STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515105	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Center	8 Rose Street Grafton, WV 26354

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on record review, facility reported incident review, and staff interview the facility delayed initiating Cardiopulmonary Resuscitation (CPR) to Resident #63 after staff identified he did not have a heart beat or breath sounds but was still warm to the touch. The residents record contained no documentation to indicate if he did or did not want to have CPR. The standard of care is when there is an absence of an advance directive CPR should be given. Resident #63 was found unresponsive with no pulse or respirations by facility staff at approximately 6:45 am on [DATE]. CPR was no initiated until 7:19 am which was approximately 34 minutes after he was round unresponsive with no pulse or respirations. The emergency medical squad arrived at 7:30 am and assumed care of the code. They received authorization to call the time of death around 7:55 am on [DATE]. The state agency on [DATE] entered the facility to initiate an investigation into this situation which was self-reported by the facility. On [DATE] the SA determined on [DATE] an immediate jeopardy (IJ) situation was present in the facility. The facility initiated a plan of correction on [DATE] and completed their plan as of [DATE]. Therefore, this IJ will be cited as past noncompliance with a start date of [DATE] and an end date of [DATE]. This was true for one (1) of eight (8) residents who expired at the facility from [DATE] to [DATE]. Resident identifier: #63. Facility Census: 62. Findings included: On [DATE] the state agency received a five (5) day follow-up report regarding an incident that took place on [DATE] involving Resident #63. The five (5) day follow-up report read as follows: [DATE] FIVE DAY FOLLOW UP REPORT Alleged Perpetrator: (First and Last Name of RN #2), RN (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Alleged Victim: (First and Last Name of Resident #63) , resident On [DATE], (First name of Resident #63) was found unresponsive with no pulse or respirations by staff around 6:45 AM. (First and last name of Resident #63) was admitted to (Name of Facility on [DATE] for a skilled stay. His pertinent diagnoses include: noninfective gastroenteritis and colitis, unspecified; diarrhea, unspecified; enterocolitis due to clostridium difficile, not specified as recurrent; type 2 diabetes mellitus without complications; gastrostomy status; dysphagia, unspecified; malignant neoplasm of esophagus, unspecified; ulcer of esophagus with bleeding; and hypoglycemia, unspecified. (First name of Resident #63) scored an , d+[DATE] on his most recent BIMS on [DATE]. His level of staff assistance varied from partial to dependent assistance for bathing, bed mobility, dressing, hygiene, and transfers. (First name of RN #2) reported she administered 30 mL of water through (First name of Resident #63)'s peg tube around 0530. He refused the Jevity 1.5 feeding citing complaints of feeling full. She advised he was pleasant and talkative, and denied being in any distress or discomfort. She reportedly obtained a finger stick at 6 AM of 124. The documented fingerstick is listed at 117. Based on statements obtained from all staff working on [DATE], (First name of Resident #63) was found unresponsive by a CNA while completing her round upon entering his room around 0645. The description she provided indicated that he wasn't breathing, his eyes and mouth were open. At this time, (First name of Resident #63) was still warm to touch per her statement. She ran to the door and called for the registered nurse, (First and last name of RN #2). Upon being informed that Mr. (Last name of Resident #63) was not responsive, (First and last name of RN #2) entered the room and completed an assessment. She was unable to discern a heartbeat, or breath sounds with her stethoscope. She was also unable to locate a pulse. She notified the physician and attempted to contact the patient's next of kin. The oncoming shift of nurses arrived at the center around 7 AM and started receiving report from (First name of RN #2) . Upon hearing that the patient had passed away, (First and last name of RN #3), RN asked (First name of RN #2) if she knew what his code status was and (First name of RN #2) replied I don't know but it isn't going to do him much good now. (First name of RN #2) advised she wasn't doing anything until I talk to (First name of the Director of Nursing (DON). (First and last name of the DON) , RN, DON spoke with staff at the center around 0719 and instructed them to begin CPR and call 911 and advised them the center was running an active code. (Name of Local emergency squad) arrived at the center around 0730 and assumed care of the code. They received authorization to call the time of death around 0755. The facility completed an audit on [DATE] for all residents to ensure they had a code status listed in the Physician Orders. