STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515129	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Place	95 Healthcare Drive Philippi, WV 26416

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews, the facility failed to ensure that each resident received adequate supervision and was protected from avoidable accident hazards. Specifically, the facility failed to prevent a resident (Resident #58) from being struck by a tray cart pushed by a CNA, which caused the resident to fall, sustain multiple traumatic brain injuries, require emergency medical intervention, and ultimately resulted in the resident's death. Resident identifier: #58 Facility Census:56 This failure placed all residents who ambulate or are present in high-traffic hallways at risk for serious harm, injury, or death due to unsafe transportation of tray carts. Findings Include:Record Review of Incident on [DATE]:On [DATE] at 6:17 PM, Resident #58 was observed via camera footage sitting in a chair at the nurse's station.At 6:22 PM, Resident #58 stood and was facing the dining room with his back to NA #1, who was pushing a tall tray cart.CNA #1 struck Resident #58 in the back with the tray cart, causing him to fall forward onto his left side.RN #3 responded immediately and a rapid response was called at 6:23 PM.The Emergency Department (ED) team and a physician arrived at 6:25 PM. A cervical collar was applied, and Resident #58 was transported to the ED.Observation on [DATE] by Surveyors:The area of the incident was observed to be well-lit, clean, and free of clutter or medical equipment.This hallway is a high-traffic area used by staff, residents, and visitors.The resident's position at the time of the incident, as seen in the video footage, showed that visibility may have been obstructed by the tray cart, which measured 5 feet 5 inches in height.Two surveillance cameras were visible in the area.ED Medical Record Review:Resident #58 was diagnosed with:Acute Extensive Traumatic Subarachnoid Hemorrhage (tSAH) - bleeding into the subarachnoid space following head trauma.Acute Left Frontal Intraparenchymal Hemorrhage - a hemorrhagic stroke due to ruptured blood vessels in the brain tissue.Left Parafalcine Subdural Hematoma - blood collection between the brain and dura mater.Resident #58 was life-flighted as a Priority Two Trauma to another hospital due to the severity of injuries.Facility Progress Notes:Resident was reported as unconscious for ~1 minute post-fall.The facility was notified later that evening (around 9:00 PM) that Resident #58 had been transported via Life Flight.On [DATE], the hospital initiated a palliative care consult, determined the resident's status to be Do Not Resuscitate (DNR), and discussed transitioning to comfort care.Facility's Five-Day Report:Abuse/neglect was not substantiated.NA was not observed acting maliciously or at excessive speed.The tray cart was tall, obstructing forward vision.The facility concluded that the resident was in close proximity when he stood and could not be seen by CNA #1.Corrective Actions Taken:As of [DATE], Assistant Administrator (AA #4) reported the following:A new policy requires two staff members to push tray carts-one pushing, one ensuring the path is clear.If only one staff member is available, they must pull the cart instead of pushing. Director of Nursing (DON) provided education records confirming staff training began immediately and was completed by [DATE].Environmental Changes:Bubble mirrors installed in the hallways on [DATE] and completed on [DATE] to improve visibility.Shorter tray carts are being ordered and utilized in hallways; taller carts are reserved for dining room delivery.This deficient practice resulted in Immediate Jeopardy beginning on [DATE] when the resident was struck (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	by a cart, suffered severe head trauma, and subsequently died. The facility's failure to ensure safe cart handling in a high-traffic resident area placed all residents at risk of serious injury or death. Immediate corrective action was required. This is now considered past-noncompliance / facility self-corrected prior to survey entrance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 609 Based on staff Interviews, Record review and Policy review the facility failed to report possible abuse allegations to state agencies within the two hours time frame. This failed practice was a random opportunity for discovery, and had the potential to affect all residents residing in the long term care facility. Resident Identifier: #1 Facility Census: 56 This standard was NOT MET as evidenced by: Based upon Staff and Resident Interviews, Record review and Policy review the facility failed to notify State Agencies of the abuse allegation with in the two hours times frame per the CMS guidelines.Findings include: 07/21/2025 1156:InterviewSpoke with resident #1 during interview and she stated there was no issues and everything was good. 07/21/2025 12:47 PM Record reviewDuring record review there was a note placed by SW #17 stating an incident took place that the resident was reluctant to come forward with.attached is the note from the patient chart. Entry was made on 7/21/2025 @ 12:21pm by Social Worker SW#17(as written in chart) Met with (Residents name her) after receiving information from PT that she had expressed concerns with a staff member. (Residents name her) was hesitant at first to talk about the issue and repeatedly stated I don't want to get her in trouble. After some reassurance, she did report having a blonde hair staff member talk a little bit hatefully to her and feels it was because she had soiled her brief. (Residents name her)could not tell Social Worder (SW) anything aside from the color of the aide's hair and that it happened a couple days ago. Reassured her that I would speak with Director of Nursing (DON) in an attempt to determine who the staff member may have been so that education can be provided. Asked (Residents name her)[NAME] if the aide was present in the facility today and she states 'no'. The facility had until 2:21PM on 7/21/2025 to notify state agencies of a potential abuse incident. 07/22/2025 1:13 PMInterviewSpoke with resident #1 again today and she stated I am upset and was crying about how I was made to feel. the tall blond aide with a ponytail, yelled at me because I had an accident, that's not rightPolicy review Upon review of the facility policy for reporting allegations of abuse on Page 5, Section 5 titled INVESTAGATION / REPORTING ; it states that all violations must be reported immediately, but no later than two hours after the allegation is made.

