STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515128	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightwood Center	840 Lee Road Follansbee, WV 26037

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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. 45173 Based on observation and staff interview, the facility failed to provide dignified dining experiences for residents eating in the dining room and their rooms. The facility failed to serve all residents seated at the same table at the same time. The facility also failed to sit down while feeding Resident #100 and #108. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Resident identifiers: 100, 108. Facility census: 109. Findings include: a) Coral Dining Room At approximately 5:20 PM on 04/22/24, facility staff were observed in the Coral Dining Room serving dinner. During the dinner service, staff were observed serving residents at different tables instead of one table at a time, leaving residents to wait as long as ten (10) minutes for their tray, after the first resident was served at their table. The Director of Nursing (DON) was present in the dining room at the time of service and acknowledged witnessing the staff serving different tables. b) 300 Hall At approximately 5:46 PM on 04/22/24, dinner service was observed on the 300 hallway of the facility. During dinner service on the 300 hallway, facility staff were observed serving different rooms, before all residents in a single room were served. An interview was conducted with Licensed Practical Nurse (LPN) #93 regarding serving different rooms. LPN #93 was asked if staff should be serving all residents in the same room before moving to the next room, LPN #93 stated Yes, we should be, I'm not sure why we aren't today. c) Resident #100 On 04/24/24 at 12:38 PM, an observation was made in the dining room near the B hall. Resident #100 requires assistance with meals. Nurse Aide (NA) #48 was observed standing while feeding Resident #100. NA #48 was notified that standing while feeding a resident is inappropriate. NA #48 replied, oh okay. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/24/24 at approximately 4:30 PM, the Director of Nursing (DON) was notified of the observation in the dining room. The DON stated, thank you for letting me know. d) Resident #108 On 04/22/24 at 5:40 PM, an observation was made of Nurse Aide (NA) #111 standing while feeding Resident #108 in the resident's room. Resident #108 required assistance for meals. NA #111 was notified of the observation. NA #111 did not make a statement. On 04/22/24 at 6:22 PM, the Director of Nursing (DON) was notified and confirmed the staff should not be standing while providing feeding assistance to residents. 49467

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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 Based on record review, resident, and staff interview the facility failed to honor a Resident choice for bathing. This affected one of one reviewed for choices, during the long-term care survey. Resident identifiers #66. Census 109. Findings include: a) Resident #66 During an interview with Resident #66 on 04/23/23 at 12:21 PM, he stated he only receives one (1) shower a week. He stated, he would like to have at least two showers a week. Medical record review revealed, Resident #66's shower schedule is Monday and Thursdays and AS needed per Residents choice. A review of the Quarterly Minimum Data Set (MDS) from 03/07/24, found the resident's brief interview for mental status was fifteen (15). MDS Section E (Behaviors) also indicated Resident #66 does not reject care such as ADL Care, medications, or treatments. A continued review of Resident #66's ADL documentation found from 03/26/24 to 04/24/24: he only received five showers. On 04/24/24 at 4:45 PM the Director of Nursing verified Resident #66 did not receive his showers as scheduled.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43340 Based on record review and staff interview, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) form to two (2) of three (3) residents reviewed for the facility's beneficiary protection notification practice during an annual survey. This failure placed residents at risk of not being informed of their rights prior to the end of Medicare Part A covered services. Resident Identifiers: #48 and #216. Facility census: 109 Findings include a) Beneficiary Notice Review On 04/24/24 at 3:18 PM, a review was completed regarding the beneficiary protection notification liability notices given for the following two (2) residents who remained at the facility following their last covered day of Medicare Part A services: - Resident #24 began Medicare Part A skilled services on 01/17/24. The last covered day of Part A service was 02/17/24. Notice of Medicare Non-Coverage (NOMNC) was signed and dated on 02/15/24. There was no evidence a SNF ABN form had been provided and signed. - Resident #216 began Medicare Part A skilled service on 11/07/23. The last covered day of Part A Service was 12/04/23. NOMNC was signed and dated on 12/01/23. There was no evidence a SNF ABN had been provided and signed. Review of Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice on Non-coverage (SNF ABN) Form CMS-10055 (2018) denoted Medicare requires Skilled Nursing Facilities to issue the SNF ABN to Medicare beneficiaries prior to providing care that Medicare usually covers, but may not pay for because the care is: - not medically reasonable and necessary; or - considered custodial. In an interview on 04/24/24 at 4:00 PM, Clinical Reimbursement Coordinator #3 acknowledged the facility failed to provide SNF ABN forms to Resident #24 and Resident #216 prior to their last covered day of Medicare Part A skilled services.