STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515142	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clay Healthcare Center	1053 Clinic Drive Ivydale, WV 25113

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on record review, and staff interviews, the facility neglected to provide the amount of assistance and supervision needed to prevent a resident from aspiration. On 05/22/25 at 6:00PM, the state agency notified the facility of the finding of past-noncompliance Immediate Jeopardy (IJ) that began on 03/19/25 and ended on 03/24/25. The deficient practices caused actual harm to Resident #16. The facility's neglect of the resident created a case of physical harm. The resident required transfer to the emergency room for evaluation and had to undergo medical testing. Resident identifier: #16. Facility census: 53. Findings included: a) Resident #16 Medical Record Review (MRR) revealed Resident #16 had resided in the facility since 2018. He did not have the capacity to make medical decisions. According to the Minimum Data Set (MDS) the resident's Brief Interview for Mental Status (BIMS) score was 3, indicating cognitive impairment. The resident had diagnoses of Neurocognitive Disorder with Lewy Bodies Disease, Aphasia following cerebrovascular disease, Dysphagia , Major Depressive Disorder, Recurrent, Visual Hallucinations, Dysphagia Oral Phase, Anxiety Disorder, Need for Assistance with Personal Care, Dementia, Parkinson's Disease with Dyskinesia, with Fluctuations, and Cognitive Communication Deficit. On 03/20/25 at 12:46 AM, the facility submitted a facility reported incident (FRI) to the state agency. The report revealed the following: On 03/19/25 at 12:15 PM in the dining room, Resident #16 was found drooling, not breathing, and was cyanotic (blue). This was reportedly observed by Activities Leader (AL) #72. AL #72 immediately notified nursing staff. The Heimlich Maneuver with finger sweep was performed by Licensed Practical Nurse (LPN) #54 without success. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After moving the resident to the hallway, Licensed Practical Nurse (LPN) #53 performed the Heimlich Maneuver and finger sweeps again without success, 911 was called. Resident #16 was transferred to his room where RN #88 performed another finger sweep and suctioned the resident with partial success. The resident was transferred to a local emergency department. Resident #16 was found to have aspiration pneumonia and a thoracic aortic aneurysm. The family declined any further interventions. The resident was transferred to the facility with antibiotics and hospice level of care. An investigation was initiated. The five (5) day follow-up investigation contained the following additional information: It had been determined there was a system failure for which the facility had taken immediate action to address. Witness statements were obtained and interviews were conducted with all staff involved in the serving of residents in the facility on the day of the incident. The facility's plan of correction initiated 03/20/25 was as follows: On 03/20/25, the Director of Nursing (DON) started an in service with all staff on level of assistance with meals, types of diets, ensuring the resident is receiving appropriate assistance, ensuring resident meal on tray matches ordered diet consistency and awareness that meal tickets are no longer printing highlighted or in red. On 03/20/25, the Activities Supervisor started an in service with all activities staff on requirements for resident's requiring assistance and allowing clinical staff to set these residents up with meals as they are prepared to assist them with their meal. On 03/20/24, The Certified Dietary Manager(CDM) started an in service with all dietary staff on ensuring that the food served matches diet order on meal ticket. As of 03/24/25, staff in services were completed. To prevent other residents who require assistance with full assist feeding, either the RN, LPN or NA that takes the tray to the resident, will be the person who will assist and/or feed the resident until the meal is completed. New CNA and Nursing employees orientation will include instruction upon meal delivery process to include diet texture and full assist definition by the DON or designee. Clinical staff also will receive follow up competency check off sheet through Relias training. On 03/20/25, The DON completed audits of all diets in the system to ensure they matched and reviewed with the CDM to ensure meal tickets also reflected. The CDM is monitored texture modification of food daily for two weeks. The CDM conducted tray line audits two times a week for four weeks. Starting 03/20/2025,The DON and ADON will be performing audits twice a week on the floor to ensure diet orders match the food texture served and those who require assistance with eating are receiving the appropriate level of