Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515155	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierpont Center at Fairmont Campus	1543 Country Club Road Fairmont, WV 26554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 39571 Based on observation, resident interview, record review and staff interview, the facility failed to ensure the residents choices were honored in regard to diet. This was true for one (1) of one (1) residents reviewed for choices. Resident identifier: #9. Facility census: 106. Findings included: a) Resident #9 On 03/11/24 at 1:39 PM Resident #9 said she is lactose intolerant and today they gave her cheese on her sandwich again. She stated that she picked the cheese off of the grilled ham and cheese sandwich and ate the ham and one slide of the bread. Resident #9 stated she did not want anything else to eat. Care Plan Review Revealed: The resident is at risk for dehydration as evidenced by medications (diuretic, laxatives). H Encourage residents to consume fluids during & between meals. Offer 1 cup Lactaid milk & 1 cup Cranberry juice at breakfast. Monitor weight per protocol and report as indicated Resident is at nutritional risk r/t (related to) dx (diagnosis) of Type 2 Diabetes Mellitus (T2DM), adult failure to thrive (FTT), hypothyroidism, major depressive disorder, Chronic Kidney Disease (CKD) Stage 3B, Congestive Heart Failure (CHF). Significant wt loss over the past 90 days. Is <UBW range of 175-185 lb. R BKA (below knee amputation) w/ AIBW (adjusted ideal body weight) of 122.3 lb. Is 133% AIBW. Monitor intake at meals; offer alternate choices as needed Provide Regular/liberalized w/ sugar substitute. Lactose intolerance: prefers Lactaid milk. (continued on next page)

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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the meal ticket on Resident #9's tray listed dislikes which included many dairy products. Ice cream, and cheese. However, it did not include cheese sandwiches. On 03/12/24 at 2:40 PM, the Director of Nursing (DON) was informed of the information above. She stated she would ensure that all dairies including cheese would be on the meal ticket.

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F 0567

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to manage his or her financial affairs.

49467

Based on resident and staff interviews, the facility failed to ensure each resident had reasonable and ready access to their personal funds held by the facility. This was true for four (4) out of 11 residents that were interviewed during the resident council meeting. This had the potential to affect more than a limited number of residents. Facility census: 106.

Findings included:

a) Resident Council

At approximately 3:00 PM on 03/12/24, a resident council meeting was held at the facility. During that meeting, four (4) residents in attendance expressed concerns about personal funds held by the facility. Residents stated that obtaining money on the evenings and weekends was difficult, with one resident stating I'm not even sure we can get the money after they leave the offices for the day, so the weekend wouldn't be possible. Another resident stated outings had to be canceled the day of the event, on more than one occasion, because the facility did not have money for the residents to take.

At approximately 12:50 PM on 03/13/24, an interview was conducted with Receptionist #107 regarding personal funds for the residents. Receptionist #107 stated they handled disbursement of funds along with the business office. Receptionist #107 stated the facility kept an emergency fund in the amount of $50 in the assisted living portion of the facility for residents to access on nights and weekends. Receptionist #107 stated residents would be limited in what they could obtain on nights and weekends, and that staff would have to ration the money in case other residents wanted money out of the emergency fund. Receptionist #107 stated all staff were aware of the emergency fund and how to access it.

Regarding canceled outings due to the facility not being able to provide residents with their personal funds, Receptionist #107 stated, There was a time a while ago there wasn't enough money for residents to go on the outing, so it had to be canceled. I'm not sure why there wasn't enough. As far as I know, there have been a couple different times this has happened.

