

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515121	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Rainelle Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 276 Pennsylvania Avenue Rainelle, WV 25962	

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)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>49465</p> <p>Based on resident interview, staff interview and record review the facility failed to protect the resident's rights to communicate with individuals confidentially by opening Resident #15's package before giving it to her. This failed practice was a random opportunity for discovery during the Long-Term Care Survey Process. Resident identifier #15. Facility Census 52.</p> <p>Findings include:</p> <p>a) Resident #15</p> <p>During an interview, on 12/11/24 at 9:40 AM, Resident #15 stated, Yesterday I got a package Resident #15 then showed me the package. It was a box that she had received through mail delivery services. Resident #15 further stated, I don't like them opening my stuff without me.</p> <p>A record review on 12/11/24 at 10:02 AM, of Resident #15's Brief Interview for Mental Status (BIMS) assessment revealed that Resident #15, had a BIMS score of (9) nine.</p> <p>During an interview on 12/11/24 at 10:13 AM, The Activity Director (AD) stated, I opened it and put it in there, because she is on a special diet, and she sometimes gets hard candy so I wanted to make sure she didn't get that.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to implement the comprehensive care plan in the area of falls. This deficient practice had the potential to affect one (1) of six (6) residents investigated for the care area of falls. Resident identifier: #12. Facility census: 52.</p> <p>Findings included:</p> <p>a) Resident #12</p> <p>Review of Resident #12's comprehensive care plan showed a focus relating to potential injury from falls was initiated on 04/05/17.</p> <p>The following intervention was initiated on 04/07/23, Staff to ensure clothes fit properly when dressing resident. If elastic is worn out in pants notify nurse and use a different pair.</p> <p>Review of Resident #12's medical records showed the resident experienced a fall on 11/30/24. A nursing note written on 11/30/2024 at 7:47 PM stated, Resident was observed to have hipsters in place, only one shoe was in place (right shoe.) Resident did not have properly fitting pajama pants as they were observed to have no elastic in the waistband. Pants were observed to be around her ankles and possibly the cause of this fall. New fall intervention: staff to ensure resident's clothing fits properly.</p> <p>On 12/11/24 at 9:48 AM, the Director of Nursing confirmed Resident #12's care plan was not implemented in the area of properly fitting pants to prevent potential falls.</p> <p>No further information was provided through the completion of the survey process.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. Neurological checks were not performed according to professional standards of practice after an unwitnessed fall. This deficient practice had the potential to affect one (1) of six (6) residents reviewed for the care area of falls. Resident identifier: #12. Facility census: 52.</p> <p>Findings included:</p> <p>a) Resident #12</p> <p>The facility's policy and standard procedure titled Neurological Checks, no implementation date given, stated neurological checks would be performed for falls with unknown head injury as follows:</p> <ul style="list-style-type: none"> <li>- Every 15 minutes for four (4) times</li> <li>- Every 60 minutes for four (4) times</li> <li>- Every four (4) hours for four (4) times</li> <li>- Daily for four (4) times</li> </ul> <p>Review of Resident #12's medical records showed the resident had an unwitnessed fall with a head laceration on 11/13/24.</p> <p>The resident was evaluated in the emergency room where the head laceration was sutured. A computed tomography showed no abnormalities. Neurological evaluations were initiated when the resident returned from the emergency room to the facility.</p> <p>On 11/17/24, the resident had another unwitnessed fall. A nurse's note written on 11/17/2024 at 6:50 AM stated, Resident found sitting in floor on buttocks with legs outstretched in front of her behind room door. Able to get door open enough to enter room. Resident assessed for injuries, no visible injuries, no c/o [complaint] or s/s [signs or symptoms] pain/discomfort with palpation of hips. Legs equal in length. ROM [range of motion] intact. Resident assisted to seated position in wheelchair and assisted to nurses station per her request. Resident immediately requested to return to room and get back in bed. Resident assisted back to bed and resting with eyes closed, bed low position, call light in reach.