| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515164 | A. Building<br>B. Wing | 03/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wyoming Healthcare Center | 236 Warrior Way<br>New Richmond, WV 24867 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>31826<br><br>Based on observation and staff interview, the facility failed to ensure residents were treated in a dignified manner. Resident #162 was administered medication in the dining room on two (2) occasions and Resident #36 was taken to Bingo and the day lounge to watch television in a shirt soiled with tube feeding. These were random opportunities for discovery. Resident identifiers: #36 and #162. Facility Census: 55.<br><br>Findings included:<br><br>a) Resident #36<br><br>On 03/27/24 during a medication administration observation at approximately 1:30 PM, Resident #36's shirt became soiled with tube feeding when some of the feeding spilt from the syringe used during the feeding. Resident #36's shirt was not changed, and she was taken to the dining room to play Bingo. At 3:05 PM on 03/28/24 Resident #36 was observed sitting in the lounge area with other residents watching a movie. She was still wearing the soiled shirt.<br><br>Registered Nurse #85 observed the resident with the surveyor at 3:05 PM on 03/27/24 and confirmed her shirt needed to be changed.<br><br>b) Resident #162<br><br>On 03/27/24 at 11:11 am, Resident #162 indicated to the surveyor she was in pain and needed her pain pill. The surveyor alerted facility staff of Resident #162's request.<br><br>At approximately 11:25 AM Licensed Practical Nurse (LPN) #63 entered the dining room and administered Resident #162 two (2) Tylenol. She was overheard telling the resident, This is Tylenol, it is not time for your other pain pill yet.<br><br>An immediate interview with LPN #63 after she exited the dining room, found she had given the Resident Tylenol at the request of Resident #162's assigned nurse. She stated, She said to give her the Tylenol now because she would have to pull the oxycodone from the emergency stock.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 11:41 Am on 03/27/24 LPN #63 again entered the dining room and administered Resident #162 another pill. The LPN motioned to the surveyor in a manner to alert her to the fact that she had given Resident #162 her scheduled oxycodone.<br><br>The corporate Registered Nurse #85 was made aware of the surveyor observations on 03/27/24 at approximately 11:50 AM. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>31826<br><br>Based on observation and staff interview, the facility failed to provide a clean homelike environment in the dining room. This was found during the observation of the lunch meal on 03/25/24 and has the potential to affect more than an isolated number of residents. Facility Census: 55.<br><br>Findings included:<br><br>a) During an observation of the noon time meal on 03/25/24 it was noted the ceiling around the vent in the dining room was dirty.<br><br>On 03/26/24 at 3:00 PM the Director of Plant Maintenance confirmed the ceiling around the vent needed to be cleaned.<br><br>On 03/27/24 during an observation of the lunch meal the ceiling around the vent in the dining room was still dirty and had not been cleaned. |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>49467<br><br>Based on record review, observation, and staff interview, the facility failed to ensure residents were free from physical, sexual, and verbal abuse. Multiple incidents took place in which Resident #213 inappropriately touched and verbally and physically assaulted other residents. The facility failed to properly document, investigate, or report these incidents of abuse. The facility was unable to identify any victims of the abuse due to the failure to properly document and investigate each incident of abuse. Resident identifier: 213. Facility census: 55.<br><br>The state agency (SA) determined these failures caused the victims of Resident #213's abuse to suffer physical and psychosocial harm. Because the victims were unable to be identified, the reasonable person standard was applied. Due to the facility's failure to identify the victims and properly investigate the abuse, proper services were unable to be provided to the victims after an instance of abuse, causing further psychosocial harm. Not only did these failures harm the victims of Resident #213's abuse, it also placed them and the remaining 55 residents in the facility at risk of serious harm/death due to the facility's failure to investigate and put proper interventions in place to ensure Resident #213 would not abuse other residents in the future. This placed all residents in an Immediate Jeopardy (IJ) situation.<br><br>The facility was first notified of the IJ at 06:44 PM on 03/25/24. The SA received the Plan of Correction (POC) at 08:15 PM on 03/25/24. The SA accepted the POC at 08:20 PM on 03/25/24.<br><br>The SA observed for the implementation of the POC and the IJ was abated at 03:45 PM on 03/26/24.