At approximately 12:57 PM on 03/13/24, an interview was conducted with Licensed Practical Nurse (LPN) #140 and Licensed Practical Nurse (LPN) #20 concerning resident funds. Both said they were there until at least 7:00 PM, and sometimes later if they were mandated. LPN #140 stated, I'm not going to lie, I have no idea how residents would get money in the evenings or weekends after the people leave the offices up front. I would guess they would have to wait until the next day, or if it is a weekend, they would have to wait until Monday. LPN #20 stated, I would tell them they would have to either wait until the next day, or Monday if it were a weekend, to get their money, if there wasn't anyone in the offices up front.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 1:00 PM on 03/13/24, an interview was conducted with Registered Nurse (RN) #28 and LPN #37 concerning resident funds. LPN #37 stated, I have no idea what to do if a resident wants money on evenings or weekends. RN #28 stated, We are not allowed to handle resident funds. They would probably have to wait until the next day or Monday when the staff were back in the offices. We have a nurse on call that we could always call during those times and find out what to do if they asked for money, but as far as I know they would have to wait because we can't handle their money.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43340 Based on record review and staff interview, the facility failed to notify the resident's representative in a timely fashion when care was altered. An antibiotic, Amoxicillin, was ordered for Resident #54 on 03/08/24 but the Resident Representative was not informed of the new medication order. The facility's failure to notify the resident's representative of a change in condition was true for one (1) of 29 residents sampled in the Long-Term Care Survey Process. Resident Identifier: #54. Facility Census: 106. Findings included: a) Resident #54 A record review, completed on 03/11/24 at 9:11 PM, revealed: -A 03/08/25 at 00:00 Encounter note which stated, Patient requested to be seen by staff for right sided facial swelling. The patient is unable to provide information, family is not available, and prior charts do not include family history. Diagnosis and Assessment: Sialectasia of parotid gland (a condition resulting from duct obstruction of the parotid or submandibular glands associated with pain and swelling) and Abscess (abscesses occur when an area of tissue becomes infected and the body's immune system tries to fight and contain it.) -A physician order, dated 03/08/24, for Amoxicillin. Instructions directed to give one (1) tablet by mouth every 12 hours for dental infection for seven (7) Days. -A 03/09/24 at 19:35 (7:35 PM) General note which stated, Resident has swelling to the left jaw area. Resident is being treated with antibiotics. The swelling appears to be decreasing but the resident has dark purple bruising to the left jaw area and neck. Will report findings to MD (doctor). -There was no evidence in the medical record that Resident #54's representative was notified of the new medication or the dental abscess. During a telephone interview, on 03/12/24 at 8:34 AM, resident's Medical Power of Attorney (MPOA) expressed she had visited the previous day and was concerned that her mother had bruising on her cheek and down her neck but had to leave before having the opportunity to speak to a nurse. The MPOA was unaware resident had a tooth infection and was on an antibiotic. The Director of Nursing, on 03/12/24 at 9:51 AM, reported the facility had no evidence the MPOA had been notified of the new order for Amoxicillin to treat the identified dental abscess.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 43340 Based on observation and staff interview, the facility failed to ensure a resident's right for privacy and confidentiality. Resident #95 had three (3) signs regarding personal care information posted throughout her room. Resident identifier: #95. Facility census: 106. Findings included: a) Resident #95 During a visit on 03/11/24 at 1:15 PM, the following three (3) typed signs were on display in Resident #95's room: -I do not get up alone. -I get help for the bathroom. -No straws. A subsequent record review, on 03/11/24 at 3:02 PM, revealed Resident #95 lacked decision-making capacity and had a family member serving as her Medical Power of Attorney (MPOA). During a telephone interview on 03/11/24 at 7:59 PM, Resident #95's MPOA stated, The nursing staff must've done that. It wasn't a request from the family. On 03/12/24 at 10:55 AM, the Social Worker #145 confirmed the signs in the resident's room were visible to others and included clinical and/or personal information on how to provide appropriate care to the resident. The Social Worker also confirmed the need for the signage to be in the resident's room was not care planned.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39571 Based on observation, resident interview and staff interview, the facility failed to ensure the living areas for residents were clean, safe, and sanitary; failed to ensure furniture was in good repair; failed to clean and/or change the P-Tac (packaged terminal air conditioner) vents (filters on the heat and air conditioners that are in each room.); and leaving a large amount of transparent type on a resident wheelchair. Resident identifiers: #35, #90. The facility census 106. Findings included: a) P-Tac vents During a tour on 03/12/24 at 2:34 PM of Rooms #301, #302, #303, #304, and #305 it was discovered the P-Tac vents were heavily soiled with a thick layer of debris. The above findings were verified on 03/12/24 at 2:54 PM with Maintenance Helper (MH) #43. MH #43 said the P-Tacs should be cleaned or replaced monthly. He went on to say it should be documentation of when it was last done on a form, he referred to Direct Supplies Tell MH #43 did not provide this documentation at the close of the survey. According to the records provided it was last marked as done on 01/12/24. b) Poor quality furniture An interview with the Administrator (NHA) on 03/11/24 at 1:05 PM two nightstands in the hallway on top of a bed pointed out the furniture was peeling exposing particle boards and therefore could not be cleaned properly. The NHA stated the facility had more and would replace it with better quality furniture. On 03/13/24 at 1:04 PM it was pointed out to the NHA the same two (2) nightstands that were previously in the hallway on top of a bed were now in room [ROOM NUMBER] being used along with two other nightstands. All four (4) had exposed particle board. Upon further observations on 03/13/24 at 2:22 PM it was found the following rooms also had nightstands in poor condition in room [ROOM NUMBER], #205, #306, #305, and 321. On 03/13/24 at 2:35 PM the above findings were verified by the Director of Nursing. c) Damaged ceilings On 03/11/24 11:18 AM it was discovered room [ROOM NUMBER] had a leaking ceiling. Resident #90 said it has been an ongoing problem for two (2) months. There was dark brown staining on the ceiling above the windows and that was the length of the wall. It was approximately two (2) feet wide. There was a large plastic barrel trash can and two gray basins on a table to catch rainwater. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #90 was saying she has looked at the stains so long she sees a duck swimming to a log and a big bird flying in the stain. Resident #90 said they (maintenance) have put tar on the roof several times, but it still leaks. On 03/12/24 at 3:02 PM Housekeeping Aide (HA) stated that Resident #22 was just now moved to another room, but her clothes and other belongings were still in there. On 03/12/24 at 3:04 PM it was discovered room [ROOM NUMBER] had a leaking ceiling and the plaster had fallen from the ceiling. The ceiling was over 70 percent discolored. The discolored ceiling had rings of brown staining and a black substance showing in many places. The missing plaster and bowed exposed sheet rock was in the middle of the room. There were tall black trash cans in the middle of the floor with bath blankets under them that also had brown rings, along with chunks of plaster that had fallen from the ceiling scattered around the room. The room had a very strong odor of musky mildew. On 03/12/24 at 3:37 PM MH #43 and the District Maintenance Manager (DMM) #158 arrived at room [ROOM NUMBER]. They were asked when did the leak start? MH #43 state on Saturday 03/09/24. MH #43 was informed that Resident #90 that is in room [ROOM NUMBER] said her ceiling had been leaking for more than two (2) months. On 03/13/24 at 8:20 AM MH #43 provided a work order that was entered on 01/28/24 by the NHA for room [ROOM NUMBER]. There was not any other evidence that any other staff had informed the maintenance department of 301 was leaking as well. Resident #22 refused to be interviewed on 03/11/24 at 12:09 PM and began yelling. Therefore, not wanting to upset the resident any further, no statement was obtained. On 03/12/24 at 4:10 PM the NHA was asked when he was made aware of the condition of room [ROOM NUMBER]. The NHA stated he was told there was a leak in the room on Saturday 03/09/24. He was asked if Resident #22 should have been moved to a safer room on Saturday? The Administrator agreed the room had a very pungent odor. The large trash cans and stained peeling ceiling was also pointed out. On 03/12/24 at 4:15 PM the NHA was shown room [ROOM NUMBER] as well. Resident #90 was in her room and spoke to the NHA. On 03/13/24 at 8:20 AM the NHA informed this surveyor that Resident #90 was also moved to another room and the Maintenance crew are currently removing the ceiling in room [ROOM NUMBER] and 301 will be started on after 303 was completed. d) Wheelchair armrest On 03/11/24 at 12:22 PM, Resident #35 was seen in the hallway in his wheelchair. It was noted on the right armrest there was a large amount of tape clear (Office tape) wrapped around the armrest holding a cup holder to the armrest. Resident #35 stated one of the aides helped him put the cup holder on his wheelchair. Licensed Practical Nurse (LPN) #16 stated she would put a work order in to have it properly attached. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/12/24 at 2:06 PM, Cooperate Nurse #157 was shown the tape was still hanging off of the armrest. On 03/13/24 at 10:20 AM Resident #35 was in his wheelchair and was very happy about the tape not being on his wheelchair and his cup hold was now attached very securely. 42120

