STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515124	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pendleton Manor	68 Good Samaritan Drive Franklin, WV 26807

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 43340 Based on observation and staff interview, the facility failed to secure and keep confidential residents personal and medical information. A restorative note was visible on a rolling workstation desk in the 400 hallway for Resident #47. The form identified Parkinson's as a diagnosis for the resident. This was a random opportunity for discovery and was true for only Resident #47. Resident #47. Facility census: 77. Findings include: a) Resident #47 On 05/01/24 at 7:54 AM, a paper restorative note was sitting on top of a rolling workstation desk in the 400 Hallway. The restorative note indicated that Resident #47 was at risk for decline in range of motion related to a diagnosis of Parkinson's. During an interview on 05/01/24 at 8:00 AM, Registered Nurse (RN) #5 verified the restorative note was visible for any passerby and should not have been left out and unattended. On 05/01/24 at 8:15 AM, the Director of Nursing confirmed the practice of leaving a restorative note on a rolling workstation desk failed to protect the privacy of the resident's medical record.

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

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 49467 Based on record review and staff interview, the facility failed to complete a new Pre-Admission Screening and Resident Review (PASARR) for residents with newly evident and possible serious mental disorders. This was true for three (3) of six (6) residents reviewed for PASARRs during the survey process. Resident Identifier: #11, #28, and #49. Facility census: 77. Findings include: A) Resident #11 At approximately 11:00 AM on 04/30/24, a record review was conducted for Resident #11. During record review, it was noted Resident #11 had been admitted to the facility on [DATE]. On 07/25/23, Resident #11 was diagnosed with Major Depressive Disorder. Resident #11 had a new PASARR submitted on 01/29/2024, which did not include the new diagnosis of Major Depressive Disorder. At approximately 8:40 AM on 05/01/24, an interview was conducted with the Director of Nursing (DON) concerning the PASARR for Resident #11. The DON confirmed the absence of major depressive disorder on the PASARR. At approximately 9:45 AM on 05/01/24, an interview was conducted with Social Worker (SW) #45 regarding the PASARR for Resident #11. SW #45 confirmed the missing major depressive disorder diagnosis and that there has been no new PASARR completed for Resident #11 to reflect the diagnosis. B) Resident #28 At approximately 1:20 PM on 04/30/24, a record review was conducted for Resident #28. During the record review, it was noted Resident #28 had been admitted to the facility on [DATE]. A diagnosis of major depressive disorder was entered into the system for Resident #28 on 06/28/23, classified as during stay. Upon review of Resident #28's PASARR, it was noted there was no diagnosis of major depressive disorder present on the PASARR. At approximately 8:40 AM on 05/01/24, an interview was conducted with the Director of Nursing (DON) concerning the PASARR for Resident #28. The DON confirmed the absence of major depressive disorder on the PASARR. At approximately 9:45 AM on 05/01/24, an interview was conducted with Social Worker (SW) #45 regarding the PASARR for Resident #28. SW #45 confirmed the missing major depressive disorder diagnosis and that there has been no new PASARR completed for Resident #28 to reflect the diagnosis. c) Resident #49 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review, completed on 04/30/24 at 3:46 PM, revealed Resident #49 was admitted to the facility on [DATE]. Review of the 02/21/20 PASARR revealed Section III. MI/MR Assessment Question #30 Current Diagnosis was answered NONE. No other PASARR was on file. On 07/22/21 Resident #49 was given a new diagnosis of Major Depressive Disorder, Recurrent. During an interview on 05/01/24 at 8:50 AM, Social Worker #71 confirmed a new PASARR had never been completed to capture the Major Depressive Disorder diagnosis.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and staff interview, the facility failed to complete a new Pre-Admission Screening and Resident Review (PASARR) for residents admitted to the facility diagnosed with possible serious mental disorders. This was true for one (1) of six (6) residents reviewed for PASARRs during the survey process. Resident Identifier: 23 . Facility census: 77. Findings include: A) Resident #23 At approximately 11:30 AM on 04/30/24, a record review was conducted for Resident #23. During the record review, it was noted Resident #23 had been admitted to the facility on [DATE]. A diagnosis of cerebral palsy was entered into the system for Resident #23 on 02/06/23 as the principal/admitting diagnosis. Upon review of Resident #23's PASARR, it was noted there was no diagnosis of cerebral palsy present on the PASARR. At approximately 8:40 AM on 05/01/24, an interview was conducted with the Director of Nursing (DON) concerning the PASARR for Resident #23. The DON confirmed the absence of cerebral palsy on the PASARR. At approximately 9:45 AM on 05/01/24, an interview was conducted with Social Worker (SW) #45 regarding the PASARR for Resident #23. SW #45 confirmed the missing cerebral palsy diagnosis and that there has been no new PASARR completed for Resident #23 to reflect the diagnosis.