<br><br>Resident Ientifiers: #213. Facility Census: 55.<br><br>Findings included:<br><br>a) Resident #213<br><br>'<br><br>At approximately 03:00 PM on 03/25/24, a record review for Resident #213 was conducted as part of the sample selection process. During this process, progress notes were reviewed, which indicated multiple incidents of sexual, physical, and verbal abuse directed at other residents in the facility, by Resident #213. These progress notes were cross referenced with the facility's incident and reportables logs, revealing none of these incidents were investigated or reported.<br><br>Progress notes of the incidents are as follows:<br><br>On 02/13/24 at 6:23 PM Resident #213 touched a female resident inappropriately<br><br>On 02/19/24 at 11:54 AM, Resident #213 rubbed a female resident's arm and stated, Tell me you love me.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 2/19/24 at 12:30 PM, Resident #213 backed their wheelchair into another resident's wheelchair repeatedly. When female resident asked Resident #213 to quit, he replied I will hit you.<br><br>On 02/19/24 at 1:43 PM, Resident #213's sister stated the resident was told if their behaviors continued, they would be sent out of the facility. Resident #213 stated they were trying to get kicked out of the facility.<br><br>On 02/22/24 at 10:13 AM, Resident #213 touched a female resident on the abdomen in a downward motion.<br><br>On 02/28/24 at 8:05 PM, Resident #213 was at the nurses station pointing at another female resident and making fun of them. The female resident became upset and started crying. Resident #213 became defensive when he was told to leave the female resident alone.<br><br>On 02/29/24 at 1:07 AM, Resident #213 kept trying to touch a female resident, and kept grabbing them by the hand. Resident became defensive when he was told they could not touch other residents. Resident #213 stated he wanted to get kicked out of the facility so they could go home.<br><br>On 03/03/24 at 7:50 PM, Resident #213 was observed arguing with another resident. Unit Manager was called to the dining room to help with the situation and Resident #213 drew his hand back to hit Unit Manager, but stopped themselves. Resident then pushed another resident's geri-char at the nurses station and stated do whatever you got to do, send me out of here, I want out of here.<br><br>At 12:45 PM on 03/05/24, Resident #213 was passing another resident in the hallway and became combative and started kicking the other resident in the leg and hand.<br><br>At 10:35 AM on 03/23/24, Resident #213 was banging closet doors together, causing a disruption for his roommate. Resident #213 went to the dining room and banged a book against a table, calling another resident an idiot and telling them to bring it on.<br><br>On 03/23/24 at 4:19 PM, Resident #213 was being pushed by a family member down the hallway, when another resident passed by, Resident #213 stated he's the one I tried to knock the piss out of earlier.<br><br>At 3:05 AM on 03/24/24, Resident #213 was trying to get into another female resident's room. Resident #213 told his roommate to shut their mouth when he woke the roommate up by banging dresser drawers.<br><br>At 10:47 PM on 03/24/24, Resident #213 was coming down the hall and kicked another resident's door. Resident #213 was in another female's personal area and was told not to touch her.<br><br>At 1:09 AM on 03/25/24, Resident #213 was found in the floor of another female resident's room. Resident #213 stated they were trying to help the female resident to bed.<br><br>B) Staff Interview<br><br>Resident #213 was at a local behavioral health hospital from 03/05/24 until 03/22/24, upon return to facility, the resident's behaviors worsened, according to Unit Manager (UM) #5.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | At 3:40 PM on 03/25/24, an interview was conducted with the Administrator and Unit Manager concerning Resident #213. The Administrator, when asked what interventions had been put into place to protect other residents, they stated, Activities sets with them during the day. Unit Manager stated, Resident #213 comes to my office during the day. However, staff could not verify what interventions were in place during evening and weekend hours. Facility staff verified that Resident #213 was not under direct supervision at all times. Resident was observed at various locations in the facility while not under direct supervision. Unit Manager stated He can retain what you tell him, but he does what he wants. He wants to get kicked out to go home. The behaviors have escalated since, probably, January when referring to Resident #213's behaviors.<br><br>When asked the identity of the victims of Resident #213's abusive behavior, both the Administrator and UM #5 stated they did not know the identities. The Administrator confirmed there were no incident reports nor were there any investigations into the abuse toward other residents.