further weekly skin observation sheets or weekly wound evaluation sheets. On 09/11/24 a new facility acquired right heel pressure ulcer/injury or suspected deep tissue injury unstageable with necrotic tissue was identified. No size was documented, the interventions in place were heel protectors. On 09/20/24 the right heel evaluation now was described as necrotic with serosanguinous (thick, watery, pale, red/pink drainage) with no size documented. The interventions in place were to offload heels. 09/28/24 the left heel evaluation showed an unstageable with size documented as 4 cm X 4 cm with slough (yellow, tan, white, stringy) with 60% slough/necrosis and serosanguineous drainage, moderate exudate with moderate dressing saturation. Interventions in place were to off load heels and encourage hydration and mobility. On 10/05/24 the right heel evaluation documented an unstageable 4 cm X 4 cm with slough to the wound bed. 60% slough/necrosis. Wound exudate: serosanguineous with a moderate amount of exudate. Dressing saturation is moderate with 26-75%. interventions in place were off load heels and encourage hydration and nutritional status evaluation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Oon 10/11/24 at 4:15 PM there was a consultation for the wound clinic for bilateral heels for one day. The order was discontinued on 10/12/24. 10/13/24 right heel unstageable 4.5 cm X 6 cm. Wound bed necrotic with 100% slough/necrosis with wound exudate purulent (think, milky, green/yellow/white/brown). Moderate exudate amount of 26-75%. Interventions in place: pressure reducing/relieving mattress, encourage hydration and mobility, nutritional status evaluation, turning and positioning routine On 10/20/24 the right heel Stage III measured 3.5 cm X 2.5 cm X 0.2 cm. The wound bed had granulation with wound exudate serosanguinous with a moderate amount of exudate, dressing saturation moderate 26-75%. Interventions in place were to off-load heels. According to the last wound evaluation dated 10/20/24 the resident had a pressure ulcer/injury or suspected DTI to his right heel which was identified as facility acquired and a Stage III full thickness tissue loss. On 10/21/24 at 12:55 PM observation found Resident #62 in bed. He was observed as tall and thin. His head was to the top of the bed frame and his knees were bent with his heels pressed into the mattress. His knees were bent against the footboard. The bed was too short. When asked, he stated he was 6' 3. On 10/22/24 at 10:10 AM during record review it was noted that Resident #61 had a physician's order dated 07/09/24 for protective heel boots to be worn every day to prevent skin breakdown. On 10/22/24 at 10:10 AM record review shows Resident #61 did not have an order or care plan for an extended length bed. On 10/22/24 at 10:30 AM during an interview with the Administrator she stated she thought he had an extension on his bed. She said she would check and get it placed on the bed or get him a longer bed. On 10/23/24 at 11:00 AM during an interview with Licensed Practical Nurse (LPN) #18 with the resident present the LPN was asked if she felt the resident needed a longer bed, she agreed he probably did. She said she would check why he was not on an extended bed. The resident stated, This is the only bed I have ever had. On 10/22/24 at 1:15 PM the record review shows the following orders: Order Summary: Cleanse right heel with wound cleanser, pat dry, apply Santyl to wound bed, cover with Opti-foam heels then wrap with kling every day shift for wound Order Summary: Clean the left heel with wound cleanser, pat dry, apply Hydrogel, cover with Opti-foam heel protector, wrap with kerlix. every day shift for wound to left heel (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 at 11:00 AM during an interview with Licensed Practical Nurse (LPN) #18 with the resident present the LPN was asked if she felt the resident needed a longer bed, she agreed he probably did. She said she would check why he was not on an extended bed. The resident stated, this is the only bed I have ever had. On 10/23/24 at 11:03 AM observation of wound care with Licensed Practical Nurse (LPN) #18 found that wound care on 10/22/24 was not performed as according to the physician's orders. On 10/23/24 at 11:03 AM when LPN #18 removed the previous day's dressing it did not have the Opti-foam feel protector in place on either heel. This was confirmed immediately with LPN #18 who agreed the treatment on 10/22/24 was not performed according to the physicians order. On 10/24/24 at 2:00 PM the resident had an appointment with the Wound Clinic in (name of city). Observation on the following dates and times found the resident to be in bed with his knees bent, heels pressed into the mattress: 10/21/24 at 12:55 PM 10/21/24 at 2:10 PM 10/22/24 at 8:05 AM 10/22/24 at 2:30 PM 10/23/24 at 11:00 AM 10/23/24 at 4:00 PM 10/24/24 at 8:15 AM 10/24/24 at 1:15 PM The following observations found Resident #61 out of bed and not having heel boots on. He had pressure ulcers to bilateral heels. 10/22/24 at 10:10 AM No heel boots on 10/22/24 at 2:05 PM No heel boots on 10/22/24 at 3:20 PM No heel boots on 10/23/24 at 8:30 AM No heel boots on 10/23/24 at 10:22 AM No heel boots on (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	10/23/24 at 3:15 PM No heel boots on 10/24/24 at 9:05 AM No heel boots on 10/24/24 at 1:15 PM No heel boots on 10/24/24 at 4:35 PM No heel boots on The care plan was reviewed and found an intervention under skin integrity which stated, Heel protectors to be worn when out of bed and as needed (prn). These issues were confirmed with the Administrator on 10/24/24 at 4:45 PM. No futher information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 39043 Based on record review and staff interview the facility failed to monitor weights as ordered by the physician for a resident at risk for weight loss. This deficient practice had the potential to affect one (1) of seven (7) residents reviewed for the care area of nutrition. Resident identifier: #64. Facility census: 63. Findings included: a) Resident #64 Review of Resident #64's comprehensive care plan showed the following focus initiated on 09/04/24, The resident has nutritional problem or potential nutritional problem r/t [related to] poor po [oral] intakes, need for