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Re-educations was provided by the DON/Designee to all licensed nurses to ensure if there is no order for code status in the resident chart; the resident is considered a full code and CPR is to be initiated and documented on the CPR/AED flowsheet with a posttest to validate understanding. Any licensed nurses not available during this time frame will be provided re-education, including post-test upon the beginning of the next shift to work. New licensed nurses will be provided education, including post-test during orientation by the DON/designee. The Unit Managers/designee will monitor starting on [DATE] new admission/readmissions and/or change in resident advance directives order to ensure the resident has an order for code status. The Nurse Practice Educator/designee will conduct mock code drills starting on [DATE] daily across all shifts for 3 days, then weekly for 2 weeks, then monthly for 3 months and randomly thereafter. Results of monitors will be reported by the DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and/or in-servicing until the issue is resolved; then randomly thereafter as determined by the QIC committee. (First and last name of RN #2) was suspended pending investigation. An initial report was made to the WV RN Board. Neglect will be substantiated due to the delay in care. (First Name of Resident #2) has been terminated effective [DATE]. The state agency initiated an on - site investigation into this facility reported incident on [DATE]. During the investigation the reportable incident was reviewed and the above referenced Five (5) day follow-up was contained in the reportable. There were staff statements which supported the statements in the five day follow- up report. The following are the staff statements which were contained in the reportable record which was provided to the surveyor: Statement from Registered Nurse (RN) #3 (typed as written) dated [DATE]: After clocking into my shift at 7am [DATE], I approached the nurses station where the night nurse (first and last name of RN #2), RN was sitting at her computer charting. I gathered my materials form shift and a report sheet. The nurse then said to me Mr. (Last name of Resident #63) just passed away. I asked the nurse when, and she stated probably between 6:,d+[DATE]:45 am because he was still warm. I then asked if he was a DNR of Full Code. She stated, I don't know, but it isn't going to do him much good now. I'm not doing anything until I talk to (First name of the DON). I then explained to her that his POST form should have been verified upon discovering he was unresponsive and that vital signs have ceased, and if no POST form was available we should have began CPR and attempted to contact MPOA. I then immediately searched the resident's chart for a POST form, which was not available and called a code blue. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Initials of RN #2), RN then called the DON (First and Last name of the DON), RN while dayshift staff members responded to the code. Upon entering the room, resident was observed to be laying flat in bed, warm to touch, and Pale in color. Vital signs ceased. CPR was initiated by (First and last name of RN #7), RN while (First and last name of Nurse Aide (NA) #10), CNA obtained an AED, and I began pulling needed supplies from the crash cart. Once other staff members responded to assist, I went to the nurses station where, (Initials of RN #2), RN was sitting at her computer and asked her if she had called 911. She then picked up the phone and dialed 911. I began printing appropriate paperwork needed for EMS to give them upon arrival. EMS responded and entered the facility. As they approached the resident's room, I gave them the needed documents and report on the patient. When asked when the last time the resident was seen stable, (Initials of RN #2), RN responded with around 3am when she flushed his PEG tube with water and that was the last time she had laid eyes on the resident. As I assisted EMS and staff wit the code, I obtained a FS (finger stick) on the resident due to HX (history of) DM (Diabetes Mellitus) and the FS read 42. EMS staff asked when the last FS was obtained, and I then asked (initials of RN #2), RN because the resident had an order for 6am FS. She responded with 127. I obtained the history from both glucometers and could not find a FS reading 127 and the last FS obtained from the A hall glucometer was timed shortly after 1am. I then called the DON and attempted to reach the president's wife/emergency contact. I explained to the wife that the resident's vitals had ceased, and we were actively running a code with EMS. Due to not having a signed POST form on file and having to perform CPR I then asked the wife whether she wished for us to continue with CPR and she responded with yes. While speaking with the wife, EMS staff had called time of death. At this time the DON had arrived to the resident's room and spoke with EMS staff. I then assisted staff and EMS with transferring the patient back