<br><br>At approximately 1:55 PM on 03/26/24, and interview was conducted with Social Services Designee (SSD) #30 concerning Resident #213 and their behaviors. SSD #30 stated the resident was like this during their last stay at the facility as well. As far as I know, this is how they have always been. SSD #30 stated Resident #213 will tell you all the time they want a girlfriend. I know Resident #213 is trying to get kicked out of the facility, and that is probably why the resident is doing mischievous things, in order to get kicked out, because he thinks he is able to go home. SSD #30 states Resident #213 knows exactly where to go to get what they want. If the resident sees something on a desk that they want, it belongs to them. They pretty much have no boundaries at all.<br><br>C) Behavior Monitoring<br><br>At approximately 4:00 PM on 03/25/24, a review of the behavior monitoring task sheets for Resident #213 was conducted. Upon review of Nurse Aide behavior monitoring task sheets the following behaviors were noted:<br><br>02/09/24 at 10:43 PM- Repetitive motions and rummaging. Redirection was attempted-behaviors unchanged.<br><br>02/11/24 2:58 PM- Disrobing in public. Redirection attempted- behaviors unchanged.<br><br>02/14/24 at 6:16 PM- Disrobing in public and rummaging. Redirection attempted-behaviors worsened<br><br>02/15/24 at 5:19 PM- Disrobing in public, entering other residents ' room/personal space, rummaging. Redirection attempted-behaviors worsened.<br><br>02/20/24 at 6:16 PM- Disrobing in public. Redirection attempted-behaviors unchanged.<br><br>02/24/24 at 6:44 PM- Grabbing others, physically aggressive towards others, disrobing in public, throwing/smearing bodily waste, wandering. Redirection attempted-behaviors unchanged.<br><br>02/28/24 at 6:38 PM- Disrobing in public, entering other residents ' room/personal space, repetitive motions, rummaging, wandering. Redirection attempted-behaviors worsened.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 02/29/24 at 5:22 PM- grabbing others, kicking others, pushing others, physically aggressive towards others, express frustration/anger at others, disruptive sounds, disrobing in public, rummaging, wandering. Redirection attempted- behaviors worsened.<br><br>03/03/24 at 10:35 PM- Kicking others, physically aggressive towards others, cursing at others, express frustration/anger towards others, screaming at others, threatening others, entering other residents ' room/personal space. Redirection attempted-behaviors unchanged.<br><br>03/05/24 at 5:43 PM- Kicking others, physically aggressive towards others, express frustration/anger at others, screaming at others, agitated. Redirection attempted-behaviors unchanged.<br><br>03/23/24 at 11:18 AM-Kicking others, physically aggressive toward others, cursing at others, express frustration/anger at others, screaming at others, threatening others, disruptive sounds, entering other resident's room/personal space, agitated, anxious, restless, elopement, exit seeking, refusing care, wandering. Redirection attempted-behaviors unchanged<br><br>03/24/24 at 12:26 AM- Express frustration/anger at others, entering other residents' room/personal space. Redirection attempted-behaviors unchanged.<br><br>03/24/24 at 3:02 PM- Grabbing others, kicking others, pushing others, physically aggressive towards others, accusing of others, cursing at others, express frustrations/anger at others, threatening others, disrobing in public, entering other residents' room/personal space, public sexual acts, repetitive motions, rummaging, spitting, agitated, anxious, restless, elopement, exit seeking, insomnia, not sleeping, pacing, wandering, withdrawn/isolating. Redirection attempted-behaviors worsened.<br><br>03/24/2024 at 10:57 PM- Physically aggressive towards others, express frustration/anger towards others, threatening others, entering other residents' room/personal space, agitated, wandering. Redirection attempted-behaviors unchanged.<br><br>D) Change of Condition Form<br><br>A change of condition form from 02/19/24 for Resident was reviewed. The symptoms and signs for the change of condition are as follows:<br><br>Resident inappropriate with females, states he is trying to get kicked out, going through other residents ' belongings, other residents are fearful.<br><br>The change of condition form is dated for 02/19/24 at 1:30 PM.<br><br>E) Observation<br><br>After notifying the facility of the IJ and accepting the POC, while observing for the implementation of the POC, the following observations were made:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | At approximately 12:37 PM on 03/26/24, Resident #213 was escorted to their room from the dining room, pushed into the room, and left there alone, after the facility instructing one (1) on one (1) care to be provided to resident at all times. At 12:53 PM, Activities Leader (AL) #71 entered Resident #213's room. AL #71 was asked if education regarding one on one care for the resident had been provided, to which they stated, No, not at this time. AL #73 then walked past surveyors and into the hallway, leaving Resident #213 alone in their room, once again. At approximately 12:47 PM, a Nurse Aide escorted Resident #213 out of their room into the Unit Managers office.