</p> <p>Resident #12's medical records contained no documentation that neurological evaluations were initiated after the resident's unwitnessed fall on 11/17/24. However, on-going neurological evaluations related to the resident's fall on 11/13/24 continued and were now being done daily for four (4) days. The neurological evaluations last been done on 11/16/24 at 2:00 PM. The daily neurological evaluations continued on 11/17/24 at 2:00 PM and 11/18/24 at 6:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/11/24 at 10:13 AM, the Director of Nursing confirmed evaluations were not initiated after the resident's unwitnessed fall on 11/17/24. She stated this was because the resident was already receiving change in condition monitoring due to the fall on 11/13/24. However, she confirmed the neurological evaluations were only being done daily after the fall on 11/17/24.</p> <p>No further information was provided through the completion of the survey.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39043</p> <p>Based on record review and staff interview, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. This deficient practice affected one (1) of six (6) residents investigated for the care area of falls.</p> <p>Resident #12 experienced actual harm from the fall because she experienced pain after the fall and required evaluation in the emergency room . X-ray examination showed an abnormality of the hip and further evaluation was recommended. However, the resident experienced another fall before further imaging could be obtained. After the second fall, the resident was found to have a hip fracture, requiring surgical intervention. Resident identifier: #12. Facility census: 52.</p> <p>Findings included:</p> <p>a) Resident #12</p> <p>Review of Resident #12's comprehensive care plan showed a focus relating to potential for injury from falls was initiated on 04/05/2017.</p> <p>The focus stated, Potential for injury from falls r/t [related to] weakness, difficulty walking, hx [history] falls, Dementia with sundowning, poor safety awareness, Afib [atrial fibrillation], HTN [hypertension], CHF [congestive heart failure], Hx closed head injury, Depression, Anxiety, Behaviors, OA [osteoarthritis], allergic rhinitis, glaucoma/bilateral cataracts, Emphysema/COPD [chronic obstructive pulmonary disease], Lumbago with Sciatica, Herniated Disc, noncompliant using walker for ambulation, Cardiomegaly, Pulmonary fibrosis and nodules, Kyphosis, Hallux Valgus L/R [left and right] foot, Hammer toe L/R foot, Tinea Unguim, urinary retention, spinal stenosis lumbar, scoliosis lumbar, intervertebral disc displacement thoracic, interveterbral disc degeneration lumbar, L (left) kidney cyst, L abd (abdominal) hernia, muscle spasms to back, possible medication s/e [side-effects], CAD [coronary artery disease], incontinence, hx dislocation/fx [fracture] L humerus, ventral hernia without obstruction or gangrene.</p> <p>The following intervention was initiated on 04/07/23, Staff to ensure clothes fit properly when dressing resident. If elastic is worn out in pants notify nurse and use a different pair.</p> <p>Other interventions were as follows:</p> <ul style="list-style-type: none"> <li>- Administer Vitamin D (Ergocalciferol) per physician order. (Initiated on 07/08/2021.)</li> <li>- Anti-rollbacks, Anti-tippers, Dycem and extended Brakes to wheelchair. (Initiated on 10/18/2019.)</li> <li>- Assure that lighting is adequate and keep room and hallways free of clutter. (Initiated on 04/05/2017.)</li> <li>- Bed buddies while in bed as tolerated. (Initiated on 08/17/2022.)</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Bed in mid to low position as tolerated (Initiated on 04/03/2018.)</li> <li>- Bedside commode placed next to bed per preference for resident to use, instead of attempting to walk to the bathroom. (Initiated on 03/17/2022.)</li> <li>- Bulb Light for ease of use, keep within reach. Check on resident frequently as she may not remember to use it. (Initiated on 04/05/2017.)</li> <li>- Cushion to outside of foot board of bed. (Initiated on 12/05/2024.)</li> <li>- Dim light on at HS [night] as resident will allow. (Initiated on 02/21/2018.)</li> <li>- Encourage patient to go to dining room for all meals as tolerated. (Initiated on 06/17/2021.)</li> <li>- Encourage patient to sleep in middle of the bed, and reposition if laying to close to edge as tolerated. (Initiated on 12/11/2021.)</li> <li>- Encourage resident if she allows to have door half open so staff can visibly see her when they pass by her room to check on her. (Initiated on 09/14/2019.)