

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 08/22/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>49650</p> <p>Based on medical record review and staff interview the facility failed to formulate an advance directive by not obtaining the signature of the Medical Power of Attorney. This was true for one (1) of four (4) residents whose advanced directives were reviewed during the long term care survey process. Resident identifier: Resident #10. Facility Census: 56.</p> <p>Findings include:</p> <p>a) Resident #10</p> <p>During a medical record review on 08/19/24 at 2:33 PM a review of the [NAME] Virginia Physician Order for Scope of Treatment (WV POST) form for Resident #10 it was identified the facility obtained a verbal confirmation of agreement from the residents Medical Power of Attorney (MPOA) on 06/09/22. It is further identified the signature of the MPOA had not been obtained. In review of the WV Post Using the Post Form Guidance for Health Care Professionals it is identified on page 20 the verbal confirmation of agreement from the patient's MPOA representative can be obtained and the form should then be signed at the earliest available opportunity.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 08/20/24 at 11:29 PM, the ADON agreed the signature had not been obtained as required.</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
---	-------	-----------

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 08/22/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>45171</p> <p>Based on observation and staff interview the facility failed to provide a homelike environment. This was true for two (2) of fifty-six (56) residents observed during the long term care survey process. Resident Identifiers: #21, #112 Facility Census: 56</p> <p>Findings include:</p> <p>a) Resident #21</p> <p>On 08/19/24 at 9:23 AM observation of Resident #21's wardrobe found the face of the drawer in the bottom of the wardrobe was missing. This was confirmed with Registered Nurse Unit Manager #76 on 08/19/24 at 9:45 AM.</p> <p>b) Resident #112</p> <p>On 08/19/24 at 9:23 AM observation of Resident #112's room found there were three (3) curtain hooks missing from the privacy curtain between the entrance door and the bed. This caused the curtain to hang down on one corner. This was confirmed with the Registered Nurse Unit Manager #76 on 08/19/24 at 9:45 AM.</p>		

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 08/22/2024
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>49650</p> <p>Based on a review of the facility policy and procedure for Abuse, Neglect and Misappropriation, facility record review, medical record review and staff interview the facility failed to implement and ensure actions were in place to prevent further potential abuse. This was a random opportunity of discovery during the long term care survey process. This had the ability to affect a limited number of residents. Resident Identifier: Resident #34. Facility Census: 56.</p> <p>Findings include:</p> <p>a) Resident #34</p> <p>During a review of the facility policy and procedure for Abuse, Neglect and Misappropriation it was identified on page 6 (six) of 20, (written as typed);</p> <p>In the event an allegation is made, the facility will take measures to protect residents from harm during an investigation. Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. If the alleged violation is verified, appropriate corrective actions will be taken by the facility.</p> <p>On 08/21/24 at approximately 10:30 AM during a facility record review of a facility reported incident dated 07/17/24, Resident #34 allegedly inappropriately attempted to move the hand of a another resident to Resident #34 groin area. At the time of the incident there were staff witnesses confirming the allegation. It is further identified through Resident #34 medical record review that the facility had initially placed Resident #34 on 1:1 (one on one) supervision. However, at the time of the incident the attending physician was in the building and it was noted that the attending physician stated the resident did not need 1:1 supervision at this time. It was further identified the physician order for 1:1 supervision was not entered until 07/18/24 at 7:00 PM. A review of the Treatment Administration Record (TAR) identifies that the 1:1 supervision started the night shift of 07/18/24.</p> <p>During an interview with the Director of Nursing (DON) on 08/21/24 at approximately 12:55 PM the DON stated she felt they had continued the 1:1 supervision but was not able to provide any documentation to support her belief. She agreed without the 1:1 supervision the residents in the facility including the victim of the incident was not provided protection from further potential abuse from the time the staff was aware of the initial abuse incident at 11:30 AM on 07/17/24 through 07/18/24 at 7:00 PM.</p>		

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 08/22/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>49467</p> <p>Based on record review and staff interview, the facility failed to report an alleged incident of resident to resident abuse involving Resident #3 and an unknown resident. This was true for one (1) of three (3) residents reviewed for abuse during the survey process. Resident identifier: #3. Facility census: 56.</p> <p>Findings include:</p> <p>a) Resident #3</p> <p>At approximately 2:15 PM on 08/20/24, a review of Resident #3's progress notes was conducted, related to behaviors the resident exhibited. It was noted on 03/18/24, Resident #3 was witnessed throwing a cup of water in the face of another resident who was not identified.</p> <p>Upon review of the incidents and reportables logs supplied by the facility, it was determined the incident was not listed on either log. At approximately 3:15 PM on 08/20/24, a copy of the reportable incident and investigation, if available, was requested from the Administrator.</p> <p>At approximately 3:45 PM, the Administrator confirmed the incident was not reported and an investigation was not started.</p> <p>Review of Resident #3's care plan discovered a note under the focus area pertaining to behaviors stating, Resident has thrown water at staff/residents.</p>		

