STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515146	A. Building B. Wing	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marmet Center	One Sutphin Drive Marmet, WV 25315

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on observation and staff interview, the facility failed to provide a safe, clean, and homelike environment for Room #D32 which had trash and food laying on the floor, Room #D37 was noted with two (2) dirty and stained nightstands and a soiled blanket with a dry, brown substance on the bed in room [ROOM NUMBER]. The facility's sit to stand lifts were also observed dirty. These were random opportunities of discovery. Facility census: 83. Findings included: a) Room #D32 On 12/19/23 at 9:20 AM, an observation was made in Room #D32. The observation found trash and food lying on the floor under the beds and in the entire room. On 12/19/23 at 9:22 AM, Registered Nurse (RN) #20 stated, We will get this cleaned up right away. On 12/19/23 at 9:50 AM, the Director of Nursing (DON) was notified of the findings. The DON stated, We will get this taken care of right away. b) Room #D37 On 12/19/23 at 9:27 AM, an observation was made in Room D37. The observation found two (2) nightstands which were dirty and stained. On 12/19/23 at 9:30 AM, Licensed Practical Nurse (LPN) #13 was notified and confirmed the nightstands were dirty and stained. On 12/19/23 at 9:50 AM, the Director of Nursing (DON) was notified of the findings. The DON stated, we will get this taken care of right away. c) Room #D40 On 12/19/23 at 9:40 AM, an observation was made in Room #D40. The observation found a soiled blanket with a dry, brown substance on the bed covering the resident. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Marmet Center	One Sutphin Drive Marmet, WV 25315

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/27 at 9:35 AM, Licensed Practical Nurse (LPN) #13 confirmed the blanket was soiled with a dry, brown substance. LPN# 13 stated, I'll get her a clean blanket. On 12/19/23 at 9:50 AM, the DON was notified and stated, The resident should always have clean linen. No further information was obtained during the survey process. d) Sit to Stand Lifts On 12/19/2023 at 9:40 AM three (3) of the facility sit-to-stand lifts were observed to be soiled with dirt and debris on the platform where residents would place their feet when being assisted to stand. During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), the NHA stated she believed it was the responsibility of the nursing staff or housekeeping to clean the units. She further stated that she thought it was a weekly schedule to clean them and or when needed. The DON agreed at this time. On 12/19/2023 at 10:15 AM, the DON provided their Infection Control Policies and Procedures. The intent of these policies and procedures were to prevent infectious spread from items or environment to patients and/staff. They were also to ensure reusable medical equipment was cleaned and disinfected properly. The policy further denotes in the practice standards under 5.3, multi-function equipment must be cleaned/ disinfected between residents. 5.4 states if an item will be stored after cleaning, bag and/or label to indicate ready for next use. 49650

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49751 Based on record review, observation and staff interview the facility failed to implement care plans for one (1) of three (3) Residents whose care plans were reviewed during the long-term care complaint survey process. Resident # 2's care plan was not implemented for placing a radio in closer reach on the left side. Resident identifier: #2. Facility census: 83. Findings included: a) Resident #2 A review of resident #2's care plan found the current care plan, updated on 10/22/23 read as follows: Potential at risk for falls and actual falls: cognitive loss, lack of safety awareness, impaired mobility, history of falls The goal read as follows: Residents will have no falls with major injury requiring hospitalization through the next review. On 12/18/23 at 11:56 AM, an observation found Resident #2 sleeping in his room no radio was found in room within reach on left side of bed. On 12/19/23 at 10:30 AM, the Director of Nursing was interviewed and asked where the radio was that is care planned to be placed close on the left side of the bed. She stated, the family had taken it home.