STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515160	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Manor Healthcare Center	199 Court Street Jane Lew, WV 26378

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 50551 Based on record review, resident interview and staff interview, the facility failed to adequately resolve a grievance. This was true for one (1) of two (2) residents reviewed for personal property. Resident identifier: #27. Facility census 59. Findings included: On 6/24/24 at 12:45 PM, Resident #27 reported that she had some clothing come up missing a couple of months ago and the facility told her family to replace the clothing and they would refund resident's family the money. She reported that the money had not yet been refunded, she can't remember if she had filed a grievance or complaint. On 06/24/24 at 3:44 PM, review of resident's grievance from 04/22/24 stated that resident had missing clothing. 8 (eight) items- green sweater, solid green shirt, denim pants, pjs, socks white, gray bra, solid red shirt, pink shirt. This grievance completed by Social Worker (SW) stated Have family replace missing items and reimburse family for money spent to replace items. On 06/25/24 at 2:25 PM, an interview with the Social Worker (SW) who reported that resident's family was reimbursed for the clothing that was missing in April and would look for a receipt. He also reported that the resident has a history of missing items that the facility had replaced. On 06/25/24 at 3:40 PM, an interview with the SW who reported that the resident's family was not reimbursed because the facility replaced the items in question. The resident's daughter also replaced the same items and requested to be reimbursed. The SW acknowledged that the grievance stated Have family replace missing items and reimburse family for money spent to replace items. The SW stated that they would make arrangements to refund the resident's family.

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 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. 49467 Based on record review and staff interview, the facility failed to update the Preadmission Screening and Resident Review (PASSAR) for Resident #3, after being diagnosed with major depressive disorder. Resident #51's PASSAR was not updated after being diagnosed with Post Traumatic Stress Disorder (PTSD) and Unspecified Psychosis. This was true for two (2) of two (2) residents reviewed for PASSAR's during the survey process. Resident identifiers: #3, #51. Facility census: 69. Findings included: a) Resident #3 At approximately 12:30 PM on 06/25/2024, a review of the electronic health record of Resident #3 was conducted. During this review, it was revealed Resident #3 was diagnosed with major depressive disorder on 09/28/2022. However, the most recent PASSAR completed for Resident #3 was on 06/10/2022, and makes no mention of the diagnosis of major depressive disorder. At approximately 1:53 PM on 06/26/2024, an interview was conducted with the Minimum Data Set (MDS) Coordinator concerning the PASSAR for Resident #3. The MDS Coordinator acknowledged the diagnosis of major depressive disorder on 09/28/2022 and the most recent PASSAR being completed on 06/10/2022. The MDS Coordinator acknowledged a new PASSAR should have been completed after Resident #3 was diagnosed with major depressive disorder. b) Resident #51 At approximately 2:30 PM on 06/24/2024, a review of the electronic health record of Resident #51 was conducted. During this review, it was revealed Resident #51 was diagnosed with PTSD and a psychosis disorder on 11/25/2022. However, the most recent PASSAR completed for Resident #51 was on 11/14/2022, and makes no mention of the diagnoses of PTSD or the psychosis disorder. At approximately 1:53 PM on 06/26/2024, an interview was conducted with the MDS Coordinator concerning the PASSAR for Resident #51. The MDS Coordinator acknowledged the diagnoses of PTSD and psychosis on 11/25/2022 and the most recent PASSAR being completed on 11/14/2022. The MDS Coordinator acknowledged a new PASSAR should have been completed after Resident #51 was diagnosed with PTSD and the psychosis disorder.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review and staff interview, the facility failed to accurately develop care plans related to capacity and one on one supervision. This failed practice was found true for (2) two of 17 residents reviewed for care plans during the Long-Term Care Survey Process. Resident identifiers: #50 and #273. Facility census: 69. Findings Included: a) Resident #50 A record review on 06/25/24 at 11:06 AM, of Resident #50's care plan revealed the following: Intervention revised on 03/06/24: The resident has a communication problem r/t vision deficit/lacks capacity to make medical decisions. Further record review revealed a capacity form completed on 01/05/24 that is marked as Resident #50 demonstrates capacity to make decisions. During an interview on 