to the bed and cleaning him up. I went back up to the nurses station where (Initials of RN #2), RN was still sitting at her computer charting . She then said to me, I don't care if I get fired, I have a job at (Initials of Local Hospital). Statement from RN #7 dated [DATE] (typed as written) : I arrived to the facility at 7:03 (AM) and proceeded to the nurses station to receive a report from the off going nurse of A hall. She proceeded to give me report after having made the statement that they had found a patient expired in his bed prior to my arrival. She had stated that she was waiting on the DON to call her back to find out what she wanted to do . During that time while she was waiting for the phone call she was giving me report on A hall patients and about 5 minutes later she received the phone call from and individual I assumed was either the DON, Aministrator, or MD (Medical Doctor). It was while she was on the phone call that I became aware that the patient did not of a DNR. Promptly after that statement made by the off going nurse, she instructed me to head down to the patients room and start CPR. Staff were alerted of the Code Blue, announced by, (First and last name of RN #3), and everyone immediately responded to the code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon reaching the patients room, I quickly performed a rapid assessment and determined the patient was indeed unresponsive and I started CPR/compression. AED pads were applied after the first round of compression/during ventilation. Compressions and ventilation were not interrupted during this transition. CPR had been underway for about ,d+[DATE] round of compressions/2 AED rhythm checks before EMS had arrived with no shockable rhythm found. Once EMS arrived they assumed care and took over CPR and compressions vis mechanical compressions unit. This statement is to the best of my knowledge and I am unable to provide any more exact times than what is contained in this statement. Statement from RN #2 dated [DATE] (typed as written): Regarding (First and Last Name of Resident #63) This nurse rounded on this resident at 0530 (5:30 am) in room (Room number redacted to maintain confidentiality). He allowed me to give him 30 ml of water through his peg tube but refused his jevity 1.5 cal feeding c/o of feeling full. He was pleasant, talkative, and denied being in any distress or discomfort. I performed his 6 am finger stick which was 124. We talked for a about fie more minutes about the importance of keeping hydrated and I left his room. The resident was stable at this time. Sometime later was notified by the NA making her rounds that this resident appeared to not be breathing. I entered the room with my stethoscope at 0645 (6:45 am) and found Mr. (Last name of Resident #63) unresponsive and not breathing. I was unable to discern a heartbeat or pulse. I found no mottling or any other areas of concern to the residents body. Dr. (last name of the attending physician) was notified at 0705 (7:05 am) at which time he told me he was on his way to the (Name of Facility). I attempted to call the resident wife but was unable to talk with her personally. I brought up the residents documents online but was unable to find a POST form that documented his wishes regarding end of life care. I immediately called my DON and recounted the above events. (Name of local EMS Service) was notified at 0726 (7:26 am) that we were actively starting CPR in lieu of no advance directives. Crash care was brought to the door of the residents room and the AED was utilized while awaiting the emergency squad. (Initials of Local EMS service) arrived at 0737 (7:37 am) and took over care of Mr. (Last name of resident #63) at this time. These statements are true to the best of my knowledge and recollection. Statement from Nurse Aide (NA) #17 this statement is not dated (Typed as written): (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I was maken [sic] our last round go to (first and last name of Resident #63) room I turn on light and see he wasn't breathen [sic} his eyes and mouth were open. I ran to the door and yelled for the nurse , (First name of RN #2). She came in also (First Name of Licensed Practical Nurse (LPN) #16) and (First name of NA #21) came in the nurse (First name of RN #2) listen to him breathe and said he was gone, we touch him and he was still warm. She said he hasn't been gone too long and she said something about his tube feeding that he was full up to or to full not sure she left. (First name of NA #21) and I washed him up. We was about done and (First Name of NA #18) came in and asked if we needed help. She help us put the flat sheet under him we got done and left next thing I new [sic] (First name of RN #3) asked (First name of NA #10) to help her because we half [sic] to do CPR on him. Coed [sic] blue. When I got to the room (First Name of RN #7) and (First name of Na #10) was doing CPR on him. (Nick Name of Activity Director) out of activities was In there too. I left and told them I would wait on the