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	12/18/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 45171 Based on record review and staff interview the facility failed to ensure a resident's Preadmission Screening and Resident Review (PASARR) reflected the pre admission diagnoses sheet for schizophrenia and anxiety disorder, This was true for one (1) of three (3) PASRR's reviewed. Resident identifier: #37. Facility Census: #89. Findings include: a) Resident #37 On 12/16/24 at 9:10 AM record review of the PASARR for Resident #37 showed a preadmission diagnosis of schizophrenia and anxiety disorder. Review of the PASRR provided by the facility which was submitted on 04/02/19, when the resident was transferred from another facility, did not have a preadmission diagoses of schizophrenia or anxiety disorder. Resident #37 had the following active orders: Ativan Oral Tablet 0.5 milligram (MG) (Lorazepam) Give 1 tablet by mouth at bedtime for Anxiety/agitation As evidenced by (AEB): pulling out PEG tube RisperiDONE Oral Solution (Risperidone) Give 0.125 mg via G-Tube at bedtime for schizophrenia AEB: poor impulse control On 12/16/24 at 2:10 PM, during an interview with Social Worker #98, she confirmed the missing diagnosis on the PASRR and stated it definitely should have been re-submitted. She attempted to locate an up to date PASRR but could not produce the document.

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

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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 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. 39043 Based on record review and staff interview, the facility failed to develop a comprehensive care plan in the area of anticoagulant medication for one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifier: #34. Facility census: 89. Findings included: a) Resident #34 Review of Resident #34's physician's orders showed the resident had been receiving the anticoagulation medication apixaban (Eliquis) for atrial fibrillation since 07/19/24. Bleeding is a side effect of anticoagulation medication. Residents receiving anticoagulation medication must be monitored for signs and symptoms of bleeding such as bloody stool or urine, nosebleeds, bruising, or changes in mental status or vital signs. Review of Resident #34's comprehensive care plan showed the care plan did not have a focus related to anticoagulation medication with interventions to monitor for signs and symptoms of bleeding. On 12/17/24 at 1:43 PM, the Clinical Resource Nurse confirmed Resident #34 had not been care planned for the use of anticoagulant medication.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 39043 Based on resident interview, family interview, record review, and staff interview, the facility failed to provide oral care to a dependent resident. This deficient practice had the potential to affect one (1) of four (4) residents reviewed for the care area of activities of daily living. Resident identifier: #69. Facility census: 89. Findings included: a) Resident #69 During an interview on 12/15/24 at 3:29 PM, Resident #69 stated she is not getting her teeth brushed twice a day per her wishes. She stated her teeth had not been brushed last night or this morning. The resident's family member was in the room for the interview and stated oral care was addressed at a recent care plan meeting but still was not being done twice a day. A grievance and concern form had been completed on 12/10/24. The form stated, Resident stated teeth not getting brushed at times. The recommended corrective action was for the activities director to ensure each morning that teeth were getting brushed and for the Director of Nursing to spot check this. A note written on the grievance/concern form stated, NHA [nursing home administrator] spoke to resident on 12/16/24. Resident stated [activities director] has come down to her room to ensure this is getting complete. Resident said night shift has also been brushing her teeth. NHA confirmed with resident this morning. CNA [certified nursing assistant] brushed her teeth and was satisfied. Will continue to monitor. Review of Resident #69's comprehensive care plan showed the following focus: Resident exhibits or is at risk for oral health or dental care problems as evidenced by potential carious teeth. An intervention initiated 06/20/23 was to Encourage resident to brush teeth and gums with verbal cues as needed by staff. Provide assistance as needed. The resident's care plan also indicated the resident required assistance with activities of daily living due to limited mobility and was dependent for transfer to her wheelchair. Resident #69's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 11/25/24 showed the resident's Brief Interview for Mental Score (BIMS) score was 10, indicating mild cognitive impairment. The resident did not have