06/26/24 at 12:15 PM, The Director of Social Services (DSS) confirmed that Resident #50 does have capacity and the care plan was wrong. b) Resident #273 Resident #273 was admitted to the facility on [DATE] with a diagnosis of a nondisplaced fracture of base of neck of right femur. The resident did not have surgery performed on the fracture, instead, she had a brace on her right leg and was non weight bearing. At approximately 12:00 PM on 06/25/24, a review of Resident #273's electronic health record was conducted related to falls the resident suffered while at the facility. During the review, it was discovered Resident #273 suffered two (2) falls with major injury while at the facility. On 04/10/24, Resident #273 suffered an unwitnessed fall that resulted in a fracture of the right elbow. On 05/22/24, Resident #273 suffered an unwitnessed fall that resulted in a laceration on her forehead of approximately two (2) inches, a laceration between the eyes, laceration of the left elbow, and a fractured neck. A review of Resident #273's care plan revealed the facility stated the resident should be 1:1 when resident tries to get up unassisted as she is non weight bearing at this time. This was listed as a fall intervention due to resident is at risk for falls r/t (related to) recent fall with fx (fracture)./rx (prescription) antidepressant. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 1:00 PM on 06/25/24, a telephone interview was conducted with a family member of Resident #273. The family member stated the facility was very aware the resident was unable to bear weight on the right leg due to the recent fracture, and the brace, and was continuously attempting to stand and walk on her own. The family member states the facility was not providing one (1) on one (1) care for Resident #273 despite stating she needed it. As a result, the family member states the family requested alarms for when Resident #273 would attempt to stand and walk on her own, but the facility told them alarms were not allowed by the State Agency (SA). The family member states that on 04/10/22, Resident #273 suffered a fall and hurt her right arm, at which time the facility ordered mobile x-rays for the resident. The family member states the facility told the resident's family the results of the mobile x-rays revealed no fracture, however, the resident continued to complain of pain in her arm, until she attended an orthopedic appointment on 04/15/22, at which time an x-ray was completed in their office. This x-ray revealed a fracture of the right elbow. Family member states the orthopedic doctor placed a brace on the resident's right arm and she returned to the facility. The next day, the family member states that while visiting the resident, the brace on her arm was gone and could not be located. The facility notes reveal the brace was found in a trash can and alleges the resident removed it. This resulted in the resident returning to the orthopedic doctor and having a cast placed on her arm. Family member states that the resident's family received a call on the night of 05/22/24 informing them the resident suffered a fall and was being transferred to the hospital. Family member states emergency services were preparing to life flight Resident #273 due to her being lethargic and almost unresponsive after the fall. Family member states the fall was unwitnessed. At approximately 2:05 PM on 06/25/24 an interview was conducted with the Interim Director of Nursing (IDON) concerning the care plan and one (1) on one (1) interventions for Resident #273. However, the IDON stated You will need to speak with (First Name) the MDS Coordinator because she is the one that put that in and she is getting ready to take over the Director of Nursing (DON) position. I wasn't here at that time and she was, so she would know more than me. At approximately 2:14 PM on 06/25/24, an interview was conducted with the MDS Coordinator concerning the one (1) on one (1) intervention in the care plan for Resident #273. During the interview, the MDS Coordinator stated she entered the one (1) on one (1) intervention due to a physician's order stemming from Resident #273 continuously attempting to stand up out of her wheelchair and walk unassisted, while being non-weight bearing. The MDS coordinator stated Resident #273 was not under constant one (1) on one (1) supervision and acknowledged it would be difficult for staff at the facility to know when the resident attempted to stand up unassisted without her being under constant supervision, making it difficult for the staff to implement the intervention of 1:1 when resident tries to get up unassisted as she is non weight bearing at this time. The MDS Coordinator acknowledged there were multiple instances of Resident #273 attempting to stand and walk unassisted prior to both falls at the facility. The MDS Coordinator stated she believes the intervention for one (1) on one (1) supervision should have been removed from the care plan but acknowledged it was never removed, and still in place at the time of both falls, meaning the care plan was not being followed at the time of the falls. The MDS Coordinator states, however, they do not know if or when the intervention should have been removed, that the old DON would know, but they were no longer with the company. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 2:50 PM on 06/25/24, an interview was conducted with a second family member of Resident #273. During this interview, the family member stated When we brought her into the facility, we were told she would need one (1) on one (1) supervision because she kept trying to stand up when she wasn't supposed to. She would try to get out of her chair, out of bed, all the time by herself and she wasn't supposed to because her leg was broken and she had the brace on it, and she was at risk of falling. The family member states the family were told both falls at the facility were unwitnessed and there was no supervision to prevent Resident #273 from getting up on her own. At approximately 3:15 PM on 06/25/24, an interview was conducted with Resident #7, a roommate of Resident #273 at the time of her falls. Concerning the fall on 05/22/2024, Resident #7 stated that Resident #273 was in her wheelchair, falling asleep, moving her head side to side. Resident #7 stated It looked like she was trying to get comfortable enough to sleep. I was watching TV and looked away for a minute. When I looked back, she was leaning forward in her chair, almost in the floor. I looked back at the TV again and that's when I heard the other lady in our room yell that (Resident's first name) Resident #273 had fallen. Resident #7 stated she saw Resident #273 lying in the floor, at which time facility staff came into the room to attend to her. Resident #7 confirmed there was no one (1) on one (1) supervision taking place at the time of the fall. Review of both facility reported incidents from 04/10/24 and 05/22/24 confirm both falls were unwitnessed and no supervision was taking place, per the care plan for Resident #273. 49467

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 39043 Based on record review and staff interview the facility failed to complete a discharge summary of Resident #72. This failed practice was found true for (1) one of (1) residents reviewed for unplanned discharge during the Long-Term Care Survey Process. Resident identifier #72. Facility census 69. Findings Include a) Resident #72 A record review on 06/26/24 at 12:54 PM, revealed that Resident #72 had an unplanned discharge from the facility. Further record review revealed that a discharge summary was not completed in its entirety. During an interview on 06/26/24 at 12:57 PM, the Director of Nursing (DON) stated, Her discharge was so confusing. It was planned in the fact that she was going home, but unplanned because we did not know when her son was coming to get her. The DON further stated, We do have a problem with our discharge process and we are working on it,

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 49467 Based on record review, and resident, family, and staff interviews, the facility failed to provide the necessary supervision required to keep the environment for Resident #273 as free from accidents as possible, causing Resident #273 to have multiple falls in which she sustained multiple injuries. This was true for one (1) of three (3) residents reviewed for falls during the survey process. Resident Identifier: #273. Facility census: 69. Additionally, based on observation and resident and staff interview, the facility failed to keep the resident environment, over which it had control, was as free of accident hazards as possible, by leaving a potentially toxic substance on Resident #66's bedside table, making it accessible to other residents in the facility. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Resident identifier:66. Facility census: 69. Findings included: a) Resident #273 Resident #273 was admitted to the facility on [DATE] with a diagnosis of a nondisplaced fracture of base of neck of right femur. The resident did not have surgery performed on the fracture, instead, had a brace on the right leg and was non weight bearing. Brief Interview of Mental Status (BIMS) conducted on the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/06/24 was seven (7). The score indicates severe cognitive impairment. Diagnoses included Dementia, Diabetes, Renal Failure, cataracts, depression, Arthritis and Congestive Heart Failure (CHF). At approximately 12:00 PM on 06/25/24, a review of Resident #273's electronic health record was conducted, related to falls the resident suffered while she was at the facility. During the review, it was discovered Resident #273 suffered two falls with major injury while at the facility. On 04/10/24, Resident #273 suffered an unwitnessed fall that resulted in a fracture of her right elbow. On 05/22/24, Resident #273 suffered an unwitnessed fall that resulted in a laceration on her forehead of approximately two (2) inches, a laceration between her eyes, laceration of her left elbow, and a fractured neck. A review of Resident #273's care plan revealed the facility stated the resident should be 1:1 when resident tries to get up unassisted as she is non weight bearing at this time. This was listed as a fall intervention due to resident is at risk for falls r/t (related to) recent fall with fx (fracture)./rx (prescription) antidepressant. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	At approximately 1:00 PM on 06/25/24, an interview was conducted over the phone with a family member of Resident #273. The family member stated the facility was very aware the resident was unable to bear weight on their right leg due to the recent fracture, and the brace, and was continuously attempting to stand and walk on her own. The family member states the facility was not providing one (1) on one (1) care for Resident #273 despite stating she needed it. As a result, the family member states the family requested alarms for when Resident #273 would attempt to stand and walk on her own, but the facility told them alarms were not allowed by the State Agency (SA). The family member states that on 04/10/22, Resident #273 suffered a fall and hurt her right arm, at which time the facility ordered mobile x-rays for the resident. The family member states the facility told the resident's family the results of the mobile x-rays revealed no fracture, however, the resident continued to complain of pain in her arm, until she attended an orthopedic appointment on 04/15/22, at which time an x-ray was completed in their office. This x-ray revealed a fracture of the right elbow. Family member states the orthopedic doctor placed a brace on the resident's right arm and she returned to the facility. The next day, the family member states that while visiting the resident, the brace on her arm was gone and could not be located. The facility notes reveal the brace was found in a trash can and alleges the resident removed it. This resulted in the resident returning to the orthopedic doctor and having a cast placed on her arm. Family member states that the resident's family received a call on the night of 05/22/2024 informing them the resident suffered a fall and was being transferred to the hospital. Family member states emergency services were preparing to life flight Resident #273 due to her being lethargic and almost unresponsive after the fall. Family member states the fall was unwitnessed. At approximately 2:05 PM on 06/25/24 an interview was conducted with the Interim Director of Nursing (IDON) concerning the care plan and one (1) on one (1) interventions for Resident #273. However, the IDON stated You will need to speak with (First Name) the MDS Coordinator because she is the one that put that in and she is getting ready to take over the Director of Nursing (DON) position. I wasn ' t here at that time and she was, so she would know more than me. At approximately 2:14 PM on 06/25/24, an interview was conducted with the MDS Coordinator concerning the one (1) on one (1) intervention in the care plan for Resident #273. During the interview, the MDS Coordinator stated she entered the one (1) on one (1) intervention due to a physician's order stemming from Resident #273 continuously attempting to stand up out of her wheelchair and walk unassisted, while being non-weight bearing. The MDS coordinator stated Resident #273 was not under constant one (1) on one (1) supervision and acknowledged it would be difficult for staff at the facility to know when the resident attempted to stand up unassisted without her being under constant supervision, making it difficult for the staff to implement the intervention of 1:1 when resident tries to get up unassisted as she is non weight bearing at this time. The MDS Coordinator acknowledged there were multiple instances of Resident #273 attempting to stand and walk unassisted prior to both falls at the facility. The MDS Coordinator stated she believes the intervention for one (1) on one (1) supervision should have been removed from the care plan but acknowledged it was never removed, and still in place at the time of both falls, meaning the care plan was not being followed at the time of the falls. The MDS Coordinator states, however, they do not know if or when the intervention should have been removed, that the old DON would know, but they were no longer with the company. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	At approximately 2:50 PM on 06/25/24, an interview was conducted with a second family member of Resident #273. During this interview, the family member stated When we brought her into the facility, we were told she would need one (1) on one (1) supervision because she kept trying to stand up when she wasn't supposed to. She would try to get out of her chair, out of bed, all the time by herself and she wasn't supposed to because her leg was broken and she had the brace on it, and she was at risk of falling. The family member states the family was told both falls at the facility were unwitnessed and there was no supervision to prevent Resident #273 from getting up on her own. At approximately 3:15 PM on 06/25/24, an interview was conducted with Resident #7, a roommate of Resident #273 at the time of her falls. Concerning the fall on 05/22/24, Resident #7 states that Resident #273 was in her wheelchair, falling asleep, moving her head side to side. Resident #7 stated It looked like she was trying to get comfortable enough to sleep. I was watching TV and looked away for a minute. When I looked back, she was leaning forward in her chair, almost in the floor. I looked back at the TV again and that's when I heard the other lady in our room yell that (Resident's first name) Resident #273 had fallen. Resident #7 stated she saw Resident #273 lying in the floor, at which time facility staff came into the room to attend to her. Resident #7 confirmed there was no one (1) on one (1) supervision taking place at the time of the fall. Review of both facility reported incidents from 04/10/2024 and 05/22/2024 confirm both falls were unwitnessed and no supervision was taking place, per the care plan for Resident #273.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on observation, record review, and staff interview, the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional principles. A multidose medication vial was not dated when opened. This was a random opportunity for discovery made during the medication storage task. Facility census: 69. Findings included: a) Medication Storage During investigation of the [NAME] and [NAME] hallways medication preparation room on 06/25/24 at 9:35 AM, a multidose vial of Tubersol tuberculin purified protein derivative was found to not have been dated when opened. Tuberculin purified protein derivative is given by injection to aid in the diagnosis of tuberculosis. According to the Tubersol package insert accompanying the vial and available on the Food and Drug Administration website, A vial of Tubersol which has been entered and in use for 30 days should be discarded. Because the vial had not been dated when opened, it could not be determined when the vial should be discarded. Licensed Practical Nurse (LPN) #59 verified the Tubersol vial was not dated when opened. No further information was provided through the completion of the survey.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 39043 Based on resident interview, staff interview and observation, the facility failed to ensure hot food were served at a temperature of at least 120 degrees Fahrenheit (F). This failed practice had the potential to affect more than a limited number of residents. Resident identifiers: #21, #50, #66, and #51. Facility Census 69. Findings included: a) Resident #21 During the initial interview on 06/24/24 at 1:30 PM, Resident #21 stated, Hell no my food isn't hot. During an observation on 06/25/24 at 12:25 PM, the temperature of the lunch food at point of service was as follows: Ground chicken thigh: 115.5 degrees F. Spinach: 117 degrees F. Further observation showed that Resident #21 had refused the lunch tray and the lunch tray was tempt immediately after the last tray was delivered. The Corporate dietary manager confirmed that temperature at point of service should be at 120 degrees F. b) Resident #50 During the initial interview on 06/24/24 at 2:00 PM, Resident #50 states, The Food is cold, to get a hot cup of coffee around here would be a miracle. During an observation on 06/25/24 at 12:25 PM, the temperature of the lunch food at point of service was as follows: Ground chicken thigh: 115.5 degrees F. Spinach: 117 degrees F. The Corporate dietary manager confirmed that temperature at point of service should be at 120 degrees F. c) Resident #66 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Manor Healthcare Center	199 Court Street Jane Lew, WV 26378

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial interview on 06/25/24 at 2:17 PM, Resident #66 states with a giggle Are you kidding me the food is always cold. During an observation on 06/25/24 at 12:25 PM, the temperature of the lunch food at point of service was as follows: Ground chicken thigh: 115.5 degrees F. Spinach: 117 degrees F. The Corporate dietary manager confirmed that temperature at point of service should be at 120 degrees F. d) Resident #51 At approximately 2:10 PM on 06/24/24, an interview was conducted with Resident #51. During the interview, Resident #51 stated I'm really happy with this place except for when my food is cold. It is cold a good bit of the time. That's the only thing I don't really like about it here. Temperatures were taken at the point of service for the lunch meal at approximately 12:25 PM, at which point the temperature of the chicken served was 115.5 degrees F and the spinach was 117 degrees F. 49467