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. 39571 Based on staff interview and record review the facility failed to ensure all residents were free from unnecessary medication psychotropic medications used for refusal of care. This was true for two (2) out of five (5) reviewed for unnecessary medication. Resident identifiers: #5. and #91. Facility census 106. Findings included: a) Resident #5 While reviewing orders for an antipsychotic named Abilify. It was discovered that Abilify was ordered on 01/07/2024. The order was written as typed below: Abilify Oral Tablet 5 MG (Aripiprazole) Give 5 mg (milligram) by mouth one time a day for antipsychotic Target behavior: refusal of care, combative, aggression. On 03/13/24 at 11:24 AM Director of Nursing (DON) was shown the above order. DON stated, We do not give medications for refusal of care. b) Resident #91 During record review for Resident #91 on 03/11/24 at approximately 12:15 PM, it was discovered the resident had the following order beginning on 01/25/24. Abilify Oral Tablet 10 MG (Aripiprazole) Give one tablet by mouth at bedtime for mood target behavior: refusal of care. At approximately 12:00 PM on 03/11/24, Resident #91 was observed sleeping in the bed. At approximately 10:15 AM on 03/12/24, Resident #91 was observed sleeping in the bed. At approximately 12:00 PM on 03/12/24, Resident #91 was observed sleeping in the bed. At approximately 12:38 PM on 03/12/24, Resident #91 was observed sleeping in the wheelchair, with their lunch tray on the bedside table, with the lid still on the tray. At approximately 10:10 AM on 03/13/24, Resident #91 was observed sleeping in the bed. At approximately 12:20 PM on 03/12/24, the Medication Administration Record (MAR) for February and March of 2024 was obtained for Resident #91. The MAR stated that Resident #91 received Abilify every day in February and, so far, every day in March. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the MAR for Resident #91, for the question Is resident free from side effects of psychotherapeutic medications? Yes or No Yes is marked for every day from February through March 11, 2024, except for 03/02/24 and 03/03/24, which are marked NA for not applicable. At approximately 12:00 PM on 03/13/24, the Director of Nursing (DON) was notified and acknowledged the order for Abilify for refusal of care, the times Resident #91 was witnessed sleeping, and the documentation of Not Applicable on days where they were given the medication and were to be monitored for side effects. 49467