care. On 3/20/25, The DON will be reviewing audit weekly with the CDM. A review of the Emergency Department (ED) Information/Report revealed the resident presented on 03/19/25 to the emergency department with a chief complaint of aspiration of turkey. The resident was hypoxemic and was. His oxygen saturation was 67%. The ED noted, He must have passed the bolus on down somewhere because his O2 sats picked up to 90. The resident was diagnosed as having Aspiration Pneumonia. The residents' family elected not to have aggressive measures taken to remove the turkey that was stuck in his right mainstream bronchus. He was discharged back to the nursing home with antibiotics and hospice care. The facility provided evidence of pre-incident training for Nurse Aide (NA) #72. The NA had received training on feeding assistance, tray/ticket breakdown and I information and tray pass services. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/24/25, a corrective action form was completed for NA #71. She was disciplined with a verbal warning for performance/policy violation for serving a tray to a full feed assist resident and not providing the correct level of assistance not validating that the resident's meal consistency matched the meal ticket. A review of the facility definition/policy of neglect revealed the following: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect, or misappropriation of their property. In the event a situation is identified as abuse, neglect, or misappropriation, an investigation by the executive leadership will immediately follow. Neglect is the failure of the facility, its employees, or service providers to provide goods and services to a resident that necessary to avoid physical harm, pain, mental anguish, or emotional distress. WV code 9-6-1 defines neglect as the unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult; or provide the care necessary to assure physical safety or health of and incapacitated adult; or unlawful expenditure or willful dissipation of the funds or other assets owned or paid to, or for the benefit of, an incapacitated adult or resident. The facility's updated Meals Policy Inservice dated February 2025 gave the following procedures and instructions: It is the responsibility of nursing staff when passing trays to verify that residents' meals are accurate according to what is on the meal ticket. Nursing staff must also ensure that residents are receiving the appropriate textured foods and level of assistance with meals. Trays are not to be set in front of a full feed assist resident unless a clinical staff is present and ready to feed. Clinical staff providing full feed assist are to remain with the resident from the time the tray is dropped off until the meal is completed. Clinical staff providing full assistance to residents during meals are to provide observation, cueing, and assistance to ensure appropriate bite size, rate of feeding, and use of liquid wash. On 07/02/24 Resident #16 was referred to Speech Therapy (ST) due to new onset of coughing/choking during oral intake indicating the need for ST to assess/evaluate least restrictive oral intake, analyze oral/pharyngeal function, develop and instruct in compensatory strategies, teach/instruct in environmental modifications and instruct family/staff in compensation techniques. The risk factors included Due to documented physical impairments and associated functional deficits, the resident was at risk for aspiration. It was recommended that the resident have supervision for oral intake. It was recommended that he have rate modifications and bolus size modifications upright posture during and upright posture for 30 minutes after meals. It was noted that staff and caregivers would be provided training regarding diet texture and positioning to enhance safety On 09/19/24 the resident was referred to Speech Therapy again for a dysphagia evaluation due to concerns of silent aspiration. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following risk factors were discussed Due to the documented physical impairments and associated functional deficits, the patient is at risk for aspiration, further decline in function, increased dependency upon caregiver, pneumonia and weight loss. The resident and primary caregivers were trained and instructed on safe swallowing, bolus size reduction, upright positioning and alternating solids and liquids. When the resident was given a cup to hold himself, he was described as not utilizing rate mod requiring max verbal cues. He was recommended to have close supervision for oral intake, full feeding assistance and to be in the dining room for lunch and dinner. A medical record review revealed the resident was on a speech therapy caseload at the time of the choking incident. On 03/20/25 due to the change in the resident's medical condition, he was discharged from Speech Therapy. A Speech Therapy final