ambulance. Time I got to the door they was here and I showed them the way. Statement from NA #10 dated [DATE] (Typed as written): This morning Friday [DATE], upon arriving at the nurses station to get shift report and begin my day. I asked (First name of NA in Training #23) where the rest of the staff was. She informed me that (NA #17) was performing post-mortem care on Mr. (Last name of Resident #63). I went to his door, Room (room number redacted to maintain confidentiality), and knocked on his door to see if (First name of NA #17) needed any assistance as I was under the impression she was in the room by herself. After learning (First and Last Name of NA #21) was also in the room, I collected my necessary materials for my shift and began filling the ice chest go a water pass in the nutrition room. After coming out of the nutrition room, I overheard discussion as to whether or not Mr. (Last name of Resident #63) was a full code or a DNR and went behind the desk at the nurse's station to see if I could be of any help. (First and Last Name of RN #2), RN was sitting at the computer and stated, I don't know if he is full code or not but it wont do him any good now. (First and Last Name of RN #3) , RN replied with, Do we have a signed POST form stating yes or no? With no reply from (First name of RN #2), (First Name of RN #3) walked over to the computer and began to see if he had one scanned into his chart and I pulled his paper chart off of the shelf and began to flip through finding no POST form. (First name of RN #2) then made the comment that was not doing anything until she talked to (First Name of the DON), the DON. I then walked down B hall and began my day with ice water pass while I waited for further instructions as to what was happening. (First and last Name of NA #18) and I got shift report from (First and Last name of NA #21) and began an Ice pass. We made it about ,d+[DATE] of the way down the hallway when, (First name of RN #3) called code blue. I went to (First name of NA #18) and told her there was a code blue in room (Room number redacted to maintain confidentiality). I observed (First name of RN #3) and (First and last name of RN #7) retrieving the crash cart and oxygen tank from the clean utility room so I got the AED and made my way to Room (Room Number redacted to maintain confidentiality). Upon arriving to the room, (First name if RN #7) was adjusting the bed to an appropriate lever for CPR and (First Name of RN #3) obtained necessary materials from the crash cart. I then opened the AED and followed prompts while (First Name of RN #7) began compressions. (First Name of RN #3) then received a phone call from (First Name of DON) so she handed me the ambu bag and told me she would be right back. I went to the head of the bed, connected the oxygen to the bag and began giving the resident rescue breaths in accordance with the guidelines of CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	While assisting in the code, I observed the resident being pale and warm to the touch. I continued aiding in CPR switching off between providing Rescue breaths and performing compressions until (Initials of local emergency squad) arrived on scene. I then followed orders of the medics as they took over the code. We lowered the resident to the floor to provide more adequate CPR and EMS attached the LUCAS machine. Once they no longer needed my assistance, I went back to B hall to finish the ICE water pass. After we completed the ice pass, I put the supplies away and went back to Room (Room number redacted to protect confidentiality) where I found (First name of RN #2) talking to the medics while they performed the code. While I was in the room the female medic asked what time was he last seen alive, when (First name of RN #2) replied with around 3 am I flushed is peg tube with 30 cc of water and he declined his feed and pain pill at that time. Resident was talking and was free of pan at that time. I asked the medics I they needed any further assistance to which they replied no and I left the room to pass breakfast trays. After passing the trays I noticed squad was still here so again I went to the room to see if they were in need of any assistance to which the female medic told me no but asked if I knew what time he was found to which I replied I was not on shift yet but I believe it was sometime between 0630 and 0700 Se expressed gratitude for my honesty as she could not get a straightforward answer from the night shift nurse. That was the end of our interactions, and I went back to b hall. Statement from NA #18 this statement does not have a date (typed as written): I came in this morning and the new girl asked me If I was a nurse or an aide. I told her aide she said they're down there in (Room number redacted to maintain confidentiality) cleaning him up and they might need help. So I went down and ask [sic] them if they needed help. They [sic] 2 aides said can you help roll him so I did and I helped put a sheet under him. We then covered him up. I went back down B hall. Oh yea