capacity to make her own medical decisions. Review of Resident #69's medical records showed a nurse aide task report for mouth care every morning and at bedtime. The task report gave the following documentation for oral care for December 2024: - 12/01/24: no documentation that oral care was performed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/02/24: documentation at 11:46 AM that the resident performed oral care; no documentation in the evening that oral care was performed. - 12/03/24: documentation at 12:37 PM that oral care was not applicable; no documentation in the evening that oral care was performed. - 12/04/24: documentation at 2:59 PM that the resident performed oral care; no documentation in the evening that oral care was performed. - 12/05/24: documentation at 2:59 PM that oral care was not applicable; no documentation in the evening that oral care was performed. - 12/06/24: documentation at 9:55 AM that the resident performed oral care; no documentation in the evening that oral care was performed. - 12/07/24: documentation at 1:38 PM that the resident performed oral care; no documentation in the evening that oral care was performed. - 12/08/24: documentation at 10:07 AM that the resident performed oral care; no documentation in the evening that oral care was performed. - 12/09/24: documentation at 11:52 AM that the resident performed oral care; no documentation in the evening that oral care was performed and documentation at 10:49 PM that the staff performed oral care for the resident. - 12/10/24: documentation at 2:59 PM that the resident performed oral care; no documentation in the evening that oral care was performed. - 12/11/24: documentation at 11:59 AM that staff performed oral care for the resident; no documentation in the evening that oral care was performed. - 12/12/24: no documentation that oral care was performed that day. - 12/13/24: no documentation that oral care was performed that day. - 12/14/24: no documentation that oral care was performed that day. - 12/15/24: documentation at 2:59 PM that the resident performed oral care; no documentation in the evening that oral care was performed. - 12/16/24: no documentation that oral care was performed that day. - 12/17/24: documentation at 12:07 PM that the resident performed oral care; no documentation in the evening that oral care was performed. On 12/18/24 at 11:23 AM, the Administrator confirmed the nurse aid task report did not document twice daily mouth care was being performed for Resident #69.

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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. 45171 Based on record review and staff interview the facility failed to follow physician's orders to obtain weights on a weekly basis and to apply a hand splint. This was true for two (2) of twenty six (26) residents reviewed in the survey sample. Resident identifier #6, #58. Facility Census: #89. a) Resident #6 On 12/17/24 at 10:02 AM record review shows a Physician's order dated 12/10/24 for weekly weights X's four (4) weeks due to weight loss. Review of the documented weights show the facility did not get a weight until 12/16/24. On 12/18/24 at 10:02 AM it was confirmed with the Director of Nursing and the Clinical Resource Nurse #96, who agreed that the weight should have been obtained on 12/10/24 or 12/11/24, depending on the time the order was placed. b) Resident #58 On 12/15/24 at 12:53 PM during an interview with Resident #58 it was observed that her right hand was severely contracted. There was no splint in place. On 12/16/24 at 12:45 PM record review showe Resident #58 had a medical diagnosis of contractures to the right hand and a Physician's order for resting hand splint to right hand when out of bed for four (4) hours daily. Monitor for redness, licensed nurse to assure skin integrity prior to apply and after removal every day shift. On 12/16/24 at 1:00 PM review of the November and December 2024 Treatment Administration Record (TAR) shows the following dates the splint was not applied: 11/03/24 11/06/24 11/08/24 11/13/24 11/20/24 11/22/24 11/28/24 12/01/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/06/24 12/11/24 12/14/24 12/15/24 During an interview with the resident on 12/18/24 at 11:56 AM, she states it is over there (pointing to the bedside table) but they do not put it on me. Observation of Resident #58 on the following dates and times found the resident did not have a splint on her right hand. Observations: 12/15/24 12:53 PM no splint on. 12/15/24 03:53 PM no splint on 12/16/24 09:10 AM no splint on 12/16/24 11:30 AM no splint on 12/16/24 02:20 PM no splint on 12/17/24 09:10 AM no splint on 12/17/24 02:15 PM no splint on 12/18/24 09:25 AM no splint on 12/18/24 11:56 AM no splint on On 12/18/24 at 12:10 PM the above findings were confirmed with the Director of Nursing and the Clinical Resource Nurse #96 who agreed the resident should have her splint on at least 4 (four) hours a day.