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45173 Based on observation and staff interview, the facility failed to safeguard the privacy of Resident #88's medical record. This was true for one (1) of 12 residents reviewed during medication administration. Resident #88. Facility Census: 109. Findings Include: a) Resident #88 On 04/24/24 at 1:46 PM, an observation was made during medication administration on the B hall. Licensed Practical Nurse (LPN) #38 was standing at the medication cart. LPN #38 was preparing to administer medication to Resident #88. At this time, Resident #12 requested LPN #38 assist her to the bathroom. Upon walking away from the medication cart, LPN #38 left the computer screen visible to anyone within the vicinity of the medication cart. On 04/24/24 at 1:51 PM, LPN #38 returned to the medication cart. LPN #38 was advised the computer screen was visible while Resident #12 was being assisted. LPN #38 stated, I'm sorry I forgot to lock my computer screen. On 04/24/24 at approximately 5:00 PM, the Director of Nursing (DON) was notified of the incident during medication administration. The DON stated, thank you for letting me know.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on record review and staff interview, the facility failed to provide an accurate Minimum Data Set (MDS) assessment for Resident #108. This was true for two (2) of 24 residents reviewed during the survey process. Resident Identifier: #108. Facility Census: 109. Findings Include: a) Resident #108 On 04/23/24 at 10:00 AM, the Admission MDS dated [DATE] was reviewed. The review found Section O entitled Special Treatments, Procedures and Programs was incorrect regarding J1. Dialysis. Section J1 did not indicate the resident was receiving dialysis treatments. On 04/23/24 at 10:19 AM, Clinical Reimbursement Coordinator (CRC) #65 was notified. CRC #65 confirmed section J1 was incorrect. CRC #65 stated, we can send in a correction right away.

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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. 43340 Based on medical record review and staff interview, the facility failed to update the care plan to reflect a change in activities of daily living (ADL) status for resident #80 and a change in Resident #108's need for assistance during meals. These were random opportunities for discovery. Resident identifiers: #80 and #108. Facility census: 109. Findings include: a) Resident #80 A medical record review was completed on 04/24/24 at 2:33 PM. Review of Resident #80's care plan revealed a discrepancy in the amount of assistance resident required for the following ADLs: -Toileting -Bed Mobility -Transfers The FOCUS section of resident's care plan stated resident required assistance/was dependent for the ADLS mentioned above. However, the INTERVENTIONS section of resident's care plan stated resident was independent in all three (3) areas. During an interview on 04/25/24 at 9:36 AM, the Director of Nursing (DON) reported Resident #80 was independent in the areas of toileting, bed mobility, and transfers. The DON acknowledged the FOCUS section had not been updated to reflect the resident's current abilities. b) Resident #108 On 04/22/24 at 5:40 PM, the resident was observed requiring maximum assistance from Nurse Aide (NA) #111 for the evening meal. On 04/22/24 at 6:00 PM, a record review was completed for Resident #108. The review found a care plan intervention stating, Provide resident/patient with set up assist x 1 (one) for eating. (Typed as written.) The documentation under the tasks for eating was reviewed from 04/05/24 through 04/22/24. The review found the resident only required set up assistance for meals 10 times in this time frame. The review found the resident was dependent for meals 31 times, moderate assistance one (1) time, and required maximum assistance three (3) times during this time frame. Therefore, the intervention found on the care plan had not been revised to reflect the resident's need for maximum assistance needed for the meal times. On 04/22/24 at 6:22 PM, the Director of Nursing (DON) was notified of the observation and the documentation of the need of assistance during meal times. The DON stated, she doesn't always need assistance. No further information was obtained during the survey process. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45173

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49467 Based on observation, record review, and resident and staff interview, the facility failed to provide a resident who is unable to carry out activities of daily living (ADL)s the necessary services to maintain good grooming for Resident #28, by not shaving the resident twice a week, as requested by the resident, and by not providing nail care and assisting Resident #24 with meals. This was true for two (2) of four (4) residents reviewed for ADL care. Resident identifiers: 28, 24. Census 109. Findings include: A) Resident #28 At approximately 12:55 PM on 04/23/24 an interview was conducted with Resident #28. Resident #28 stated he had requested to be shaved twice a week. Resident #28 stated he gets a shower one day a week and is supposed to be shaved during the shower,plus an additional day a week, however, Resident #28 states Sometimes they'll say they don't have time to shave me. Resident #28 had not been shaved at this time and stated they had not been shaved in at least a week. At approximately 11:20 AM on 04/24/24, an interview was conducted with Nurse Aide (NA) #103 concerning shaving Resident #28. NA #103 stated We try to shave everyone in the shower if they want it at least one time a week, sometimes it's hard to do it though, because we don't always have enough people to do