evaluation was on 03/20/25. Medical Record Review (MRR) revealed that on 03/20/25 Resident was discharged from Speech Therapy to Hospice. The MRR revealed on 10/04/24 the resident had an order for a regular diet dysphagia advanced texture with thin liquids and a raised lip plate with all meals. He was also supposed to have fortified foods with meals and was considered to need full feeding assistance related to his dysphagia. The resident's care plan review revealed a care plan dated 12/27/24 that said the resident was dependent in the area of eating with the helper doing all the effort. Nurse Aide (NA) # 71 was interviewed via phone on 05/22/25 at 11:00 AM. She stated she did take Resident #16 his tray and noticed the meat was not totally ground up but was in longer strips. She said she cut the turkey into smaller pieces and stated she would have fed him, if she had not been assigned to Resident #36 that day. She did not remember which staff told her to feed Resident #36. While feeding Resident #36, she stated she was not able to see Resident #16's face because his back was to her at the table. She stated she was told previously that Resident #16 was ok to eat on his own, unsupervised in the dining room where he could sit upright but was a full feed assist if he was fed in his room. NA #71 stated she did not remember full feed training before the incident but was trained 2 days afterward. She stated, We are trying so hard to feed all full feed assists. NA #71 said she felt there was not enough staff. During an interview with Activities Leader #71 on 05/22/25 at 10:00AM, she stated she did not feed the residents, and she was not the one who checked Resident #16's tray, but she did check tray tickets to make sure everything was right on the tray and to make sure the residents receive the correct meal according to their meal ticket. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On the day of the incident, after she checked tray tickets, she walked around to check to see if anyone needed her help when she approached Resident #16. She said he was not breathing and was choking on a piece of turkey. She said she saw it hanging out of his mouth. His face and lips were blue. She stated that was when she screamed for help. She stated she had training to check the tickets and check the meal prior to the incident in the dining room and had since been re-trained within two (2) days after the incident. On 05/22/25 at 2:30PM, in an interview with NA #23, she explained one process of full feed assist, that she had helped Resident #16 with eating. She stated she had been in-serviced after the choking incident. The Regional Operations Coordinator (ROC) was interviewed on 5/21/25 at 3:00 PM. She stated there was a meal service system failure as Resident #16 was to have ground meat and was a full feed assist, but the turkey was not completely ground. The ROC said, Resident #16's tray was set up by the NA who cut the meat into smaller pieces, then left him to eat without supervision instead of being fed by a staff member. In an interview with Speech Therapy (ST) on 05/22/25 at approximately 2:00 PM, she stated that Resident #16 had been seen by ST at different times since admission. ST stated Resident #16 had issues with wanting to bolus (a soft , rounded mass of chewed food or liquid that is ready to be swallowed) food and drink and therefore recommended he be a full feed assist.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based upon record review and staff interview, the facility failed to update the Pre admission Screening and Resident Review (PASARR) when the resident was diagnosed with Major Depressive disorder. This was found to be true for one (1) resident of the four (4) reviewed during the annual survey process. Resident identifier #53. Facility census: 53 Findings included: a) Resident #53 Record review revealed Resident #53 had a diagnosis of Major Depression dated 01/28/25. A new PASARR should have been updated with diagnosis of Major depressive disorder following diagnosis received on 01/28/25 Resident #53 had a Care Plan developed on 01/28/25 for major depressive disorder. The PASARR and resident diagnoses were reviewed with the Director of Social Services on 05/20/25 in the afternoon. She agreed the PASARR should have been updated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and staff interview, the facility failed to have a diagnosis of depression for the order of an antidepressant medication. This was true for one (1) of seventeen (17) residents reviewed during this annual survey process. Resident identifier # 258. Facility census: 53 Findings included: a) Resident #258 The medical record revealed the resident had an order for Duloxetine 60 milligrams (1 capsule by mouth at bedtime) for depression. This order was had an active date of 05/08/25. A review of the Medication Administration Record (MAR) revealed the Duloxetine 60 mg had been discontinued on 05/18/25. A review of the care plan revealed the resident used an antidepressant related to depression. This was dated 05/14/25. A pharmacy review revealed that the physician did not want to attempt a gradual dose reduction on the Duloxetine because the resident had recently started the antidepressant. This finding was reviewed with the Regional Operations Manager on 05/20/25 late in the afternoon.