Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515133	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansted Center	96 Tyree Street Ansted, WV 25812

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on record review and staff interview, the facility failed to provide the residents with an environment free from abuse from other residents. Resident #9 was physically abused by Resident#159. Resident #159 slapped Resident #9in the face. This was determined as Past Non-Compliance immediate jeopardy. Immediate jeopardy was determined to begin on 06/22/24 and was abated on 07/11/24. Resident identifiers: #159, #9. Facility census: 60. Findings included: a) Resident #159 During a medical record review on 09/30/24 at approximately 10:30 AM, it was found that Resident #159 was admitted on [DATE]. Admitting diagnoses included encephalopathy, altered mental status, cognitive communication deficit, and Unspecified dementia, unspecified severity with other behavioral disturbance, and anxiety disorder. It was further identified that the resident did not have the capacity to make medical decisions and had a score of six (6) for a Brief Interview for Mental Status (BIMS). 05/22/247:34 PM a behavioral status evaluation revealed the resident had physical aggression and was a danger to self or others. The resident took the lever off the mechanical lift and hit the emergency exit door and cracked the window in the door. Resident became combative with staff when attempting to remove resident from the situation and was placed 1:1. 05/28/24 at7:05 PM a progress note revealed a nurse heard banging at the end of unit 2hallway. Resident was noted to be banging on a window. Staff attempted to redirect residents. Resident started to swing a bar at the staff that he had. Staff were able to intercept and get the bar away from the resident. But resident showed continual aggression by cussing and punching staff. No injuries. Upon inspection of the window a hole through the glass was noted. 05/28/24 at 7:22 PM progress note revealed the resident was sent to a local hospital for psychiatric evaluation. 05/30/245:00 PM progress note revealed the resident returned to the facility from the psychiatric evaluation. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	06/22/24 at 8:21 PM a note revealed nursing staff tried to give resident Buspar and behavior was observed. The resident was aggressive with a female resident when she tried to wheel past him. He cursed at her and stated, I will knock the hell out of you. He was immediately moved away from the resident. 06/27/24 at11:11 PM the resident was by FNP (Family Nurse Practitioner) for medication review. - The note by the FNP stated, Resident is refusing medications and having increased behaviors. History of present illness: Resident has had behaviors where he has busted out windows at the nursing and was sent to the ER at BARH. Sent back with no new orders or medication changes. The resident continues to have increased behaviors, to where he swings his fists at other residents when he passes them, refuses medication, very difficult to redirect. Assessment and plan: Medications reviewed, nursing manager will call Dr. (name) concerning resident's increased behaviors and medication refusal and ask for medication adjustments. 06/30/24 at 8:48 PM a nursing note stated, Resident attempting to go out door. Several attempts to finally get him to calm down. He states he wants to go home, and he had been trying to call his girlfriend but did not get an answer, which upset him. Refused to take meds. 07/04/24 at 9:20 AM a nursing note stated, Resident kicking exit door in dining room. Being combative towards staff. Grabbed the arm of CNA (certified nursing assistant) when she attempted to redirect and move him away from door. Upon intervention, he stated I stated I hate this f-ing place, and I will beat the hell out of all of you. Attempted to contact girlfriend, left voicemail. Resident sitting in front of office door at this time, no signs or symptoms of distress at this time. Offered snacks and drinks, he declined. 07/04/24 at10:41 a nursing note stated the resident had hit another resident who was trying to push the telehealth device away. The power of attorney was unable to be contacted by phone and nursing was unable to do 1:1 supervision. The resident was sent out for treatment. A note on 07/11/24 at 4:56 PM revealed Resident #159 slapped Resident #9 in the face and Resident #9 was noted to have redness to the left side of face. It was identified in the medical record for Resident #9 that was a long-term resident of the facility and does not have capacity. Resident #9 is severely impaired cognitively for daily decision making. Resident #9 mobility was with a wheelchair and is constantly traveling throughout the facility. During an interview with NA #20 at 3:15 PM on 09/30/24. NA #20 stated that on 07/11/214 Resident#159 was yelling and screaming but that was the first time she had seen him hit someone. NA #20 said she had seen the resident pushing Resident#9's wheelchair trying to aggravate her. NA #20 further stated Resident #159 would yell at the victim (Resident #9) at this time. NA #20stated, I think there are times he has hit other people, but I have not seen that. NA #20 states she witnessed Resident #159 tell the Resident #9 prior to Resident #9 being slapped in the face and saying, I'll knock the hell out of you. The incident of verbal abuse where Resident #159 told Resident #9 he would knock the hell out of her was not identified, reported or investigated as allegations of verbal abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansted Center	96 Tyree Street Ansted, WV 25812

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Nurse Aide (NA) #74 at 6:20 PM on 09/30/24 NA #74 stated she had witnessed, multiple times prior to the 07/11/24 incident where Resident #159 would say to Resident #9, Don't fxxxxxx bump into me and I'll beat the sxxx out of you. This incident of verbal abuse of Resident #159 towards Resident #9 was not identified to have been identified, reported or investigated. A medical record review on 09/30/24 at 5:30 PM identified Licensed Practical Nurse (LPN)#75 documented on 06/02/24 at 8:21 PM note text stating that LPN #75 tried to give resident Buspar, and behavior was observed, resident was aggressive with female resident when she tried to wheel past him. He cursed at her and stated, I will knock the hell out of you. He was immediately moved away from the resident and no other behaviors were noted since then. Continue to monitor. Further medical review, prior to this incident on 06/02/24, identified two (2)incidents dated 5/22/24 and 5/28/24 that Resident #159 was identified to remove the bar from the mechanical lift and as he brandished the weapon, he began beating the emergency exit doors and windows and busting the windows each time. It is identified that Resident #159's girlfriend and Medical Power of Attorney attempted to be reached numerous times during episodes but was unsuccessful. On 07/04/24at 9:20 AM the resident was trying to kick the door in the dining room. At10:41 AM the facility tried to reach the MPOA to send residents to hospital but was unable to reach MPOA. 07/15/24 at4:11 PM - a note revealed, Resident placed on 1:1. Resident#159 was transferred to a local hospital on 08/27/24 and passed away at a local hospice on 09/14/24. During an interview with the Administrator on 10/01/24 at approximately 1:00 PM the Administrator stated the facility had self-identified concerns with implementing their policy with regards to identifying, reporting and investigating allegations of abuse. An immediate jeopardy (IJ) template was provided to the administration on 10/01/24 at1:07 PM. The Administrator stated that after the event on 07/11/24 the facility self-identified concerns with the activities not being effective with person centered interventions to implement and concerns with the need of psych service training for the nursing staff in the event it was to be needed again. The Administrator stated the facility had completed the following Plan of correction on 07/11/24. The Administrator further stated that the verbal abuse incident would be reported immediately, and the staff involved would be addressed. Upon receiving the Plan of Corrections documentation on 10/02/24 at approximately 2:30 PM an audit of the plan of correction began. A review of the staff education signatures of completion were verified via the staff roster. Facility Plan of Correction- 07/11/24 1. Implemented Policy and Procedure on abuse prohibition 2. Education completed on 07/11/24 with all staff for reporting abuse and neglect. 3.Telehealth training for psych services in the event the situation happened again and services were needed. 4. Audit of getting to know me tools with activities and implementing them with person centered care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ began on 06/22/24 and ended on 07/11/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on record review and staff interview, the facility failed to ensure they implemented written policies and procedures that prohibited physical abuse, and investigated allegations of physical abuse. Resident #9 was physically abused by Resident#159. Resident #159 slapped Resident #9in the face. This was determined as Past Non-Compliance. Resident identifiers: #159, #9. Facility census: 60. Findings included: a) Resident #159 During a medical record review on 09/30/24 at approximately 10:30 AM, it was found that Resident #159 was admitted on [DATE]. Admitting diagnoses included encephalopathy, altered mental status, cognitive communication deficit, and Unspecified dementia, unspecified severity with other behavioral disturbance, and anxiety disorder. It was further identified that the resident did not have the capacity to make medical decisions and had a score of six (6) for a Brief Interview for Mental Status (BIMS). 05/22/247:34 PM a behavioral status evaluation revealed the resident had physical aggression and was a danger to self or others. The resident took the lever off the mechanical lift and hit the emergency exit door and cracked the window in the door. Resident became combative with staff when attempting to remove resident from the situation and was placed 1:1. 05/28/24 at7:05 PM a progress note revealed a nurse heard banging at the end of unit 2hallway. Resident was noted to be banging on a window. Staff attempted to redirect residents. Resident started to swing a bar at the staff that he had. Staff were able to intercept and get the bar away from the resident. But resident showed continual aggression by cussing and punching staff. No injuries. Upon inspection of the window a hole through the glass was noted. 05/28/24 at 7:22 PM progress note revealed the resident was sent to a local hospital for psychiatric evaluation. 05/30/245:00 PM progress note revealed the resident returned to the facility from the psychiatric evaluation. 06/22/24 at 8:21 PM a note revealed nursing staff tried to give resident Buspar and behavior was observed. The resident was aggressive with a female resident when she tried to wheel past him. He cursed at her and stated, I will knock the hell out of you. He was immediately moved away from the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/27/24 at11:11 PM the resident was by FNP (Family Nurse Practitioner) for medication review. - The note by the FNP stated, Resident is refusing medications and having increased behaviors. History of present illness: Resident has had behaviors where he has busted out windows at the nursing and was sent to the ER at BARH. Sent back with no new orders or medication changes. The resident continues to have increased behaviors, to where he swings his fists at other residents when he passes them, refuses medication, very difficult to redirect. Assessment and plan: Medications reviewed, nursing manager will call Dr. (name) concerning resident's increased behaviors and medication refusal and ask for medication adjustments. 06/30/24 at 8:48 PM a nursing note stated, Resident attempting to go out door. Several attempts to finally get him to calm down. He states he wants to go home, and he had been trying to call his girlfriend but did not get an answer, which upset him. Refused to take meds. 07/04/24 at 9:20 AM a nursing note stated, Resident kicking exit door in dining room. Being combative towards staff. Grabbed the arm of CNA (certified nursing assistant) when she attempted to redirect and move him away from door. Upon intervention, he stated I stated I hate this f-ing place, and I will beat the hell out of all of you. Attempted to contact girlfriend, left voicemail. Resident sitting in front of office door at this time, no signs or symptoms of distress at this time. Offered snacks and drinks, he declined. 