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31826 Based on record review and staff interview the facility failed to administer medications within the physician ordered time frames. Resident # 2, Resident # 27 and Resident #46 had medications administered late on multiple occasions during the month of 12/2023. This was true for three (3) of three (3) residents reviewed for medication administration during a complaint survey. Resident Identifiers: #2, #27, and #46. Facility Census: 83. Findings Included: a) Resident #27 A review of Resident #27's medication administration audit report for the month of 12/2023 found on the following occasions Resident #27 medication was administered more than one (1) and one (1) half hour past the scheduled time of administration: -- Insulin Sliding Scale was scheduled for 11:30 am on 12/03/23 and was not administered until 4:32 PM this was five (5) hours and two (2) minutes late. -- cyanocobalamin tablet was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Duloxetine HCl oral capsule was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Diltiazem HCl ER Beads was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Torsemide Oral Tablet was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Isosorbide Mononitrate was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Protonix Oral Tablet was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Warfarin Sodium was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Neurontin was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Calcitriol was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- Neuriva Plus was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Clonidine HCl was scheduled to be administered at 10:00 AM on 12/06/23 and was not administered until 12:08 PM which was two (2) hours and eight (8) minutes late. -- Warfarin Sodium was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:40 AM which was one (1) hour and 40 minutes late. -- Protonix Oral Tablet was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:43 AM which was one (1) hour and 43 minutes late. -- Isosorbide Tablet was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:43 AM which was one (1) hour and 43 minutes late. -- Clonidine was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:42 AM which was one (1) hour and 42 minutes late. -- Neuriva was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:43 AM which was one (1) hour and 43 minutes late. -- Calcitriol was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:41 AM which was one (1) hour and 41 minutes late. -- Torsemide was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:44 AM which was one (1) hour and 44 minutes late. -- Diltiazem was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:42 AM which was one (1) hour and 42 minutes late. -- Duloxetine was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:43 AM which was one (1) hour and 43 minutes late. -- Cyanocobalamin was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:42 AM which was one (1) hour and 42 minutes late. -- Gabapentin was scheduled to be administered at 10:00 AM on 12/08/23 and was not administered until 11:41 AM which was one (1) hour and 41 minutes late. An interview with the Director of Nursing at approximately 1:30 PM on 12/19/23 confirmed the above findings. She stated, I just got two (2) new med carts and I am hiring some more nurses to break up the med pass. b) Resident #2 On 12/19/23 at 1:00 PM, a record review of the Medication Administration Audit Report from 12/01/23 through 12/18/23 was completed for Resident #2. The review found the following medications were administered late and the physician's orders were not followed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's orders dated for 12/01/23 at 10:00 PM were not administered as ordered. --Brimonidine Tartrate 0.15% was administered at 12:44 AM which is 2 hours and 44 minutes late --Melatonin 5mg was administered at 12:44 AM which is 2 hours and 44 minutes late --Tylenol 650mg was administered at 12:44 AM which is 2 hours and 44 minutes late --Levoxyl 50mcg was administered at 12:44 AM which is 2 hours and 