it, especially twice a week. At approximately 11:30 AM on 04/24/24 Resident #28 was observed as still not having been shaved. At approximately 3:00 PM on 04/24/24 an interview was conducted with Resident #28 regarding being shaved. Resident #28 stated he had asked for someone to shave him earlier in the day and was told staff would return to do it when they had time. Resident #28 was observed as still unshaven at the time of this observation. A record review of Resident #28 ' s care plan states the resident is dependent/requires assistance in all ADLs. B) Resident #24 Nail Care At approximately 11:34 AM on 04/23/24, an interview was conducted with Resident #24. Resident #24 stated she wished to have her fingernails cut but stated I can't get anyone to do it. They will tell me ' When I get time ' but then time never comes, they never come back. Resident #24 stated they have told staff multiple times they wanted their fingernails cut but it has not been done. Resident #24 stated My nails are getting caught on my blanket all the time, I just need them cut. At approximately 11:20 AM on 04/24/24, an interview was conducted with Nurse Aide (NA) #103 concerning nail care for Resident #24. NA #103 stated She has told us she needs her nails cut, we try to get to it as we can, but there are times we just don't have the time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24 was observed at approximately 1:00 PM on 04/24/24 her fingernails were still long and had not been cut. Resident #24 was observed at approximately 10:00 AM on 04/25/24, her fingernails still had not been cut. Record review was conducted of Resident #24's care plan, which stated the resident was to receive nail care twice a week. C) Resident #24 Meal Assistance At approximately 1:00 PM on 04/24/24, this surveyor walked into Resident #24's room to follow up with the resident about their nail care. When this surveyor entered the room, Resident #24 was sitting up in bed, attempting to eat, but was not able to get their food off of the plate, and stated They won't feed me, I can't eat and they won't feed me. Resident #24 was asked if staff offered to assist her with her lunch when they brought it in, to which she replied, They just brought it in and laid it down on my table, they didn't ask if I needed help with anything, they just sat it down and left. At approximately 1:05 PM on 04/24/24, the Director of Nursing (DON) was made aware of Resident #24 needing assistance with lunch, and not receiving it. The DON accompanied this surveyor to Resident #24's room and confirmed the resident needed assistance with eating and did not receive it. Record review was conducted of Resident #24's Minimum Data Set (MDS). Section GG under self care, question A, indicates Resident #24 required a one person physical assist when eating.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42120 Based on record review and staff interview the facility failed to provide information and/or offer the Respiratory Syncytial Virus (RSV) immunization per recommendation of the CDC in a timely manner, complete neurological checks or accurately provide pain management. This failed practice had the potential to affect more than a limited number of residents who currently reside in the facility. Resident Identifier: #27 and #80. Facility census: 109. Findings include: a) RSV immunization During a review of the facility documents regarding immunizations, found zero (0) out of 109 residents have been provided educational information about the risk and benefits of receiving the RSV vaccination. On 04/25/24 at 11:09 AM, Infection Preventionist (IP) stated the facility has not started giving the information or offering the vaccine to anyone yet. b) The Centers for Disease Control and Prevention (CDC) Respiratory syncytial virus, or RSV, is a common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious. Infants and older adults are more likely to develop severe RSV and need hospitalization . Vaccines are available to protect older adults from severe RSV. Monoclonal antibody products are available to protect infants and young children from severe RSV. CDC recommends RSV vaccines to protect adults ages 60 and older from severe RSV, using shared clinical decision-making. According to the CDC the RSV vaccine was made available on early August of 2023. In general, simultaneous administration of vaccines remains a best practice. Providers should continue to simultaneously administer the vaccines for which a patient is eligible, including COVID-19, influenza, and pneumococcal vaccines. Simultaneous administration of RSV vaccine with other vaccines for older adults is also acceptable. When deciding whether to simultaneously administer other vaccines with RSV vaccine on the same day, providers should consider whether the patient is up to date with recommendations for currently recommended vaccines, the feasibility of administering additional vaccine doses later, risk for acquiring vaccine-preventable disease, vaccine reactogenicity profiles, and patient preferences. b) Resident #27 Upon record review, it was noted Resident #27 suffered a fall on 01/25/24 which resulted in a nasal fracture. Neurological assessment records were requested from the facility to ensure all assessments were completed post fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 10:00 AM on 04/25/24, the Director of Nursing (DON) presented the neurological assessment for Resident #27. It was noted the first one (1) hour check at 11:00 PM on 01/25/24 was not completed. The second one (1) hour check scheduled for midnight on 01/26/24 was not completed. The third one (1) hour check scheduled for 1:00 AM on 01/26/24 was not completed. The fourth one (1) hour check for 2:00 AM on 01/26/24 