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45171 Based on observation and staff interview, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible when a medication cart was left unlocked and unattended and razors were found at the bedside. This was a random opportunity for discovery. This deficient practice had the potential to affect more than a limited number of residents. Resident identifiers: #69 and Facility. Facility Census: #89 Findings include: a) Medication carts On 12/16/24 at 7:55 AM upon arriving on the C-hall it was observed that the medication cart parked between Rooms #C-24 and #C-26 was unlocked and unattended. Licensed Practical Nurse (LPN) #26 came out of Room #C-22 which she had been in with the door closed.This was confirmed with LPN #26 at this time. At 8:01 AM LPN #26 retrieved medications for the resident in #C-26 and went into the room, leaving the medication cart unattended and did not lock the medication cart. On 12/16/24 8:30 AM it was confirmed with the Director of Nursing who confirmed the medication carts should remain locked when unattended. b) Resident #69 On 12/17/24 at 10:22 AM, Resident #69's resident representative reported to the surveyo that the resident had razors in her bedside table. On 12/17/24 at 10:25 AM, the Director of Nursing (DON) accompanied the surveyor into Resident #69's room and found two (2) razors in the resident's bedside table. The DON stated razors were not to be kept in residents' rooms unless they are in locked boxes for residents who are safe to use razors by themselves. She agreed other residents could have access to the razors in Resident #69's bedside table. She removed the razors from the resident's room and stated she would speak with the resident. Resident #69's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 11/25/24 showed the resident's Brief Interview for Mental Score (BIMS) score was 10, indicating mild cognitive impairment. The resident did not have capacity to make her own medical decisions. The resident was independent for eating and was not on an anticoagulant medication. No further information was provided through the completion of the survey process.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49465 Based on record review and staff interview the facility failed to ensure the residents maintained acceptable parameters of nutrition to prevent weight loss, by not documenting accurate meal intakes. This failed practice was found true for (1) one of (4) four residents reviewed for nutrition during the Long-Term Care Survey Process. Resident identifier #82. Facility Census 89. Findings Include: a) Resident #82 A record review on 12/15/24 at 3:44 PM, revealed that Resident #82 had the following weights recorded since 09/06/24: 11/28/24-108.8 Pounds (Lbs) 11/26/24 -110.0 Lbs 11/19/24 -110.0 Lbs 11/11/24 -110.0 Lbs 11/7/24 -110.2 Lbs 11/1/24-116.0 Lbs 11/1/24-116.0 Lbs 10/28/24 -115.6 Lbs 10/21/24-116.0 Lbs 10/14/24-118.6 Lbs 10/7/24-120.4 Lbs 9/30/24-122.6 Lbs 9/25/24-122.8 Lbs 9/6/24-140.8 Lbs This averaged out to 22.73% percent weight loss in (2) two months. Further record review of Resident #82's medical record revealed that her Ideal Body weight (IBW) was 125.1 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review on 12/16/24 at 11:33 AM, of Resident #82's meal intake from 09/01/24 to present revealed that out of a possible 318 meals, 45 were not recorded. 75 of the 273 that were recorded revealed that Resident #82 had eaten 25% percent or less of her meal. During an interview, on 12/16/24 at 1:48 PM, Clinical Resource Nurse (CRN) #96 stated, We feel like we had a problem with her admission weight. We think they just put the weight in from the hospital rather than weighing her. We do have a Performance Improvement Plan (PIP) for this issue. During an interview, on 12/16/24 at 2:20 PM, the Registered Dietician (RD) stated, They do have a PIP on recording weights from the hospital rather than getting the actual weight. I feel like that might have happened. During an interview, on 12/16/24 at 2:40 PM, the administrator confirmed the proper meal intake had not been recorded to get an actual picture of the cause of the weight loss.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 39043 Based on record review and staff interview, the facility failed to monitor and treat pain in occurrence with professional standards of practice. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifier: #34. Facility census: 89. Findings included: a) Resident #34 The facility's policy titled Pain Management with effective date 01/01/04 and revision date 11/01/23 stated reasons for PRN (as needed) pain medication would be documented. Review of Resident #34's physician's orders showed an order written on 08/04/24 for acetaminophen (Tylenol) 650 milligrams (mg) by mouth every six (6) hours as needed for pain. Review of Resident #34's Medication Administration Record (MAR) showed the resident had received acetaminophen one (1) time, on 12/15/24 at 2:08 PM. The MAR documents the medication was effective in relieving the resident's pain. However, the location and the severity of the resident's pain was not recorded on the MAR or in the nurse's progress notes. On 12/17/24 at 1:42 PM, the Clinical Resource Nurse confirmed assessment of Resident #34's pain had not been documented prior to administration of PRN medication on 12/15/24. No further information was provided through the completion of the survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 45171 Based on record review and staff interview, the facility failed to ensure the pharmacist completed monthly medication regimen reviews and that the physician addressed recommendations made by the pharmacist. This deficient practice had the potential to affect three (3) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifiers: #34, #16, #54. Facility census: 89. Findings included: a) Policy review The facility's policy titled Medication Regimen Review and Reporting dated January 2024 stated the consultant pharmacist would review the medication regimen and medical chart of each resident at least monthly. The policy also stated the facility would follow up on pharmacy recommendations to verify appropriate action had been taken within thirty calendar days for issues that did not require urgent action. For issues requiring physician intervention, the attending physician would accept or reject recommendations, documenting rationale for rejections. b) Resident #34 Review of Resident #34's pharmacist medication regimen reviews showed a review performed on 07/26/24. The review stated as follows: Dear Dr. [name redacted]: The resident has experienced a recent fall. After reviewing the current medications, please consider evaluating use of the following medications for possible discontinuation or change as it has a high potential for causing or contributing to falls and possible fracture. Bupropion HCL (XL) tablet extended release 24 hour 300 mg [milligrams] daily Duloxetine HCL capsule delayed release particles 60 mg daily Trazodone 50 mg at bedtime. The bottom of the review form contained a section for the physician or prescriber to agree or disagree with the recommendations, and to provide clinical rationale for disagreement if applicable. The section was blank. Review of Resident #34's current physician's orders showed the resident's bupropion dosage had been decreased to 150 mg on 12/17/24. The resident's duloxetine dosage remained at 60 mg and the resident's Trazodone dosage remained at 50 mg. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24 at 11:39 AM, the Clinical Resource Nurse stated there was no documentation the physician had reviewed the pharmacy recommendations for Resident #34 on 07/26/24 and documented agreement or disagreement with the recommendations. No further information was provided through the completion of the survey. c) Resident #16 On 12/18/24 at 9:10 AM during a review for unnecessary medications, record review shows Resident #16 had dagnoses of dementia, severe with agitation, schizophrenia and anxiety disorder. There were also the following Physicians order: Quetiapine Fumarate Tablet 50 milligram (MG) Give 1 tablet by mouth one time a day for schizophrenia as evidenced by (AEB): throwing things and using profanity. Quetiapine Fumarate Oral Tablet 100 MG (Quetiapine Fumarate) Give 100 mg by mouth one time a day for schizophrenia AEB: throwing things and using profanity Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 500 mg by mouth at bedtime for dementia w/behaviors AEB: throwing things and using profanity Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 500 mg by mouth one time a day for behaviors supervised self-administration AEB: throwing things and using profanity Record review of the last twelve (12) months of pharmacy Medication Regimen Reviews (MRR) found the January through March MRRs' not available. On 12/17/24 at 1:02 PM the Clinical Resource Nurse #96 confirmed the January through March MRR's were not available. 49465 d) Resident #54 A record review on 12/17/24 at 1:00 PM, revealed that Resident #54 had no indications of a pharmacy review for the months of 01/2024, 02/2024, and 03/2024 in the medical record. During an interview on 12/17/24 at 2:00 PM, the Clinical Resource Nurse (CRN) #96 stated, I ain't gonna lie. I can't find the pharmacy reviews for January, February or March.