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 08/22/2024
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>49467</p> <p>Based on record review and staff interview, the facility failed to accurately complete the Minimum Data Set (MDS) Assessment for Resident #60 upon discharge. This was true for one (1) of one (1) residents reviewed for discharge during the survey process. Resident identifier: 60. Facility census: 56.</p> <p>Findings include:</p> <p>a) Resident #60</p> <p>At approximately 9:15 AM on 08/20/24, during a record review for Resident #60, the following note, entered by the Social Worker (SW) was discovered (typed as written):</p> <p>7/1/24 14:56 Social Services Note:</p> <p>Note Text: (Resident #60's name)'s family would like (Resident #60's name) to discharge on 7/3/24 related to progress made on goals. They plan on picking her up sometime after 4:00p.m. No equipment needs. Home health will be arranged with (Home Health Provider). Per daughters the family all take turns staying with (Resident #60's name) and she has 24 hour care at home.</p> <p>According to the discharge summary provided by the facility, Resident #60 was discharged home on 07/03/24.</p> <p>Upon review of the discharge MDS Assessment completed by the facility, specifically section A completed and signed by the SW, the discharge location for Resident #60 was entered as Short-Term General Hospital (acute hospital, IPPS) instead of Home/Community.</p> <p>At approximately 2:26 PM on 08/21/24, an interview was conducted with the SW regarding the MDS for Resident #60 upon discharge. The SW acknowledged the mistake on the MDS and stated It must have just been a typo. I was probably looking at where she came from, which was a short-term hospital, and just entered that into the discharge location by accident.</p>		

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 08/22/2024
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467</p> <p>49650</p> <p>Based on medical record review and staff interview the facility failed to update the [NAME] Virginia Department of Health and Human Resources Pre-admission Screening (PASARR) with new qualifying diagnoses of major depressive disorder. This was true for two (2) of three (3) residents whose PASSARR's were reviewed during the long term survey process. Residents identifiers: #34, #39. Facility Census: 56.</p> <p>Findings included:</p> <p>a) Resident # 34</p> <p>During a medical record review [NAME] Virginia Department of Health and Human Resources Pre-admission Screening (PASSARR) on 08/21/24 at 12:00 PM, it was identified the PASSARR was completed on 11/25/22. During a further medical record review it was identified on 03/20/24 the resident was diagnosed with Major Depressive disorder. An updated PASSARR could not be found for this new diagnosis.</p> <p>During an interview with the Social Worker (SW) #77 on 08/21/24 at 12:21 PM, SW #77 agreed that the PASSARR should have been updated at the time of the new diagnosis of major depressive disorder on 03/20/24.</p> <p>b) Resident #39</p> <p>At approximately 8:30 AM on 08/20/24, a record review for Resident #39 was conducted. During this review, it was noted the resident was admitted to the facility on [DATE]. During the resident's stay at the facility, 08/09/23, he was diagnosed with major depressive disorder.</p> <p>Review of the PASSAR for Resident #39 indicated there was not a new one completed to reflect the new diagnosis of major depressive disorder.</p> <p>At approximately 12:37 PM on 08/20/24, an interview was conducted with the Social Worker. The SW confirmed she was responsible for submitting the PASSARRs at the facility. The SW confirmed there was no new PASSAR for Resident #39 following the diagnosis and stated We are working on redoing the PASSARRs for residents that need them.</p>		

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 08/22/2024
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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>45171</p> <p>Based on record review and staff interview the facility failed to ensure a Preadmission Screening and Review (PASARR) form had the appropriate diagnoses present. This was true for one (1) of three (3) PASSr's reviewed during the long term care survey process. Resident Identifier: #20 Facility Census: 56</p> <p>Findings Include:</p> <p>a) Resident #20</p> <p>On 08/20/24 at 10:29 AM record review of the transfer PASARR provided by Social Worker #77, dated 04/15/24 found that the only diagnosis listed was dementia.</p> <p>A review of Resident #20 medical diagnosis found the following diagnosis:</p> <p>Dementia, upon admission</p> <p>Bipolar, upon admission</p> <p>Depression, upon admission</p> <p>Generalized Anxiety Disorder, upon admission</p> <p>On 08/20/24 at 3:10 PM this was confirmed with Social Worker #77 who agreed all the listed diagnosis should be on the PASARR.</p>