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43340 Based on record review and staff interview, the facility failed to ensure a resident fall resulting in serious bodily injury was reported in a timely manner to the appropriate state agencies. This failed practice was true for one (1) of two (2) residents reviewed for falls during the Long-Term Care Survey Process. Resident identifier: #29. Facility Census: 106. Findings included: a) Resident #29 A record review, completed on 03/11/24 at 8:36 PM, revealed the following: A General Note, dated 11/22/2023 at 8:56 PM, indicated a resident had fallen in her bathroom. The resident was alert and verbal. The resident complained of right arm pain and left hip pain. Resident's physician was notified, and the resident was sent to the hospital for further evaluation. Another General Note, dated 11/23/2023 at 2:19 AM, documented, Resident returned from ER (emergency room) with diagnosis of facial contusion, cervical sprain, contusion of left hip, skin tear of right top hand, and nasal bone fracture. Review of the facility's reportable log, completed on 03/12/24 at 1:25 PM, revealed the fall with serious bodily injury was not reported within two (2) hours of the facility having knowledge of the nasal bone fracture. The reportable log indicated it was not reported until 11/27/23, four (4) days after the facility had knowledge of the serious bodily injury. During an interview on 03/12/24 at 2:10 PM, Social Worker #145 communicated the facility had not reported the fall with major injury incident in a timely fashion because both social workers had been off over the Thanksgiving Holiday.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 31498 Based on medical record review and staff interview, the facility failed to provide the Notice of Transfer to the State Ombudsman. This was discovered for one (1) of one (1) residents reviewed for a transfer/discharge during the Long-term Care Survey Process. Resident #105 was transferred to another long-term care facility and no notice of transfer was sent to the State Ombudsman. Resident identifier #105. Facility census: 106. Findings included: a) Resident #105 A medical record review on 03/13/24 revealed the notice of transfer was not sent to the State Ombudsman for Resident #105 when transferred to another facility on 12/12/23. In an interview with the Licensed Social Worker (LSW) on 03/13/24 at 9:45 AM, verified the Notice of Transfer was not sent to the State Ombudsman regarding the transfer for Resident #105, who was transferred to another long-term care facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and staff interview, the facility failed to update the PASARR for a resident that had a diagnosis of a serious mental disorder after admission to the facility. This was true for one (1) of ten (10) residents reviewed for Pre Admission Screening and Resident Review (PASARRs) during the long-term care survey process. Resident Identifier: #6. Facility census: 106. Findings included: a) Resident #6 At approximately 9:00 AM on 03/12/24, a record review was conducted for Resident #6. It revealed that Resident #6 was admitted to the facility on [DATE] and was diagnosed with schizophrenia on 09/07/19 and the resident's PASARR was not updated to reflect the diagnosis. According to the PASARR for Resident #6, seizure disorder is marked as a current diagnosis, however, schizophrenia is not. At approximately 12:00 PM on 03/13/24, the Director of Nursing was notified and acknowledged the missing diagnosis from Resident #6's PASARR.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31498 39571 42120 43340 49467 Based on record review and staff interview, the facility failed to update the Pre Admission Screening and Resident Review (PASRR) for a resident that was diagnosed with a serious mental disorder upon admission to the facility. This was true for nine (9) of ten (10) residents reviewed for Preadmission Screening and Resident Review (PASARRs) during the long-term care survey process. Resident Identifiers: #82, #38, #6, #32, #29, #37, #102, #77. Facility census:106. Findings included: a) Resident #82 At approximately 9:00 AM on 03/12/24, a record review was conducted for Resident #82. It was revealed that Resident #82 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder. According to the PASRR for Resident #82, major depressive disorder was not marked. At approximately 12:00 PM on 03/13/24, the Director of Nursing (DON) was notified and acknowledged the missing diagnosis from Resident #82's PASRR. b) Resident #38 At approximately 9:00 AM on 03/12/24, a record review was conducted for Resident #38. It revealed that Resident #38 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder. A review of the PASRR for Resident #38 revealed major depressive disorder was not marked. At approximately 12:00 PM on 03/13/24, the DON was notified and acknowledged the missing diagnosis from Resident #38's PASRR. c) Resident #6 At approximately 9:00 AM on 03/12/24, a record review was conducted for Resident #6. It revealed that Resident #6 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the PASRR for Resident #6, seizure disorder is marked as a current diagnosis, however, major depression is not. At approximately 12:00 PM on 03/13/24, the Director of Nursing was notified and acknowledged the missing diagnosis from Resident #6's PASRR. d) Resident #32 A record review, completed on 03/11/24 at 3:02 PM, revealed Resident #32 was admitted to the facility on [DATE] with a bipolar diagnosis. Further record review, completed on 03/12/24 at 9:49 AM, revealed two (2) PASRRs on file: -Resident's admitting PASRR, dated 02/28/23, did not identify Resident #32 had a bipolar diagnosis on Section III, Question 30 of the PASRR. This PASRR indicated no Level II was required. -Resident's Readmission PASRR, dated 04/24/23, also failed to identify Resident #32 had a bipolar diagnosis on Section III, Question 30 of the PASRR. This PASRR indicated no Level II was required. During an interview on 03/12/24 at 10:30 AM, an interview with Social Worker #145 acknowledged neither PASARR identified the resident's bipolar diagnosis. The Social Worker added, We will complete a new one. e) Resident #29 A record review, completed on 03/11/24 at 2:57 PM, revealed Resident #29 was admitted to the facility on [DATE] with a diagnosis of bipolar and a major depressive disorder. Further record review, completed on 03/12/24 at 12:00 PM, revealed two (2) PASRR evaluations file: Resident's admitting PASRR, dated 07/21/23, did not identify Resident #29 had bipolar diagnosis or a major depressive disorder on Section III, Question 30 of the PASRR. This PASRR indicated no Level II was required. This PASRR indicated there was a possibility the resident may be able to return home. The facility completed another PASRR on 09/31/23 to indicate the physician did not feel the resident would be able to return home. Again, this PASRR did not identify Resident #29 had a bipolar diagnosis or a major depressive disorder diagnosis on Section III, Question 30 of the PASRR. This PASRR indicated no Level II was required. During an interview on 03/12/24 at 12:25 PM, Social Worker #14 confirmed both PASRR evaluations on file failed to identify the resident's bipolar and major depression diagnoses. The Social Worker added, We will work on submitting a new one. f) Resident #37 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/12/24, a record review of the resident's electronic medical record (EMR), the resident's most recent PAS, dated 02/22/18, indicated no level II not required. Section lll #30 MI/MR Assessment indicated no current diagnosis of Psychosis. The record also revealed the resident received a diagnosis of Psychosis on 07/19/18 but did not receive a new PAS to address whether or not specialized services were needed. On 03/13/24 at 12:55 PM the DON verified Resident #37's PAS did not reveal her diagnosis of Psychosis. The DON confirmed a new PASRR was not completed. g) Resident #102 On 03/12/24, a record review of the resident's electronic medical record (EMR), the resident's most recent PASARR, dated 02/16/24, indicated no level II not required. Section lll #30 MI/MR Assessment indicated no current diagnosis. The record also revealed the resident had a diagnosis of Bipolar on Admission 02/16/24 but did not receive a new PASRR to address whether or not specialized services were needed. On 03/13/24 at 12:55 PM the DON verified Resident #102's PASRR did not reveal the diagnosis of bipolar disorder. The DON confirmed a new PASRR was not completed. h) Resident #77 A record review on 03/13/24, revealed Resident #77 had an admitting diagnosis of bipolar on 05/12/23. A PASRR, dated 11/01/23, did not identify Resident #77 had a bipolar diagnosis in Section III, Question 30. Further record review indicated a new PASRR had not been completed to identify the resident's bipolar diagnosis and to address whether any specialized services were required. During an interview on 03/13/24 at 12:20 PM, the DON acknowledged the PASRR completed on 11/01/23 failed to identify the resident's bipolar diagnosis and no new PASRR had been completed to reflect the bipolar diagnosis.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31498 Based on record review and staff interview, the failed to develop a comprehensive person-centered care plan for the area of discharge planning. This was true for one (1) of one (1) resident care plans reviewed for discharge planning during the Long-Term Care Survey Process. The care plan for Resident #105 was not developed for discharge planning. Resident identifier: #105. Facility census: 106. Findings included: a) Resident #105 A medical record review on 03/13/24, revealed Resident #105 was discharged on [DATE]. The comprehensive person-centered care plan had not been developed for any discharge planning for Resident #105. In an interview with the Licensed Social Worker (LSW) on 03/13/24 at 9:20 AM, verified the care plan had not been developed for discharge planning for Resident #105.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 31498 Based on record review and staff interview, the facility failed to revise a person-centered comprehensive care plan. This was true for one (1) of four (4) resident care plans reviewed for urinary catheter care during the Long-Term Care Survey Process (LTCSP). The care plan for Resident #84 had not been revised when the urinary catheter was removed. Resident identifier: #84 Facility census: 106. Findings included: a) Resident #84 A medical record review on 03/13/24 indicated Resident #84 had an indwelling urinary catheter removed on 02/05/24. The care plan had not been revised to indicate the urinary catheter had been removed for Resident #84. During an interview with the Director of Nursing (DON) on 03/13/24 at 11:54 AM, verified the care plan had not been revised when the urinary catheter had been removed on 02/05/24 for Resident #84.