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview, the facility was unable to provide evidence that the attending physician reviewed any irregularities identified by the pharmacist and either accepted or rejected the recommendations. This was true for two (2) of five (5) residents reviewed under the Unnecessary Medications pathway in the Long-Term Care Survey Process. Resident identifiers: #30 and #52. Facility census: 53 Findings included: a) Resident #30: On 05/17/25 10:58 AM, during Medication Regimen Review two pharmacist reviews dated 01/24/25 and 02/04/25 were located. The facility could not provide the pharmacist consult report that contained the recommendations they made nor the Physician response to those recommendations. In an interview with the Regional Director of Operations Coordinator (RDOC) on 03/17/2025 at 11:50PM, she stated she was not able to provide the pharmacist recommendations nor the physician response for recommendations dated on 01/20/25, and 02/04/25. b) Resident #52: On 05/19/25 at 12:10PM during review of the Medication Regimen Review for 01/28/25, the facility could not provide the pharmacist consult report nor the physician response to the pharmacist recommendations. On 05/19/25 at approximately 1:35PM the RDOC stated she was unable to provide the physician response and signatures for the pharmacist recommendations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to store food in accordance with professional standards for food service safety. This was a random opportunity for discovery with the ability to affect a multiple number of residents. Facility census: 53. Findings include: a) On 05/13/25 at 9:40AM, during the kitchen initial visit, employee personal items such a purse, keys, and a jacket were observed on a chair in the kitchen pantry room. In an interview with the Corporate District Manager at 9:50AM on 5/13/25, he acknowledged the personal staff items on the chair in the pantry, stating staff had been using this corner for personal items. On 5/14/25 at 3:35PM, during an interview with the Corporate District Manager, he stated personal items were no longer allowed to be stored in the kitchen pantry room.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and staff interviews, the facility failed to ensure disposal of garbage and refuse was properly contained in the kitchen pantry and in dumpsters with lids closed or covered. This was a random opportunity for discovery with the possibility of affecting multiple residents. Facility census: 53. Findings included: a) On 05/13/25 at 9:30 AM, it was observed in the dish room that a trash receptacle lid at the hand washing station was blocked by a box sitting on top. This blocked staff's ability to dry hands without contamination. In an interview with The Corporate District Manager on 05/13/25 at 9:32AM, he acknowledged the box sitting on the top of the trash receptacle was blocking the ability to dry hands without contamination and removed the box stating it should not have been there. On 05/13/25 at approximately 10:35 AM, it was observed that the dumpster lid was left open while not in use. During an interview on 05/13/25 at 10:40 AM, with the Assistant Director of Nursing (ADON), she acknowledged the dumpster lid was not in use but the lid was left open.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based upon record review, staff interview and resident interviews, the facility failed to maintain an accurate medical record. This was found to be true for two (2) of seventeen (17) records reviewed during the annual survey process. Resident identifiers: #50 and #51. Facility census: 53 Findings included: a) Resident #50 A Bed safety evaluation completed on 05/02/25, marked no for floor mats. Resident #50 ' s orders and care plan have one floor mat documented on the right side of bed. A visual observation of the resident's room on 05/22/25 during the morning hours, found a floor mat on the right side of the bed. The floor mat intervention was implemented following a post fall of the resident on 04/28/25, according to the resident's care plan. This was reviewed with the Regional Operations Manager on 05/20/25 in the afternoon, who said she would check into it. b) Resident #51 West Virginia POST form was completed on 02/14/25 for Resident #51. Resident's gender was identified as a Female. MDS screening upon admission, under Section A Demographics, showed the resident was a male. This discrepancy was reviewed with the Director of Social Services on 05/20/25 in the afternoon. The Director of Social Services had no comment to make when the error was pointed out.