07/04/24 at10:41 a nursing note stated the resident had hit another resident who was trying to push the telehealth device away. The power of attorney was unable to be contacted by phone and nursing was unable to do 1:1 supervision. The resident was sent out for treatment. A note on 07/11/24 at 4:56 PM revealed Resident #159 slapped Resident #9 in the face and Resident #9 was noted to have redness to the left side of face. It was identified in the medical record for Resident #9 that was a long-term resident of the facility and does not have capacity. Resident #9 is severely impaired cognitively for daily decision making. Resident #9 mobility was with a wheelchair and is constantly traveling throughout the facility. During an interview with NA #20 at 3:15 PM on 09/30/24. NA #20 stated that on 07/11/214 Resident#159 was yelling and screaming but that was the first time she had seen him hit someone. NA #20 said she had seen the resident pushing Resident#9's wheelchair trying to aggravate her. NA #20 further stated Resident #159 would yell at the victim (Resident #9) at this time. NA #20stated, I think there are times he has hit other people, but I have not seen that. NA #20 states she witnessed Resident #159 tell the Resident #9 prior to Resident #9 being slapped in the face and saying, I'll knock the hell out of you. The incident of verbal abuse where Resident #159 told Resident #9 he would knock the hell out of her was not identified, reported or investigated as allegations of verbal abuse. During an interview with Nurse Aide (NA) #74 at 6:20 PM on 09/30/24 NA #74 stated she had witnessed, multiple times prior to the 07/11/24 incident where Resident #159 would say to Resident #9, Don't fxxxxxx bump into me and I'll beat the sxxx out of you. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER: Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 96 Tyree Street, Ansted, WV 25812	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This incident of verbal abuse of Resident #159 towards Resident #9 was not identified to have been identified, reported or investigated. A medical record review on 09/30/24 at 5:30 PM identified Licensed Practical Nurse (LPN)#75 documented on 06/02/24 at 8:21 PM note text stating that LPN #75 tried to give resident Buspar, and behavior was observed, resident was aggressive with female resident when she tried to wheel past him. He cursed at her and stated, I will knock the hell out of you. He was immediately moved away from the resident and no other behaviors were noted since then. Continue to monitor. Further medical review, prior to this incident on 06/02/24, identified two (2)incidents dated 5/22/24 and 5/28/24 that Resident #159 was identified to remove the bar from the mechanical lift and as he brandished the weapon, he began beating the emergency exit doors and windows and busting the windows each time. It is identified that Resident #159's girlfriend and Medical Power of Attorney attempted to be reached numerous times during episodes but was unsuccessful. On 07/04/24at 9:20 AM the resident was trying to kick the door in the dining room. At10:41 AM the facility tried to reach the MPOA to send residents to hospital but was unable to reach MPOA. 07/15/24 at4:11 PM - a note revealed, Resident placed on 1:1. Resident#159 was transferred to a local hospital on 08/27/24 and passed away at a local hospice on 09/14/24. During a review of the facility policy and procedure for abuse prohibition it is identified (typed as written); 6. Stall will identify events- such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse- and determine the direction of the investigation. This also includes patient to patient abuse. 6.1 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. 6.1. 1 The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law. 6.1.2 The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. 6.1.3 All reports of suspected abuse must be reported to the patients family and attending physician. 6.2 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injury of unknown origin, or misappropriation of patient property must also report to outside agencies if required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6.2.1 Staff are obligated to report reasonable suspicion of a crime against the elderly to the state agency and local law enforcement. Administrators and Directors of Nursing must assist in reporting. 6.3 If the suspected abuse is patient-to patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. 6.3.1 The Center will provide adequate supervision when the risk of patient-to-patient altercation is suspected. 6.3.2 The Center is responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. 6.3.3 The patient representative and physician will be notified and any follow-up recommended will be completed (e.g. psychiatric evaluation). During an interview with the Administrator on 10/01/24 at approximately 1:00 PM the Administrator stated the facility had self-identified concerns with implementing their policy with regards to identifying, reporting and investigating allegations of abuse. The Administrator stated that after the event on 07/11/24 the facility self-identified concerns with the activities not being effective with person centered interventions to implement and concerns with the need of psych service training for the nursing staff in the event it was to be needed again. The Administrator stated the facility had completed the following Plan of correction on 07/11/24. The Administrator further stated that the verbal abuse incident would be reported immediately, and the staff involved would be addressed. Upon receiving the Plan of Corrections documentation on 10/02/24 at approximately 2:30 PM an audit of the plan of correction began. A review of the staff education signatures of completion were verified via the staff roster. Facility Plan of Correction- 07/11/24 1. Implemented Policy and Procedure on abuse prohibition 2. Education completed on 07/11/24 with all staff for reporting abuse and neglect. 3.Telehealth training for psych services in the event the situation happened again and services were needed. 4. Audit of getting to know me tools with activities and implementing them with person centered care. 1. Implemented Policy and Procedure on abuse prohibition. 2. Education completed on 07/11/24 with all staff for reporting abuse and neglect. 3. Telehealth training for psych services in the event the situation happened again and services were needed. 4. Audit of getting to know me tools with activities and implementing them with person centered care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515133	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansted Center	96 Tyree Street Ansted, WV 25812

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional steps taken for not reporting verbal abuse on 06/02/24 5. Final Written warning for Nurse Assistant (NA) #20, NA #74 and LPN #75 for not reporting verbal abuse. 6. Education for leadership on reviewing statements to be aware of possible related concerns. 7. Facility reported the verbal abuse incident of 06/02/24 on 10/01/24. Upon receiving the Plan of Corrections documentation on 10/02/24 at approximately 2:30 PM an audit of the plan of correction. A review of the staff education signatures of completion were verified via the staff roster.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansted Center	96 Tyree Street Ansted, WV 25812

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49650 Based on record review, medical record review, staff interview and the facility abuse prohibition policy review, the facility failed to report abuse. Resident #9 was verbally abused and then physically abused. Resident identifiers: 159, #9. Facility Census: 60. Findings Included: a) On 09/30/24 at approximately 12:15 PM during a record review revealed Resident #159 had slapped Resident #9 in the face on 07/11/24 at 4:56 PM. Resident #9 was noted to have redness to the left side of face. During a review of the investigation and the staff interviews obtained at the time of the incident, the staff interview for Nurse Assistant (NA) #20's statement began with After first incident . During an interview with NA #20 at 3:15 PM on 09/30/24. NA #20 stated that Resident #159 was yelling and screaming. NA #20 said, It was the first time I saw him hit someone. NA #20 had seen the resident pushing the victim's wheelchair trying to aggravate her. NA #20 further stated Resident #159 was yelling at the victim (Resident #9) at this time. NA #20 stated, I think there are times he has hit other people, but I have not seen that. NA #20 states she witnessed Resident #159 tell the Resident #9 prior to Resident #9 being slapped in the face I'll knock the hell out of you. This incident of verbal abuse of Resident #159 towards Resident #9 was not identified, reported or investigated. Further interview with the second witness identified, Nurse Aide (NA) #74 at 6:20 PM on 09/30/24. NA #74 stated she had witnessed, multiple times prior to the incident of Resident #159 slapping Resident #9 that Resident #159 would say to the victim, Don't fucking bump into me and I'll beat the shit out of you. This incident of verbal abuse of Resident #159 towards Resident #9 was not identified to have been identified, reported or investigated. A medical record review on 09/30/24 at 5:30 PM identified Licensed Practical Nurse (LPN) #75 documented on 06/02/24 at 8:21 PM a note stating note text stating that she tried to give resident buspar and behavior was observed, resident was aggressive with female resident when she tried to wheel past him. He cursed at her and stated, I will knock the hell out of you. He was immediately moved away from the resident and no other behaviors were noted. This incident of verbal abuse of Resident #159 towards Resident #9 on 06/02/24 at 8:21 PM was not identified to have been identified, reported or investigated. During a review of the facility policy and procedure for abuse prohibition it is identified (typed as written); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Stall will identify events- such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse- and determine the direction of the investigation. This also includes patient to patient abuse. 6.1 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. 6.1. 1 The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law. 6.1.2 The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. 6.1.3 All reports of suspected abuse must be reported to the patients family and attending physician. 6.2 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injury of unknown origin, or misappropriation of patient property must also report to outside agencies if required. 6.2.1 Staff are obligated to report reasonable suspicion of a crime against the elderly to the state agency and local law enforcement. Administrators and Directors of Nursing must assist in reporting. 6.3 If the suspected abuse is patient-to patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. 6.3.1 The Center will provide adequate supervision when the risk of patient-to-patient altercation is suspected. 6.3.2 The Center is responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. 6.3.3 The patient representative and physician will be notified, and any follow-up recommended will be completed (e.g. psychiatric evaluation). During an interview with the Administrator on 10/01/24 at approximately 1:00 PM the Administrator stated the facility had self-identified concerns with implementing their policy with regards to identifying, reporting and investigating allegations of abuse. The Administrator stated that after the event on 07/11/24 the facility self-identified concerns with the activities not being effective with person centered interventions to implement and also concerns with the need of psych service training for the nursing staff in the event it was to be needed again. The Administrator stated the facility had completed the following Plan of correction on 07/11/24. The Administrator further stated that the verbal abuse incident would be reported immediately, and the staff involved would be addressed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansted Center	96 Tyree Street Ansted, WV 25812