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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. 49467 Based on record review and resident and staff interview, the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This was true for one (1) of one (1) residents reviewed for ADL care during the long-term care survey process. Resident Identifier: #38. Facility census: 106. Findings included: a) Resident #38 At approximately 1:41 PM on 03/11/24, an interview was conducted with Resident #38. During the interview, the resident stated they had been at the facility for a couple of weeks and had only received bed baths. The resident said, I would really like to get in the shower to get my hair washed. At approximately 1:30 PM on 03/12/24, records were obtained from the Director of Nursing (DON) pertaining to Resident #38's showers. The DON stated Resident #38 was to receive baths on Wednesdays and Saturdays. Upon review of the records obtained from the DON, it was revealed Resident #38 was documented as receiving showers, since admission on 03/03/24, on 03/05/24 at 10:59 PM, 03/06/24 at 12:54 AM, 03/07/24 at 1:32 PM, and 03/11/24 at 10:59 PM. At approximately 1:40 PM on 03/12/24, Resident #38 was interviewed, along with Licensed Practical Nurse (LPN) #140, in which the resident confirmed a preference for showers, and wanted their hair washed, but had only received bed baths up to this point. At approximately 1:51 PM on 03/12/24, LPN #140 was interviewed concerning the documentation stating Resident #38 was given showers as opposed to the bed baths they received. LPN #140 confirmed Resident #38 had received bed baths instead of showers on the listed dates. LPN #140 stated I usually just check to see if my aides have completed their documentation, I didn't know there was even a place on there for them to choose between showers and bed baths. LPN #140 stated, We have had a ton of problems with documentation from our aides. LPN asked who the Nurse Aides were that documented showers were given instead of bed baths. LPN #140 was notified that Nurse Aide (NA) #11 and NA #160 documented showers instead of bed baths, to which they replied That explains a lot then. At approximately 12:00 PM on 03/13/24, the Director of Nursing (DON) was notified and acknowledged bed baths were given over the preferred showers, and that Resident #38 had not had their hair washed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42120 Based on record review and staff interview, the facility failed to provide information and/or offer the Respiratory Syncytial Virus (RSV) immunization per recommendation of the CDC in a timely manner and failed to follow a physician's order regarding Insulin. This failed practice had the potential to affect more than a limited number of residents who currently reside in the facility. Facility census 106. Findings included: a) RSV immunization During a review of the facility documents regarding immunization it was determined that zero (0) out of 106 residents had been provided educational information about the risk and benefits of receiving the RSV vaccination. On 03/13/24 at 1:25 PM, the Infection Preventionist (IP) stated she had not offered the RSV vaccine. She stated that the facility did not offer the RSV vaccine. b) The Centers for Disease Control and Prevention (CDC) Respiratory Syncytial virus, or RSV, is a common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious. Infants and older adults are more likely to develop severe RSV and need hospitalization . Vaccines are available to protect older adults from severe RSV. Monoclonal antibody products are available to protect infants and young children from severe RSV. CDC recommends RSV vaccines to protect adults ages 60 and older from severe RSV, using shared clinical decision-making. According to the CDC the RSV vaccine was made available in early August of 2023. In general, simultaneous administration of vaccines remains a best practice. Providers should continue to simultaneously administer the vaccines for which a patient is eligible, including COVID-19, influenza, and pneumococcal vaccines. Simultaneous administration of the RSV vaccine with other vaccines for older adults is also acceptable. When deciding whether to simultaneously administer other vaccines with RSV vaccine on the same day, providers should consider whether the patient is up to date with recommendations for currently recommended vaccines, the feasibility of administering additional vaccine doses later, risk for acquiring vaccine-preventable disease, vaccine reactogenicity profiles, and patient preferences. The Above information was taken from the website: Centers for Disease Control and Prevention (.gov) b) Resident #95 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/11/24 at 8:05 PM, an electronic medical record review was completed. There was an order for Resident #95 to receive insulin on a sliding scale. The term sliding scare refers to the progressive increase in doses, based on predefined blood glucose ranges. The physician order outlined the following: NOVOLOG FLEXPEN 100/ML INSULIN PEN Inject as per sliding scale, if 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units Inject subcutaneously before meals and at bedtime for DM If Blood Sugar above 400 notify MD Start Date 10/07/2023 at 6:30 AM Review of the October 2023, November 2023, and December 2023 Medication Administration Records (MARs) revealed the following dates and times where nursing failed to obtain blood glucose levels, leaving the MAR completely blank: -10/21/23 at 6:30 AM -10/28/23 at 6:30 AM -11/04/23 at 6:30 AM -11/05/23 at 6:30 AM -11/11/23 at 6:30 AM -11/18/23 at 6:30 AM -11/25/23 at 6:30 AM -12/10/23 at 6:30 AM During an interview on 03/12/24 at 10:02 AM, the Director of Nursing (DON) reported the documentation on the above-mentioned dates failed to meet professional standards of practice. The DON stated nursing staff should have taken the resident's blood glucose level, documented it, and assessed if Novolog needed to be administered or not. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43340

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43340 Based on observation and staff interview, the facility failed to ensure the resident environment remained free of accident hazards over which it had control. A prescribed medication was found on the floor in Resident #43's room. This was a random opportunity for discovery. Resident Identifier: #43. Facility census: 106. Findings included: a) Resident #43 During an in-room visit on 03/11/24 at 12:14 PM, an unidentified white, round, scored (having a line down the middle to make it easier to split) pill was found on the floor in front of Resident #43's bed. On 03/11/24 at 12:17 PM, Social Worker #145 confirmed the pill was on the floor During an interview, on 03/11/24 at 12:20 PM, LPN #16 identified the pill as Amiodarone and stated resident received the medication for AFib (atrial fibrillation, which is a type of arrhythmia, or abnormal heartbeat.) According to Healthline, (https://www.healthline.com/health/amiodarone-oral-tablet), the medication Amiodarone has boxed warnings. A boxed warning is the most serious warning from the Food and Drug Administration (FDA). It alerts doctors and patients about drug effects that may be dangerous. -Amiodarone should only be used if the patient has a life threatening arrhythmia or irregular heart rate. -If a patient needs to be treated with Amiodarone for an irregular heart rate, they need to be admitted into the hospital to get the first dose. This is to make sure that Amiodarone is given to the patient safely and it's effective. The Director of Nursing (DON), on 03/12/24 at 10:50 AM, reported she had been made aware of the medication being found on the floor in Resident #43's room. The DON stated it is a professional standard of practice for nurses to be certain all medications have been swallowed before documenting successful administration on the MAR (medication administration record) and walking away.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 39571 .Based on staff interview and record review, the facility failed to ensure all residents were free from unnecessary psychotropic medications used for refusal of care, no rationale provided for continuing to use a psychotropic PRN (take as needed) medication used longer than 14 days. This was true for two (2) out of five (5) reviewed for unnecessary medication. Resident identifiers: #5. and #91. Facility census 106. Findings included: a) Resident #5 While reviewing orders for an antipsychotic medication Abilify it was discovered that Abilify was ordered on 01/07/2024. The order was written as typed below: Abilify Oral Tablet 5 MG (Aripiprazole) Give 5 mg by mouth one time a day for antipsychotic Target behavior: refusal of care, combative, aggression. On 03/13/24 at 11:24 AM the Director of Nursing (DON) was shown the above order. DON stated, We do not give medications for refusal of care. Medical records show Resident #5 was ordered Xanax 0.25 mg 1 tablet Q12 hours as needed for anxiety on 01/07/24. On 03/13/24 at 11:24 AM, the DON could not provide a rationale for having an order for a PRN (as needed) for more than 14 days. At the close of this survey no additional information was available. b) Resident #91 During record review for Resident #91 on 03/11/24 at approximately 12:15 PM, it was discovered the resident had the following order beginning on 01/25/24: Abilify Oral Tablet 10 MG (Aripiprazole) Give one tablet by mouth at bedtime for mood target behavior: refusal of care. At approximately 12:00 PM on 03/11/24, Resident #91 was observed sleeping in the bed. At approximately 10:15 AM on 03/12/24, Resident #91 was observed sleeping in the bed. At approximately 12:00 PM on 03/12/24, Resident #91 was observed sleeping in the bed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 12:38 PM on 03/12/24, Resident #91 was observed sleeping in the wheelchair, with their lunch tray on the bedside table, with the lid still on the tray. At approximately 10:10 AM on 03/13/24, Resident #91 was observed sleeping in the bed. At approximately 12:20 PM on 03/12/24, the Medication Administration Record (MAR) for February and March of 2024 was obtained for Resident #91. The MAR revealed that Resident #91 received Abilify every day in February and, so far, every day in March. On the MAR for Resident #91, for the question Is resident free from side effects of psychotherapeutic medications? Yes or No Yes was marked for every day from February through March 11, 2024, except for 03/02/24 and 03/03/24, which are marked NA for not applicable. At approximately 12:00 PM on 03/13/24, the Director of Nursing (DON) was notified and acknowledged the order for Abilify for refusal of care, the times Resident #91 was witnessed sleeping, and the documentation of Not Applicable on days where they were given the medication and were to be monitored for side effects. 49467