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 08/22/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>31826</p> <p>Based on record review, family interview, observation and staff interview the facility failed to develop a comprehensive care plan for Resident #44 related to diet restrictions associated with a medical condition. This was true for one (1) of four (4) residents reviewed for the care area of nutrition during the long term care survey process. Resident Identifier: # 44. Facility Census: 56.</p> <p>Findings Include:</p> <p>a) Resident #44</p> <p>Observation of the noon time meal on 08/21/24 at 12:47 PM found Resident #44 was sitting in the dining room. She was served her meal and on her plate was a serving of corn. Resident #44 immediately stated, I can not eat corn, they know that. She then pushed her plate to the side.</p> <p>A few minutes later Resident #44's family member entered the dining room and said, oh we can just take that corn off your plate. She then helped Resident #44 remove the corn from her plate. An interview with Resident #44's family at this time found, the facility always gives her stuff she should not eat due to her ileostomy.</p> <p>A review of Resident #44's tray ticket found she was supposed to be served the alternate vegetable instead of the corn.</p> <p>A record review of Resident #44's care plan found the care plan to be void of any special diet restrictions related to Resident #44's ileostomy.</p> <p>An interview with the Registered Dietician on 08/21/24 at 1:00 PM found the resident should not have been served corn. She stated, there are foods she should avoid and corn is one because it could cause a blockage related to her ileostomy.</p> <p>An interview with the Director of Nursing (DON) in the afternoon of 08/21/24 confirmed Resident #44's care plan was void of any diet restrictions related to her ileostomy.</p>		

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 08/22/2024
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>45171</p> <p>.</p> <p>Based on record review and staff interview the facility failed to revise the comprehensive care plan in a timely manner. Revisions required for new diagnosis and medication changes. This was true for three (3) of twenty three (23) residents reviewed during the long-term care survey process. Resident Identifier: Resident #34, Resident #14 and Resident #24. Facility Census: 56.</p> <p>Findings Include:</p> <p>a) Resident #34</p> <p>During a medical record review 08/21/24 at approximately 12:21 PM, it was found Resident #34 diagnosis includes a diagnosis of major depression disorder with the onset date of 03/20/24. Further review of the residents care plan the diagnosis of major depression disorder is not identified.</p> <p>During an interview with the Director or Nursing (DON) on 08/21/24 at 1:29 PM the DON stated the comprehensive care plan had not been revised to reflect the diagnosis of major depression disorder with the onset date of 03/20/24.</p> <p>b) Resident #14</p> <p>On 08/20/24 at 2:24 PM a record review found that Resident #14 was care planned for antipsychotic medications and listed Seroquel related to schizophrenia, agitation and use of abrasive language. Further review found that Resident #14's Seroquel was discontinued on 04/02/24. However, the care plan had not been revised to reflect this as required.</p> <p>Resident #14 was care planned for insomnia and was receiving Melatonin. This medication had been discontinued on 04/23/24 and the care plan had not been revised to reflect this as required.</p> <p>This was confirmed with the Director of Nursing on 08/20/24 at 2:15 PM when she agreed the care plan should have been revised.</p> <p>c) Resident #24</p> <p>On 08/20/24 at 2:24 PM a record review found Resident #24 was care planned for anti- depression medications and listed Zolofl related to depression. Further review found Resident #24's Zolofl was discontinued on 05/31/24. However, the care plan had not been revised to reflect this as required.</p> <p>This was confirmed with the Director of Nursing on 08/20/24 at 2:15 PM when she agreed the care plan should have been revised.</p> <p>49650</p>		

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 08/22/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45171</p> <p>Based on record review and staff interview the facility failed to act on a Physician's order which caused a delay in treatment. This was true for one (1) of twenty three (23) resident records reviewed during the long term care survey process. Resident Identifier: #53 Facility Census: 56</p> <p>Findings Include:</p> <p>a) Resident #53</p> <p>On 08/20/24 record review found Resident #53 had an active order dated 07/26/24 to hemocult stools (a screening test that checks for hidden blood in stool) X 3 samples for an abnormal lab result. As of 08/20/24 the staff had only obtained one stool sample.</p> <p>The one sample which was retrieved on 08/17/24 returned with a positive result for blood being present. Upon notifying the off hours physician (Never Alone) new orders were received to continue monitoring. Resident to also follow up with in house physician for a possible Gastrointestinal (GI) referral.</p> <p>There was no documentation to show the in house physician had been notified. There were no stool samples retrieved after 08/17/24.</p> <p>On 08/20/24 at 3:34 PM when it was discussed with the Director of Nursing it took twenty one (21) days to obtain the stool sample and it had been twenty four (24) days since the original order was placed and there was no action taken she agreed it should have been addressed by now.</p>