mechanically altered diet, T2DM [type II diabetes mellitus], anxiety, PCM [protein calorie malnutrition], dementia, depression, Alzheimer's, underweight, presence of wound increasing needs. Review of Resident #64's physicians' orders showed an order written on 08/31/24 for the resident to be weighed daily for three (3) days, weekly for four (4) weeks, then monthly. Resident #64's documented weights were as follows: - 08/31/24: 128.2 pounds (lbs) - 09/01/24: 128.2 lbs - 09/23/24: 122.2 lbs - 10/01/24: 121.8 lbs Resident #64's Medication Administration Record (MAR) indicated the resident refused to be weighed on 09/16/24. The MAR indicated the resident was scheduled to be weighed on 09/02/24 and 09/09/24. However, the areas to indicate the weight was left blank on these two (2) days. No weight was documented, nor did the MAR indicate the resident had been unavailable or refused to be weighed on 09/02/24 and 09/09/24. On 10/23/24 03:07 PM, the Director of Nursing stated she was unable to locate documented weights for Resident #64 on 09/02/24 and 09/09/24.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 42120 Based on observation and staff interview the facility failed to ensure the daily nursing posting was completed accurately for 13 of 16 days. This was a random opportunity for discovery. Facility census: 63. Findings included: a) Staffing data An observation on 10/21/24, 10/22/24, and 10/23/24 of the facility posted staffing data, found the facility name was not on the document. A facility record review of posted staffing data for 11/18/23, 11/19/23, 11/20/23, and 05/25/34 found the required shift census was not documented. On 05/26/24, 10/04/24, 10/05/24, 10/06/24, 10/19/24 and 10/20/24 found the required facility name not documented. During an interview on 10/24/24 at 10:08 AM the administrator verified the census and facility name was not documented. She stated that she would add the facility name now.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. 39043 Based on record review and staff interview, the facility failed to have laboratory reports filed in the resident 's clinical record. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifier: #64. Facility census: 63. Findings included: a) Resident #64 Review of Resident #64's physicians' orders showed an order for laboratory testing written on 09/03/24. The laboratory testing to be performed was complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid-stimulating hormone (TSH), and Hemoglobin A1c (HgA1c). Resident #64's medical records contained the results for a CBC and HgA1c obtained on 09/05/24. The results contained the notation that the records were reviewed by [physician's initials] on 09/06/24. On 10/23/24, the Director of Nursing (DON) brought the CMP and TSH results to the surveyor. She stated she had obtained the results from the hospital laboratory who had tested the blood sample. The DON stated she didn't know why these results were not in the resident's records. The glucose level was elevated at 257. (Normal is 74-111.) The carbon dioxide was slightly elevated at 32. (Normal is 23-30). The alkaline phosphatase was slightly elevated at 122 and the aspartate aminotransferase (AST) was slightly elevated at 48. (Normal levels are 38-120 and 8-40, respectively.) Because the results were obtained directly from the hospital laboratory, there was no notation indicating the records were reviewed by the resident's physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Glenville Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Fairground Road Glenville, WV 26351	

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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42120 Based on observation and staff interviews, the facility failed to store a resident's beverages in accordance with professional standards for food service safety related to storage. This has the ability to affect more than a limited number of Residents. Facility census: 63. Findings included: a) Nutrition pantry During the initial kitchen tour on 10/21/24 at 11:30 AM an observation of the nutrition pantry found a Residents 12 pack of Coke cans and two (2) six (6) packs of bottled Dr Pepper, and a coffee pot stored under the sink by the sewer/waste disposal pipe. On 10/21/24 at11:35 AM during an interview with the Dietary Manager (DM) verified that resident's soda or coffee pot should not be stored under any sink. The soda and the coffee pot were removed at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 20490 Based on a review of the Electronic Medical Record (EMR) and staff interview, the facility failed to maintain an accurate medical record for Resident #6. This was true for one (1) of three (3) residents reviewed for pressure ulcers. This had the potential to affect a limited number of residents. Resident identifier: #6. Facility census: 62. Findings included: a) Resident #6 A review of the EMR on 12/18/24 at approximately 2:15 PM found pressure ulcer measurements for Resident #6 on 11/26/24, 11/29/24, 12/06/24, 12/13/24, and 12/17/24. The resident was in the hospital from 11/26/24 through 12/08/24 when the Resident returned to the facility. At approximately 3:00 PM on 12/18/24, the Director of Nursing (DON) stated that she had made a mistake and there were no measurements during the time in which Resident #6 was in the hospital. In addition the DON stated that the measurements on 12/13/24 and 12/17/24 were correct and that the measurements on 11/26/24, 11/29/24, 12/06/24 had been struck out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45171 Based on observation and staff interview the facility failed to maintain an infection prevention program to help prevent the development and transmission of communicable diseases and infections by not providing hand hygiene prior to meals. Facility Census: #63 Findings include: On 10/23/24 at 11:55 PM during the noon meal pass it was observed that residents in the dining room were not provided hand hygiene prior to their meal. On 10/23/24 at 12:17 PM It was confirmed with Licensed Practical Nurse #26 that the residents are to be offered hand hygiene prior to their meal. She stated it is usually either a towelette or a pump of hand sanitizer (anti bacterial disinfectant), I am not sure why they did not offer it to the residents today.