44 minutes late --Symbicort 160-4.5mcg was administered at 12:44 AM which is 2 hours and 44 minutes late --Valporic Acid 500mg was administered at 12:44 AM which is 2 hours and 44 minutes late --Docusate Sodium 100mg was administered at 12:44 AM which is 2 hours and 44 minutes late --Latanoprost Solution 0.005% was administered at 12:44 AM which is 2 hours and 44 minutes late --Cosopt Opthlamic Solution 2-0.5% was administered at 12:44 AM which is 2 hours and 44 minutes late The physician's orders dated for 12/02/23 at 9:00 PM were not administered as ordered. --Rhopressa Opthalmic Solution 0.02% was administered at 12:32 AM which is 3 hours and 32 minutes late --Eliquis 5mg was administered at 12:32 AM which is 3 hours and 32 minutes late --Buspar 5mg was administered at 12:32 AM which is 3 hours and 32 minutes late The physician's orders dated for 12/02/23 at 10:00 PM were not administered as ordered. --Brimonidine Tartrate 0.15% was administered at 12:32 AM which is 2 hours and 32 minutes late --Melatonin 5mg was administered at 12:32 AM which is 2 hours and 32 minutes late --Tylenol 650mg was administered at 12:32 AM which is 2 hours and 32 minutes late --Levoxyl 50mcg was administered at 12:32 AM which is 2 hours and 32 minutes late --Symbicort 160-4.5mcg was administered at 12:32 AM which is 2 hours and 32 minutes late --Valporic Acid 500mg was administered at 12:32 AM which is 2 hours and 32 minutes late --Docusate Sodium 100mg was administered at 12:32 AM which is 2 hours and 32 minutes late --Latanoprost Solution 0.005% was administered at 12:32 AM which is 2 hours and 32 minutes late (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Cosopt Opthlamic Solution 2-0.5% was administered at 12:32 AM which is 2 hours and 32 minutes late The physician's orders dated for 12/03/23 at 9:00 PM were not administered as ordered. --Rhopressa Opthalmic Solution 0.02% was administered at 12:32 AM which is 3 hours and 32 minutes late --Eliquis 5mg was administered at 12:32 AM which is 3 hours and 32 minutes late --Buspar 5mg was administered at 12:32 AM which is 3 hours and 32 minutes late The physician's orders dated for 12/03/23 at 10:00 PM were not administered as ordered. --Brimonidine Tartrate 0.15% was administered at 12:32 AM which is 2 hours and 32 minutes late --Melatonin 5mg was administered at 12:32 AM which is 2 hours and 32 minutes late --Tylenol 650mg was administered at 12:32 AM which is 2 hours and 32 minutes late --Levoxyl 50mcg was administered at 12:32 AM which is 2 hours and 32 minutes late --Symbicort 160-4.5mcg was administered at 12:32 AM which is 2 hours and 32 minutes late --Valporic Acid 500mg was administered at 12:32 AM which is 2 hours and 32 minutes late --Docusate Sodium 100mg was administered at 12:32 AM which is 2 hours and 32 minutes late --Latanoprost Solution 0.005% was administered at 12:32 AM which is 2 hours and 32 minutes late --Cosopt Opthlamic Solution 2-0.5% was administered at 12:32 AM which is 2 hours and 32 minutes late The physician's orders dated for 12/04/23 at 9:00 PM were not administered as ordered. --Rhopressa Opthalmic Solution 0.02% was administered at 12:48 AM which is 3 hours and 48 minutes late --Eliquis 5mg was administered at 12:48 AM which is 3 hours and 48 minutes late --Buspar 5mg was administered at 12:48 AM which is 3 hours and 48 minutes late The physician's orders dated for 12/05/23 at 9:00 PM were not administered as ordered. --Rhopressa Opthalmic Solution 0.02% was administered at 12:51 AM which is 3 hours and 51 minutes late --Eliquis 5mg was administered at 12:51 AM which is 3 hours and 51 minutes late (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Buspar 5mg was administered at 12:51 AM which is 3 hours and 51 minutes late The physician's orders dated for 12/06/23 at 9:00 PM were not administered as ordered. --Rhopressa Opthalmic Solution 0.02% was administered at 11:37 PM which is 2 hours and 37 minutes late --Eliquis 5mg was administered at 11:37 PM which is 2 hours and 37 minutes late --Buspar 5mg was administered at 11:37 PM which is 2 hours and 37 minutes late The physician's orders dated for 12/06/23 at 10:00 PM were not administered as ordered. --Guaifenesin ER 600mg was administered at 11:37 PM which is 1 hour and 37 minutes late --Doxycycline 100mg was administered at 11:37 PM which is 1 hour and 37 minutes late --Brimonidine Tartrate 0.15% was administered at 11:37 PM which is 1 hour and 37 minutes late --Melatonin 5mg was administered at 11:37 PM which is 1 hour and 37 minutes late --Tylenol 650mg was administered at 11:37 PM which is 1 hour and 37 minutes late --Levoxyl 50mcg was administered at 11:37 PM which is 1 hour and 37 minutes late --Symbicort 160-4.5mcg was administered at 11:37 PM which is 1 hour and 37 minutes late --Valporic Acid 500mg was administered at 11:37 PM which is 1 hour and 37 minutes late --Docusate Sodium 100mg was administered at 11:37 PM which is 1 hour and 37 minutes late --Latanoprost Solution 0.005% was administered at 11:37 PM which is 1 hour and 37 minutes late --Cosopt Opthlamic Solution 2-0.5% was administered at 11:37 PM which is 1 hour and 37 minutes late The physician's orders dated for 12/08/23 at 9:00 AM were not administered as ordered --Buspar 5mg was administered at 12:27 PM which is 3 hours and 27 minutes late --Eliquis 5mg was administered at 12:27 PM which is 3 hours and 27 minutes late The physician's orders dated for 12/08/23 at 10:00 AM were not administered as ordered. --Symbicort 160-4.5mcg was administered at 12:27 PM which is 2 hours and 27 minutes late --GlycoLax 17 grams was administered at 12:27 PM which is 2 hours and 27 minutes late --Amiodarone 200mg was administered at 12:27 PM which is 2 hours and 27 minutes late (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Docusate Sodium 100mg was administered at 12:27 PM which is 2 hours and 27 minutes late --Valporic Acid 500mg was administered at 12:27 PM which is 2 hours and 27 minutes late --Cosopt Opthlamic Solution 2-0.5% was administered at 12:27 PM which is 2 hours and 27 minutes late --Brimonidine Tartrate Solution 0.15% was administered at 12:27 PM which is 2 hours and 27 minutes late --Doxycycline 100mg was administered at 12:27 PM which is 2 hours and 27 minutes late --Lexapro 5mg was administered at 12:27 PM which is 2 hours and 27 minutes late --Abilify 20mg was administered at 12:27 PM which is 2 hours and 27 minutes late The physician's orders dated for 12/09/23 at 9:00 PM were not administered as ordered. --Rhopressa Opthalmic Solution 0.02% was administered at 10:54 PM which is 1 hour and 54 minutes late --Eliquis 5mg was administered at 10:54 PM which is 1 hour and 54 minutes late --Buspar 5mg was administered at 10:54 PM which is 1 hour and 54 minutes late The physician's orders dated for 12/10/23 at 2:00 PM were not administered as ordered. --Tylenol 650mg was administered at 4:58 PM which is 2 hours and 58 minutes late --Lasix 20mg was administered at 4:58 PM which is 2 hours and 58 minutes late The physician's orders dated for 12/11/23 at 2:00 PM were not administered as ordered. --Tylenol 650mg was administered at 3:51 PM which is 1 hour and 51 minutes late --Lasix 20mg was administered at 3:51 PM which is 1 hour and 51 minutes late The physician's order dated for 12/12/23 at 9:00 PM was not administered as ordered. --Rhopressa Opthalmic Solution 0.02% was administered at 10:41 PM which is 1 hour and 41 minutes late The physician's orders dated for 12/14/23 at 9:00 AM were not administered as ordered. --Buspar 5mg was administered at 11:09 AM which is 2 hours and 9 minutes late --Eliquis 5mg was administered at 11:10 AM which is 2 hours and 10 miniutes late (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's orders dated for 12/16/23 at 10:00 PM were not administered as ordered. --Levoxyl 50mcg was administered at 2:33 AM which is 4 hours and 33 minutes late --Symbicort 160-4.5mcg was administered at 2:33 AM which is 4 hours and 33 minutes late --Melatonin 5mg was administered at 2:33 AM which is 4 hours and 33 minutes late --Valporic Acid 500mg was administered at 2:33 AM which is 4 hours and 33 minutes late --Latanoprost Solution 0.005% was administered at 2:33 AM which is 4 hours and 33 minutes late --Cosopt Opthalmic Solution 2-0.5% was administered at 2:33 AM which is 4 hours and 33 minutes late The physician's orders dated for 12/18/23 at 9:00 PM were not administered as ordered. --Eliquis 5mg was administered at 10:56 PM which is 1 hour and 56 minutes late --Buspar 5mg was administered at 10:56 