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 08/22/2024
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 record review and resident and staff interviews, the facility failed to ensure sufficient nursing staff was deployed to meet the needs of each resident. This was a random opportunity for discovery. Resident identifiers: #44, #34. Facility census: 56.</p> <p>Findings include:</p> <p>A) Resident #44</p> <p>At approximately 1:30 PM on 08/20/24, during resident council, Resident #44 stated they rang their call light last night (08/19/24) at approximately 4:20 AM. Resident #44 stated her light was finally answered at approximately 5:00 AM, at which time, the employee who answered the light stated staff was unable to answer the call light earlier because her assigned aide had been pulled to do one on one (1:1) care with Resident #34.</p> <p>At approximately 10:00 AM on 08/21/24, an interview was conducted with Resident #44. During the interview, the resident stated, I waited from about 4:20 in the morning until a little after 5:00 in the morning for someone to answer my light. When the aide finally answered my light, she told me the aide that was assigned to me at the beginning of the evening couldn't answer my light because they had been reassigned to be a sitter (1:1) for (Resident #34's name). She told me after my aide was reassigned, they only had two people to cover the entire nursing home and they could not answer the light. I needed help and they didn't answer the light because they were sitting with (Resident #34's name). I don't think that's right.</p> <p>Upon review of the facility staff assignment sheet for the night of 08/19/24, it was discovered Nurse Aide (NA) #33 was assigned to provide one on one care for Resident #34 from 7:00 PM on 08/19/24 until 3:00 AM on 08/20/24. There were no other assigned aides to provide one on one care for Resident #34 after that time.</p> <p>At approximately 10:40 AM on 08/21/24, an interview was conducted with the Director of Nursing (DON) regarding the incident. The DON acknowledged the NA was assigned to provide one on one care until 3:00 AM on 08/20/24. When asked what the facility did at that time, the DON stated, We would have just assigned someone else to sit with him (Resident #34). I believe they pulled (NA #71's name) to do one on one the rest of the night. They should have reassigned the aides at that point, but I'm not sure if they documented the new assignments anywhere.</p> <p>Review of the assignment sheet indicated NA #71 was the aide assigned to provide care for Resident #44. The DON acknowledged NA #71 was originally assigned to Resident #44's unit.</p> <p>The incident was reported to the Administrator at approximately 1:07 PM on 08/21/24. An investigation was started. According to a statement obtained by the facility from NA #59, NA #59 states she answered Resident #44's call light after arriving to work at 5:00 AM on 08/20/24. The resident stated her call light had been on for a bit and stated she was wet.</p> <p>(continued on next page)</p>		

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 08/22/2024
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No documentation to confirm reassignments was provided</p>

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 08/22/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467</p> <p>Based on record review and staff interview, the facility failed to monitor Resident #3 for side effects of antianxiety, antidepressant, and mood stabilizing medications as ordered, as well as monitoring for behaviors as ordered, per shift. This was true for one (1) of one (1) residents reviewed for psych/opioid side effects during the survey process. Resident identifier: #3. Facility census: 56.</p> <p>Findings include:</p> <p>a) Resident #3</p> <p>At approximately 11:00 AM on 08/19/2024, a record review was conducted concerning side effects of psychotropic medications and opioids for Resident #3. During the review, it was noted Resident #3 had the following orders (typed as written):</p> <p>ANTIANSXIETY side effect monitoring but not limited to: Dystonia: torticollis(stiffness of neck), Anticholinergic symptoms: Dry mouth, blurred vision, constipation, urinary retention. Hypotension, Sedation/drowsiness, increased falls/dizziness, Cardiac abnormalities (tachycardia, bradycardia, irregular H.R;NMS). Anxiety/agitation, blurred vision, sweating, rashes, headache, urinary retention/hesitancy. Weakness, hangover effect. Every shift</p> <p>ANTIDEPRESSANT side effect monitoring but not limited to: Dystonia: torticollis(stiffness of neck), Anticholinergic symptoms: Dry mouth, blurred vision, constipation, urinary retention. Hypotension, Sedation/drowsiness, increased falls/dizziness, Cardiac abnormalities (tachycardia, bradycardia, irregular H. R;NMS). Anxiety/agitation, blurred vision, sweating, rashes, headache, urinary retention/hesitancy. Weakness, tremors, appetite change/weight change, insomnia, confusion, tardive dyskinesia, suicidal ideations. Every shift</p> <p>MOOD STABILIZER Side effect monitoring: Hives, rash, fever, or swollen glands. Signs of [NAME]-[NAME] syndrome, which causes dangerous sores on the mucous membranes of the mouth, nose, genitals, and eyelids. Confusion. Slurred speech. Nausea, vomiting, and diarrhea. Trembling. Increased thirst and increased need to urinate. Weight gain in the first few months of use. Drowsiness. Every shift.</p> <p>Behaviors</p> <ol style="list-style-type: none"> 1. Hallucinations 2. Delusions 3. Violent outbursts 4. Throwing objects <p>Non-Pharmacological intervention</p> <p>(continued on next page)</p>		