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on record review and staff interview, the facility failed to ensure they had evidence that allegations of abuse were thoroughly investigated. Resident #9 was physically and verbally abused by Resident#159. Resident #159 slapped Resident #9in the face. Prior to this Resident #159 threatned harm to Resident #9. The facility did not identify this verbal abuse nor did they investigate it. This was determined as Past Non-Compliance. Resident identifiers: #159, #9. Facility census: 60. Findings included: a) Resident #159 During a medical record review on 09/30/24 at approximately 10:30 AM, it was found that Resident #159 was admitted on [DATE]. Admitting diagnoses included encephalopathy, altered mental status, cognitive communication deficit, and Unspecified dementia, unspecified severity with other behavioral disturbance, and anxiety disorder. It was further identified that the resident did not have the capacity to make medical decisions and had a score of six (6) for a Brief Interview for Mental Status (BIMS). 05/22/247:34 PM a behavioral status evaluation revealed the resident had physical aggression and was a danger to self or others. The resident took the lever off the mechanical lift and hit the emergency exit door and cracked the window in the door. Resident became combative with staff when attempting to remove resident from the situation and was placed 1:1. 05/28/24 at7:05 PM a progress note revealed a nurse heard banging at the end of unit 2hallway. Resident was noted to be banging on a window. Staff attempted to redirect residents. Resident started to swing a bar at the staff that he had. Staff were able to intercept and get the bar away from the resident. But resident showed continual aggression by cussing and punching staff. No injuries. Upon inspection of the window a hole through the glass was noted. 05/28/24 at 7:22 PM progress note revealed the resident was sent to a local hospital for psychiatric evaluation. 05/30/245:00 PM progress note revealed the resident returned to the facility from the psychiatric evaluation. 06/22/24 at 8:21 PM a note revealed nursing staff tried to give resident Buspar and behavior was observed. The resident was aggressive with a female resident when she tried to wheel past him. He cursed at her and stated, I will knock the hell out of you. He was immediately moved away from the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansted Center	96 Tyree Street Ansted, WV 25812

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/27/24 at11:11 PM the resident was by FNP (Family Nurse Practitioner) for medication review. - The note by the FNP stated, Resident is refusing medications and having increased behaviors. History of present illness: Resident has had behaviors where he has busted out windows at the nursing and was sent to the ER at BARH. Sent back with no new orders or medication changes. The resident continues to have increased behaviors, to where he swings his fists at other residents when he passes them, refuses medication, very difficult to redirect. Assessment and plan: Medications reviewed, nursing manager will call Dr. (name) concerning resident's increased behaviors and medication refusal and ask for medication adjustments. 06/30/24 at 8:48 PM a nursing note stated, Resident attempting to go out door. Several attempts to finally get him to calm down. He states he wants to go home, and he had been trying to call his girlfriend but did not get an answer, which upset him. Refused to take meds. 07/04/24 at 9:20 AM a nursing note stated, Resident kicking exit door in dining room. Being combative towards staff. Grabbed the arm of CNA (certified nursing assistant) when she attempted to redirect and move him away from door. Upon intervention, he stated I stated I hate this f-ing place, and I will beat the hell out of all of you. Attempted to contact girlfriend, left voicemail. Resident sitting in front of office door at this time, no signs or symptoms of distress at this time. Offered snacks and drinks, he declined. 07/04/24 at10:41 a nursing note stated the resident had hit another resident who was trying to push the telehealth device away. The power of attorney was unable to be contacted by phone and nursing was unable to do 1:1 supervision. The resident was sent out for treatment. A note on 07/11/24 at 4:56 PM revealed Resident #159 slapped Resident #9 in the face and Resident #9 was noted to have redness to the left side of face. It was identified in the medical record for Resident #9 that was a long-term resident of the facility and does not have capacity. Resident #9 is severely impaired cognitively for daily decision making. Resident #9 mobility was with a wheelchair and is constantly traveling throughout the facility. During an interview with NA #20 at 3:15 PM on 09/30/24. NA #20 stated that on 07/11/214 Resident#159 was yelling and screaming but that was the first time she had seen him hit someone. NA #20 said she had seen the resident pushing Resident#9's wheelchair trying to aggravate her. NA #20 further stated Resident #159 would yell at the victim (Resident #9) at this time. NA #20stated, I think there are times he has hit other people, but I have not seen that. NA #20 states she witnessed Resident #159 tell the Resident #9 prior to Resident #9 being slapped in the face and saying, I'll knock the hell out of you. The incident of verbal abuse where Resident #159 told Resident #9 he would knock the hell out of her was not identified, reported or investigated as allegations of verbal abuse. During an interview with Nurse Aide (NA) #74 at 6:20 PM on 09/30/24 NA #74 stated she had witnessed, multiple times prior to the 07/11/24 incident where Resident #159 would say to Resident #9, Don't fxxxxxx bump into me and I'll beat the sxxx out of you. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This incident of verbal abuse of Resident #159 towards Resident #9 was not identified to have been identified, reported or investigated. A medical record review on 09/30/24 at 5:30 PM identified Licensed Practical Nurse (LPN)#75 documented on 06/02/24 at 8:21 PM note text stating that LPN #75 tried to give resident Buspar, and behavior was observed, resident was aggressive with female resident when she tried to wheel past him. He cursed at her and stated, I will knock the hell out of you. He was immediately moved away from the resident and no other behaviors were noted since then. Continue to monitor. Further medical review, prior to this incident on 06/02/24, identified two (2)incidents dated 5/22/24 and 5/28/24 that Resident #159 was identified to remove the bar from the mechanical lift and as he brandished the weapon, he began beating the emergency exit doors and windows and busting the windows each time. It is identified that Resident #159's girlfriend and Medical Power of Attorney attempted to be reached numerous times during episodes but was unsuccessful. On 07/04/24at 9:20 AM the resident was trying to kick the door in the dining room. At10:41 AM the facility tried to reach the MPOA to send residents to hospital but was unable to reach MPOA. 07/15/24 at4:11 PM - a note revealed, Resident placed on 1:1. Resident#159 was transferred to a local hospital on 08/27/24 and passed away at a local hospice on 09/14/24. During a review of the facility policy and procedure for abuse prohibition it is identified (typed as written); 6. Stall will identify events- such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse- and determine the direction of the investigation. This also includes patient to patient abuse. 6.1 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. 6.1. 1 The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law. 6.1.2 The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. 6.1.3 All reports of suspected abuse must be reported to the patients family and attending physician. 6.2 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injury of unknown origin, or misappropriation of patient property must also report to outside agencies if required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6.2.1 Staff are obligated to report reasonable suspicion of a crime against the elderly to the state agency and local law enforcement. Administrators and Directors of Nursing must assist in reporting. 6.3 If the suspected abuse is patient-to patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. 6.3.1 The Center will provide adequate supervision when the risk of patient-to-patient altercation is suspected. 6.3.2 The Center is responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. 6.3.3 The patient representative and physician will be notified and any follow-up recommended will be completed (e.g. psychiatric evaluation). During an interview with the Administrator on 10/01/24 at approximately 1:00 PM the Administrator stated the facility had self-identified concerns with implementing their policy with regards to identifying, reporting and investigating allegations of abuse. The Administrator stated that after the event on 07/11/24 the facility self-identified concerns with the activities not being effective with person centered interventions to implement and concerns with the need of psych service training for the nursing staff in the event it was to be needed again. The Administrator stated the facility had completed the following Plan of correction on 07/11/24. The Administrator further stated that the verbal abuse incident would be reported immediately, and the staff involved would be addressed. Upon receiving the Plan of Corrections documentation on 10/02/24 at approximately 2:30 PM an audit of the plan of correction began. A review of the staff education signatures of completion were verified via the staff roster. Facility Plan of Correction- 07/11/24 1. Implemented Policy and Procedure on abuse prohibition 2. Education completed on 07/11/24 with all staff for reporting abuse and neglect. 3.Telehealth training for psych services in the event the situation happened again and services were needed. 4. Audit of getting to know me tools with activities and implementing them with person centered care. 1. Implemented Policy and Procedure on abuse prohibition. 2. Education completed on 07/11/24 with all staff for reporting abuse and neglect. 3. Telehealth training for psych services in the event the situation happened again and services were needed. 4. Audit of getting to know me tools with activities and implementing them with person centered care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional steps taken for not reporting verbal abuse on 06/02/24 5. Final Written warning for Nurse Assistant (NA) #20, NA #74 and LPN #75 for not reporting verbal abuse. 6. Education for leadership on reviewing statements to be aware of possible related concerns. 7. Facility reported the verbal abuse incident of 06/02/24 on 10/01/24. Upon receiving the Plan of Corrections documentation on 10/02/24 at approximately 2:30 PM an audit of the plan of correction. A review of the staff education signatures of completion were verified via the staff roster. 50552

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 51554 Based on record review and observation, the facility failed to ensure accuracy of assessment for one (1) of two (2) residents reviewed for dental status. Resident identifier: #37. Facility census: 60. Findings included: a) Resident #37 A record review on 10/01/24 at 3:11 PM revealed the last dental assessment from a dentist was greater than one year ago. Visual observation of Resident #37, revealed the resident had two missing teeth. During an interview the Social Worker stated the resident's two front teeth were missing upon admission to the facility. However, MDS completed on 7/20/24 (post admission) had no indications of missing teeth. MDS assessments on 04/14/23, 08/21/24 and 09/14/24 further indicated no dental issues. Registered Nurse (RN) #11 was interviewed and she acknowledged she missed entering missing natural teeth on assessment. Further record review revealed that on 09/25/24 a dentist from 360 Care was set to see the resident, but the resident refused treatment. The resident had an appointment with a dentist from 360 Care on 4/10/24 but was not seen because the resident was sick. Resident was scheduled to be seen by 360 Care Dentist in December 2024 10/02/24 10:21 AM Resident MDS for 9/14/24 was amended to show the resident was missing teeth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on medical record review and staff interview the facility failed to update Preadmission Screening and Resident Review (PASRR)with new qualifying diagnosis of . This was a random opportunity of discovery during the long-term care survey process. This had the ability to affect a minimum number of residents. Resident identifier: #159. Facility Census: 60. Findings Included: a) Resident #159 During a medical record review on 09/30/24 at approximately 10:30 AM it was identified that Resident #159 admitted on [DATE]. It is further identified that the resident did not have capacity with a Brief Interview for Mental Status (BIMS) of six (6) and was admitted with the following diagnoses dated 02/10/24: * Encephalopathy * Dysphagia, * Gastroesophageal reflux disorder * Hypertension * Unspecified voice and resonance disorder * Atherosclerotic heart disease of native coronary artery without angina pectoris * Hypothyroidism * Other disorders of the pituitary gland, unspecified abnormalities of gait and mobility * Other symptoms and signs involving the genitourinary system * Nicotine dependence * Other specified health status weakness * Altered mental status, cognitive communication deficit * Muscle weakness. During a review of the PASSR completed prior to the resident's admission, the PASSR was completed accurately and did not require level II. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER: Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 96 Tyree Street Ansted, WV 25812	