I forgot he was still warm. I also tried to close his mouth which it wouldn't close. My self and (First name of NA #10) went to pass water down b hall then (First name of NA #10 said that (First name of RN #3) called Code Blue but told her Code Blue so we went down to (Room number redacted to maintain confidentiality) (First name of NA #10) grabbed the AED and put pads on his chest and her and (First Name of RN #7) started doing compressions. (First Name of RN #3) called 911. Ambulance Came and they took the man off the bed and place him in the floor and proceeded to continue CPR After Ambulance came I came out of room I was just standing there. Statement from LPN #16 dated [DATE] (typed as written): On [DATE] at 645 am this nurse pulled scheduled medications and tube feed for Room (Room number redacted to maintain confidentiality). Upon entering room, resident was repositioned blood pressure obtained and tube fed site was cleaned and dressing applied. While administering meds and tube fed this nurse heard someone say something but could not make out what was said. Then heard someone say he's gone. As soon as feeding syringe was empty, I capped feeding tube and went to check. I entered room (room number redacted to maintain confidentiality) and CNA stated he's gone. Resident noted to be very pale with mouth open. Turned to get the other nurse who was walking into room. Returned to Room (room number redacted to maintain confidentiality) to ensure no medications were left unattended. Statement from NA #19 dated [DATE] (typed as written): (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	We checked resident in (room number redacted to maintain confidentiality) around ,d+[DATE] (am) he was not wet an no BM, he couldn't find his TV remote so we helped him find it (in his bed) and I talked to him a little about watching, The wheel of fortune and asked if he was okay and needed anything else, he said he was fine and we left the room. Statement from Activity Director #20 dated [DATE] (typed as written): On Friday Morning I was in activity room and I heard them call a code blue. When I gotin the room a nurse was in there performing CPR and A SNA was using ambu bag giving breaths. I asked if the nurse needed a break at this time and the nurse and CNA just switched jobs and when I notice CAN getting tired I jumped in and did one round of compressions and then the squad came and took over. Resident was not responsive to CPR. When I got in the room he was pale in color. Statement from NA #21 dated [DATE] (typed as written): We had been in room (room number redacted to maintain confidentiality) between 3:30 am and 4:00 am. Resident was dry and ok. Was talking about watching Wheel of Fortune. That room was the last one to check on the 5 am round. (First name of NA #17) had gowned up and went in ahead of me. She came to the door and said we need a nurse Upon entering the room the resident had a waxy color and did not appear to be breathing but was warm to the touch. (First name of RN #2) entered the room just after me with a stethoscope. She listened to him and checked for a pulse and told us he was gone. (First name of NA #17) and I started cleaning him up and (First Name of NA #18) came in to help us finish him up. The final two statements in the investigation were from NA #12 and NA #15 both of whom stated they had no interaction with the resident until after the code was over and they helped to get the resident back into the bed. A review of the medical record for Resident #63 found there was no documentation in his medical record pertaining to this incident. The only documentation in the record to indicate the resident had expired was a death in facility minimum data set with an assessment reference date of [DATE] and four (4) e-mar notes which indicated, PT (patient) expired as a reason why the medication was not administered. An interview with the Nursing Home Administrator (NHA) at 9:04 am on [DATE] confirmed there was no documentation in the medical record regarding this incident. She indicated they found that during the end of their investigation. Their training does incorporate making sure the code and the steps of the code are documented in the medical record. Further review of the medical record found Resident #63's care plan was void of any information pertaining to his code status. There was not a physician order or a Physician order for Scope of Treatment (POST) form in the record. An interview with the Nursing Home administrator on the afternoon of [DATE] confirmed there was no post for or code status order. She stated, it is usually addressed by the admitting nurse, but they missed his and there was not one. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility initiated a plan of correction on [DATE] which read as follows: F678 Resident #(First and last initial of Resident #63) no longer resides in the facility. All residents of the facility have the potential to be affected. The Director of Nursing (DON/Designee) conducted an audit on [DATE] for all residents to ensure all residents had a code status listed in the Physician Orders. The DON conducted an audit on [DATE] for all licensed nursing staff including any non licensed nursing personnel to validate their current Cardiopulmonary Resuscitation (CPR) certification with corrective action immediately upon discovery. Re-education was provided by the DON/Designee to all licensed nurses on [DATE] to ensure if there is no order for code status in the resident chart the resident is considered a full code and CPR to be initiated and documented on the CPR/AED flow sheet with a posttest to validate understanding. Any licensed nurses not available during this time frame will be provided re-education, including post test during orientation by the DON/Designee. The unit managers (UM)/designee will monitor starting [DATE] new admission/readmissions and/or change in resident advance directives order to ensure the resident has an order for code status and the CPR/AED flowsheet is utilized for all CPR daily for 2 weeks including weekends and holidays, then five times a week for four (4) weeks , then three (3) times a week for 4 weeks then randomly thereafter. The nurse Practice Educator (NPE)/designee will conduct mock code drill starting [DATE] daily across all shifts X 3 days, then weekly for 2 weeks , then monthly for 3 months, then randomly thereafter. Results of monitors will be reported by the Director of Nursing (DON)/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and or in servicing until the issue is resolved, then randomly thereafter as determined by the QIC committee. An interview with the Director of Nursing (DON) around 10:00 am on [DATE] confirmed she and the nurse practice educator (NPE) conduct the mock CPR drills she explained the process as follows: We take the CPR dummy to different places in the facility and have the staff run a code. She stated, we observe to make sure they are completing all steps of the CPR process correctly and that everyone is knowledgeable about what they need to do an when. She stated, if we identify staff that may need a little extra help we will focus the next drill on them to ensure they are getting the training they need. Licensed Practical Nurse (LPN) #4, LPN #5, and LPN #6 were interviewed on [DATE] and [DATE] they were knowledgeable about the education they received and were able to accurately describe the steps they would follow in initiating or not initiating CPR. They were asked questions about different scenarios and was able to accurately answer all questions. (continued on next page)

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	515105	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Center	8 Rose Street Grafton, WV 26354

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the training and audits provided by the facility found all the training and audits they mentioned in their Plan of correction were completed with the last trainings taking place on [DATE]. The audits remain ongoing to ensure continued compliance. Any nurses who have not been educated have not worked since the incident and will be educated when they return to work. All residents who expired in the facility from [DATE] were reviewed. There were eight (8) total including Resident #63. Resident #64, 65, 66, 67, 68, 69 and 70. The seven (7) residents excluding Resident #63 all had orders for Do Not Resuscitate: New admissions the facility was also reviewed to ensure there were no issues with the code status and/or orders for such. The Findings of the review are below: -- Resident #6 admitted on [DATE] is a full code and it is identified accurately throughout her medical record. --Resident #11 admitted on [DATE] is a DNR which was established by the facility on [DATE] and is identified accurately throughout the medical record. -- Resident #12 admitted on [DATE] is a DNR which was established by the facility on [DATE] and is identified accurately throughout the medical record. -- Resident #16 admitted on [DATE] is a full code and it is identified accurately throughout his medical record. -- Resident #25 admitted on [DATE] is a full code and it is identified accurately throughout her medical record. --Resident #34 admitted on [DATE] is a full code and it is identified accurately throughout his medical record. -- Resident #40 admitted on [DATE] is a DNR and this is identified accurately throughout her medical record. -- Resident #50 was admitted on [DATE] and is a full code and it is identified accurately throughout her medical record. -- Resident #59 was admitted on [DATE] and is a full code and it is identified accurately throughout her medical record. All CPR certifications were reviewed by the SA and all licensed nursing staff have current CPR certifications. All posttests completed by the facility was also reviewed and all staff had completed the training and the post test.