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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. 39571 Based on observation and staff interview, the facility failed to ensure all vials of multi-use insulin were labeled with the initial date it was opened. This was true for three (3) out of three (3) vials found in the medication cart. Resident identifiers: #32, #72, and #71. Facility census 106. Findings included: a) Medication cart On 03/13/24 at 9:06 AM Registered Nurse (RN) #28 verified the following insulin vials for the following residents did not have a date to indicate what day it was initially opened. The facility staff should date the label of any multi-use vial when the vial is first accessed and access the vial. A multi-use vial of Lispro belonging to Resident # 32 did not have a date on the vial. A multi-use vial of Lantus belonging to Resident # 71 did not have a date on the vial. A multi-use vial of Levemir belonging to Resident # 72 did not have a date on the vial. A multi-use vial once punctured is not to be used longer than 30 days per the CDC. On 03/13/24 at 11:30 AM the Director of Nursing (DON) was informed of the issues above.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 42120 Based on observation and staff interview, the facility failed to provide appropriate assistive devices to residents who need them to maintain or improve their ability to eat independently. This was a random opportunity for discovery. Resident identifier: #37. Facility census: 106. Findings Included: a) Resident #37 An observation on 03/11/24 at 12:36 PM, noon meal, found Resident #37 having issues drinking her milk. Review on 03/11/24 of Resident #37's tray card revealed regular water in a spout cup. During an interview on 03/11/24 at 12:40 PM, Nurse Aide #67 stated that Resident #37 doesn't like the spout cup, so they don't provide it to her. A record review on 03/12/24 at 9:12 AM revealed a care plan: Focus: - Resident was dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Paralysis affecting left extremities. Goals: Residents ADL care needs will be anticipated and met throughout the next review period. Intervention: The resident must use a proval cup (blue handles) for all liquids. Continued review revealed a diet order: - Dysphagia Advanced texture with start date 06/13/23 During an interview on 03/13/24 at 12:51 PM the Corporate Nurse confirmed that Resident #37 needed the blue handled cup.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierpont Center at Fairmont Campus	1543 Country Club Road Fairmont, WV 26554

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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. 31498 Based on observations and staff interview, the facility failed to store food in accordance with professional standards for food service safety. It was discovered food was not stored properly in the freezer, a trash can was situated near the beverage dispensers, a broken floor tile and a dirty floor in the walk-in freezer. This had the potential to affect all residents receiving nutrition from the kitchen. Facility census: 106. Findings included: a) Kitchen tour During a kitchen tour, on 03/11/24 at 11:30 AM, it was discovered that a box of breaded fish filets were not sealed properly exposing the filets to the elements in the walk-in freezer. A trash can was stored in front of the beverage dispensers, causing the staff to lean over the trash can in order to fill the beverage pitchers, beside the ice machine there was a large section of a floor tile missing. Also the floor of the walk-in freezer had debris and food particles under the shelving unit. In an observation and interview with the Dietary Manager (DM), on 03/11/24 at 11:45 AM, the DM verified the breaded fish filets were not covered properly, which allowed the filets to be exposed to the elements. He agreed the trash can should not be situated in front of the beverage dispensers, making staff lean over the unsanitary trash can to fill the beverage pitchers. He verified the floor tile was missing and needed to be repaired. He also verified the floor of the walk-in freezer had food debris under the shelving unit and needed to be cleaned.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 43340 Based on record review and staff interview, the facility failed to ensure the facility assessment identified the staffing levels and training requirements needed to provide the necessary care and services for their residents. This deficient practice had the potential to affect more than a limited number of residents. Facility census: 106. Findings included: a) Facility Assessment A review of the Facility Assessment was completed on 03/11/24 at 9:27 PM. On page 20, Section II. Staffing, Training, Services & Personnel A.1. Function - Sufficiency Analysis Summary had the following guidance: Considerations: Use and/or refer to: 1. Staffing and scheduling systems 2. Staff training and competency program 3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. Please document the total #/average/range of staff required to ensure a sufficient number of qualified staff are available to meet each resident's needs. Refer to the Staffing and Personnel Worksheet spreadsheet above for documentation assistance. Other than the guidance described above, there was nothing written under this section. On page 26, Section II. Staffing, Training, Services & Personnel B.1. Acuity - Sufficiency Analysis Summary had the following guidance: Considerations: Use and/or refer to: 1. Staffing and scheduling systems 2. Staff training and competency program (continued on next page)

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	515155	A. Building B. Wing	03/13/2024