was not completed. The third eight (8) hour check scheduled for 2:00 AM on 01/27/24 was not completed. The DON stated It hurts to have to give you this right now, confirming the neurological assessments for Resident #27 were not completed post fall. c) Resident #80 A record review, completed on 04/24/24 at 10:11 AM, revealed the following physician order: -traMADol HCl Oral Tablet 50 MG - Give 1 tablet by mouth every 8 hours as needed for TID (three (3) times a day) PRN (as needed) pain scale 5-10 Review of the December 2023, January 2023, and February 2023 Medication Administration Records (MARs) identified the following dates the medication was administered outside of the scope of the physician order: -On 12/04/23 resident's pain was rated at a four (4) and traMADol was administered -On 12/06/23 resident's pain was rated at a four (4) and traMADol was administered -On 12/10/23 resident's pain was rated at a four (4) and traMADol was administered -On 12/13/23 resident's pain was rated at a four (4) and traMADol was administered -On 12/25/23 resident's pain was rated at a four (4) and traMADol was administered -On 01/04/24 resident's pain was rated at a four (4) and traMADol was administered -On 01/05/24 resident's pain was rated at a four (4) and traMADol was administered -On 01/16/24 resident's pain was rated at a four (4) and traMADol was administered -On 01/20/24 resident's pain was rated at a three (3) and traMADol was administered -On 01/21/24 resident's pain was rated at a three (3) and traMADol was administered -On 01/33/24 resident's pain was rated at a four (4) and traMADol was administered -On 02/04/24 resident's pain was rated at a zero (0) and traMADol was administered -On 02/05/24 resident's pain was rated at a three (3) and traMADol was administered -On 02/16/24 resident's pain was rated at a four (4) and traMADol was administered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 02/28/24 resident's pain was rated at a four (4) and traMADol was administered During an interview on 04/24/24 at 1:00 PM, the Director of Nursing (DON) confirmed nurses had incorrectly administered the medication when the resident's pain level was not between 5-10. 43340 49467

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45173 Based on observation, record review and staff interview, the facility failed to maintain a safe and accident free environment as possible. This was a random opportunity for discovery. Resident Identifier: #58. Facility Census: 109. Findings Include: a) Resident #58 On 04/23/24 at 9:50 PM, a bottle of lubricating eye drops were found at Resident #58's bedside. The resident stated, I don't know how long they have been sitting there. On 04/23/24 at 9:52 PM, Licensed Practical Nurse (LPN) #92 was notified the eye drops were found at bedside. LPN #92 confirmed the eye drops should not have been left at bedside. On 04/24/24 at 9:20 AM, the Director of Nursing (DON) was notified of the incident regarding the eye drops found at bedside. The DON stated, medication should not be left at bedside.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45173 Based on record review, resident interview and staff interview, the facility failed to manage Resident #5's chronic pain. This is true for one (1) of two (2) residents reviewed under the care area of pain. Resident Identifier: #5. Facility Census: 109. Findings Include: a) Resident #5 On 04/22/24 at 2:15 PM, an interview was conducted with Resident #5. The resident stated, I have had four (4) back surgeries .they won't give me pain medication .they say they are referring me to a pain clinic. On 04/22/24 at 5:00 PM, a record review was completed for Resident #5. The review found two (2) current physician's orders for the following: -- Tylenol Extra Strength 500mg (milligram) give two (2) tablets by mouth every 6 (six) hours as needed for general discomfort 1-4 (one to four) pain scale. Do not exceed 3 (three) gram within 24 hours. Code for non-pharm (pharmacological) intervention 0 (zero) nonpain 1 Reposition 2 massage 3 apply cold 4 apply heat 5 (five) Ambulate/movement 6 (six) limit movement 7 (seven) promote relaxation/calm environment 14 other-add to PN the description (Typed as written.) --Norco Oral Tablet 5-325mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every six hours as needed x 2 tablets uncontrolled pain (Typed as written.) The Medication Administration Record was reviewed for 03/01/24 through 03/31/24 and 04/01/24 through 04/30/24. The review found one (1) dose of the Norco Oral Tablet was given on 03/05/24 and no additional doses were given. On 04/24/24 at 2:25 PM, the Director of Nursing stated, (Name of the physician) in the community was writing her prescriptions for her narcotics prior to coming to the facility. The community physician advised the facility he wouldn't be writing the prescriptions anymore. On 03/05/24, the resident advised the nursing staff she was experiencing uncontrolled pain in her back. The facility physician wrote a prescription for the as needed Norco for two (2) doses only. The resident only requested one dose since the order was obtained. The DON also stated, the resident does receive Valium for muscle spasms as well. On 04/24/24 at 4:40 PM, an additional interview was conducted with the DON regarding the clarity of the physician's order. The DON stated, the physician's order was not specific regarding a rating of pain; also, the physician's order is not clear regarding being prescribed for only two (2) doses. The DON agreed the physician's order needs to be clarified with the facility physician. The DON also verified the resident is scheduled to see a pain specialist on 04/30/24 at 8:15 AM. No further information was obtained during the survey process.