</li> <li>- Encourage resident to have rails in bathroom down so resident can use to help with stability. (Initiated on 12/08/2018.)</li> <li>- Encourage resident to pull up pants prior to trying to ambulate/transfer. (Initiated on 10/28/2019.)</li> <li>- Ensure empty isolation cart outside of room, resident uses as landmark to find room. (Initiated on 05/06/2024.)</li> <li>- Ensure resident is wearing double sided non-skid socks when ambulating or transferring as tolerated (resident likes to remove socks when in room) or non skid slippers. (Initiated on 04/05/2017.)</li> <li>- Ensure resident's cord to call light is not in the way of her walking path to transfer to her bedside commode. (Initiated on 08/09/2024.)</li> <li>- Ensure residents bedside table and wheelchair are within easy reach. (Initiated on 07/11/2024.)</li> <li>- Grab bar to wall between bathroom and sink for resident to use for steadiness while ambulating/transferring. (Initiated on 06/27/2022.)</li> <li>- Hand sanitizer on wall in bathroom (Initiated on 04/19/2022.)</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Staff to observe resident while dining in her room in order to pick up her tray promptly when done. (Initiated on 03/23/2024.)</li> <li>- Staff to offer assistance with toileting prior to meals, after meals, upon rising in the morning and at bedtime. (Initiated on 07/25/2020.)</li> <li>- Staff to offer laying down to rest after lunch If refuses place in common area as tolerated. (Initiated on 11/25/2022.)</li> <li>- Staff to put long sleeve sweater on resident during AM care as requested. (Initiated on 08/15/2022.)</li> </ul> <p>Revision on: 07/11/2024</p> <ul style="list-style-type: none"> <li>- Staff to stay with resident when she is observed on bedside toilet as resident tolerates. (Initiated on 09/21/2023.)</li> <li>- Turn heat on prior to taking resident for shower to ensure room is warm when she comes out. (Initiated on 06/11/2020.)</li> <li>- When staff sees resident is wheeling self down hall towards her room offer to assist her to bathroom/bed. (Initiated on 09/24/2022.)</li> </ul> <p>Upon observations during the investigation 12/10/24 through 12/11/24, Resident #12's fall interventions were in place.</p> <p>Resident #12's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 11/20/24 showed the resident's Brief Interview for Mental Status (BIMS) score was 3, indicating severe cognitive impairment. The resident had a diagnosis of vascular dementia.</p> <p>Review of Resident #12's medical records showed the resident experienced a fall on 11/30/24. A nursing note written on 11/30/2024 at 7:23 PM stated, At approximately 1845 resident observed sitting in floor on her buttocks in her doorway, tearful. Resident was stating, help me honey, help I'm hurt bad. Resident's left leg was observed to be slightly rotated outwards. Pillows were placed behind resident's back, and she was assisted to lay flat on her back on the floor. Resident continued to call out in pain and was not able to move her left lower extremity. L (left) hip observed to have a palpable knot which was tender to touch. V/S [vital signs] obtained: T [temperature]: 98.2 P [pulse]: 94 RR [respiratory rate]: 18 B/P [blood pressure]: 168/90 manual in L arm, O2 [oxygen saturation]: 96% on RA [room air]. Using nursing judgement this nurse called 911 at 1849 for emergency transfer to ER [emergency room ] for evaluation of L hip/LLE [left lower extremity]. While awaiting ambulance resident was observed to begin to move LLE but continued with s/s [signs and symptoms] of pain i.e. facial grimacing. MPOA [medical power of attorney], Dr [doctor] and DON [director of nursing] made aware of situation. Resident left facility at 1904 via [ambulance service]. Called and gave report to [nurse's name] RN [Registered Nurse] at [hospital name] at 1920.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note written on 11/30/2024 at 7:47 PM stated, Resident was observed to have hipsters in place, only one shoe was in place (right shoe.) Resident did not have properly fitting pajama pants as they were observed to have no elastic in the waistband. Pants were observed to be around her ankles and possibly the cause of this fall. New fall intervention: staff to ensure resident's clothing fits properly.</p> <p>The emergency room documentation reported the resident's hip pain had resolved prior to evaluation in the emergency room . X-ray of the left hip and leg showed a very small clinically irrelevant stress fracture. An incidental viewing of the right hip showed a potential abnormality, potentially a right femoral neck fracture but more likely a positional abnormality due to the fact that the resident had no pain in the right hip or symptoms of fracture. However, this x-ray abnormality was not discovered until the resident had left the emergency room . The emergency room contacted the facility on 12/01/24 to advise them to order an x-ray of the right hip.