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39043 Based on observation and staff interview, the facility failed to store medications in accordance with professional standards of practice. Multi-use vials of medications stored in the D hallway med cart were past the manufacturer's expiration dates. Additionally, insulin pens for three (3) residents were not dated when first accessed. These were random opportunities for discovery during the medication storage and labeling facility task investigation. Resident identifiers: #390, #34, #7. Facility census: 89. Findings included: a) Expired medications On 12/16/24 at 8:40 AM, Licensed Practical Nurse #24 was observed preparing medications for Resident #80. The resident poured a vitamin C tablet from a multi-use bottle. The manufacturer's expiration date on the bottle was September 2024. The bottle had been dated as opened by the facility on 10/24/24. LPN #24 confirmed the vitamin C tablets were past the manufacturer's expiration date. Examination of the D hallway medication cart also found the following multi-dose medication bottles were past the manufacturer's expiration dates: - Senna Syrup, expired March 2024, dated as opened by the facility on 11/09/24. - Loratadine 10 mg, expired June 2024, dated as opened by the facility on 10/03/24. - Guaifenesin 400 mg, expired August 2024, dated as opened by the facility on 01/20/24. LPN #24 confirmed these multi-dose bottles of medications were past the manufacturer's expiration dates. b) Undated Insulin Pens On 12/16/24 at 9:20 AM, the D hallway medication cart was inspected with LPN #24 in attendance. Three (3) insulin pens were noted to not have been dated when first accessed. It is important to document when insulin pens were first accessed because they must be discarded after 28 days of use. The undated insulin pens were as follows: - Lispro insulin for Resident #390, delivered from the pharmacy on 12/05/24 - Glargine insulin for Resident #34, delivered from the pharmacy on 12/07/24 - Glargine insulin for Resident #7, delivered from the pharmacy on 11/25/24 (continued on next page)

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Marmet Center	One Sutphin Drive Marmet, WV 25315

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #24 verified these three (3) insulin pens had not been dated when first accessed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49465 Based on observation, policy review, and staff interview the facility failed to follow the menus by not providing the appropriate serving size to residents.This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents during the Long-Term Care Survey Process. Facility Census 89. Findings Include: a) Food service in the Alzheimer's unit A dining observation on 12/15/24 at 12:30 PM, in the Alzheimer's unit, revealed that the Activity Directory (AD) was in a kitchen area fixing the plates for the lunch meal for the residents on that unit. Further observation revealed that the AD was serving the turkey with a mouth sized fork, serving the stuffing with a spatula, and serving the peas with a ladle. During an interview on 12/15/24 at 12:32 PM, the AD stated, I don't have the right size utensils over here. The kitchen did not send them. During an interview on 12/15/24 at 12:40 PM, the administrator confirmed that the appropriate utensils for portion size were not being used. A review on 12/16/24 at 2:30 PM, of the corporate recipe for the lunch meal on 12/15/24 indicates that (3) three ounces of turkey, a 1/2 cup of dressing and a 1/2 of cup of peas were to be served for the meal. A review on 12/16/24 at 2:40 PM, of the policy titled {3.0 Menu Standards}, under purpose, reads as follows: To ensure nutritional adequacy, regulatory compliance, operational efficiencies, and patient/resident quality of life. Under process, number (1) one reads as follows: Menus are developed by the food Advisory Council (FAC) according to established, national guidelines.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 49465 Based on observation, resident interview and staff interview the facility failed to ensure residents special dietary requirements including preferences were met. This failed practice was a random opportunity for discovery during the Long-Term Care Survey Process. Resident identifier #54. Facility Census 89. Findings Include: a) Resident #54 An observation, on 12/15/24 at 1:04 PM, of Resident #54 eating lunch revealed that Resident #54 was served turkey, stuffing, and peas. Further observation revealed a meal ticket that indicated Resident #54 was to receive a chicken sandwich, lettuce and tomato, chef salad and a baked potato. During an interview on 12/15/24 at 1:04 PM, Resident #54 stated, I am supposed to get a salad. I don't always like what they give me but I try to eat it. During an interview, on 12/15/24 at 1:06 PM, Dietary Aide #30 stated, We don't have the chicken sandwich. I took her a salad and put the baked potato in now. A record review on 12/16/24 at 11:30 AM, revealed a Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/04/24, section C, that had a Brief Interview for Mental Status (BIMS) of 14. This score indicated the resident's cognitive response was intact.