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Brightwood Center	840 Lee Road Follansbee, WV 26037

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45173 , Based on record review and staff interview, the facility failed to maintain professional standards of care for residents receiving dialysis. This was true for one (1) of two (2) residents reviewed under the care area of dialysis. Resident Identifier: #108. Facility Census: 109. Findings Include: a) Resident #108 On 04/22/24 at 6:40 PM, a record review was completed for Resident #108. The review found the resident receives dialysis on Tuesday, Thursday and Fridays. The resident's chair time is 10:30 AM. A review of the Dialysis Communication forms was completed on 04/24/24 at 9:30 AM. The following Dialysis Communication form was found to be incomplete: --04/06/24 pre-dialysis facility nurse's signature was missing On 04/24/24 at 10:30 AM, the Director of Nursing (DON) was notified. The DON confirmed the Dialysis Communication forms should be filled out completely.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49467 Based on record review and resident and staff interview, the facility failed to deploy sufficient staff to meet resident care needs by failing to provide Activities of daily living (ADL) care for Residents #28, 24, and 81, while failing to meet state minimum staffing numbers on reviewed days. This has the potential to affect more than a limited number of residents. Resident identifiers: 28, 24, 81. Facility census: 109 Findings include: A) Resident #28 At approximately 12:55 PM on 04/23/24, an interview was conducted with Resident #28. Resident #28 stated he had requested to be shaved twice a week. Resident #28 stated he gets a shower one day a week and is supposed to be shaved during the shower,plus an additional day a week, however, Resident #28 states Sometimes they'll say they don't have time to shave me. Resident #28 had not been shaved at this time and stated they had not been shaved in at least a week. At approximately 11:20 AM on 04/24/24, an interview was conducted with Nurse Aide (NA) #103 concerning shaving Resident #28. NA #103 stated, We try to shave everyone in the shower if they want it at least one time a week, sometimes it's hard to do it though, because we don't always have enough people to do it, especially twice a week. At approximately 11:30 AM on 04/24/24, Resident #28 was still not shaved. At approximately 3:00 PM on 04/24/24, an interview was conducted with Resident #28 regarding being shaved. Resident #28 stated, he had asked for someone to shave him earlier in the day and was told staff would return to do it when they had time. Resident #28 was still not shaved at the time of this interview. A record review of Resident #28's care plan states the resident is dependent/requires assistance in all ADLs. B) Resident #24 Nail Care At approximately 11:34 AM on 04/23/24, an interview was conducted with Resident #24. Resident #24 stated she wished to have her fingernails cut but stated I can't get anyone to do it. They will tell me ' When I get time ' but then time never comes, they never come back. Resident #24 stated they have told staff multiple times they wanted their fingernails cut but it has not been done. Resident #24 stated My nails are getting caught on my blanket all the time, I just need them cut. At approximately 11:20 AM on 04/24/24, an interview was conducted with Nurse Aide (NA) #103 concerning nail care for Resident #24. NA #103 stated She has told us she needs her nails cut, we try to get to it as we can, but there are times we just don't have the time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #24 was observed at approximately 1:00 PM on 04/24/24, and her fingernails had not been cut. Resident #24 was observed again at approximately 10:00 AM on 04/25/24 and her fingernails had still not been cut. Record review was conducted of Resident #24's care plan, which stated the resident was to receive nail care twice a week. C) Resident #24 Meal Assistance At approximately 1:00 PM on 04/24/24, this surveyor walked into Resident #24's room to follow up with the resident about their nail care. When this surveyor entered the room, Resident #24 was sitting up in bed, attempting to eat, but was not able to get their food off of the plate, and stated They won't feed me, I can't eat and they won't feed me. Resident #24 was asked if staff offered to assist her with her lunch when they brought it in, to which she replied, They just brought it in and laid it down on my table, they didn't ask if I needed help with anything, they just sat it down and left. At approximately 1:05 PM on 04/24/24, the Director of Nursing (DON) was made aware of Resident #24 needing assistance with lunch, and not receiving it. The DON accompanied this surveyor to Resident #24's room and confirmed the resident needed assistance with eating and did not receive it. Record review was conducted of Resident #24's Minimum Data Set (MDS). Section GG under self care, question A, indicates Resident #24 required a one person physical assist when eating. D) Resident #81 At approximately 11:58 AM on 04/25/24 an interview was conducted with Resident #81. Resident #81 stated Nurse Aides (NAs) on night shift do not do two (2) hour checks and he frequently does not see any NAs on night shift until shift change in the morning. Resident #81 stated he saw an NA at 12:00 AM on 04/25/24 and did not see another NA until 6:00 AM on 04/25/24 when day shift reported for work. An interview with a family member of Resident #81 noted the NAs do not complete rounds and the resident frequently goes long periods of time without seeing them. E) Staffing Review During record review of facility staffing numbers, the facility was found to be below the state minimum Hours Per Patient Day (HPPD) requirements of 2.25 hours on the following days: 10/15/23- 2.10 HPPD 10/29/24- 2.23 HPPD 12/9/23- 2.10 HPPD (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12/10/23- 2.02 HPPD 12/16/23- 2.21 HPPD 02/11/24- 1.98 HPPD 03/10/24- 2.21 HPPD