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 31826 Based on record review and staff interview the facility failed to ensure Nurse Aide (NA) # 14 had a performance evaluation completed every 12 months as required. This was true for one (1) of five (5) nurse aide files reviewed. This failed practice had the potential to effect more than isolated number of residents. Staff identifier: NA # 14 Facility Census: 62. Findings include: a) NA # 14 On 09/11/24 in the early afternoon the employee file for NA #14 was requested. N #14's hire date was 02/08/22. As part of the request her 12-month performance evaluation was requested. When the facility provided the employee file there was no performance evaluation found. The performance evaluation was again requested from Clinical Advisor #22. Later in the afternoon Clinical Advisor #22 returned and stated they did not have an up-to-date performance evaluation for NA #14. She stated, The DON was on leave, and this was missed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on record review, facility reported incident review, and staff interview the facility failed to ensure the resident record was complete and accurate. Resident #63 expired at the facility on [DATE] and cardiopulmonary resuscitation was initiated but failed. The medical record contained no information regarding the events of [DATE]. Resident identifier: #63. Facility Census: 62. Findings include: a) Resident #63 On [DATE] the state agency received a five (5) day follow-up report regarding and incident that took place on [DATE] involving Resident #63. The five (5) day follow-up report read as follows: [DATE] FIVE DAY FOLLOW UP REPORT Alleged Perpetrator: (First and Last Name of RN #2), RN Alleged Victim: (First and Last Name of Resident #63) , resident On [DATE], (First name of Resident #63) was found unresponsive with no pulse or respirations by staff around 6:45 AM. (First and last name of Resident #63) was admitted to (Name of Facility on [DATE] for a skilled stay. His pertinent diagnoses include: noninfective gastroenteritis and colitis, unspecified; diarrhea, unspecified; enterocolitis due to clostridium difficile, not specified as recurrent; type 2 diabetes mellitus without complications; gastrostomy status; dysphagia, unspecified; malignant neoplasm of esophagus, unspecified; ulcer of esophagus with bleeding; and hypoglycemia, unspecified. (First name of Resident #63) scored an , d+[DATE] on his most recent BIMS on [DATE]. His level of staff assistance varied from partial to dependent assistance for bathing, bed mobility, dressing, hygiene, and transfers. (First name of RN #2) reported she administered 30 mL of water through (First name of Resident #63)'s peg tube around 0530. He refused the Jevity 1.5 feeding citing complaints of feeling full. She advised he was pleasant and talkative, and denied being in any distress or discomfort. She reportedly obtained a finger stick at 6 AM of 124. The documented fingerstick is listed at 117. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on statements obtained from all staff working on [DATE], (First name of Resident #63) was found unresponsive by a CNA while completing her round upon entering his room around 0645. The description she provided indicated that he wasn't breathing, his eyes and mouth were open. At this time, (First name of Resident #63) was still warm to touch per her statement. She ran to the door and called for the registered nurse, (First and last name of RN #2). Upon being informed that Mr. (Last name of Resident #63) was not responsive, (First and last name of RN #2) entered the room and completed an assessment. She was unable to discern a heartbeat or breath sounds with her stethoscope. She was also unable to locate a pulse. She notified the physician and attempted to contact the patient's next of kin. The oncoming shift of nurses arrived at the center around 7 AM and started receiving report from (First name of RN #2) . Upon hearing that the patient had passed away, (First and last name of RN #3), RN asked (First name of RN #2) if she knew what his code status was and (First name of RN #2) replied I don't know but it isn't going to do him much good now. (First name of RN #2) advised she wasn't doing anything until I talk to (First name of the Director of Nursing (DON). (First and last name of the DON) , RN, DON spoke with staff at the center around 0719 and instructed them to begin CPR and call 911 and advised them the center was running an active code. (Name of Local emergency squad) arrived at the center around 0730 and assumed care of the code. They received authorization to call the time of death around 0755. The facility completed an audit on [DATE] for all residents to ensure they had a code status listed in the Physician Orders. Re-educations was provided by the DON/Designee to all licensed nurses to ensure if there is no order for code status in the resident chart; the resident is considered a full code and CPR is to be initiated and documented on the CPR/AED flowsheet with a posttest to validate understanding. Any licensed nurses not available during this time frame will be provided re-education, including post-test upon the beginning of the next shift to