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further medical record reviewed that Resident #159 was diagnosed on [DATE] with anxiety disorder and was diagnosed with on 07/16/34 with unspecified dementia, unspecified severity with other behavioral disturbance. During an interview with the Director of Nursing on 10/01/24 at approximately 9:40 AM the DON acknowledged that the PASSR had not been updated with the new diagnosis. The DON agreed that the PASSR requirements were not met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on medical record review and staff interview the facility failed to update Preadmission Screening and Resident Review (PASRR) after one resident's behaviors intensified. This was a random opportunity of discovery during a long-term care survey process. This had the ability to affect a minimum number of residents. Resident Identifier: Resident #159. Facility Census: 60. Findings Included: a) Resident #159 During a medical record review on 09/30/24 at approximately 10:30 AM it is identified that Resident #159 was admitted on [DATE]. It is further identified that the resident did not have capacity with a Brief Interview for Mental Status (BIMS) of six (6) and was admitted with the diagnosis; During a review of the PASSR completed prior to the resident's admission, the PASSR was completed accurately and did not require Level II. With further medical record review for Resident #159 an exacerbation of behaviors was identified in the following residents progress notes: 03/08/24 at 10:14 AM Resident does not obey commands - 05/22/24 7:34 PM behavioral status evaluation revealed the resident had physical aggression danger to self or others. The resident took the lever off the mechanical lift and hit the emergency exit door and cracked the window in the door. The resident became combative with staff when attempting to remove the resident from the situation and placed 1:1. -05/28/24 at 1:47 PM a nursing note revealed, The patient showing aggressive behavior stating he is not taking any medication while using foul language. -05/28/24 at 7:05 PM A nursing note revealed, Nurse heard banging at end of unit 2 hallway. Resident was noted to be banging on a window. Staff attempted to redirect resident. Resident started to swing a bar at the staff that he had. Staff was able to intercept and get bar away from resident. But resident showed continual aggression by cursing and punching staff. No injuries. Upon inspection of window a hole through the glass was noted. -05/28/24 at 7:22 PM a note revealed the resident was sent to (name of local hospital) for psychiatric evaluation -06/01/24 at 9:20 AM a note revealed the resident refused all his medications. The resident stated the medications were poison. -06/01/24 at 1:41 PM a note revealed the resident was agitated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-06/2/24 9:12 AM a note revealed the resident refused medication and was agitated. -06/22/24 at 8:21 PM note a note revealed the nurse tried to give the resident Buspar and the resident was aggressive with Resident #9 and told her he would hit her when she tried to roll past him. -06/16/24 at 8:44 PM Buspar-Refused meds stating those are those damn clone pills Resident stated he could not stand the smell of the pills. -06/25/24 at 5:44 AM Pantoprazole refused I don't want it or need it. -06/26/24 at 5:01 PM to receive a new roommate. -06/27/24 at 11:11 PM Seen by FNP (Family Nurse Practitioner) - Chief complaint is medication review. Resident is refusing medications and having increased behaviors. History of present illness: Resident has had behaviors where he has busted out windows at the nursing and was sent to the ER at BARH. Sent back with no new orders or medication changes. The resident continues to have increased behaviors, to where he swings his fists at other residents when he passes them, refuses medication, very difficult to redirect. Assessment and plan: Medications reviewed, nursing manager will call Dr. [NAME] concerning resident's increased behaviors and medication refusal and ask for medication adjustments. -06/30/24 at 8:48 PM a nursing note stated, Resident attempting to go out door. Several attempts to finally get him to calm down. He states he wants to go home and he had been trying to call his girlfriend but did not get answer, which upset him. Refused to take meds. - 07/04/24 at 9:20 AM- a nursing note stated, Resident kicking exit door in dining room. Being combative towards staff. Grabbed the arm of CNA (certified nursing assistant) when she attempted to redirect and move him away from door. Upon intervention, he stated I stated I hate this f-ing place and I will beat the hell out of all of you. Attempted to contact girlfriend, left voicemail. Resident sitting in front of office door at this time, no signs or symptoms of distress at this time. Offered snacks and drinks, he declined. -07/04/24 at 10:41 AM Resident #159 hit Resident #9 in the face -07/04/24 at 9:19 PM- Nursing note stated, Given buspar with behaviors. Resident going to exit saying he is getting out. Strikes out at staff when they try and redirect him. -07/04/24 at 10:55 PM Nursing note stated, Resident has been up to desk several times using phone to call girlfriend. Did not get answer which made him angry. He has attempted to go to exit a few times this evening. Has been belligerent with staff, refused night time meds, went to bed on his own at this time, will continue to monitor. -07/11/24 at 5:24 PM- Nursing note stated, Resident was threatening and hitting other residents and refusing medications. Resident sent to (name of hospital). -07/18/24 at 3:50 PM- Nursing note stated, Resident moved to q15 minute checks (safety check occurring every 15 minutes) to ensure safety for resident and others due to aggression and outbursts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-07/28/24 at 2:08 PM- Nursing note stated, Resident attempting to elope out front entrance by pushing on door. Another resident ' s family member was trying to walk in and this resident seemed to block the entrance as he tried going out the door. Resident balled his fist up and shook it at the visitor in the doorway because she would not move out of his way. The nurse attempted to redirect resident and resident started trying to push nurse away. CNA managed to pull resident in wheelchair away from front entrance and attempted to redirect resident. Redirection unsuccessful. Resident proceeded to roll back to front entrance in wheelchair and attempted to elope. Pushed on front door and set the alarm off. Another CNA took resident to dining room and offered coffee as they talked. Redirection successful. -08/05/24 at 9:46 PM- Nursing note stated, Exit seeking, belligerent and combative with staff. Running into things in the hallway with his wheelchair purposefully. After a while he calmed down and went to bed. -08/08/24 at 3:22 AM- increased agitation. Exit seeking. Redirected with 1:1 food and - 08/27/24 at 7:10 PM- Nursing note stated, Danger to self and others with physical aggression. Resident was combative, striking out at staff and family members. I'm going to kill all you sons of bitches, you motherfuckers. Kicking and attempting to turn over computers. Family requested to be sent to BARH. NP states he was not able to be redirected. Told nurse to go ahead and administer Zyprexa. Family requested that he be sent out. During an interview with the Director of Nursing on 10/01/24 at approximately 9:40 AM the DON acknowledged that the PASSR had not been updated with the behaviors that had been identified. The DON agreed that the PASSR requirements were not met. .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review and staff interview the facility failed to ensure residents were assessed to identify risk factors and provide care and services that are resident centered to prevent falls with injury by failing to develop and implement a resident centered fall risk care plan. This was true for 1 (one) of 6 (six) residents reviewed. Resident identifier: #162. Facility census: 60. Findings include: a) Resident #162 Findings include: a) Resident #162 On 10/01/24 at approximately 03:30 PM, a record review was started for Resident #162 which reveal that Resident #162 was an [AGE] year-old female admitted on [DATE] status post hospitalization for an unwitnessed fall that occurred at home. Resident #162 was admitted with the following past medical history: -Alzheimer's Disease -Hypothyroidism -Essential Hypertension -Repeated Falls -Cognitive Communication Deficit -Parkinson's Disease -Insomnia -Depression -Tremors Resident #162 was receiving the following medications upon admission: -Carbidopa-Levodopa- diagnosis (dx): Parkinson's -Cympbalta- dx: Depression -Metoprolol Succinate Extended Release- dx: Hypertension (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Rozeram- dx: Insomnia -Miralax- dx: Constipation A further review of Resident #162 admitting orders revealed an order for non-skid footwear for safety was entered upon the resident's admission with an active date of 12/11/23. Resident #162 was deemed incapacitated with long term duration due to a dx of Alzheimer's Disease on 12/13/24. Furthermore, Resident #162 scored an 8 on the Brief Interview For Mental Status (BIMS) Evaluation which indicates moderate cognitive impairment. A review of the Policy and Procedure entitled, Falls Management revealed that all patients will be assessed for risk of falls upon admission, with reassessments routinely, including post fall, to determine ongoing needs for fall prevention precautions. The policy stated, The Center will implement and document patient-centered interventions according to the individual risk factors to the patient plan of care. The Center, to the extent possible, will provide the patient and/or patient representative with opportunities to participate in the care planning process for risk reduction and fall reduction strategies. In addition, the policy states for Post-Fall Management the circumstances of the fall will be documented as well as the post fall assessment. Resident #162 progress notes were reviewed which revealed the following documented notes (typed as written): 12/11/23 at 11:30 PM Nursing Documentation Note: Patient was admitted /readmitted for the following reason(s): admission Additional details about this note: Resident resting in bed at this time. admitted from (name of hospital) due to resident having a fall. Resident alert with some confusion at this time. Pt. has a history of falls. Neurological system reviewed Mental Status: Alert. Severely impaired in decision making skills for daily routine. Highly impaired hearing. A physiatry progress note dated 12/13/24 revealed the resident had mobility and activities of daily living (ADL) deficits secondary to a fall. The note stated the resident would be getting skilled therapy services with the goal of increasing strength, endurance and self care abilities as well as working on neuromotor training, stair climbing and functional moblity trainng. On 12/16/23 at 11:30 PM a note revealed the resident was found in the floor on her right side facing the door. She was found by a nurse aide (NA). She was awake and able to answer questions and stated she was trying to get up to go home. The note revealed the resident had no regular white ankle socks and the bed was in the lowest position. On 12/18/24 a progress note revealed the fall huddle meeting was held and a new intervention was put into place for a fall mat to the right side of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/23 a progress note stated, Called to room by social worker with the resident noted lying on the floor on right side with fall mat in place. The note reflected that the resident had a laceration to the right side of the forehead. The resident was sent to the emergency department for further evalution. A note dated 12/21/23 stated the resident had been transferred to a larger area hospital due to subdural hematoma. On 