PM which is 1 hour and 56 minutes late --Rhopressa Opthalmic Solution 0.02% was administered at 10:57 PM which is 1 hour and 57 minutes late On 12/19/23 at 1:30 PM, the Director of Nursing (DON) was notified and confirmed the physician's orders were not followed as written. C) Resident #46 The physician's orders dated for 12/01/23 at 8:00 AM were not given as ordered: --Buspirone HCL 5mg given at 10:16am which is 2 hours and 16 minutes late --Insulin Detemir 100 unit/mil given at 10:16am which is 2 hours and 16 minutes late The physician ' s orders dated for 12/03/23 at 6:00pm were not given as ordered: --Hydrocodone-Acetaminophen 5-325MG was given at 8:04 which is 2 hours and 4 minutes late The physician ordered dated 12/08/23 at 12:00 PM were not given as ordered: --Hydralazine HCL 50 MG was given at 2:50 OM which is 2 hours 50 minutes late The physician ' s orders dated for 12/16/23 at 12:00 PM were not given as ordered: --Hydralazine HCL 50 MG was given at 2:28 PM which is 2 hours and 28 minutes late The physician ' s orders dated for 12/01/23 at 8:00 PM were not given as ordered: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Gabapentin 400mg was given at 10:20pm which is 2 hours and 20 minutes late --Hydralazine HCL 50 MG was given at 10:20 PM which is 2 hours and 20 minutes late --Warfarin Sodium 4 MG was given at 10;20 PM which is 2 hours and 20 minutes late --Furosemide 40 MG was given at 10:19pm which is 2 hours and 19 minutes late --Melatonin 5 MG was given at 10:20PM which is 2 hours and 20 minutes late --Zoloft 100 MG was given at 10:20 PM which is 2 hours and 20 minutes late --Calvitriol 0.25 was given at !0:29 PM which is 2 hours and 29 minutes late --FiberCon 625 MG was given at 10:29 PM which is 2 hours and 29 minutes late The physician ' s orders dated 12/02/23 at 8:00 PM were not given as ordered: --Zoloft 100 MG was given at 4:07 AM which us 8 hours and 7 minutes late --Melatonin 5 MG was given at 4:07 AM which us 8 hours and 7 minutes late --FiberCon 625 MG was given at 4:07 AM which us 8 hours and 7 minutes late --Hydralazine 50 MG was given at 4:07 AM which us 8 hours and 7 minutes late --Calcitriol 0.25 MG was given at 4:07 AM which us 8 hours and 7 minutes late --Furosemide 40 MG was given at 4:07 AM which us 8 hours and 7 minutes late --Warfarin Sodium 4 MG was given at 4:07 AM which us 8 hours and 7 minutes late --Gabapentin 400 MG was given at 4:07 AM which us 8 hours and 7 minutes late --Insulin Detemir 100 UNIT/ML was given at 4:07 AM which us 8 hours and 7 minutes late --Norco 5-325 MG was given at 4:07 AM which us 8 hours and 7 minutes late The physician's orders dated 12/16/23 at 8:00 PM were not given as ordered: --Gabapentin 400 MG was given at 10:05 pm which is 2 hours and 5 minutes late. --Insulin Detemir 100 UNIT/ML was given at 10:05 pm which is 2 hours and 5 minutes late. --Hydralazine 50 MG was given at 10:05 pm which is 2 hours and 5 minutes late. --FiberCon 625 MG was given at 10:05 pm which is 2 hours and 5 minutes late. (continued on next page)

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	515146	A. Building B. Wing	12/19/2023

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Furosemide 40 MG was given at 10:05 pm which is 2 hours and 5 minutes late. --Warfarin Sodium 4 MG was given at 10:06 pm which is 2 hours and 6 minutes late. --Calcitriol 0.25 MG was given at 10:05 pm which is 2 hours and 5 minutes late. --Melatonin 5 MG was given at 10:06 pm which is 2 hours and 6 minutes late. On 12/19/23 at 1:00 PM, the Director of Nursing (DON) was notified and confirmed the medication was not administered as ordered. 45173 49751

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515146	A. Building B. Wing	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marmet Center	One Sutphin Drive Marmet, WV 25315