<br><br>f) Facility's PLan of Correction<br><br>The facility's accepted Plan of Correction read as follows:<br><br>3-25-24 Abatement Plan<br><br>1. Resident # 213 was placed on 1:1 direct observation with a facility staff member until physician interventions are successful in managing behaviors. An immediate fax reporting of allegation was completed and sent to OHFLAC. The physician was notified with new orders as follows; increased Trazadone to 150mg at bedtime, changed his Paxil to bedtime, and 1 on 1 with staff member. The residents care plan was updated with new orders and 1:1 observation intervention.<br>2. All residents in the facility have the potential to be affected by the alleged deficient practice. All alert residents were interviewed by the Unit Managers to identify other concerns and no other issues were identified.<br>3. All staff members in the facility on 3-25-24 were immediately re-educated on reporting allegations of abuse immediately to OHFLAC, APS, Ombudsman or other licensing board as warranted by the Unit Manager. All staff were educated on notifying a supervisor of any allegation immediately to assist with interventions necessary for immediate protection of residents. All staff not available on 3-25-24 will be re-educated on reporting allegations of abuse and notifying a supervisor immediately prior to the start of their next scheduled shift.<br>4. The Unit Managers will monitor progress notes daily to identify potential concerns of abuse. The Administrator and Director of Nursing will review incident and accident reports daily for two<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | weeks, then three times a week for two weeks, then monthly for three months to identify potential concerns. Any allegations will be reported to OHFLAC, Ombudsman, APS and other licensing boards as warranted. All allegations of abuse and neglect will be reviewed at the facilities Quality Assurance and Performance Improvement meeting each month. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>49467<br><br>.<br><br>Based on record review and staff interview, the facility failed to investigate allegations of abuse from Resident #213 to other residents in the facility. This was true for 1 out of 1 resident reviewed for allegations of abuse. This has the potential to affect more than a limited number of residents. Resident identifier: 213. Facility census: 55.<br><br>Findings include:<br><br>a) Resident #214<br><br>Progress Notes<br><br>At approximately 3:00 PM on 03/25/24, a record review for Resident #213 was conducted as part of the sample selection process. During this process, progress notes were reviewed, which indicated multiple incidents of sexual, physical, and verbal abuse directed at other residents in the facility, by Resident #213. These progress notes were cross referenced with the facility's incident and reportables logs, revealing none of these incidents were investigated or reported.<br><br>Progress notes of the incidents are as follows:<br><br>On 02/13/24 at 6:23 PM Resident #213 touched a female resident inappropriately.<br><br>On 02/19/24 at 11:54 AM, Resident #213 rubbed a female resident's arm and stated, Tell me you love me.<br><br>On 2/19/24 at 12:30 PM, Resident #213 backed their wheelchair into another resident's wheelchair repeatedly. When female resident asked Resident #213 to quit, they replied I will hit you.<br><br>On 02/19/24 at 01:43 PM, Resident #213's sister stated the resident was told if their behaviors continued, they would be sent out of the facility. Resident #213 stated they were trying to get kicked out of the facility.<br><br>On 02/22/24 at 10:13 AM, Resident #213 touched a female resident on the abdomen in a downward motion.<br><br>On 02/28/24 at 08:05 PM, Resident #213 was at the nurses' station pointing at another female resident and making fun of them. The female resident became upset and started crying. Resident #213 became defensive when they were told to leave the female resident alone.<br><br>On 02/29/24 at 01:07 AM, Resident #213 kept trying to touch a female resident, and kept grabbing them by the hand. Resident #213 became defensive when they were told they could not touch other residents. Resident #213 stated they wanted to get kicked out of the facility so they could go home.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/03/24 at 7:50 PM, Resident #213 was observed arguing with another resident. The Unit Manager was called to the dining room to help with the situation and Resident #213 drew their hand back to hit Unit Manager but stopped themselves. Resident then pushed another resident's geri-char at the nurses' station and stated, do whatever you got to do, send me out of here, I want out of here.<br><br>At 12:45 PM on 03/05/24, Resident #213 was passing another resident in the hallway and became combative and started kicking the other resident in the leg and hand.