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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. F0880S483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This Standard is NOT MET as evidenced by: Based upon Random observation of lunch cart and Staff Interview, the facility failed to maintain a clean and sanitary transportation of resident meals on tray carts. During lunch service Tall food cart was delivered into main dining hall with a dirty spoon on top of cart. There was also a Styrofoam cup on top of cart that was next to the spoon, intended for a resident meal. Census:56Finding include: 07/22/2025 12:40 PM Observations:During lunch service Tall food cart was delivered into main dining hall with a dirty spoon on top of cart. There was also a Styrofoam cup on top of cart that was next to the spoon, intended for a resident meal. 07/22/2025 12:50 PMInterview:Dietary Supervisor #67 was questioned and she stated that the cup was for a resident and that it was placed on top d/t it not fitting in the tray cart. When asked about how the staff knows who's cup that is, she said its on his meal ticket. I confirmed it was on the residents meal ticket for the cup of soda. It stated soda in cup on top of meal cart. When asked about the spoon she said well shoot and took it off the top and when into the kitchen with it.This confirmed the spoon was not supposed to be there and not inline with standards of practice.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on record review and staff interviews, the facility failed to follow orders to release Resident #7 from the seat belt every two (2) hours. This was a random opportunity for discovery during the Long Term Care Survey. Resident identifier: #7 Facility Census: 56 Findings include:Record review:07/23/2025 10:00 AM Orders placed on 2/3/25Release seatbelt every two hours, reposition, skin checks, proper attachment of seat belt and pericare.Special Instructions: prevent skin breakdown.Every 2 Hours07:00, 09:00, 11:00, 13:00, 15:00, 17:00no documentation showing release belt and checking of resident every two hours as per orderresident #7 unable to self release belts due medical conditions. This is considered a restraint when a patient can not release belt by themselves.Don #102 stated that she would look into the matter and bring me any documentation they find.Interviews:7/23/2025 @1030 Interview with Nurse Aide (NA) and nurse on hall with residentNA #101 stated when he is up we check on him every 2 hours, but CNA's don't have a place to chart it. CNA #101 also stated the resident is not up for very long daily as he gets upset and wants back in his room and will throw a fit.Registered Nurse (RN #40) (newly hired and still in training) was unsure of where to chart a restraint in the system when asked.Licensed Practical Nurse (LPN #98) (Trainer) was also unable to find where to chart that they preformed the check. 7/23/2025 @1040Don #102 said they was unable to locate any documentation on the releasing and checking on resident every two hours per order. She said when order was placed it wasn't made a task on the system and therefore didn't show up on the TAR (treatment record). She stated she fixed that error and should be resolved going forward. It will now be a task that a nurse has to check off on their charting.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 637 Based on record review and staff interview, the facility failed to do a change in condition Minimum [NAME] Set (MDS) after resident #9 developed a pressure ulcer, and correctly documented on the MDS from 6/26/25 the status of Resident #9's injuries. This failed practice was a random opportunity for discovery and had the potential to affect more than a minimal number of residents residing in the Long Term Care Facility. Resident Identifier: #9 Facility Census: 56Findings include: 7/22/2025 3:27 PM Record Review MDS on 6/29/25 -section m0210 states that there is an unhealed Pressure Ulcer (PU) / injury section M0300does not state PU stg(stage) 4 or unstageable on left 4th toe, or that it is resolvedwas not resolved until 6/30 according to charting States there is a deep tissue injury (no location given) Section M1040 stated there were no other wounds (Z) is markedL(left) foot 3rd toe abrasion was not resolved until 6/30 Wound note review6/6/25 there was a wound found on L 4th toe found by Registered Nurse (RN #3). 6/9/25 was re assessed by Registered Nurse (RN#44) and ordered updated6/16/25 weekly assessment done by RN #44, cont. treatment for L 4th toe6/23/25 weekly assessment done by RN #3, cont. treatment of L 4th toe. Left 3rd toe noted to have eschar.6/30/25 weekly assessment done by RN #44, noted Left 3rd and 4th toe injuries are resolved. InterviewDirector of Nursing (Don #102) Stated she is aware of some consistency issues when charting wounds on both in house forms and the MDS. Different nurses call wounds by different names sometimes.