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45173 Based on observation, resident interview and staff interview, the facility failed to ensure respiratory care was provided according to professional standards of practice. These were random opportunities of discovery. Resident Identifier: #2, #76, #28 and #1. Facility Census: 83. Findings Included: a) Resident #2 On 12/19/23 at 9:24 AM, an observation was made of Resident #2's nebulizer mask laying on the nightstand without being in a respiratory bag. On 12/19/23 at 9:25 AM, Licensed Practical Nurse (LPN) #13 was notified and confirmed the nebulizer mask was not stored correctly. LPN #13 stated, I will get a respiratory bag. On 12/19/23 at 10:00 AM, the Director of Nursing (DON) and the Administrator were notified and confirmed the nebulizer mask should have been placed in a respiratory bag. b) Resident #76 On 12/19/23 at 9:24 AM, an observation was made of Resident #2's nebulizer mask laying on the nightstand without being in a respiratory bag. On 12/19/23 at 9:25 AM, Licensed Practical Nurse (LPN) #13 was notified and confirmed the nebulizer mask was not stored correctly. LPN #13 stated, I will get a respiratory bag. On 12/19/23 at 10:00 AM, the Director of Nursing (DON) and the Administrator were notified and confirmed the nebulizer mask should have been placed in a respiratory bag. c) Resident #28 On 12/19/23 at 9:30 AM, an observation was made of Resident #28's nasal cannula laying directly on the floor. On 12/19/23 at 9:35 AM, LPN #13 was notified and confirmed the nasal cannula should not be laying directly on the floor. LPN #13 stated, I'll go get a new cannula. On 12/19/23 at 10:00 AM, the DON and the Administrator were notified and confirmed the nasal cannula should not be laying in the floor. d) Resident #1 On 12/19/23 at 9:53 AM, an observation was made of Resident #1's nebulizer mask laying on the night stand without being in a respiratory mask. (continued on next page)

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Marmet Center	One Sutphin Drive Marmet, WV 25315

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/23 at 9:54 AM, Registered Nurse (RN) #47 was notified and confirmed the nebulizer mask was not stored correctly. RN #47 stated, I will get this taken care of. On 12/19/23 at 10:00 AM, the DON and the Administrator were notified and confirmed the nebulizer mask should have been placed in a respiratory bag. No further information was obtained during the survey process.

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	515146	A. Building B. Wing	12/19/2023

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 31826 . Based on observation, record review and staff interview the facility failed to establish a system that determines drug records are in order and an account of all controlled drugs is maintained and periodically reconciled. The facility had controlled substances that had been removed from the medication card and was then taped back into the medication card on two separate medication carts. Also for Resident # 27 his tramadol, a controlled substance was signed out on the Controlled Substance log but was not documented as given on the Medication Administration Record (MAR). These failed practices have the potential to affect more than a limited number of residents. Resident Identifier: #27, #36 and # 75. Facility Census: 83. Findings Included: a) Medication cart for the A hall and D hall. An observation of the medication cart utilized for the A and D hall of the facility with Licensed Practical Nurse (LPN) # 13 on 12/19/23 at 10:41 am, found Resident # 36 had four (4) lorazepam .5 milligram tablets left in her medication card. As LPN #13 pulled it out of the controlled substance out of the locked compartment on the medication cart she stated, Oh one of these has been taped back in. I did not do that. Observation of the card found one (1) of the four (4) remaining pills had been removed from the card and a pill had been replaced and a piece of tape was placed over the back of the card to keep the pill in place. LPN #13 took the medication and the controlled substance log to the Director of Nursing and advised her what had happened. The DON stated, We need to waste that pill. That's what she should have done to start with. b) Medication Cart on Mary's Garden An observation of the medication cart utilized for Mary's Garden with LPN #1 on 12/19/23 at 10:50 am found, Resident #75 had 25 clonazepam .5 (milligram) mg tablets left in his medication card. When LPN #1 removed the card from the controlled substance compartment on the medication cart to show the surveyor she said, Oh there is one taped in. Pill number eight (8) had been removed from the card and a