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. Please document total #/average/range of staff required to ensure a sufficient number of qualified staff were available to meet each resident's needs. Refer to the Staffing and Personnel Worksheet spreadsheet above for documentation assistance. Other than the guidance described above, there was nothing written under this section. On page 28, Section II. Staffing, Training, Services & Personnel C.1. - Cognitive - Sufficiency Analysis Summary had the following guidance: Considerations: Use and/or refer to: 1. Staffing and scheduling systems 2. Staff training and competency program 3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. Please document the total #/average/range of staff required to ensure a sufficient number of qualified staff are available to meet each resident's needs. Refer to the Staffing and Personnel Worksheet spreadsheet above for documentation assistance. Other than the guidance described above, there was nothing written under this section. There was no evidence the facility identified the type of staff members, other health care professionals, and medical practitioners that were needed to provide support and care for residents. There was no evidence the facility described their staffing plan/general approach to staffing to ensure that they would have sufficient staff to meet the needs of the residents at any given time. There was no evidence the facility described the staff training/education and competencies that would be necessary to provide the level and types of support and care needed for their resident population b) Interview with Administrator During an interview, on 03/12/24 at 2:00 PM, the Administrator agreed the facility reviewed their facility-wide assessment, which was meant to include both their resident population and the resources the facility needs to care for their residents. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When asked to identify the areas in the Facility Assessment where the facility had determined the staffing level needed to meet resident needs, how the facility determined the skills and competencies required by those providing care, and where the facility had addressed the facility's training program to ensure any training needs were met for all new and existing staff, the Administrator indicated he would review the Facility Assessment and report back. On 03/12/24 at approximately 4:10 PM, the Administrator reported he felt the above-mentioned questions had been addressed in the B.1. Acuity - Sufficiency Analysis Summary and C.1. - Cognitive - Sufficiency Analysis Summary sections.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49467 Based on record review and resident and staff interview, the facility failed to maintain accurate and complete medical records by failing to accurately record side effects of psychotropic medications, and not accurately documenting the type of ADL care provided to dependent residents. This was true for two (2) of two (2) residents reviewed for documentation during the long-term care survey process. Resident identifiers: #38, #91. Facility census: 106. Findings included: a) Resident #38 At approximately 1:41 PM on 03/11/24, an interview was conducted with Resident #38. During the interview, the resident stated they had been at the facility for a couple of weeks and only received bed baths. The resident said, I would really like to get in the shower to get my hair washed. At approximately 1:30 PM on 03/12/24, records were obtained from the Director of Nursing (DON) pertaining to Resident #38's showers. The DON stated Resident #38 was to receive baths on Wednesdays and Saturdays. Upon review of the records obtained from the DON, it was revealed Resident #38 was documented as receiving showers, since admission on 03/03/24, on 03/05/24 at 10:59 PM, 03/06/24 at 12:54 AM, 03/07/24 at 1:32 PM, and 03/11/24 at 10:59 PM. At approximately 1:40 PM on 03/12/24, Resident #38 was interviewed, along with Licensed Practical Nurse (LPN) #140. At this time the resident confirmed a preference for showers, and wanted their hair washed. The resident commented only bed baths had been received up to this point. At approximately 1:51 PM on 03/12/24, LPN #140 was interviewed concerning the documentation that revealed Resident #38 was given showers as opposed to the bed baths they received. LPN #140 confirmed Resident #38 had received bed baths instead of showers on the listed dates. LPN #140 stated I usually just check to see if my aides have completed their documentation, I didn't know there was even a place on there for them to choose between showers and bed baths. LPN #140 stated, We have had a ton of problems with documentation from our aides. LPN was asked who the Nurse Aides (NAs(ere that documented showers were given instead of bed baths. LPN #140 was notified that NA #11 and NA #160 documented showers instead of bed baths, to which LPN #140 replied, That explains a lot then. At approximately 12:00 PM on 03/13/24, the Director of Nursing (DON) was notified and acknowledged bed baths were given over the preferred showers, and that Resident #38 had not had their hair washed. B) Resident #91 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review for Resident #91 on 03/11/24 at approximately 12:15 PM, it was discovered the resident had the following order beginning on 01/25/24: Abilify Oral Tablet 10 MG (Aripiprazole) Give one tablet by mouth at bedtime for mood target behavior: refusal of care. At approximately 12:00 PM on 03/11/24, Resident #91 was observed sleeping in their bed. At approximately 10:15 AM on 03/12/24, Resident #91 was observed sleeping in their bed. At approximately 12:00 PM on 03/12/24, Resident #91 was observed sleeping in their bed. At approximately 12:38 PM on 03/12/24, Resident #91 was observed sleeping in their wheelchair, with their lunch tray on the bedside table, with the lid still on the tray. At approximately 10:10 AM on 03/13/24, Resident #91 was observed sleeping in their bed. At approximately 12:20 PM on 03/12/24, the Medication Administration Record (MAR) for February and March of 2024 was obtained for Resident #91. The MAR review revealed that Resident #91 received Abilify every day in February and, so far, every day in March. On the MAR for Resident #91, the question Is resident free from side effects of psychotherapeutic medications? Yes or No Yes was marked for every day from February through March 11, 2024, except for 03/02/24 and 03/03/24, which are marked NA for not applicable. At approximately 12:00 PM on 03/13/24, the DON was notified and acknowledged the order for Abilify for refusal of care, the times Resident #91 was witnessed sleeping, and the documentation of Not Applicable on days where they were given the medication and were to be monitored for side effects.

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F 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31498

Based on observations and staff interviews, the facility failed to ensure the Quality Assessment and Assurance committee made good faith attempts to correct quality deficiencies of which it did have or should have had knowledge. The discovery was made during the facility tasks area for a Safe/Clean/Comfortable and Homelike environment for leaks in the ceiling, damaged furniture, a resident's wheelchair had damage to the armrest and the heating, ventilation and air conditioning (HVAC) units had an excessive amount of dust buildup. These deficient practices did not allow for a safe, clean, comfortable and homelike environment for residents. Facility census: 106.

Findings included:

Based on observation, resident interview and staff interview, the facility failed to ensure the living areas for residents were clean, safe, and sanitary; failed to ensure furniture was in good repair; failed to clean and/or change the Packaged Terminal Air Conditioner (P-Tac) vents (filters on the heat and air conditioners that are in each room.); and leaving a large amount of transparent type on a resident wheelchair. Resident identifiers: #35, # 90. The facility census 106.

Findings included:

a) P-Tac vents

During a tour on 03/12/24 at 2:34 PM of rooms 301, 302, 303, 304, and 305 it was discovered the P-Tac vents were heavily soiled with a thick layer of debris.

The above findings were verified on 03/12/24 at 2:54 PM with Maintenance Helper (MH) #43. MH #43 said the P-Tacs should be cleaned or replaced monthly. He went on to say it should be documentation of when it was last done on a form, he referred to Direct Supplies Tell MH #43 did not provide this documentation at the close of the survey. According to the records provided it was last marked as done on 01/12/24.

b) Poor quality furniture

An interview with the Administrator (NHA) on 03/11/24 at 1:05 PM two nightstands in the hallway on top of a bed pointed out the furniture was peeling exposing particle boards and therefore could not be cleaned properly. The NHA stated the facility had more and would replace it with better quality furniture.