work. New licensed nurses will be provided education, including post-test during orientation by the DON/designee. The Unit Managers/designee will monitor starting on [DATE] new admission/readmissions and/or change in resident advance directives order to ensure the resident has an order for code status. The Nurse Practice Educator/designee will conduct mock code drills starting on [DATE] daily across all shifts for 3 days, then weekly for 2 weeks, then monthly for 3 months and randomly thereafter. Results of monitors will be reported by the DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and/or in-servicing until the issue is resolved; then randomly thereafter as determined by the QIC committee. (First and last name of RN #2) was suspended pending investigation. An initial report was made to the WV RN Board. Neglect will be substantiated due to the delay in care. (First Name of Resident #2) has been terminated effective [DATE]. The state agency initiated an on - site investigation into this facility reported incident on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the investigation the reportable incident was reviewed and the above referenced Five (5) day follow-up was contained in the reportable. There were staff statements which supported the statements in the five day follow- up report. A review of the medical record for Resident #63 found there was no documentation in his medical record pertaining to this incident. The only documentation in the record to indicate the resident had expired was a death in facility minimum data set with an assessment reference date of [DATE] and four (4) e-mar notes which indicated, PT (patient) expired as a reason why the medication was not administered. An interview with the Nursing Home Administrator (NHA) at 9:04 am on [DATE] confirmed there was no documentation in the medical record regarding this incident. She indicated they found that during the end of their investigation. Further review of the medical record found Resident #63's care plan was void of any information pertaining to his code status. There was not a physician order or a Physician order for Scope of Treatment (POST) form in the record. An interview with the Nursing Home administrator on the afternoon of [DATE] confirmed there was no post for or code status order. She stated, it is usually addressed by the admitting nurse, but they missed his and there was not one.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 31826 Based on record review and staff interview the facility failed to ensure the staff abuse and neglect training contained training related dementia management and resident abuse prevention. This was true for five (5) of five (5) nurse aides reviewed. This failed practice had the potential to affect more than an isolated number of residents. Nurse Aide (NA) Identifiers: #10, #11, #12, #13, and #14. Facility Census: 62. Findings Include: a) Abuse Training Review A review of the following nurse aides personnel record found the following: -- NA #10 had a hire date of 03/23/22. Her training record was reviewed from 01/01/23 until 12/31/24. This review found she had the following abuse training: Protecting residents from assault and abuse for a total of 40 minutes. A review of the learning objectives for this training found it was void of any specific training related to dementia management and resident abuse prevention. -- NA # 11 had a hire date of 06/04/00. Her training record was reviewed from 01/01/23 until 12/31/24. This review found she had the following abuse training: Protecting residents from assault and abuse for a total of 40 minutes. A review of the learning objectives for this training found it was void of any specific training related to dementia management and resident abuse prevention. -- NA #12 had a hire date of 08/23/16. Her training record was reviewed from 01/01/23 until 12/31/24. This review found she had the following abuse training: Protecting residents from assault and abuse for a total of 40 minutes. A review of the learning objectives for this training found it was void of any specific training related to dementia management and resident abuse prevention. -- NA #13 had a hire date of 07/02/18. Her training record was reviewed from 01/01/23 until 12/31/24. This review found she had the following abuse training: Protecting residents from assault and abuse for a total of 40 minutes. A review of the learning objectives for this training found it was void of any specific training related to dementia management and resident abuse prevention. -- NA #14 had a hire date of 02/08/22. Her training record was reviewed from 01/01/23 until 12/31/24. This review found she had the following abuse training: Protecting residents from assault and abuse for a total of 40 minutes. A review of the learning objectives for this training found it was void of any specific training related to dementia management and resident abuse prevention. This was confirmed with Clinical Advisor #22 and assisting Nursing Home Administrator #24 on 09/11/24 at 4:49 PM.