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49465 Based on observation, staff interview, and policy review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents during the Long-Term Care Survey Process. Facility Census 89. Findings Include: a) Alzheimer's unit refrigerator The initial tour of the Alzheimer's unit on 12/15/24 at 11:44 AM, revealed a kitchen area with a refrigerator that had 14 apple crisp in it on a tray with no date. During an interview on 12/15/24 at 11:45 AM, Licensed Practical Nurse (LPN) #33 stated, I am not sure when the Apple crisp was put in here. Maybe this morning. I really don't know. LPN #33 confirmed that the apple crisp did not have a date on them. A review on 12/16/24 at 3:00 PM, of the policy titled {5.7 Refrigerated/Frozen Storage}, under Process, refrigeration, 1.5 reads as follows: Prepared foods are labeled and dated with name of product, date opened, and use by date. b) Kitchen walk-in freezer The initial tour of the kitchen on 12/15/24 at 11:48 AM, revealed (4) four boxes stored on the floor in the walk-in freezer. During an interview on 12/15/24 at 11:49 AM, Kitchen Aide #30 stated, Our chef put those up. I guess he left some on the floor. Kitchen Aide #30 confirmed the items were on the floor. A review on 12/16/24 at 3:00 PM, of the policy titled {5.7 Refrigerated/Frozen Storage}, under process, freezer, 2.1 reads as follows: All shelves, storage racks and platforms are at least (6) six inches off the floor or per state regulation and 18 inches below the sprinkler head or ceiling and away from pipes and vents. c) Kitchen serving area The initial tour of the kitchen on 12/15/24 at 11:48 AM, revealed a white blanket behind the kitchen door in the food service area. During an interview on 12/15/24 at 11:49 AM, Kitchen Aide #30 stated, When it rains, a lot of water seeps up there from a drain, so we put the blanket there.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465 Based on record review, staff interview, and observation the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations and codes by not ensuring staff serving food had a food handlers card. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Facility Census 89. Findings Include: a) Food Handlers Card A dining observation on 12/15/24 at 12:30 PM, in the Alzheimer's unit, revealed that the Activity Directory (AD) was in a kitchen area fixing the plates for the lunch meal for the residents on that unit. During an interview on 12/15/24 at 12:32 PM, the surveyor asked the AD if she had a food handlers card. The AD replied, No, I do not. A review on 12/16/24 at 2:30 PM, of the Kanawha-[NAME] Health Department web site revealed the following requirement for Food Handlers in Kanawha county: If you handle, prepare, serve. sell or give away food for human consumption, even if you bus tables or wash dishes, you are a food worker and need this training within 30 days of starting to work. During an interview on 12/16/24 at 2:40 PM, the administrator confirmed that the AD did not at the time have a food handlers card as the county requires.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review and staff interview, the facility failed to ensure medical records were complete and accurate. This deficient practice had the potential to affect two (2) of 26 residents in the long-term care survey sample. Resident #34's skilled nursing evaluations were inaccurate in the area of genitourinary status. Resident #10's Physician Orders for Scope of Treatment form was not signed by the resident's representative. Resident identifiers: #34, #10. Facility census: 89. Findings included: a) Resident #34 Review of Resident #34's medical records showed the resident was admitted on [DATE] with an indwelling urinary catheter that had been inserted in the hospital. A physician's order was written on 06/22/24 to remove the catheter and monitor the resident's urine output. However, Resident #34's skilled nursing evaluations on 06/23/24, 06/24/24, 06/25/24, 06/26/24, 06/27/24, and 07/02/24 continued to document the resident had an indwelling urinary catheter. On 12/18/24 at 10:08 AM, the Clinical Resource Nurse confirmed Resident #34's skilled nursing evaluations were inaccurate in the area of genitourinary status. 45171 b) Resident #10 On 12/15/24 at 2:06 PM record review shows the Physician Order for Scope of Treatment (POST) with a verbal approval signature from the resident's wife which was his Medical power of Attorney (MPOA). The verbal approval was obtained over the telephone on 10/01/24. During a family interview with Resident #10's wife on 12/15/24, she stated she came to visit often, and actually was in the facility for a Christmas dinner last week. On 12/17/24 at 10:04 AM during an interview with the Social Worker #98 she confirmed the POST should have a physical signature obtained by this time.