</p> <p>A nursing note written on 12/1/2024 at 6:45 AM, ER physician called and stated that when radiologist read image of left hip x-ray he saw a right Fem [femoral] neck abnormality from a small part of right side that [was] visible on image. Suggested a portable x-ray on Monday for follow up. PCP [primary care physician] notified. No new orders at this time.</p> <p>A nursing note written on 12/1/2024 at 8:11 AM stated, POA [power of attorney] aware of this, POA stated she would like resident to stay in facility and have portable x-ray done as resident is not having pain at this time, she does not feel it is necessary to have resident sent to ER. Dr. gave orders to obtain x-ray of right hip, R knee.</p> <p>A nursing note written on 12/1/2024 at 2:23 PM stated, Resident is alert and oriented to baseline this shift, observed to be in a pleasant mood. Resident has allowed staff to assist her with oral care x1 [once] this shift. No issues noted in relation to this. No s/s of pain or distress noted at this time. Resident did complain of pain to R knee earlier this shift but topical biofreeze was effective for pain management. R knee is currently elevated on pillows. All fall interventions are in place. Call light is within reach.</p> <p>A nursing note written on 12/01/24 at 8:05 PM stated, Called to room by CNA's [certified nursing assistants]. Observed resident to be laying on floor between bed and table on left side with head toward head of bed and legs stretched out and arms to chest. Resident alert and talking with staff. Blood noted on left cheek and ear. Lacerations to left cheek noted and partial detachment of left ear lobe observed with moderate bleeding noted. Lacerations x 2 [two] noted on left forearm with minimal bleeding. Resident c/o [complained of] pain from lacerations but no other complaints of pain voiced. PCP notified. 911 called for EMS [emergency medical services] transfer due to lacerations and bleeding. POA also notified of fall and injuries and states she will meet EMS at hospital.</p> <p>A computed tomography (CT) scan performed at the hospital showed a right femoral neck fracture, requiring surgical intervention.</p> <p>The resident returned to the facility on [DATE] at 4:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to ensure medical records were complete and accurate regarding fall risk evaluations for one (1) of six (6) residents reviewed for the care area of falls. Resident identifier: #54. Facility census: 52.</p> <p>Findings included:</p> <p>a) Resident #54</p> <p>Review of Resident #54's medical records showed the resident had been admitted to the facility after a falling at home and fracturing her hip.</p> <p>A Fall Risk Observation Tool assessment was performed on 07/19/24 and documented the resident required minimum transfer assistance with gait belt. The assessment also documented the resident had a balance problem while walking and was unable to lift her head. The assessment also documented the resident had a fall history, currently took one (1) or two (2) medications that could contribute to a fall, and had one (1) or two (2) medical conditions that could contribute to falls.</p> <p>A Fall Risk Observation Tool assessment was repeated on 07/31/24 and documented the resident required minimum transfer assistance with gait belt. The assessment also documented the resident had a balance problem while standing. The assessment also documented the resident had a fall history, currently took one (1) or two (2) medications that could contribute to a fall, and had one (1) or two (2) medical conditions that could contribute to falls.</p> <p>Section E of both Fall Risk Observation Tools stated, Based on this assessment, the resident has been identified as a potential risk for falls. Proceed to care plan.</p> <p>Section F of both Fall Risk Observation Tools answered No to the question, After completing this assessment, is there a statement displayed in section 'E' above that identifies the resident as a potential risk for falls?</p> <p>Review of Resident #54's comprehensive care plan showed the resident was care planned for a risk for falls.</p> <p>On 12/10/24 at 3:55 PM, the Director of Nursing (DON) stated Section F of the Fall Risk Observation Tools incorrectly answered No because Section E correctly indicated Resident #54 had a potential risk for falls.</p> <p>No further information was provided through the completion of the survey process.</p>		