

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Fayetteville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Hresan Boulevard Fayetteville, WV 25840	

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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>49467</p> <p>Based on resident and staff interview, the facility failed to ensure each resident received proper hydration due to no water being passed to Resident #52 and other residents present during a resident council meeting. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Resident identifiers: #52, #7, #32, #36, #41, #48, #54. Facility census: 60.</p> <p>Findings include:</p> <p>a) Resident #52</p> <p>At approximately 10:13 AM on 06/10/24, an interview was conducted with Resident #52. During the interview, Resident #52 stated she did not feel the facility had enough staff because the water pass was so inconsistent. Resident #52 stated, I didn't get any water last night and kept asking for it. They told me 'We are getting it now ' but they would never come back with water. That happens a lot. There are times that I get nauseous and would like some cold water, but I don't always have it. They are supposed to pass it at seven in the morning and seven in the evening, but that rarely happens, they just don't pass it at night. Resident #52 said, Sometimes they are really short, like last night, I would press my light and ask for water and the same boy would come in here and tell me to hold on because there were only two aides. During the interview, this surveyor noticed staff members in the hallway, outside the resident's room, with a cart of Styrofoam cups with water in them. At this time, this surveyor approached Nurse Aide (NA) #44 and asked if they were passing water. NA #44 stated Yes, we are going down this hallway right now (Resident #52's hallway). A surveyor entered Resident #52's room to confirm water was delivered to the resident, however, it was not, as no staff entered the room with water during this time. When the surveyor exited the room, the cart with the Styrofoam cups full of water was no longer in the hallway.</p> <p>(continued on next page)</p>