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 08/22/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Snacks</p> <p>2. Fluids</p> <p>3. Activities</p> <p>4. Distraction</p> <p>Every shift for Behaviors.</p> <p>It was discovered behavior monitoring was absent from the Medication Administration Record (MAR) for the following days and shifts:</p> <p>April 7:00 AM - 7:00 PM: 19th and 20th</p> <p>7:00 PM - 7:00 AM: 2nd, 3rd, 5th, 22nd</p> <p>May 7:00 AM - 7:00 PM: 2nd</p> <p>June 7:00 AM - 7:00 PM: 1st</p> <p>July 7:00 AM - 7:00 PM: 7th</p> <p>August 7:00 AM - 7:00 PM: 8th</p> <p>It was discovered side effect monitoring was missing for the following days and shifts:</p> <p>April-</p> <p>Antianxiety- 7:00 AM - 7:00 PM: 19th-20th 7:00 PM - 7:00 AM: 2nd, 3rd, 5th, 22nd</p> <p>Antidepressants- 7:00 AM - 7:00 PM: 19th-20th 7:00 PM - 7:00 AM: 2nd, 3rd, 5th, 22nd</p> <p>Mood Stabilizer- 7:00 AM - 7:00 PM:19th-20th 7:00 PM - 7:00 AM: 2nd, 3rd, 5th, 22nd</p> <p>May-</p> <p>Antianxiety- 7:00 AM - 7:00 PM: 2nd</p> <p>Antidepressants- 7:00 AM - 7:00 PM: 2nd</p> <p>Mood Stabilizer- 7:00 AM - 7:00 PM: 2nd</p> <p>June-</p> <p>Antianxiety- 7:00 AM - 7:00 PM: 1st, 18th, 19th, 20th 7:00 PM - 7:00 AM: 18th, 19th, 20th</p> <p>Antidepressant- 7:00 AM - 7:00 PM: 1st, 18th, 19th, 20th 7:00 PM - 7:00 AM: 18th, 19th, 20th</p> <p>(continued on next page)</p>

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 08/22/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Mood Stabilizer- 7:00 AM - 7:00 PM: 1st, 18th, 19th, 20th 7:00 PM - 7:00 AM: 18th, 19th, 20th</p> <p>The Director of Nursing (DON) acknowledged the missing monitoring at approximately 11:05 AM on 08/22/2024.</p>		

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 08/22/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>45171</p> <p>Based on record review and staff interview the facility failed to ensure significant medication errors did not occur. This was a random opportunity for discovery. Resident identifier: #43 Facility Census: #56</p> <p>Findings included:</p> <p>a) Resident #43</p> <p>On 08/20/24 at 9:52 AM a record review found Resident #43 had a medication error on 08/12/24 at 1:41 PM .</p> <p>Further review of the Record found Resident #43 had the following medications ordered:</p> <p>Atorvastatin 40 mg at bedtime (for hyperlipidemia)</p> <p>Buspirone 30 mg twice a day (for anxiety and depression)</p> <p>Colestid 1 gram two times a day (for diarrhea)</p> <p>Dicyclomine 10 mg three times a day (for diarrhea)</p> <p>Empagliflozin 10 mg daily (for diabetes)</p> <p>Loratadine 10 mg daily (for allergies)</p> <p>Losartan Potassium 50 mg daily (for hypertension)</p> <p>Magnesium Oxide 400 mg twice a day (for supplement)</p> <p>Metformin 1000 mg twice a day(for diabetes)</p> <p>Metoprolol Succinate ER 25 mg daily (for hypertension)</p> <p>Omeprazole 20 mg daily (for GERD)</p> <p>Remeron 15 mg at bedtime (for insomnia)</p> <p>Sertraline 100 mg twice a day(for depression)</p> <p>Tylenol 500 mg every 6 hours as needed (for pain)</p> <p>Zenpap DR 4000-126000 units 2 capsules three times a day (for diarrhea)</p> <p>However on 08/12/24 at 1:41 PM she received the following medications in error:</p> <p>(continued on next page)</p>		