On 03/13/24 at 1:04 PM it was pointed out to the NHA the same two (2) nightstands that were previously in the hallway on top of a bed were now in room [ROOM NUMBER] being used along with two other nightstands. All four (4) had exposed particle broad.

Upon farther observations on 03/13/24 at 2:22 PM it was found the following rooms also had nightstands in poor condition in rooms 202, 205, 306,305, and 321.

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F 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 03/13/24 at 2:35 PM the above findings were verified by the Director of Nursing.

c) Damaged ceilings

On 03/11/24 11:18 AM it was discovered room [ROOM NUMBER] had a leaking ceiling. Resident #90 said it has been an ongoing problem for two (2) months. There was dark brown staining on the ceiling above the windows that was the length of the wall. It was approximately two (2) feet wide.

There was a large plastic barrel trash can and two gray basins on a table to catch rainwater.

Resident # 90 was saying she has looked at the stains so long she sees a duck swimming to a log and a big bird flying in the stain. Resident #90 said they (maintenance) have put tar on the roof several times, but it still leaked.

On 03/12/24 at 3:02 PM Housekeeping Aide (HA) stated that Resident #22 was just now moved to another room, but her clothes and other belongings were still in there.

On 03/12/24 at 3:04 PM it was discovered that room [ROOM NUMBER] had a leaking ceiling and the plaster had fallen from the ceiling. The ceiling was over 70 percent discolored. The discolored ceiling had rings of brown staining and a black substance showing in many places. The missing plaster and bowed exposed sheet rock was in the middle of the room. There were tall black trash cans in the middle of the floor with bath blankets under them that also had brown rings, along with chunks of plaster that had fallen from the ceiling scattered around the room. The room had a very strong odor of musky mildew.

On 03/12/24 at 3:37 PM MH #43 and the District Maintenance Manager (DMM) #158 arrived at room [ROOM NUMBER]. They were asked when the leak started. MH #43 stated it started on Saturday 03/09/24. MH #43 was informed that Resident #90 in room [ROOM NUMBER] said her ceiling had been leaking for more than two (2) months.

On 03/13/24 at 8:20 AM MH #43 provided a work order that was entered on 01/28/24 by the NHA for room [ROOM NUMBER]. There was no other evidence that any other staff had informed the maintenance department that room [ROOM NUMBER] was leaking as well.

Resident #22 refused to be interviewed on 03/11/24 at 12:09 PM and began yelling. Therefore, not wanting to upset the resident any further, no statement was obtained.

On 03/12/24 at 4:10 PM the NHA was asked when he was made aware of the condition of room [ROOM NUMBER]. The NHA stated he was told there was a leak in the room on Saturday 03/09/24. He was asked if Resident #22 should have been moved to a safer room on Saturday. The Administrator agreed the room had a very pungent odor. The large trash cans and stained peeling ceiling was also pointed out.

On 03/12/24 at 4:15 PM the NHA was shown room [ROOM NUMBER] as well. Resident #90 was in her room and spoke to the NHA.

On 03/13/24 at 8:20 AM the NHA informed this surveyor that Resident #90 was also moved to another room and the Maintenance crew are currently removing the ceiling in room [ROOM NUMBER] and #301 would be started on room [ROOM NUMBER] was completed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d) Wheelchair armrest On 03/11/24 at 12:22 PM, Resident #35 was seen in the hallway in his wheelchair. It was noted on the right armrest there was a large amount of tape clear (Office tape) wrapped around the armrest holding a cup holder to the armrest. Resident #35 stated one of the aides helped him put the cup holder on his wheelchair. Licensed Practical Nurse (LPN) #16 stated she would put a work order in to have it properly attached. On 03/12/24 at 2:06 PM, Cooperate Nurse #157 was shown the tape was still hanging off of the armrest. On 03/13/24 at 10:20 AM Resident # 35 was in his wheelchair and was very happy about the tape not being on his wheelchair and that his cup hold was now attached very securely.

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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. 42120 Based on observations and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent cross-contamination and the development and transmission of communicable diseases and infections with regards to laundry services, bed pan storage and the community ice machine. This practice had the potential to affect all resident's resident in the Facility. Resident Identifiers: #16, #256, #257, and #59. Facility census: 106. Findings included: a) Bedpan Storage An observation of Resident's #16, #256, and #257's adjoining restroom found their used bed pans stored together without covers in the bathtub. During an interview and observation on 03/11/24 at 2:05 PM Nurse Aide (NA) #92 stated they should be stored in bags. When asked how to tell them apart she stated that they should have names on them. She proceeded to put the used bed pans in bags and place them back in the bathtub. b) Laundry Services An observation during the laundry tour on 03/13/24 at 3:20 PM found, the laundry room did not have a sealed separation from the soiled laundry area to the clean laundry area. There was also no negative air flow pulling from the clean area to the soiled area, failing to maintain a functional and safe laundry area to avoid contamination. The laundry was in progress in both areas, with clean laundry being exposed on the table being folded. Observation of 11 bags of soiled isolation gowns, 1 bag of soiled cleaning rags, 2 bags of resident's soiled clothing, and multiple loose soiled isolation gowns laying on the floor of the soiled laundry room. Four washers with lint buildup on the filter. Signs on washers (clean filter daily.) Return vent and exhaust vent were not working or cleaned, buildup of lint, dust and dirt were observed. During an interview with the Laundry Supervisor, on 03/13/24 at 3:20 PM, confirmed there was no sealed separation from the soiled laundry area to the clean laundry area. She verified the Bags of soiled laundry should be placed in carts and not be on the floor. She also verified the filters on the washers had not been cleaned daily and the vents were not working and had a buildup of lint. Further discussion revealed the facility was aware for this issue and she was working on correcting the issues in the laundry area. c) Resident #59 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 8:50 AM on 03/12/24, Resident #59 was observed retrieving ice out of the ice chest located in front of the kitchen door. Resident #59 had two cups and filled them both with ice. Receptionist #107 witnessed Resident #59 retrieve ice from the ice chest. At approximately 12:00 PM, on 03/13/24, the Director of Nursing (DON) was notified of Resident #59 retrieving ice from the ice chest. The DON stated We have told the resident multiple times they cannot get ice from the coolers themselves. I don't know what we are going to do. 49467