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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At approximately 11:10 AM on 06/10/24, an interview was conducted with Resident #52. During the interview, there was still no water present in the resident's room. Resident #52 was asked if they ever brought water, to which she stated No, I still haven't seen anyone, they never did bring any in here. At approximately 1:09 PM on 06/10/24, an interview was conducted with Resident #52. Resident #52 stated, I still don't have any water, I don't know why they didn't bring any in here, but I would like to have some. No water pitcher was present in the room at this time. At approximately 1:13 PM on 06/10/24, an interview was conducted with Unit Manager RN (UMRN) #41. UMRN was informed Resident #52 did not have water in their room and was asked if there was any reason they did not receive water when it was being passed earlier that morning. UMRN #41 stated, I don't believe there's any reason she wouldn't have gotten it, maybe she tossed it in the trash when they gave it to her. This surveyor told UMRN #41 they were present in the room when the water was being delivered and the staff never brought water into Resident #52's room, and there have been three observations throughout the day of Resident #52 not having water. UMRN #41 stated Maybe we should go find out, and went into the dining room with this surveyor to interview NA #44, one of the NAs passing water. UMRN #41 asked, Is there any reason (Resident #52's name) would not have gotten water this morning when you guys passed it? NA #44 stated We were down that hallway passing it so someone should have taken it in there. UMRN#41 stated He (surveyor) was in the room when it was being passed and no one ever took water in there, so would there be any reason, or just oversight? NA #44 replied, I guess it was just an oversight, we must have just missed taking it in there.</p> <p>b) Resident Council</p> <p>At approximately 2:15 PM on 06/11/24, this surveyor attended the monthly resident council meeting at the facility. During this meeting, Residents #7, #32, #36, and #41, voiced their concerns about not receiving water consistently when talking about the facility nursing staff. Resident #41 stated, I still have water in my room from last night and have not gotten any today. There are times that you will get water both shifts, and it's rare, there are times you will get it on one shift and not the other, and then there are plenty of times you don't get it on any shift. Resident # 32 stated, It's so inconsistent. You will get it sometimes and not get it other times. Resident #7 stated, I don't get water all the time. Resident #36 stated, They don't bring it when they are supposed to, sometimes they don't bring it at all.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>49467</p> <p>Based on observation, record review, and resident and staff interview, the facility failed to have sufficient nursing staff available to meet the needs of each resident residing in the facility. This was true for three (3) of three (3) residents interviewed during the survey process, as well as resident council members. This had the potential to affect more than a limited number of residents. Resident identifiers: #8, #32, #36, #41, #52. Facility census: 60.</p> <p>Findings include</p> <p>a) Resident #8</p> <p>At approximately 10:05 AM on 06/10/24, an interview was conducted with Resident #8. During the interview, Resident #8 stated, There have been several times that I have needed up, or needed changed, and I was told it was going to be a while because they were working short. There are a lot of days they will say 'We just don't have enough people ' and you will have to wait a long time on your light to be answered, or if they answer it, they'll say, 'We will be right back' but they never come back.</p> <p>b) Resident #52</p> <p>At approximately 10:13 AM on 06/10/24, an interview was conducted with Resident #52. During the interview, Resident #52 stated she did not feel the facility had enough staff because the water pass was so inconsistent. Resident #52 stated, I didn't get any water last night and I kept asking for it. They told me 'We are getting it now' but they would never come back with water. That happens a lot. There are times that I get nauseous and would like some cold water, but I don't always have it. They are supposed to pass it at seven (7) in the morning and seven (7) in the evening, but that rarely happens, they just don't pass it at night. Resident #52 stated, Sometimes they are really short, like last night, I would press my light and ask for water and the same boy would come in here and tell me to hold on because there were only two aides. They won't come back and pick up my tray after my meal; they regularly leave it sitting here until the next meal, it clutters up my table and I don't like it sitting there. I didn't get a shower last Saturday (June 1st) because they said they were too short staffed, and they weren't able to do showers. There are times on both shifts, but especially on night shift, where I will wait almost an hour to have my call light answered. A review of the facility task sheet for the day of 06/01/24, revealed Resident #52's shower was marked as not applicable for that day, indicating she did not receive it. At approximately 11:04 AM on 06/10/24, an interview was conducted with Unit Manager RN (UMRN) #41 regarding the status of not applicable on task sheets. UMRN #41 stated the staff should never be using the not applicable option asway to document someone did not receive a shower. Review of the facility's daily punch audit sheet revealed Nurse Aide (NA) #55 clocked in at 6:56 PM on 06/09/24 and NA #49 clocked in at 7:16 PM on 06/09/24. NA #55 and #49 were the only two (2) aides on the floor until NA #19 clocked in at 11:11 PM on 06/09/24.</p> <p>.C) Anonymous Resident</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At approximately 3:44 PM on 06/10/24, an anonymous resident interview was conducted. During the interview, the resident stated, I like it here and I love the staff, but they are often very short staffed. Day shift, they work short, night shift they are almost always short, and they almost always have two (2) people working. At night, the staff will sit at the table in the activity room and not answer call lights; they won't pass fresh water. You're always going to wait at least 25 minutes for your call light to be answered at nighttime, if not longer. I will see people slumped over in their chairs that need helped up, but they will leave them that way for hours. There was a man in the hallway a couple weeks ago that kept yelling and yelling one night. He was in his chair and wanted to go to bed. I told the CNA that he needed to go to bed, and the CNA said 'He's going to have to wait because we are short tonight.' They finally put the man to bed 30 to 45minutes later and he stopped yelling, but he sat there and yelled the whole time. C) Resident Council At approximately 2:15 PM on 06/11/24, this surveyor attended the monthly resident council meeting at the facility. During this meeting, Residents # 7, 32, 36, and 41, voiced their concerns about not receiving water consistently when talking about the facility nursing staff. Resident #41 stated I still have water in my room from last night and I have not gotten any today. There are times that you will get water both shifts, and it's rare, there are times you will get it on one shift and not the other, and then there are plenty of times you don't get it on any shift. Resident # 32 stated It's so inconsistent. You will get it sometimes and not get it other times. Resident #7 stated I don ' t get water all the time. Resident #36 stated They don ' t bring it when they are supposed to, sometimes they don ' t bring it at all. Resident #41 stated The staff does not do rounds at night. You will see them when they first get here, and then you don't see them again until the new shift arrives at seven (7) the next morning. Resident #36 stated You hardly ever see any staff at nighttime. D) Observation At approximately 10:50 PM on 06/10/24, a tour of the facility was conducted during the night shift. Upon entering the facility, this surveyor noted two call lights ringing on the C Hall of the facility. Nurse Aide in Training (NAIT) #60 was sitting outside a resident's room on C Hall conducting one (1) on one (1) supervision. When this surveyor walked down B Hall, two Nurse Aides (NA), #55 and 19, were sitting at the table in the activities room talking. This surveyor continued to walk down B Hall, observe residents in their rooms, turn around at the end of B Hall, and walk back towards the nurse station. When this surveyor reached the activity room, NA #55walked out into the hallway and stated, Are you lost? At this time, this surveyor informed NA #55 that they were from the State Agency (SA), at which time NA #55 and NA #19 left the activity room and began answering call lights. The call lights were answered at 11:03 PM.</p> <p>e) Staff interview</p> <p>At approximately 11:09 PM on 06/10/24, an interview was conducted with Registered Nurse (RN) #45 regarding facility staffing. RN #45was asked if they felt the facility had enough staff, to which they replied, Nursing-wise, it's not a problem, CNA-wise, it's been a big problem, I think they are working towards resolving it, but it has been a big problem. There aren't enough of them at times.</p> <p>f) Record Review</p> <p>At approximately 10:47 AM on 06/10/24, a record review was conducted of facility staffing information and the facility assessment. On 04/25/25, the facility daily punch audit revealed the facility had three (3) NAs on the floor from 7:00 AM until 3:14 PM, when one other NA clocked in, giving them four (4) from 3:14 PM until 7:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 06/01/24, the facility daily punch audit revealed the facility had three (3) day shift NAs until 11:00 AM when two (2) more clocked in. One NA clocked out at 11:59 AM, leaving four (4) remaining. Two (2) NAs Clocked in for night shift at 7:00 PM, while two (2) remained from day shift, until 11:00 PM, leaving two NAs on the floor.</p> <p>On 06/08/24, the facility daily punch audit revealed the facility had two (2) NAs on the floor from 7:00 PM to 5:00 AM. and three (3) from 5:00 AM to 7:00 AM.</p> <p>On 06/09/24, the facility daily punch audit reveals the facility had two (2) NAs on the floor from 7:00 PM until 11:00 PM, and three(3) from 11:00 PM until 5:00 AM, and four (4) from 5:00 AM until 7:00 AM.</p> <p>A review of the facility assessment, page 19, Part 3: Facility resources needed to provide competent support and care for our resident population every day and during emergencies, under the section Staffing Plan revealed the facility has identified five (5) Nurse Aides are required per shift to provide competent support and care for their resident population.</p>		