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 08/22/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Lipitor 20 mg (used for hyperlipidemia)</p> <p>Isosorbide Dinitrate 10 mg (used for coronary artery disease)</p> <p>Doxepin HCL 10 mg (used for anxiety or depression)</p> <p>Melatonin 10 mg (used for insomnia)</p> <p>Propranolol HCL 20 mg (used for hypertension)</p> <p>Buspirone 20 mg (used for anxiety)</p> <p>PreserVision AREDS table (used for eye health)</p> <p>Klonopin 0.5 mg (used for anxiety)</p> <p>Upon identifying the error, the physician was notified and a new order was received to hold Resident #43's night time medications except her Sertraline and monitor for adverse reactions. The Residents Medical Power of Attorney was notified. Neurological checks were initiated and completed.</p> <p>There was education provided for the Five Rights of Medication to the nursing staff. The five rights consist of 1) the right resident 2) the right time 3) the right medicine 4) the right dose 5) the right route. According to the facility Policy and Procedure for Medication Administration . Observe the five rights in giving each medication .</p> <p>Review of the Record of in Service Training dated 08/14/24, conducted by the Clinical Manager Registered Nurse #12, shows that eight (8) of the twenty five (25) nurse staff identified on the staffing list provided by the Administrator had signed that they were educated of the five rights Licensed Practical Nurse #53 identified as the nurse that made the error had not signed in as being educated on the five rights.</p> <p>On 08/20/24 at 3:08 PM, the Director of Nursing stated the nurse who administered the medications was fairly new and not familiar with the residents. She erroneously administered Resident #43's room mates medications to Resident #43. This incident was also confirmed with Unit Manager Registered Nurse #76 and #49.</p>		

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 08/22/2024
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 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>31826</p> <p>Based on record review, observation, family interview and staff interview the facility failed to provide Resident #44 with a diet that met her special dietary needs related to her ileostomy. This was true for one (1) of four (4) residents reviewed for the care area of nutrition during the long term care survey process. Resident Identifier: 44. Facility Census: 56.</p> <p>Findings Include:</p> <p>a) Resident #44</p> <p>Observation of the noon time meal on 08/21/24 at 12:47 PM found Resident #44 was sitting in the dining room. She was served her meal and on her plate was a serving of corn. Resident #44 immediately stated, I can not eat corn they know that. She then pushed her plate to the side.</p> <p>A few minutes later Resident #44's family member entered the dining room and said, oh we can just take that corn off your plate. She then helped Resident #44 remove the corn from her plate. An interview with Resident #44's family at this time found, the facility always gives her stuff she should not eat due to her ileostomy.</p> <p>A review of Resident #44's tray ticket found she was supposed to be served the alternate vegetable of squash medley instead of the corn.</p> <p>A record review of Resident #44's care plan found the care plan to be void of any special diet restrictions related to Resident #44's ileostomy.</p> <p>An interview with the Registered Dietician on 08/21/24 at 1:00 PM found the resident should not have been served corn. She stated, there are foods she should avoid and corn is one because it could cause a blockage related to her ileostomy. She stated, I have it in tray tracker and it should print on the tray ticket. The Registered Dietician then checked the residents tray ticket and confirmed the tray ticket did say she should receive squash medley instead of corn.</p> <p>An interview with the certified dietary manger in the afternoon of 08/21/24 after the meal service was concluded confirmed she just missed it on her ticket and gave her the wrong vegetable.</p>		

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 08/22/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49650</p> <p>Based on observation and staff interview the facility failed to ensure the safe food handling practices was used. A glass was held barehanded by the rim during mixing for a thickened diet. This was a random opportunity for discovery identified during the long term care survey process and had the potential to affect a limited number of residents. Facility Census: 56.</p> <p>Findings include:</p> <p>a) Thickened drink.</p> <p>On 08/20/24 at 08:15 AM during an observation of the dining room breakfast prep it was observed that Certified Nursing Assistant (CNA) #45 was mixing thickened juice drink for a resident. It was further observed that CNA #45 was holding the glass with her bare hand. She had placed her pointer finger and thumb on the top rim of the glass as she stirred the liquid with the opposite hand. When asked if the resident would be drinking from the rim of the glass she stated yes and that she would re-mix another drink.</p> <p>During an interview with the Clinical Manager Registered Nurse (CM RN) #12 on 08/20/24 at approximately 8:19 AM, CM RN #12 stated that the CNA's know better than that and CM RN #12 disposed of the drink.</p>		