12/21/24 a fall huddle meeting was held a a new intervention was placed in the room. A sign was placed to remind resident to call for assistance with transfers. On 10/02/24 at approximately 08:30 AM, Resident #162 care plan was reviewed which revealed the following: Focus: Resident is at risk for falls: cognitive loss, lack of safety awareness. Date initiated: 12/12/23 Goal: Resident will have no falls with injury throughout the next review period. Date initiated: 12/12/23 Interventions: Place glasses within reach in a consistent place and encourage use. Date initiated: 12/12/23 Bed in low position. Date initiated: 12/12/23 Fall mat to right side of bed. Date initiated: 12/18/23 Signage in room to remind resident to call for assistance with transfers. Date initiated: 12/21/23 Provide resident/caregiver education for safe techniques of when to use call light for assistance. Date initiated: 12/21/23 Assist resident/caregiver to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement. Date initiated: 12/12/23. In addition, Resident #162 Standard Assessments were reviewed which revealed no Fall Risk Evaluation performed on admission or for post fall for 12/16/23 and for post fall 12/20/23. The Change in Condition Evaluation assessment for the dates of 12/16/23 and 12/20/23 were also reviewed and revealed the following information: A review of functional status evaluations dated 12/16/23 and 12/20/23 revealed in Section 2 that the resident's supine, sitting and standing blood pressures were to be entered were blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 09:00 AM, the Policy and Procedure entitled, Accidents/Incidents was completed which revealed that when conducting an investigation, the Administrator, DON or designee will make every effort to ascertain the cause of the accident/incident and document the root cause and initiate actions to prevent or reduce recurrence of further accident/incident. On 10/02/24 at 9:55 AM, an interview was conducted with the Director of Nursing (DON). At that time the DON acknowledged the following: 1. Fall Risk Evaluation were to be completed on admission 2. Fall Risk Evaluation were to be completed post fall 3. Nursing should document circumstances surrounding falls and were not. These circumstances include things such as incontinence and assistive devices. 4. Nursing assessments should be completed in their entirety andorthostatic blood pressure readings should be obtained. 5. No admission fall risk evaluation was completed for Resident #162, as per policy. 6. No post-fall fall risk evaluation for the dates of 12/16/23 and 12/20/23 were completed, as per policy. At this time, this Surveyor reviewed Resident #162 incident forms, dated 12/16/23 and 12/20/23, which had sections to be completed for predisposing physiological factors and predisposing situation factors with the DON. The DON acknowledged that both forms lacked required documentation such as, Resident # 162 received and antidepressant, antihypertensive, antiparkinsonian, laxative and wore glasses. In addition, the DON acknowledged, the incident form dated, 12/16/23 lacked the required documentation that Resident #162 was newly admitted within the last 7 (seven) days and that Resident #162 was wearing unsafe footwear and not the non-skid sole footwear ordered on admission. The DON then stated, the IDT team relies heavily on the nurses note and looks at trends to know which fall interventions to put in place. At that time, this Surveyor asked the DON, If you don't have the circumstances of the fall documented, how do you do that? The DON then states, You have a point. Resident #162 was noted to expire on 12/27/23 On 10/02/24 at 1:04 PM, an interview was conducted with the Director of Nursing (DON). At this time, the DON acknowledged the Center had knowledge Resident #162's history of falls at home prior to admission. When this Surveyor reviewed the 12/15/23 72 hour post admission meeting documentation with the DON, she stated when she spoke with Resident #162 daughter, the daughter stated to her, We can't keep her off the floor, that's why she is here. At this time, this Surveyor asked the DON if she asked Resident #162 daughter about circumstances surrounding Resident #162 falls at home in order to implement resident centered relevant interventions to prevent further falls, the DON stated, I am sure I did. When asked the DON to provide documentation of this, the DON acknowledged that she was unable to provide it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER: Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 96 Tyree Street, Ansted, WV 25812	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Surveyor asked the DON if root causes were performed on Resident #162 falls. The DON stated, Yes. The DON acknowledged was unable to provide these root cause analysis. This Surveyor then asked the DON what the root causes where for Resident #162 falls, to which the DON acknowledged she could not provide them. This Surveyor asked how interventions to prevent falls were determined to be resident centered based on the resident's individual risk factors, relevant and appropriate for Resident #162 to which the DON acknowledged she was unable to provide that. This Surveyor then reviewed the Policy and Procedure, Falls Management and Accidents/Incidents and asked the DON to review these policies. Then DON then said, I am aware of what they say. On 10/03/24, shortly after arrival to the facility at approximately 08:25 AM, the Senior Executive Director stated to this Surveyor, We found that a risk evaluation is built into the admission assessment last night. On 10/03/24 at approximately 08:30 AM, an interview was conducted with the DON. At this time, the DON stated that Point Click Care has since been updated and changed, however, the previous admission assessments had a fall risk evaluation embedded in it. At this time, the DON pulled an admission assessment up on her computer and clicked on a number by the admission assessment which was a hyperlink. The DON clicked on this link, which pulled up an addendum which gave a numeric value for different risks factors based on the answers from the admission assessment. The DON stated, We accidentally found this last night. At that time, this Surveyor asked the DON if facility staff were aware of this tool and how was it utilized to develop the plan of care based on the resident's individualized risk factors. The DON stated, We didn't utilize it. In addition, this Surveyor asked the DON to review the resident's fall care plan and interventions, which were done. This Surveyor then asked the DON, based off said resident's risk factors, how did the care planned interventions address and mitigate this resident's individual risk factors. The DON stated, They don't.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 20490 Based on record review and staff interview, the facility failed to provide resident centered activities. A resident was not provided individual activities. This is idenified as Past Non Compliance. Resident identifiers: #159, #9. Facility Census: 60. Findings Included: a) Resident #159 On 09/30/24 at approximately 12:15 PM during a record review of a an incident it was identified that Resident #159 had slapped Resident #9 in the face at 07/11/24 at 4:56 PM and Resident #9 face was noted to have redness to the left side. During a review of the investigation the Nurse Assistant (NA) #20's statement began with After first incident . During an interview with NA #20 at 3:15 PM on 09/30/24 NA #20 stated that on 07/11/24 Resident #159 was yelling and screaming but it was the first time she saw him hit someone. NA #20 said she saw Resident #159 pushing Resident #9's wheelchair trying to aggravate her. NA #20 further stated Resident #159 was yelling at the victim (Resident #9) at this time. NA #20 stated, I think there are times he has hit other people but I have not seen that. NA # 20 states she witnessed Resident #159 tell the Resident #9 prior to Resident #9 being slapped in the face that I'll knock the hell out of you. Further interview with the second witness Nurse Aide (NA) #74 at 6:20 PM on 09/30/24. NA #74 stated she has witnessed, multiple times prior to the 07/11/24 incident. She said Resident #159 would say to the Resident #9, Don't fxxxxxg bump into me and I'll beat the shxt out of you. During a medical record review on 09/30/24 at 5:30 PM it further identified though a nursing note by Licensed Practical Nurse (LPN) #75 note that on 06/02/24 at 8:21 PM LPN #75 tried to give resident buspar and behavior was observed. Resident #159 was aggressive with female resident when she tried to wheel past him. He cursed at her and stated, I will knock the hell out of you. He was immediately moved away from the resident and no other behaviors were noted since then. Continue to monitor. Further medical review identified two (2) incidents dated 05/22/24 and 05/28/24 that Resident #159 was identified to remove the bar from the mechanical lift and as he brandished the weapon he began beating the emergency exit doors and windows and busting the windows each time. It is identified that Resident #159's girlfriend and Medical Power of Attorney (MPOA) was attempted to be reached numerous times during episodes but was unsuccessful. On 07/04/24 at 9:20 AM the resident was trying to kick the door in the dining room. At 10:41 AM the facility tried to reach the MPOA to send residents to hospital but was unable to reach MPOA. Resident #159 was transferred from the facility to a local hospital on 08/27/24. The resident passed away at a local hospice house on 09/14/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Recreation Participation Record on 10/01/24 at 11:19 PM revealed no recreation activity completed to identify the individual person centered engagement for the entire months of June, July and August. Resident #159 activities assessment completed identified residents' preferences to be alone in his room, watching tv, listening to rock music, family visits, going for rides, woodworking, tinkering, fishing and sitting outdoors. He enjoys eating chips and sandwiches. These activities were not identified as being used for interventions during the incidents other than food was offered. During an interview with the Administrator on 10/01/24 at approximately 1:00 PM the Administrator stated the facility had self identified concerns with implementing their policy with regards to identifying, reporting and investigating allegations of abuse. The Administrator stated that after the event on 07/11/24 the facility self identified concerns with the activities not being effective with person centered interventions to implement and also concerns with the need of psych service training for the nursing staff in the event it was to be needed again. Plan of Correction for incident on 07/11/24 Implemented Policy and Procedure on abuse prohibition. 1. Education completed on 07/11/24 with all staff for reporting abuse and neglect. 2. Telehealth training for psych services in the event the situation happened again and services were needed. 3. Audit of getting to know me tools with activities and implementing them with person centered care. . Education for leadership on reviewing statements to be aware of possible related concerns. Upon receiving the Plan of Corrections documentation on 10/02/24 at approximately 2:30 PM an audit of the plan of correction. A review of the staff education signatures of completion were verified via the staff roster. The plan of correction was accepted on 10/02/24 at 2:45 PM. 49650 Based on record review and staff interview, the facility failed to provide resident centered activities as a resident was not provided individual activities. This is a Past Non Compliance and was identified during a complaint/long term care survey process. This had the potential to affect a limited number of residents. Resident Identifier: #159, #9. Facility Census: 60. Findings Included: a) Resident #159 On 09/30/24 at approximately 12:15 PM during a record review of a complaint #WV00033344 an incident was identified where Resident #159 had slapped Resident #9 in the face at 07/11/24 at 4:56 PM and Resident #9 face was noted to have redness to the left side of face. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the investigation the staff interview for Nurse Assistant (NA) #20 ' s statement began with After first incident . During an interview with NA #20 at 3:15 PM on 09/30/24. NA #20 states that the Resident #159 was yelling and screaming but It was the first time I saw him hit someone. States NA saw the resident pushing the victim ' s wheelchair trying to aggravate her. NA #20 further stated Resident #159 was yelling at the victim (Resident #9) at this time. NA #20 stated I think there are times he has hit other people but I have not seen that. NA # 20 states she witnessed Resident #159 tell the Resident #9 prior to Resident #9 being slapped in the face that I'll knock the hell out of you. Further interview with the second witness Nurse Aide (NA) #74 at 6:20 PM on 09/30/24. NA #74 stated she has witnessed, multiple times prior to the incident of Resident #159 slapping Resident #9 that Resident #159 say to the victim, Don't fucking bump into me and I'll beat the shit out of you. During a medical record review on 09/30/24 at 5:30 PM it further identified with a Licensed Practical Nurse (LPN) #75 note on 06/2/24 at 8:21 PM note text stating that LPN #75 tried to give resident buspar and behavior was observed, resident was aggressive with female resident when she tried to wheel past him. He cursed at her and stated I will knock the hell out of you. He was immediately moved away from the resident and no other behaviors were noted since then. Continue to monitor. Further medical review identifies two (2) incidents dated 5/22/24 and 5/28/24 that Resident #159 was identified to remove the bar from the mechanical lift and as he brandished the weapon he began beating the emergency exit doors and windows and busting the windows each time. It is identified that Resident #159's girlfriend and Medical Power of Attorney (MPOA) was attempted to be reached numerous times during episodes but was unsuccessful. On 07/04/24 at 9:20 AM the resident was trying to kick the door in the dining room. At 10:41 AM the facility tried to reach the MPOA to send residents to hospital but was unable to reach MPOA. Review of the Recreation Participation Record on 10/01/24 at 11:19 PM revealed there was no recreation activity completed to identify the Individual person centered engagement for the entire months of June, July and August. Resident #159 activities assessment completed identified residents' preferences to be alone in his room, watching tv, listening to rock music, family visits, going for rides, woodworking, tinkering, fishing and sitting outdoors. He enjoys eating chips and sandwiches. These activities are not identified as being used for interventions during the incident other than food was offered. During an interview with the Administrator on 10/01/24 at approximately 1:00 PM the Administrator stated the facility had self identified concerns with implementing their policy with regards to identifying, reporting and investigating allegations of abuse. The Administrator stated that after the event on 07/11/24 the facility self identified concerns with the activities not being effective with person centered interventions to implement and also concerns with the need of psych service training for the nursing staff in the event it was to be needed again. The Administrator stated the facility had completed the following Plan of correction on 07/11/24. The Administrator further stated that the verbal abuse incident would be reported immediately and the staff involved would be addressed Plan of Correction for incident on 07/11/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Implemented Policy and Procedure on abuse prohibition. 2. Education completed on 07/11/24 with all staff for reporting abuse and neglect. 3. Telehealth training for psych services in the event the situation happened again and services were needed. 4. Audit of getting to know me tools with activities and implementing them with person centered care. Additional steps taken for not reporting verbal abuse on 06/02/24 5. Final Written warning for Nurse Assistant (NA) #20, NA #74 and LPN #75 for not reporting verbal abuse. 6. Education for leadership on reviewing statements to be aware of possible related concerns. 7. Facility reported the verbal abuse incident of 06/02/24 on 10/01/24. Upon receiving the Plan of Corrections documentation on 10/02/24 at approximately 2:30 PM an audit of the plan of correction. A review of the staff education signatures of completion were verified via the staff roster. The plan of correction was accepted on 10/02/24 at 2:45 PM. Failed to provide meaningful activities to Resident #159.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER: Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on record review and staff interview the facility failed to ensure residents were assessed to identify risk factors and provide care and services that are resident centered to prevent falls with injury and to ensure medications were administered as ordered. This was true for 3 (three) of 6 (six) residents reviewed for the Long Term Care Survey Process. Facility census: 60. Resident identifiers: Resident #162, Findings include: a) Resident #162 On 10/01/24 at approximately 03:30 PM, a record review was started for Resident #162 which reveal that Resident #162 was an [AGE] year-old female admitted on [DATE] status post hospitalization for an unwitnessed fall that occurred at home. Resident #162 was admitted with the following past medical history: A further review of Resident #162 admitting orders revealed that an order for non-skid footwear for safety was entered upon admission with an active date of 12/11/23. Resident #162 was deemed incapacitated with long term duration due to a dx of Alzheimer's Disease on 12/13/24. Furthermore, Resident #162 scored an 8 on the Brief Interview For Mental Status (BIMS) Evaluation which indicates moderate cognitive impairment. A review of the Policy and Procedure entitled, Falls Management revealed that all patients will be assessed for risk of falls upon admission, with reassessments routinely, which includes post fall, to determine ongoing needs for fall prevention precautions. The Center will implement and document patient-centered interventions according to the individual risk factors to the patient plan of care. The Center, to the extent possible, will provide the patient and/or patient representative with opportunities to participate in the care planning process for risk reduction and fall reduction strategies. In addition, the policy states for Post-Fall Management the circumstances of the fall will be documented as well as the post fall assessment. In addition, Resident #162 progress notes were reviewed which revealed the following documented notes (typed as written): 12/11/23 at 11:30 PM Nursing Documentation Note: Patient was admitted /readmitted for the following reason(s): admission Additional details about this note: Resident resting in bed at this time. admitted from (name of hospital) due to resident having a fall. Resident alert with some confusion at this time. System Review: Neurological system reviewed Mental Status: Alert. Oriented to Person Severely impaired in decision making skills for daily routine Vision Reviewed Hearing and Speech reviewed Highly impaired hearing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	12/16/23 at 11:30 PM eINTERACT SBAR Summary for Providers: CNA called me to residents room. Resident in floor on right side facing door. Bed in lowest position, resident has regular white ankle socks on. Resident awake and able to answer questions, states she was trying to get up to go home No new pain complaints, resident has multiple bruises in various stages of healing from previous falls. ROM wnl. neuro's initiated. mpoa notified as well as NP. vitals obtained. 12/18/23 T 4:05 PM General Fall huddle meeting held. New intervention for fall mat to right side of bed 12/20/23 at 3:56 PM eINTERACT SBAR Summary for Providers Called to room by social worker, resident noted to be lying on the floor on her right side, fall mat was in place at the time of fall, resident alert, Neuro assessment complete with no issues noted, skin assessment completed, lacerated noted to right side of forehead, first aide administered, resident sent to ER for further evaluation. Relevant medical history is: Dementia 12/21/23 at 00:42 AM General Spoke with nursing staff at PMC ER, Resident transferred to CAMC General division for Subdural Hematoma 12/21/24 at 9:09 AM General Fall huddle meeting held. New intervention to place signage in room to remind resident to call for assistance for transfers On 10/02/24 at approximately 08:30 AM, Resident #162 care plan was reviewed which revealed the following fall care plan: Focus: Resident is at risk for falls: cognitive loss, lack of safety awareness. Date initiated: 12/12/23 Goal: Resident will have no falls with injury throughout the next review period. Date initiated: 12/12/23 Interventions: Place glasses within reach in a consistent place and encourage use. Date initiated: 12/12/23 Bed in low position. Date initiated: 12/12/23 Fall mat to right side of bed. Date initiated: 12/18/23 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Signage in room to remind resident to call for assistance with transfers. Date initiated: 12/21/24 Provide resident/caregiver education for safe techniques of when to use call light for assistance. Date initiated: 12/21/23 Assist resident/caregiver to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement. Date initiated: 12/12/23. In addition, Resident #162 Standard Assessments were reviewed which revealed no Fall Risk Evaluation performed on admission or for post fall for 12/16/23 and for post fall 12/20/23. The eINTERACT Change in Condition Evaluation assessment for the dates of 12/16/23 and 12/20/23 were also reviewed and revealed the following information: 12/16/23 Section 2 Functional Status Evaluation in which the resident's supine, sitting and standing blood pressures are to be entered are blank. 12/20/23 Section 2 Functional Status Evaluation in which the resident's supine, sitting and standing blood pressures are to be entered are blank. On 10/02/24 at 09:00 AM, the Policy and Procedure entitled, Accidents/Incidents was completed which revealed that when conducting an investigation, the Administrator, DON or designee will make every effort to ascertain the cause of the accident/incident and document the root cause and initiate actions to prevent or reduce recurrence of further accident/incident. On 10/02/24 at 09:55 AM, an interview was conducted with the DON. At that time the DON acknowledged the following: 1. Fall Risk Evaluation is to be completed on admission 2. Fall Risk Evaluation is to be completed post fall 3. Nursing should be documenting circumstances surrounding fall and aren't. Such as incontinence and assistive devices. 4. Nursing assessments should be completed in their entirety and that orthostatic blood pressure readings should be obtained. 5. No admission fall risk evaluation was completed for Resident #162, as per policy. 6. No post-fall fall risk evaluation for the dates of 12/16/23 and 12/20/23 was completed, as per policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	At this time, this Surveyor reviewed Resident #162 incident forms, dated 12/16/23 and 12/20/23, which has sections to be completed for predisposing physiological factors and predisposing situation factors with the DON. At this time, the DON acknowledged that both forms lacked required documentation such as, Resident # 162 was receiving and antidepressant, antihypertensive, antiparkinsonian, laxative and wore glasses. In addition, the DON acknowledged, the incident form dated, 12/16/2,3 lacked the required documentation that Resident #162 was newly admitted within the last 7 (seven) days and that Resident #162 was wearing unsafe footwear and not the ordered non-skid sole footwear on admission. The DON then stated, the IDT team relies heavily on the nurses note and look at trends to know which fall interventions to put in place. At that time, this Surveyor asked the DON if you don't have the circumstances of the fall documented, how do you do that? The DON then states, You have a point. On 10/02/24 at approximately 12:00 PM, this Surveyor completed a review of the emergency room documentation for Resident #162 fall which occurred on 12/20/23. Resident #162 was sent from the Center to [NAME] Area Medical Center (CAMC) Plateau Medical Center (PMC) following the fall that occurred on 12/20/23, which revealed the following: CAMC PMC 12/20/23: Resident #162 was transferred to CAMC General for neurosurgery, higher level of care with diagnoses: 1. Traumatic Subdural Hemorrhage 2. Laceration without foreign body of scalp 3. History of falling Review of the documentation from CAMC General revealed the following: Resident #162 was admitted to the hospital to the Intensive Care Unit (ICU) with hourly neuro-checks. Resident #162 underwent a repeat Cat Scan (CT) of her head which initially slightly increased, but was then subsequently stable, at which point Resident #162 was transferred from the ICU to the floor. Resident #162 subsequently developed decreased mental status and underwent repeat CT imaging which showed increased subdural with a midline shift. Resident #162 was transferred back to the ICU after which a discussion with family was held who believed that in light of the patient's recent decision to be a Do No Resuscitate (DNR), Resident #162 would not want any invasive procedures or prolonged hospital course. The decision was made to proceed with comfort care with transition to hospice care. Resident #162 was noted to expire on 12/27/23 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansted Center	96 Tyree Street Ansted, WV 25812