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49467 Based on record review and staff interview, the facility failed to ensure narcotic medications for Resident #91 were not misappropriated by failing to properly reconcile the narcotic medication count. This was true for one (1) of one (1) for pharmacy records during the survey process. Resident identifier: 91. Facility census: 91. Findings include: A) Incident At approximately 6:00 AM on 04/06/24, Registered Nurse (RN) #5 noticed a bottle of liquid morphine was empty, indicating a discrepancy in the narcotic medication count. RN #5 signed the narcotic medication count sheet, indicating the count was correct, however it was not. When the Registered Nurse Supervisor (RNS) #106 reported to work that day at 8:00 AM, RN #5 reported the discrepancy, failing to follow facility policy on reporting discrepancies in narcotic medication counts immediately. B) Investigation RNS #106 was made aware of the discrepancy for Resident #91's liquid morphine on the narcotic medication count sheet. RNS #106 went to verify the count with Licensed Practical Nurse (LPN) #51, confirming the bottle of liquid morphine, which should have contained 4 ML of medication, was empty. RNS #106 then reached out to the Director of Nursing (DON), who notified the Administrator, who notified the local police department. Statement from LPN #51 states I was the nurse working E/F Hall. We did report and while taking the narcotics count, I was counting the narcotics and RN #84 was counting the narcotics sheets. When doing the count for Resident #91's morphine bottle, I glanced at the bottle and saw there was liquid in it so I believed it to be the correct amount remaining. LPN #51 states LPN #90 came to assist them on med pass due to them falling behind, stating LPN #90 came to help me by pulling medications and I would pass them. I did not draw Resident #91's morphine, however I did check to see if the correct dose was in the syringe before administering the dose. I did not see the remaining dose in the morphine bottle after it was pulled, I signed the narcotics book and RN #5 took over the cart. LPN #90 gave a statement during the investigation stating after they helped LPN #51 on their medication pass by preparing medications, while LPN #51 administered the medications. LPN #90 stated there was 1-2 doses left in the bottle after helping LPN #51. LPN #90 states they were unsure if they put the lid back on the medication bottle correctly, making spillage a possibility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the DON at approximately 11:20 AM on 04/23/24 regarding the incident. The DON stated the facility went back three days from 04/06/24 and took statements from Nurses that worked on that particular medication cart and could not find a discrepancy in the narcotic medication counts until the morning of 04/06/24. The DON states nurses should not be administering medications that another nurse prepares, as this could lead to situations such as this. The DON confirmed the facility found no evidence of medication spillage. The DON confirmed the facility was unable to account for the whereabouts of the missing medication. The DON states during the investigation it was discovered counts were not being done accurately. C) Corrective action The facility identified a discrepancy in the narcotic medication count and reported the incident to the local police department and State Agency (SA). At approximately 2:15 PM on 04/23/24, the DON supplied copies of all education provided to the facility staff following the incident. The DON stated during the interview that the nurses involved were put on performance improvement plans and given their final written warning due to not performing the narcotic medication count accurately. All nurses involved were drug tested and tested negative for opiates. According to the facility's corrective action plan, An audit of narcotics with correct narcotic count will be completed by RNUM/DON/designee for 7 days/week for fourteen days, then 5 days/week for 30 days, and then PRN. Copies of education, post tests, and sign in sheets supplied are as follows: Management of controlled drugs, inventory control of controlled substance, routine reconciliation of controlled substances, and loss or theft of medications. At approximately 3:30 PM on 04/23/24, interviews were conducted with RN #84 and RN #87 regarding the education they received pertaining to the incident. Both RN #84 and RN #87 were able to relay points from the education and show understanding of the subject matter. At approximately 10:05 PM on 04/23/24, interviews were conducted with LPN #90 and LPN #92 regarding the education they received pertaining to the incident. Both LPN #90 and LPN #92 were able to relay points from the education and show understanding of the subject matter.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 49467 Based on observation and staff interview, the facility failed to complete temperature logs for food items being maintained on the steam table at meal service. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Facility census: 109. Findings include: At approximately 1:25 PM on 04/22/24, during the initial tour of the kitchen, service line temperature logs were reviewed for the month of April. During this review, it was noted the service line temperature log for 04/15/24 was not completed for any meals that day, while the service line temperature log was not completed for dinner service on 04/16/24. The Dietary Manager (DM) confirmed the temperature logs were incomplete for the preceding dates and stated We ' re not perfect, we are going to miss some things.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49467 Based on observation and staff interviews, the facility failed to post accurate menus prior to meal times. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Facility census: 109. Findings include: At approximately 1:38 PM on 04/22/24, it was noted the menus for 04/21/24 were still displayed outside of the Fiesta Dining Room. The Housekeeping Manager (HM) was standing outside the dining room at the time and confirmed the menus from 04/21/24 were still up after lunch service had taken place on 04/23/24. The HM was asked to accompany this surveyor across the facility to check for other places that accurate menus were not placed. Menus for 04/21/24 were found to still be displayed at the A Nurses Station and the B Nurses Station. At approximately 1:44 PM on 04/22/24, an interview was conducted with the Dietary Manager (DM) regarding the menus. The DM stated I had to make new menus because my truck didn't come. I just forgot to hang them up.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 43340 Based on resident interview, resident council meeting, and anonymous staff interviews, the facility failed to offer residents a nourishing evening/bedtime snack. This failed practice had the potential to affect an unlimited number of residents. Resident identifiers: #80, #48, #28, #13, #40, #72, #66, #48, #63, #50, #105, #78, #53, #55, #68, #19, and #11. Facility census: 109. a) Evening/Bedtime Snack During an interview on 04/22/24 at 3:34 PM, Resident #80 reported she was not offered an evening snack. A subsequent review of Resident #80's Significant Change in Status minimum data set (MDS), with an assessment reference date (ARD) of 03/29/24, indicated resident's Brief Interview for Mental Status (BIMS) score was 15. This score signified the resident was cognitively intact. During a resident council meeting, on 04/23/24 at 10:40 AM, the 18 residents in attendance reported they were not offered evening/bedtime snacks but would like them if they were offered. One (1) resident stated she knew some residents had a physician order to receive a snack in the evening and those snacks were received from the kitchen (i.e. a resident with a diabetic diagnoses may receive an ordered evening snack.) Another resident stated she believed the kitchen did send snacks to the units before going home for the day but that the snacks were not distributed to the residents unless they approached the nurses station and asked for a snack. It was discussed by one (1) resident that her roommate did not have the cognitive ability to remember evening snacks would be at the nurses station nor did she have the ability to physically make it to the nurses station. Three (3) anonymous interviews with nurses, who had experience working the evening shift, confirmed residents were not routinely asked if they would like to have an evening snack. One (1) nurse stated that only the physician-ordered snacks were delivered to residents each evening. Another nurse stated some residents would come to the nurses station if they wanted to request a snack.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49467 Based on observation and staff interview, the facility failed to store food in a safe and sanitary manner, and maintain sanitary equipment. This has the ability to affect more than a limited number of residents. Facility census: 109 Findings include: A) Salad At approximately 1:00 PM on 04/22/24, a tour was conducted of the kitchen in the facility. During the tour, three salads, in plastic bowls with lids, were found in the reach in refrigerator without dates on them. The Dietary Manager (DM) acknowledged and confirmed the salads had been prepared the previous week and had no date on them. B) Sauerkraut At approximately 1:02 PM on 04/22/24, during the tour of the facility's kitchen, a plastic container of sauerkraut was found in the walk in refrigerator without a date on it. The DM acknowledged and confirmed the sauerkraut had been prepared the previous week and had no date on it. C) Apple Sauce At approximately 1:12 PM on 04/22/24 during a tour of the nourishment rooms, a jar of opened apple sauce was found in the Nourishment Room A refrigerator with the date of 04/01/24 with no discard date written on it. The DM acknowledged and confirmed there was no discard date on the apple sauce. D) Steam tables At approximately 4:45 PM on 04/22/24, a tour of the kitchen was conducted to observe dinner service. During the observation, it was noted that in two of the steam table wells, there was thick, dark black debris covering the bottom of the steam wells. The Dining Service District Manager (DSDM) was present at the time of the observation and stated the steam wells are cleaned monthly or as needed. The DSDM acknowledged and confirmed the debris inside of the steam wells and stated they needed to be cleaned.