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 08/22/2024
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 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>31826</p> <p>Based on observation and staff interview the facility failed to dispose of garbage and refuse properly by not ensuring the lid on the dumpster was closed. This was found while completing the facility task of the Kitchen and has the potential to affect all residents currently residing in the facility. Resident Census: 56.</p> <p>Findings include:</p> <p>a) Dumpster</p> <p>An observation of the facility's dumpster on 08/21/24 at 1:40 PM with the Nursing Home Administrator (NHA) present found the lid to the dumpster was opened. When looking into the dumpster it was noted there was a bag trash inside the dumpster. The NHA confirmed the dumpster lid should have been closed.</p>

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 08/22/2024
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650</p> <p>Based on medical record review and staff interview the facility failed to accurately document the discharge of a resident and the facility failed to accurately complete a residents capacity form. This was true for two (2) of 23 residents reviewed during the long term care survey process. Resident Identifiers: Resident #5, and #35. Census: 56.</p> <p>a) Resident #59</p> <p>During a review of the medical record review of 08/20/24 at 9:09 AM of Resident #59 a Social Service note identified the resident had went on a therapeutic leave with his daughter. It was further identified the daughter notified the facility he would not be returning to the facility. During this medical record review a physician note entry for the discharge to family could not be identified.</p> <p>Further review of the Minimum Data Set (MDS) dated [DATE] it is identified under section A, under (f) the resident had discharged and was not expected to return it is further identified under (g) the discharge was unplanned.</p> <p>During an interview with the Director of Nursing (DON) on 08/20/24 09:43 AM the DON stated the Social Worker said she had talked with the daughter and she stated she decided for Resident # 59 to stay home and he would not be returning. The DON further stated the residents attending physician did not see the resident and did not agree with the discharge. The DON stated Resident #59 had discharged against medical advice (AMA).</p> <p>A medical record review of the discharge data entered on the facility census list identified the discharge being coded as a DD (discharge date).</p> <p>During an interview with the Administrator on 08/22/24 at approximately 9:07 AM the Administrator agreed the coding for the discharge was not accurate and it should have identified the resident discharged AMA.</p> <p>49467</p> <p>b) Resident #35</p> <p>During review of Review of Resident #35's record, it was noted the Physician's Determination of Capacity, signed by the physician on 10/16/2023, was not completed appropriately.</p> <p>Under the duration section, the option long term was marked. Under the nature section, short term memory loss, aphasia, inability to process information is marked. Under the causes section, CVA is written in and checked. The physician signed the form and marked annual at the bottom of the form. However, the two options for capacity, which are demonstrates capacity to make decisions and demonstrates incapacity to make decisions were both left unmarked, not specifying whether Resident #35 demonstrated capacity or incapacity.</p> <p>(continued on next page)</p>		

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 08/22/2024
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At approximately 12:05 PM on 08/20/2024, an interview was conducted with the Unit Manager RN (UMRN) regarding the capacity form. The UMRN stated It's not completed correctly, but I would guess it means she does not have capacity.</p>

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 08/22/2024
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 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>49467</p> <p>Based on record review and resident interview, the facility failed to ensure residents entering into a binding arbitration agreement were able to understand the agreement prior to signing. This was true for two (2) of two (2) residents reviewed for arbitration during the survey process. Facility Census: 56.</p> <p>Findings include:</p> <p>A) Arbitration Agreements</p> <p>At approximately 9:20 AM on 08/22/24, a list of residents entering into the facility's binding arbitration agreement was reviewed. It was determined Residents #112 and Resident #34 were the only two (2) residents in the facility who signed the agreement.</p> <p>At approximately 9:30 AM on 08/22/24, an interview was conducted with Resident #112 regarding the arbitration agreement. Resident #112 stated, I don't recall signing anything like that. They brought something in here the day after I got here and had me sign it, but I don't know what it was I even signed. I signed so many things when I got here. The arbitration agreement was explained to Resident #112 and she stated I don't remember anything like that. They just handed me papers and told me to sign them and I signed them. That doesn't sound familiar to me, I don't know anything about it.</p> <p>Review of Resident #34's record indicated he was deemed incapacitated on 10/14/22 and signed the arbitration agreement on 12/20/22, while still incapacitated.</p> <p>At approximately 9:50 AM on 08/22/24 an interview was conducted with the facility Social Worker (SW) who was responsible for arbitration. The SW stated they were not aware Resident #112 did not understand the arbitration agreement before she signed it. As far as Resident #34 entering into an arbitration agreement while incapacitated, the SW acknowledged not reviewing the capacity form before having the resident sign, stating I must not have seen the capacity form. If I don't see a capacity form, I assume they have capacity.</p>		