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 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/02/24 at 1:04 PM, an interview was conducted with the Director of Nursing (DON). At this time, the DON acknowledged that the Center had knowledge Resident #162 had a history of falls at home prior to admission. When this Surveyor reviewed the 12/15/23 72 hour post admission meeting documentation with the DON, she stated when she spoke with Resident #162 daughter, the daughter stated to her, We can't keep her off the floor, that's why she is here. At this time, this Surveyor asked the DON if she asked Resident #162 daughter about circumstances surrounding Resident #162 falls at home in order to implement resident centered relevant interventions to prevent further falls, the DON stated, I am sure I did. When asked the DON to provide documentation of this, the DON acknowledged that she was unable to provide it. This Surveyor then asked the DON if root causes were performed on Resident #162 falls. The DON stated, Yes. When asked the DON to provide documentation, the DON acknowledged she was unable to provide it. This Surveyor then asked the DON what the root causes where for Resident #162 falls, to which the DON acknowledged she could not provide them. This Surveyor then asked how interventions to prevent falls were determined to be resident centered based on the resident's individual risk factors, relevant and appropriate for Resident #162 to which the DON acknowledged she was unable to provide that. This Surveyor then reviewed the Policy and Procedure, Falls Management and Accidents/Incidents and asked the DON to review these policies. Then DON then said, I am aware of what they say. On 10/03/24, shortly after arrival to the facility at approximately 08:25 AM, the Senior Executive Director stated to this Surveyor, We found that a risk evaluation is built into the admission assessment last night. On 10/03/24 at approximately 08:30 AM, an interview was conducted with the DON. At this time, the DON stated that Point Click Care has since been updated and changed, however, the previous admission assessments had a fall risk evaluation embedded in it. At this time, the DON pulled an admission assessment up on her computer and clicked on a number by the admission assessment which was a hyperlink. The DON clicked on this link, which pulled up an addendum which gave a numeric value for different risks factors based on the answers from the admission assessment. The DON stated, We accidentally found this last night. At that time, this Surveyor asked the DON if facility staff were unaware of this tool, how was it utilized to develop the plan of care based on the resident's individualized risk factors. The DON stated, We didn't utilize it. In addition, this Surveyor asked the DON to review said resident's fall care plan and interventions, which were done. This Surveyor then asked the DON, based off said resident's risk factors, how does the care planned interventions address and mitigate this resident's individual risk factors? The DON stated, They don't. 49650 b) Resident #10 During a medical record 10/01/24 at 2:46 PM, Resident #10's physician order identified an order for Sinemet Tablet 25-100 MG (Carbidopa-Levodopa) and to give 2 tablet by mouth five times a day for Parkinson disease active date of 01/09/23. During further review of the Residents Medication Administration Record (MAR) it is identifeid that the following doses were not documented to have been administered per the physicians order. * 06/29/24, the 1800 hour dose is missing * 08/29/24 the 1800 hour dose is missing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	* 09/15/24 the 1800 hour dose is missing During an interview with the Director of Nursing on 10/01/24 at approximately 10:40 AM the DON acknowledged the doses were not documented as being administered per the physicians order. 50552 Based on record review and staff interview the facility failed to ensure residents were assessed to identify risk factors and provide care and services that are resident centered to prevent falls with injury and to ensure medications were administered as ordered. This was true for 2 (two) of 6 (six) residents reviewed for the Long Term Care Survey Process. Resident identifiers: #162, #10. Facility census: 60. Findings include: a) Resident #162 On 10/01/24 at approximately 03:30 PM, a record review was started for Resident #162 which reveal that Resident #162 was an [AGE] year-old female admitted on [DATE] status post hospitalization for an unwitnessed fall that occurred at home. Resident #162 was admitted with the following past medical history: -Alzheimer's Disease -Hypothyroidism -Essential Hypertension -Repeated Falls -Cognitive Communication Deficit -Parkinson's Disease -Insomnia -Depression -Tremors Resident #162 was receiving the following medications upon admission: -Carbidopa-Levodopa- diagnosis (dx): Parkinson's -Cympbalta- dx: Depression -Metoprolol Succinate Extended Release- dx: Hypertension (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	-Rozeram- dx: Insomnia -Miralax- dx: Constipation A further review of Resident #162 admitting orders revealed an order for non-skid footwear for safety was entered upon the resident's admission with an active date of 12/11/23. Resident #162 was deemed incapacitated with long term duration due to a dx of Alzheimer's Disease on 12/13/24. Furthermore, Resident #162 scored an 8 on the Brief Interview For Mental Status (BIMS) Evaluation which indicates moderate cognitive impairment. A review of the Policy and Procedure entitled, Falls Management revealed that all patients will be assessed for risk of falls upon admission, with reassessments routinely, including post fall, to determine ongoing needs for fall prevention precautions. The policy stated, The Center will implement and document patient-centered interventions according to the individual risk factors to the patient plan of care. The Center, to the extent possible, will provide the patient and/or patient representative with opportunities to participate in the care planning process for risk reduction and fall reduction strategies. In addition, the policy states for Post-Fall Management the circumstances of the fall will be documented as well as the post fall assessment. Resident #162 progress notes were reviewed which revealed the following documented notes (typed as written): 12/11/23 at 11:30 PM Nursing Documentation Note: Patient was admitted /readmitted for the following reason(s): admission Additional details about this note: Resident resting in bed at this time. admitted from (name of hospital) due to resident having a fall. Resident alert with some confusion at this time. Pt. has a history of falls. Neurological system reviewed Mental Status: Alert. Severely impaired in decision making skills for daily routine. Highly impaired hearing. A physiatry progress note dated 12/13/24 revealed the resident had mobility and activities of daily living (ADL) deficits secondary to a fall. The note stated the resident would be getting skilled therapy services with the goal of increasing strength, endurance and self care abilities as well as working on neuromotor training, stair climbing and functional moblity trainng. On 12/16/23 at 11:30 PM a note revealed the resident was found in the floor on her right side facing the door. She was found by a nurse aide (NA). She was awake and able to answer questions and stated she was trying to get up to go home. The note revealed the resident had no regular white ankle socks and the bed was in the lowest position. On 12/18/24 a progress note revealed the fall huddle meeting was held and a new intervention was put into place for a fall mat to the right side of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/20/23 a progress note stated, Called to room by social worker with the resident noted lying on the floor on right side with fall mat in place. The note reflected that the resident had a laceration to the right side of the forehead. The resident was sent to the emergency department for further evalution. A note dated 12/21/23 stated the resident had been transferred to a larger area hospital due to subdural hematoma. On 12/21/24 a fall huddle meeting was held a a new intervention was placed in the room. A sign was placed to remind resident to call for assistance with transfers. On 10/02/24 at approximately 08:30 AM, Resident #162 care plan was reviewed which revealed the following: Focus: Resident is at risk for falls: cognitive loss, lack of safety awareness. Date initiated: 12/12/23 Goal: Resident will have no falls with injury throughout the next review period. Date initiated: 12/12/23 Interventions: Place glasses within reach in a consistent place and encourage use. Date initiated: 12/12/23 Bed in low position. Date initiated: 12/12/23 Fall mat to right side of bed. Date initiated: 12/18/23 Signage in room to remind resident to call for assistance with transfers. Date initiated: 12/21/23 Provide resident/caregiver education for safe techniques of when to use call light for assistance. Date initiated: 12/21/23 Assist resident/caregiver to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement. Date initiated: 12/12/23. In addition, Resident #162 Standard Assessments were reviewed which revealed no Fall Risk Evaluation performed on admission or for post fall for 12/16/23 and for post fall 12/20/23. The Change in Condition Evaluation assessment for the dates of 12/16/23 and 12/20/23 were also reviewed and revealed the following information: A review of functional status evaluations dated 12/16/23 and 12/20/23 revealed in Section 2 that the resident's supine, sitting and standing blood pressures were to be entered were blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/02/24 at 09:00 AM, the Policy and Procedure entitled, Accidents/Incidents was completed which revealed that when conducting an investigation, the Administrator, DON or designee will make every effort to ascertain the cause of the accident/incident and document the root cause and initiate actions to prevent or reduce recurrence of further accident/incident. On 10/02/24 at 9:55 AM, an interview was conducted with the Director of Nursing (DON). At that time the DON acknowledged the following: 1. Fall Risk Evaluation were to be completed on admission 2. Fall Risk Evaluation were to be completed post fall 3. Nursing should document circumstances surrounding falls and were not. These circumstances include things such as incontinence and assistive devices. 4. Nursing assessments should be completed in their entirety andorthostatic blood pressure readings should be obtained. 5. No admission fall risk evaluation was completed for Resident #162, as per policy. 