pill had been placed back in the card and a piece of tape had been placed on the medication card to keep it in place. LPN #1 stated, I did not notice that before, I did not do that, LPN #1 took the card to the DON who stated they would waste the pill. The DON was asked if it was an acceptable practice to tape a pill in a controlled substances medication card. She confirmed it was not an acceptable standard of practice and should not be done. c) Resident #27 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #27's medical record on 12/19/23 at 12:00 PM found a physician order for tramadol 50 milligram (MG) give one tablet by mouth every 12 hours as needed for pain. A review of the controlled substance log for the tramadol found on the following dates and times Resident #27 had a tramadol signed out on the controlled substance log but it was not documented as administered on the medication administration record: -- 12/09/23 at 10:00 am, -- 12/14/23 at 12:00 am, and -- 12/19/23 at 10:18 am. An interview with the Director of Nursing (DON) at approximately 1:30 PM on 12/19/23 confirmed the above findings. She indicated, I saw that, and I am working on a plan to correct it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45173 Based on observation, resident interview and staff interview, the facility failed to maintain appropriate infection control standards for the disposal of soiled linens in Rooms #D38 and #D32, the storage of a wash basin in Room #C26, the storage of a urinal in Room #C25, and in Room #D31 the storage of a used bed pan. These were random opportunities for discovery. Facility Census: 83. Findings Included: a) Room D38 On 09/19/23 at 9:30 AM, an observation was made of soiled linen in Room #D38 which was in two (2) clear plastic bags left open and untied sitting in floor of the room by the bathroom. Resident #76 stated, Those are from when they cleaned us up. On 09/19/23 at 9:35 AM, Licensed Practical Nurse (LPN) #13 was notified and confirmed the soiled linen bags should have been tied up and removed from the room. On 09/19/23 at 10:15 AM, the Director of Nursing (DON) was notified and confirmed the soiled linen bags should have been tied up and removed from the room. The DON stated, they know better than this .we will get it cleaned up. b) Room D32 On 09/19/23 at 9:45 AM, an observation was made of soiled linen in Room D32 which was in two (2) plastic bags sitting on the floor of the room by the door. On 09/19/23 at 9:50 AM, LPN #13 was notified and confirmed the soiled linen bags should have been removed from the room. On 09/19/23 at 10:15 AM, the Director of Nursing (DON) was notified and confirmed the soiled linen bags should have been tied up and removed from the room. The DON stated, they know better than this .we will get it cleaned up. c) Room C26 On 09/19/23 at 9:53 AM, a tour of Room C26 was completed. During the tour, a used wash basin was laying on the floor behind the commode in the bathroom. On 09/19/23 at 9:55 AM, Registered Nurse (RN) #47 was notified and removed the used wash basin from the bathroom. On 09/19/23 at 10:15 AM, the Director of Nursing (DON) was notified and confirmed the wash basin was not stored properly. The DON stated, we will get this taken care of. d) Room C25 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/23 at 9:58 AM, a tour of Room #C25 was completed. During the tour, a dirty urinal with a dried brown substance was hanging on the safety rail in the bathroom. On 09/19/23 at 10:01 AM, RN #47 was notified and removed the dirty urinal from the bathroom. On 09/19/23 at 10:15 AM, the Director of Nursing (DON) was notified and confirmed the dirty urinal should have been disposed of. The DON stated, The resident was sent to the hospital with blood in his urine .that's what the dried brown substance is. e) Room #D31 On 09/19/23 at 10:23 AM, a tour of Room #D31 was completed. An observation of a used bed pan laying in the floor behind the commode was made. On 09/19/23 at 10:25 AM, RN #20 was notified and confirmed the bed pan was not stored correctly. RN #20 stated, We will get this cleaned up right away. On 09/19/23 at 10:30 AM, the DON and Administrator were notified and confirmed the bed pan was not stored correctly and would be removed right away. 49751