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 08/22/2024
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 0881</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171</p> <p>Based on record review and staff interview the facility failed to implement their antibiotic stewardship program. Resident #44's attending physician received the urine culture results which indicated the resident's infection was resistant to Macrobid. However, the physician ordered Macrobid to treat the urinary tract infection (UTI). The resident did not improve and when questioned the facility reviewed the culture again and discovered the wrong antibiotic was ordered. This resulted in actual harm for Resident #44. Her UTI symptoms persisted and she was later hospitalized with sepsis. This was discovered during the completion of the infection control task during the long term care survey process. Resident Identifier: #44 Facility Census: 56</p> <p>Findings Included:</p> <p>a) Resident #44</p> <p>On 08/21/24 a record review found Resident #44 had a urinalysis and culture and sensitivity performed on a urine sample collected at the facility on 04/11/24.</p> <p>On 04/15/24 at 6:03 PM the urine culture and sensitivity showed the bacteria identified in the urine culture was providencia stuartii. Each antibiotic was listed and identified as the bacteria being resistant (meaning it will not kill the bacteria) or susceptible (meaning it will kill the bacteria) to each antibiotic.</p> <p>The bacteria was identified as being resistant to Nitrofurantoin (Macrobid). The in house physician ordered Macrobid 100 mg twice a day for seven (7) days.</p> <p>The resident received the seven (7) days prescribed. On 04/27/24 documentation shows the .family requested an increase in the dose of Macrobid as the symptoms were not resolving. Review of the labs demonstrated that the organism was resistant to Macrobid so, changed to susceptible abx - Bactrim. Renal function reviewed. acceptable. Full dose for 5 dose .</p> <p>The resident then received Bactrim 800-160 mg one capsule twice a day X five (5) days. The resident received the five (5) days as prescribed.</p> <p>Record review shows Resident #44 was sent out to the local hospital on 05/09/24 at 10:31 AM with an admitting diagnosis from the hospital as Sepsis: The discharge diagnosis is documented as: Sepsis, Metabolic Encephalopathy secondary to Urinary tract infection (UTI), Acute kidney injury (AKI) secondary to sepsis versus urinary retention and acute urinary retention. She was hospitalized for nine (9) days and returned to the facility on [DATE].</p> <p>According to the facility Antibiotic Stewardship Plan Policy and Procedure:</p> <p>.the facility participates in an Antibiotic Stewardship program to protect residents and reduce the threat of antibiotic resistance in this setting .</p> <p>(continued on next page)</p>		

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 08/22/2024
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 0881</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>.The Infection Preventionist Nurse will have expertise and date to inform strategies to improve antibiotic use. This includes but not limited to: 1) using evidence based published criteria during the evaluation and management of treated infections 2) Reviewing antibiotic resistance patterns in the facility .</p> <p>.support the antibiotic stewardship program in the facility. This includes but no limited to 1) timely and appropriate ordering of antibiotics 2) reviewing culture data .</p> <p>On 08/21/24 at 1:55 PM the Director of Nursing stated the Physician read the culture wrong and ordered the wrong antibiotic. When the family questioned why the resident was not improving they re-addressed the lab culture and discovered the organism was resistant to the antibiotic the physician had ordered. He was contacted and gave new orders for a new antibiotic.</p> <p>On 08/21/24 at 2:28 PM during an interview with the Infection Preventionist #12 she stated the day the urine culture in question came back, the physician came in her office about the same time the culture came in. She showed him, he looked at it and he verbally ordered Macrobid 100 mg BID X 7 days. She placed the culture in the box to be scanned and ordered. She had no reason to pull the culture again and follow up on it or to question the physician's original order.</p> <p>The Infection Prevetionist said her normal process would be when she gets the culture back she emailed the physician with the resident name, the culture results and which medications are resistant or susceptible. The culture goes in a box on her desk until she gets a return email from the physician with an order. If she does not get a response within 24 hours, she reaches out again. She felt this was missed due to the time frame the culture came in, the physician placed the order and her filing the culture away. Under normal circumstances, she would look at a culture several times.</p>