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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. 45173 Based on record review and staff interview, the facility failed to maintain an accurate and complete record for Resident #22. This was true for one (1) of 24 residents reviewed during the survey process. Resident Identifier: #22. Facility Census: 109. Findings Include: a) Resident #22 On 04/22/24 at 5:18 PM, a record review was completed for Resident #22. The review found the Physician's Scope of Orders for Treatment (POST) form was not complete. The POST form was not signed or dated by the resident or the resident representative. On 04/22/24 at 6:41 PM, the Director of Nursing (DON) was notified of the incomplete POST form. The DON confirmed the form was missing the signature of the resident or the resident representative as well as the date. No further information was obtained during the survey process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on observation and staff interview, the facility failed to maintain proper infection control practices by failing to ensure soiled specimen collection devices were not left in rooms, resident trays were not placed in nourishment room refrigerators, dirty linens were not left in the floor, linen carts were not uncovered, and that items that could contaminate clean linen were not placed on linen carts. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Facility census: 109. Findings include: A) Nourishment Room A At approximately 1:12 PM on 04/22/24, during a tour of the nourishment room A, a resident's lunch tray from their room was found to be placed in the nourishment room refrigerator. The Dietary Manager (DM) was present during the tour and stated I don't know why that's in there. They know they are not supposed to put those in there because it causes an issue. B) room [ROOM NUMBER] At approximately 2:15 PM on 04/22/24, during a tour of the facility, a specimen collection hat was found sitting on the back of the toilet in room [ROOM NUMBER]. The specimen collection hat was observed as being covered in a watery black substance. The watery black substance was on the inside of the collection hat and splattered on the outside. The Guest Services Director (GSD) entered the room and acknowledged the specimen collection hat and the watery black substance. At approximately 2:18 PM on 04/22/24, Registered Nurse (RN) #84 entered the room and acknowledged the specimen collection hat and the watery black substance. C) Dirty Linens At approximately 9:47 PM on 04/23/24, during a tour of the facility, a bag of dirty linens was found to be laying on the floor beside the A Nurse Station. At approximately 9:52 PM Licensed Practical Nurse (LPN) #92 stated I believe one of the aides just bathed a couple people and laid the bag of dirty clothes there until they could get into the room to put them into the soiled linens. Nurse Aide (NA) #36 then walked to the nurse station, grabbed the bag of dirty linens and stated It was me, I just gave a couple residents a bath and didn't pick them up. Write me up, I don ' t care. d) Linen Cart on 100 Hall (continued on next page)

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Brightwood Center	840 Lee Road Follansbee, WV 26037

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation, on 04/24/24 at 9:50 AM, found a computer tablet (commonly shortened to tablet) stored in the clean linen cart on the 100 Hall. A tablet is a mobile computing device that has a flat, rectangular form like that of a magazine or pad of paper, that is usually controlled by means of a touch screen, and that is typically used by certified nursing aides to enter their documentation of resident care. On 04/24/24 at 10:00 AM, Certified Nursing Assistant (CNA) #47 came out of a nearby resident room and retrieved the tablet from the clean linen cart. When asked if the tablet should be stored in the clean linen cart, CNA #47 stated as far as he knew it was OK to store the tablet in the cart. He then stated, That's how I can do my job effectively and have easy access to the tablet in order to document. During an interview on 04/24/24 at 10:30 AM, the Director of Nursing (DON) stated CNA #47 was a newer staff member but should have known not to contaminate the clean linen cart by storing a tablet in it. e) Large Linen Cart On 04/23/24 at 9:49 PM, a tour of the B hall was completed. During the tour, an observation of a large linen storage cart was made. The observation found the flap was draped over the top of the linen cart, which left the clean linen uncovered. On 04/23/24 at 9:50 AM, Licensed Practical Nurse (LPN) #92 confirmed the large linen cart was left uncovered due to the flap being draped over the top of the cart. On 04/24/24 at 9:30 AM, the Director of Nursing (DON) was notified and confirmed the clean linen cart should not have the flap draped over the top of the cart. The DON stated, it should be covered. 45173 49467