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview the facility failed to ensure Preadmission Screening and Resident Review (PASRR) was completed accurately . This failed practice was found true for 2 of 5 residents reviewed for the PASRR care area during the Long Term Care Survey. Resident Identifier: #2 and #23 Facility Census: 56 Findings include: a) Resident #2 During Record review on 07/22/25 of Resident #2's most recent PASRR completed on 02/17/25 which revealed no diagnosis were checked. Further record review of Resident#2's medical diagnosis revealed they were diagnosed with Bipolar Disorder on 04/21/25 as Primary DiagnosisAn interview with the Social Worker on 07/27/25 at 11:30 am was completed and confirmed Bipolar Disorder was not marked on Resident #2's PASRR. b) Resident #23During Record review on 07/23/25 of resident #23's medical diagnosis revealed the following diagnoses Anxiety disorderSchizoaffective disorderDepression, unspecifiedFurther record review on 07/23/25 of resident #23's PASRR revealed Major Depression was checked. Further research regarding Major Depression and Depression on Psych Central webpage found the following definition Unspecified depressive disorder is a diagnostic term. It means you show symptoms characteristic of a depressive disorder, but they don't meet the specific criteria for more common depressive disorders, such as major depressive disorder. (https://psychcentral.com/depression/unspecified-depressive-disorder#definition)During an interview on 07/23/25 at approximately 11:45 AM the Social Worker stated If they have a diagnosis for Depression i mark Major Depression on the PASRR confirmed Depression should be checked under Other on the PASRR.

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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. 657 Based on staff Interviews, Record review and Policy review the facility failed to follow established care plan and order of the resident and ensure they were checked on every two hours . This failed practice was a random opportunity for discovery, and had the potential to affect all residents residing in the long term care facility. Resident Identifier: #7 Facility Census: 56This standard of care was NOT MET as evidenced by:Findings include:Record review:07/23/2025 10:00 AM Orders placed on 2/3/25Release seatbelt every two hours, reposition, skin checks, proper attachment of seat belt and pericare.Special Instructions: prevent skin breakdown.Every 2 Hours07:00, 09:00, 11:00, 13:00, 15:00, 17:00no documentation showing release belt and checking of resident every two hours as per orderresident #7 unable to self release belts due medical conditions. This is considered a restraint when a patient can not release belt by themselves.Don #102 stated that she would look into the matter and bring me any documentation they find.Interviews:7/23/2025 @1030 Interview with CNA and nurse on hall with residentCNA #101 stated when he is up we check on him every 2 hours, but CNA's don't have a place to chart it. CNA #101 also stated the resident is not up for very long daily as he gets upset and wants back in his room and will throw a fit.RN #40 (newly hired and still in training) was unsure of where to chart a restraint in the system when asked.LPN #98 (Trainer) was also unable to find where to chart that they preformed the check. 7/23/2025 @1040Don #102 said they was unable to located any documentation on the releasing and checking on resident every two hours per order. She said when order was placed it wasn't made a task on the system and therefore didn't show up on the TAR (treatment record). She stated she fixed that error and should be resolved going forward. It will now be a task that a nurse has to check off on their charting.

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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. Based on Record review and Staff interview, the facility failed to maintain medical records on each resident by not noting residents received Pharmacy Reviews/ Recommendations for the month of June, 2024. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents residing in the long term care facility. Facility Census: 56 Findings Include: During Record review on 07/23/25 it showed residents did not have a Pharmacy Recommendation or review for the month of June, 2024. for Resident's #2, #6, and #18.During an interview with the Director of Nursing (DON) on 07/23/24 at 10:00 AM who stated (I think that was around the time i took this position and they were done i have the list, i just did not note it in the resident's chart. At this time the DON provided surveyors with a list of residents who had Pharmacy reviews/Recommendations for the month of June, 2025. The report was from the Pharmacy and showed residents #2. #6. and #18 did actually have Pharmacy Reviews/ Recommendations done for the month in question. At this time the DON confirmed it should have been noted in the residents chart that they received pharmacy reviews.