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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. 39043 Based on observation, record review and staff interview, the facility failed to implement Enhanced Barrier precautions in accordance with professional standards of care and the facility's policies and procedures. These were random opportunities for discovery that had the potential to affect more than a limited number of residents. Resident identifiers: #22, #37. Facility census: 89. Findings included: a) Policy and Procedures The facility's policy and procedure titled Enhanced Barrier Precautions with effective date 01/06/24 and revision date 12/16/24 stated Enhanced Barrier Precautions (EBP) would be used for residents with an indwelling medical device without secretions or excretions that are unable to be covered or contained and not known to be infected or colonized with any multi-drug resistant organisms. The procedure also stated the appropriate EBP sign would be posted on the patient's room door. b) Resident #22 On 12/15/24 at 12:23 PM, Resident #22 was observed to have a tube feeding pump in her room. The resident was non-interviewable. There was not an EBP sign on the door or near the entry to the resident's room. Personal Protective Equipment (PPE) was available in a plastic caddy further down in the hallway. Review of Resident #22's progress notes show the resident had a percutaneous endoscopic gastrostomy (PEG) tube for enteral nutrition. Review of Resident #22's comprehensive care plan showed the resident had been care planned for having enhanced barrier precautions since 07/26/24. Upon further observation on 12/16/24 at 2:25 PM, Resident #22's room had a sign on the door indicating the resident was on enhanced barrier precautions. On 12/16/24 at 4:04 PM, the Clinical Resource Nurse confirmed the Enhanced Barrier Precautions sign had been placed on Resident #22's door that day. 45171 c) Resident #37 On 12/15/24 at 12:03 PM, Resident #37 was observed to have a tube feeding pump in her room. The resident was non-verbal and unable to interview. There was no Enhanced Barrier Precaution (EBP) sign on the door or near the entry to the resident's room. Personal Protective Equipment (PPE) was available in a plastic caddy outside the doorway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #37's progress notes show the resident had a percutaneous endoscopic gastrostomy (PEG) tube for enteral nutrition. Review of Resident #37's current orders showed she receives enteral tube feeding 16 hours per day. A review of the comprehensive care plan showed Resident #37 was totally dependent on staff for enteral nutrition as well as care at the PEG tube site. On 12/15/24 at 12:55 PM the above findings were confirmed with the Clinical Regional Nurse #96 who agreed the EBP sign should be placed on the door due to the PEG tube being placed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 49465 Based on observation, staff interview, and policy review the facility failed to maintain all electrical equipment in safe operating condition. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Facility census 89. Findings include: a) Stove in the Alzheimer's unit The initial tour of the Alzheimer's unit on 12/15/24 at 12:30 PM, revealed an electric cooking stove in a kitchen area. The stove had (4) four places for stove eyes. (1) one stove eye was in place. The other (3) three stove eyes were missing and replaced with a glass serving plate. During an interview on 12/15/24 at 12:38 AM, Licensed Practical Nurse (LPN) #33 stated, It's been like this for a while. We don't use the stove. Activities use it sometimes. During an interview on 12/15/24 at 12:40 PM, The administrator confirmed that the stove eyes were not in place and the holes were covered with glass plates. A review on 12/16/24 at 2:30 PM, of the policy titled {FNS411 Department Mainenance}, revealed: To ensure the environment and equipment are in good working condition in order to store, prepare, and serve food in a safe and sanitary manner.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 51554 Based on observation and staff interview the facility failed to ensure a physical environment with an effective pest control program. Observations were made of gnats in two (2) different resident rooms. Room identifiers: #A01, #B11. Facility census: 89. Findings included: a) Observations during the initial tour on 12/15/24 revealed gnats were observed flying in the bathrooms of Rooms #A01, #B11; and the administrative conference room. The observation in Room #A01 was at 11:30 AM and #B11 was12:30 AM. In an interview with facility administrator on 12/16/24 at 1:20 PM administrator stated she would request housekeeping to take care of this.