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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. 42120 Based on medical record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. The facility failed to collaborate with Hospices services. This was true for one (1) of one (1) residents reviewed for hospice services during the long term care survey. Resident Identifier: Resident # 63. Facility Census: 77. Findings Include: a) Resident #63 A medical record review revealed Resident #63 was receiving Hospice Services starting on 03/27/24. A continued record review of physician's orders showed an order for: -- Admit to Hospice, DX dementia. Review of Resident # 63's Hospice documentation notebook showed it did not contain an active care plan or collaborating documentation from Hospice Services. During an interview with the Director of Nursing on 05/01/24 at 2:13 PM, She verified Resident #63 was receiving Hospice Services and had no current coordinated plan of care with the Hospice provider identifying the provider responsible for performing each or any specific services/functions that had been agreed upon. She stated, she had to call hospices services today and have documentation faxed to the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43340 Based on observation and staff interview, the facility failed to provide an environment which was free from accident hazards over which they had control. The facility did not identify a toaster that was plugged in and operable in the Kitchenette on the 500 Hall as a hazard. This had the potential to affect every resident residing on the 500 hall. Resident identifiers: #64, #7, #30, #56, #26, #3, #6, #39, #19, #65, #42, #8, #28. Facility census: 77 Findings include: a) Toaster in the 500 Hall Kitchenette An observation, made on 04/30/24 at 10:25 AM, found the 500 hall kitchenette had a toaster plugged in and accessible to any passerby. Further investigation confirmed when the handle/lever was pushed down, the coils began to glow red which indicated the toaster was fully operable. During an interview on 04/30/24 at 10:35 AM, the Director of Nursing (DON) verified the plugged in toaster was an accident hazard, unplugged it, and removed the toaster from the area.

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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. 43340 Based on record review and staff interview, the facility failed to ensure complete and accurate medical records. Physician Orders for Scope of Treatment (POST) forms were incomplete and/or inaccurate for two (2) of three (3) records reviewed for accurate POST forms. Resident identifiers: #176 and #9. Facility census: 77. Findings include: a) Review of Using the POST Form Guidance for Health Care Professionals, 2021 Edition The 2021 POST form guidance states: -The patient or incapacitated patient's Medical Power of Attorney (MPOA) or Health Care Surrogate (HCS) must sign and date for the form to be legally valid. -The health care provider / physician completing this form must print their name, sign, and date for the form to be legally valid. b) Resident #176 An electronic medical record review, completed on 04/29/24 at 2:34 PM, found: -A POST form signed by resident's legal representative but not dated -The POST form was signed and dated by the physician on 04/16/24 A subsequent review of the original POST form at the nurses' station revealed it had also not been dated by Resident #176's legal representative. During an interview on 04/30/24 at 2:50 PM, Social Worker #71 acknowledged the form was not legally valid. c) Resident #9 An electronic medical record review, completed on 04/30/24 at 10:11 AM, found: -A POST form signed and dated by resident's legal representative on 03/20/24 -The POST form was not signed and dated by Resident #9's physician. A subsequent review of the original POST form at the nurses' station revealed it had also not been signed and dated by the physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/24 at 2:53 PM, Social Worker #71 acknowledged the form was not legally valid.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on observation, medical record review, and staff interview the facility failed to establish and maintain an infection prevention program to help prevent the development and transmission of communicable diseases and infections including Covid-19 in regard to, precaution signage on the entrance, positive Covid-19 precaution signage on resident doors, water management and expired Sani Wipes. This has to potential to affect all residents that reside in the facility. Identifier: room [ROOM NUMBER]. Facility Census: 77. Findings Include: a) Precaution Signage on Entrance Door An observation on [DATE] at 12:00PM of the facility's front entrance revealed no precautionary signage located on the door informing visitors of Covid-19 in the building. During an interview on [DATE] at 4:02 PM, the Director of Nursing verified there was no precautionary signage for visitors on the front entrance. b) Precaution Signage room [ROOM NUMBER] Observations during the initial tour on [DATE] at 12 noon revealed no signs near the door frames of room [ROOM NUMBER]. Continued review revealed Resident # 65's clinical record revealed the resident was admitted to the facility on [DATE], and was on precautions for Covid-19. Subsequent review revealed Resident # 128 was admitted to the facility on [DATE], and was on precautions for Covid-19. During an interview on [DATE] at 4:02 PM the Director of Nursing verified there was no precautionary signage for Covid-19 on room [ROOM NUMBER] where resident's #65 and #128 is residing. She stated there should be precaution signs on the door. c) Water Management During facility record review of the water management plan revealed, the documentation was not maintained to prevent growth of water borne pathogens including the description of the building water system. The facility did not have a flow diagram or text that Identified the buildings water systems for which Legionella control measures are needed. Subsequent review found there was no documentation in regard to flushing the water system in dead leg areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:43 AM the Maintenance Director verified the facility did not maintain documentation describing the building water systems using text, flushing, or testing protocols. d) 100 Hall Medication Room An observation on [DATE] at 2:30 PM during the medication storage task revealed Sani wipes Large Canister (160 Count) in the 100-hall medication room that expired ,d+[DATE]. During an interview on [DATE] at 2:31 PM Licensed Practical Nurse #109 confirmed the Sani wipes were expired and should not be in the medication room.