6. No post-fall fall risk evaluation for the dates of 12/16/23 and 12/20/23 were completed, as per policy. At this time, this Surveyor reviewed Resident #162 incident forms, dated 12/16/23 and 12/20/23, which had sections to be completed for predisposing physiological factors and predisposing situation factors with the DON. The DON acknowledged that both forms lacked required documentation such as, Resident # 162 received and antidepressant, antihypertensive, antiparkinsonian, laxative and wore glasses. In addition, the DON acknowledged, the incident form dated, 12/16/23 lacked the required documentation that Resident #162 was newly admitted within the last 7 (seven) days and that Resident #162 was wearing unsafe footwear and not the non-skid sole footwear ordered on admission. The DON then stated, the IDT team relies heavily on the nurses note and looks at trends to know which fall interventions to put in place. At that time, this Surveyor asked the DON, If you don't have the circumstances of the fall documented, how do you do that? The DON then states, You have a point. Resident #162 was noted to expire on 12/27/23 On 10/02/24 at 1:04 PM, an interview was conducted with the Director of Nursing (DON). At this time, the DON acknowledged the Center had knowledge Resident #162's history of falls at home prior to admission. When this Surveyor reviewed the 12/15/23 72 hour post admission meeting documentation with the DON, she stated when she spoke with Resident #162 daughter, the daughter stated to her, We can't keep her off the floor, that's why she is here. At this time, this Surveyor asked the DON if she asked Resident #162 daughter about circumstances surrounding Resident #162 falls at home in order to implement resident centered relevant interventions to prevent further falls, the DON stated, I am sure I did. When asked the DON to provide documentation of this, the DON acknowledged that she was unable to provide it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0684 Level of Harm - Actual harm Residents Affected - Few	This Surveyor asked the DON if root causes were performed on Resident #162 falls. The DON stated, Yes. The DON acknowledged was unable to provide these root cause analysis. This Surveyor then asked the DON what the root causes where for Resident #162 falls, to which the DON acknowledged she could not provide them. This Surveyor asked how interventions to prevent falls were determined to be resident centered based on the resident's individual risk factors, relevant and appropriate for Resident #162 to which the DON acknowledged she was unable to provide that. This Surveyor then reviewed the Policy and Procedure, Falls Management and Accidents/Incidents and asked the DON to review these policies. Then DON then said, I am aware of what they say. On 10/03/24, shortly after arrival to the facility at approximately 08:25 AM, the Senior Executive Director stated to this Surveyor, We found that a risk evaluation is built into the admission assessment last night. On 10/03/24 at approximately 08:30 AM, an interview was conducted with the DON. At this time, the DON stated that Point Click Care has since been updated and changed, however, the previous admission assessments had a fall risk evaluation embedded in it. At this time, the DON pulled an admission assessment up on her computer and clicked on a number by the admission assessment which was a hyperlink. The DON clicked on this link, which pulled up an addendum which gave a numeric value for different risks factors based on the answers from the admission assessment. The DON stated, We accidentally found this last night. At that time, this Surveyor asked the DON if facility staff were aware of this tool and how was it utilized to develop the plan of care based on the resident's individualized risk factors. The DON stated, We didn't utilize it. In addition, this Surveyor asked the DON to review the resident's fall care plan and interventions, which were done. This Surveyor then asked the DON, based off said resident's risk factors, how did the care planned interventions address and mitigate this resident's individual risk factors. The DON stated, They don't. b) Resident #10 During a medical record review on, 10/01/24 at 2:46 PM, it was revealed that Resident #10's physician order identified an order for Sinemet Tablet 25-100 MG (Carbidopa-Levodopa) and to give 2 two tablet by mouth 5 times a day for Parkinson disease active date of 01/09/23. During further review of the Residents Medication Administration Record (MAR) it is identifeid that the following doses were not documented to have been administered per the physicians order. * 06/29/24, the 1800 hour dose is missing * 08/29/24 the 1800 hour dose is missing * 09/15/24 the 1800 hour dose is missing During an interview, with the Director of Nursing on 10/01/24 at approximately 10:40 AM, the DON acknowledged the doses were not documented as being administered per the physicians order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER: Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 96 Tyree Street Ansted, WV 25812	

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on record review and resident and staff interview, the facility failed to ensure fall interventions were in place for Resident #27 and to ensure a mechanical lift was used, per company policy, to assist Resident #159 out of the floor following a fall. This was true for two (2) of five (5) residents reviewed for accidents during the survey process. Resident identifiers: #27, 159. Facility census: 60. Findings include: a) Resident #27 Resident #27 was admitted to the facility on [DATE] with the following diagnoses: Dementia, Unspecified severity with psychotic disturbance. Muscle Weakness (generalized) Weakness Unspecified abnormalities of gait and mobility Other specified fracture of right pubis, subsequent encounter for fracture with routine healing. Resident #27 suffered falls at the facility on 05/02/24, 05/07/24, 06/09/24, and 07/03/24. As a result of the fall on 05/07/24, Resident #27 suffered a fractured left hip. This was confirmed by an x-ray on 05/09/24. Resident #27 received the following diagnoses after the fall on 05/07/24: Other specified fracture of left pubis, initial encounter for closed fracture. Upon review of Resident #27's care plan, it was discovered the resident was a fall risk, based on the four (4) previous falls she had, along with the following care plan focus: Resident is at risk for falls related to cognitive loss, lack of safety awareness, CVA (Cerebrovascular Accident or a stroke), Impaired mobility, and HX fall with fracture. Due to Resident #27 being a fall risk, the following interventions were implemented by the facility: Bed in low position and fall mat to right and left side of bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon observation of the resident's room on 10/01/24, it was noted Resident #27 was in bed and the right-side side of her bed was against the wall. Furthermore, the resident's bed was not in the lowest position, nor was the fall mat in the floor to the left side of the bed, per the resident's care plan. The administrator of the facility acknowledged the bed was not in the lowest position and the missing fall mat at approximately 8:20 AM on 10/01/24. b) Resident #159 On 10/01/24 at 3:17 PM during a medical record review of Resident #159's fall on 05/07/24 it was identified in the Risk Management documents that the immediate action taken was Licensed Practical Nurse (LPN) and the Nurse Aid #75 assisted Resident #159 up to wheelchair. A review of the Falls Management Policy was completed, and it stated under the fall definition that (typed as written) Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented. A total lift will be used to lift patients off of the floor unless contraindicated. During a further review of the lift assessment completed for Resident #159 on 02/10/24 it identified Resident #159 as a total lift with the use of divided Leg Sling. During an interview with the DON on 10/02/24 at approximately 2:30 PM the DON agreed that the resident should have been assisted with the lift assessment with a total lift with divided Leg Sling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 49467 Based on record review and resident and staff interview, the facility Medical Director (MD) failed to sign orders in a timely manner to ensure Resident #37 did not miss doses of a controlled pain medication. This was true for one (1) of three (3) residents reviewed for pain management during the survey process. Resident identifier: 37. Facility census: 60. Findings included: A) Resident #37 At approximately 1:40 PM on 09/29/2024 during an interview with Resident #37, she stated she was in constant pain a majority of the time, and had missed her pain medication on occasions because the doctor didn't sign the orders for them so the nurses couldn't get them. Resident #37 was asked how she was aware the missing doses were due to the doctor not signing the orders, she stated, The nurses came to give me my medicines and told me they couldn't give me my pain medication because they were out of it and couldn't get any more of it because the doctor hadn't signed for it. At approximately 9:00 AM on 09/30/2024, an interview was conducted with the Director of Nursing (DON) regarding the pain medication at the facility. The DON supplied a list of the controlled pain medications the facility had in their emergency stock, showing the facility had the medication Resident #37 had orders for in their stock. A review of Resident #37's record indicated she had the following order: Norco Oral Tablet 10-325 MG (Hydrocodone Acetaminophen) Give one (1) tablet by mouth every four (4) hours for pain. Further review of the resident's record indicated on 03/25/24, she did not receive a dose of the Norco. Review of the progress notes on the resident's record revealed the following notes: 03/25/2024 at 9:00 AM- Norco Oral Tablet 10-325 MG Give one (1) tablet by mouth every four (4) hours for pain - ON ORDER. 03/25/2024 at 1:00 PM- Norco Oral Tablet 10-325 MG Give one (1) tablet by mouth every four (4) hours for pain ON ORDER. 03/25/2024 at 5:00 PM- Norco Oral Tablet 10-325 MG Give one (1) tablet by mouth every four (4) hours for pain ON ORDER. 03/25/2024 at 9:00 PM- Norco Oral Tablet 10-325 MG Give one (1) tablet by mouth every four (4) hours for pain awaiting pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 10:15 AM on 10/02/2024, interviews were conducted with the DON and Registered Nurse (RN) #6 regarding the missing medications. During the interview, RN #6 stated the pharmacy in use by the facility during the time in question would have allowed the facility to pull from the emergency stock, if there was a valid, active prescription, and the medication was set to be delivered from the pharmacy. The DON stated the pharmacy in use by the facility during that time would deliver to the facility three (3) times a day during the week and two (2) times a week during the weekends. At this time, the DON supplied, upon request, a copy of the order for the Norco tablet prescribed to Resident #37. The order was entered into the system at 12:54 AM on 03/25/24 by RN #29, with a prescribed order start date of 03/25/24 at 1:00 AM. Further review of the order revealed the prescription was not signed by the MD until 7:33 PM on 03/25/24, meaning, according to the DON, had the order been signed earlier, the pharmacy would have allowed the facility to pull from the emergency stock machine, so Resident #37 would continue to get the medication until the pharmacy delivered. During this interview, the DON stated the facility will gather orders for the MD to sign every Sunday night and the MD stated he would sign the orders every Monday. However, the DON stated if a prescription was missed, or the facility obtained a new order for a new or existing resident after Monday, the MD would refuse to sign any more orders during the week, making them wait until the following Monday, despite the MD being able to sign the order from his computer or phone. The order for Resident #37's Norco was signed on an iPhone, with an authentication method of password and device token. The facility had a fax number for the MD posted next to the copy/fax machine to send orders to as well. However, during the survey process, multiple staff interviews were conducted related to the MD signing orders, at which time the staff interviewed stated the MD would not respond to calls or messages related to resident care or needed orders. At approximately 3:00 PM on 10/03/2024, The DON acknowledged the progress notes and Medication Administration Record (MAR) indicating Resident #37 did not receive her Norco. The DON acknowledged the reason the resident did not receive the pain medication was because the MD did not sign the order in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Ansted Center		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Tyree Street Ansted, WV 25812	

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 45171 Based on observation and staff interview the facility failed to to ensure two (2) residents was supplied with working call light. and/or accessible call lights. Resident #2's call light was not working and#55's call light was not within reach. Facility census: 60. Findings included: a) Resident #2 09/29/24 an observation of Resident #2's call light revealed it was not functioning. On 09/30/24 at 2:56 PM the Director of Nursing (DON) said the facility was not aware the call light was not functioning prior to yesterday upon the surveyor finding it. Per an interview with the resident at this time, she states she does not know if anyone knew it was not working. She did not specifically tell anyone that she could recall. b) Resident #55 During interview and observation on on 09/29/24 it was determined that Resident #55's call light cord was pressed between the bed and the wall and then draped over the overhead lights. The cord would not move due to being stuck between the bed and wall. A Nurse Aide (NA) was summoned to the room and she moved the bed away from the wall, moved the cord and call light button so the resident could reach it. He is able to use if accessible.