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, medical record review and staff interviews, the facility failed to maintain an effective infection control program. Failed to complete hand hygiene after removing gloves and did not re-glove when providing care for a resident who was on enhanced barrier precautions (EBP). In addition, ten (10) Personnel Protection Equipment (PPE) Storage Bins were sitting directly on the hallway floor. Three (3) wheelchairs were found with cracked arm rests and could not be sanitized. A Nurse Aide (NA) did not perform hand hygiene prior to feeding a resident. These failed practices had the potential to affect more than a limited number of residents. Resident identifiers: #15, #16, and #30. Facility census: 53. Findings included: a) Resident #15 On 05/19/25 at 11:35 AM, an observation revealed NA's #64 and #24 performed Foley catheter care for Resident #15. Resident #15 was on EBP for the Foley catheter. NA #64 and #24 completed catheter care per policy and then removed gloves. They did not perform hand hygiene nor put on a new set of gloves as they pulled up the pajama bottoms, straightened linens, etc. When asked if they normally take off contaminated gloves and complete their task with no gloves both stated No. Both stated that they were nervous, and both agreed that they change gloves after catheter care and put on new gloves to finish providing care. On 05/19/25 at 2:19 PM a random opportunity for discovery found PPE Storage Bins were sitting directly on the floor outside of resident rooms who were on EBP. There were ten (10) storage boxes throughout the building. An interview with the Regional Operations Coordinator Registered Nurse (ROCRN) #87 on 05/19/25 at approximately 10:00 AM revealed the ROCRN said no when asked if the PPE storage bins were to be sitting on the floor. c) Resident #16 On 5/13/24 at 2:20PM, during an observation of Resident #16's room, it was observed that his wheelchair had cracks around the edges of arm pads exposing inner padding. After leaving Resident #16's room, observation revealed an extra wheel chair sitting at the end of the 100 hallway was discovered to have a small round hole in the seat with exposed padding. An observation of Resident #16s lunch tray delivered at 12:00 PM revealed the Assistant Director of Nursing took Resident # 16s tray to his room and asked for assistance with his positioning. She raised his bed up via buttons and assisted with repositioning him in bed then touched his bedside table to adjust height to accommodate for feeding him. She then began to feed him without changing her gloves nor washing her hands. On 05/13/25 at 12:10PM, during an interview with the ADON regarding hand hygiene, she acknowledged she did not wash her hands and change her gloves between adjusting the bedside table and bed height and positioning the resident before feeding him. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d) Resident #30 During an observation of Resident # 30's room on 5/19/25 at 12:20 PM, it was observed that his wheelchair had a crack in the top of the chair back with exposed inner padding. In an interview with the ADON on 5/13/25 at 2:30PM, she acknowledged Resident #16's w/chair and stated it needed to be removed. She also acknowledged the hole in the cushion on the wheelchair in the hall and stated it was just an extra chair but did agree that it would be used for a resident when/if needed. On 5/19/25 at 12:30 PM, During an interview with The Regional Operations Coordinator. She acknowledged the crack in the top of the chair back on Resident # 30's wheelchair and stated it would be taken care of.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to ensure the call system was accessible to residents while in their bed or other sleeping accommodations within the resident's room. This was a random opportunity for discovery. Resident identifier: #19. Facility census: 53. Findings include: a) Resident #19 During facility entrance on 05/13/25 at 2:03 PM, an observation in room [ROOM NUMBER] revealed Resident #19 was sitting up on the side of her bed. She asked for assistance to find her call button. She stated she needed to get some help for her roommate. Upon checking around, the call button was found on the floor under the bed and out of the resident's reach. On 05/13/25 at 2:13PM, in an interview with CNA #24 she acknowledged the call button was not within reach of the resident and stated that sometimes residents knock them off the bed. She then placed the call button back on the bed without securing it. On 5/13/25 at 2:30PM during an interview with the DON, she acknowledged she had been made aware of the call light not being within Resident #19's reach.