<br><br>At 10:35 AM on 03/23/24, Resident #213 was banging closet doors together, causing a disruption for their roommate. Resident #213 went to the dining room and banged a book against a table, calling another resident an idiot and telling them to bring it on.<br><br>On 03/23/24 at 04:19 PM, Resident #213 was being pushed by a family member down the hallway, when another resident passed by, Resident #213 stated, He's the one I tried to knock the piss out of earlier.<br><br>At 03:05 AM on 03/24/24, Resident #213 was trying to get into another female resident's room. Resident #213 told his roommate to shut their mouth when they woke roommate up by banging dresser drawers.<br><br>At 10:47 PM on 03/24/24, Resident #213 was coming down the hall and kicked another resident's door. Resident #213 was in another female's personal area and told not to touch her.<br><br>At 01:09 AM on 03/25/24, Resident #213 was found in the floor of another female resident's room. Resident #213 stated they were trying to help the female resident to bed.<br><br>b) Staff interview:<br><br>At approximately 3:40 PM on 03/25/24, an interview was conducted with the Administrator and Unit Manager (UM) #5 about the allegations of abuse. When asked about the investigation status and the identities of the victims of Resident #213's abusive behavior, both the Administrator and UM #5 stated they did not know the identities. The Administrator confirmed there were no incident reports nor were the incidents reported to the required state agencies and no investigations had been completed. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>49751<br><br>Based on record review and staff interview the facility failed to identify a diagnosis of schizoaffective disorder on a quarterly Minimum Data Set (MDS). This was a random opportunity for discovery and was true for Resident #20. Resident identifier: #20. Facility census: 55.<br><br>Findings included:<br><br>a) Resident #20<br><br>On 03/27/24 at 10:03 AM a record review on Resident #20 found the Pharmacy recommendations on 01/05/24. The FNP (Family Nurse Practitioner) had a note stating to add medical diagnosis of schizoaffective disorder and bipolar disorder to the resident's medical record.<br><br>Further record review on 03/27/24 showed bipolar disorder on Resident #20's medical diagnosis, however, it did not show a medical diagnosis for schizoaffective disorder.<br><br>A review of the quarterly MDS with an Assessment Reference Date (ARD) of 03/08/24 revealed Resident #20 had a diagnosis of schizoaffective disorder .<br><br>During an interview on 03/27/24 at 11:00 AM a staff interview with the Corporate Nurse #85, Regional Director #85 and Administrator all confirmed the Diagnosis for Schizoaffective Disorder was not on the MDS |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>49467<br><br>Based on record review and staff interview, the facility failed to update the Preadmission Screening and Resident Review (PASRR) for Resident #6, after the resident was diagnosed with a major mental disorder after admission to the facility. This was true for one (1) of 16 residents reviewed during the survey process. Resident identifier: #6. Facility census: 55.<br><br>Findings included:<br><br>a) Resident #6<br><br>At approximately 2:30 PM on 03/25/24, a record review was conducted for Resident #6. During the Record review, the PASRR for Resident #6 was reviewed.<br><br>The PASARR, dated 08/19/10, had None marked under the current diagnosis tab of the MI/MR (Mental Illness/Mental Retardation) assessment portion.<br><br>Upon further review, Resident #6 was diagnosed with major depressive disorder in 2017 and a new PASARR was not completed.<br><br>At approximately 1:41 PM on 03/27/24, an interview was conducted with the Director of Nursing (DON). During this interview, the DON acknowledged there was no diagnosis on the PASRR for major depressive disorder. The DON also acknowledged Resident #6 had been diagnosed with major depressive disorder in 2017, and the PASRR on file was the most up to date, having not been redone to reflect the diagnosis |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>49751<br><br>Based on record review and staff interview, the facility failed to add a diagnosis of schizoaffective disorder for one (1) of (16) residents reviewed for the care area of pre-admission screening and resident review (PASARR) this failed practice had the potential to affect a limited number of residents in facility. Resident identifier: #20. Facility census: 55.<br><br>Findings include:<br><br>A review of Resident #20's medical record on 03/27/24 found the resident received a diagnosis of Schizoaffective disorder prior to admission.<br><br>Further Record review of Resident #20's medical record on 03/27/24 of the pre-admission screening and resident review ( PASARR) found the PASARR did not contain a diagnosis of schizoaffective Disorder.<br><br>An interview on 03/27/24 at 10:10 AM, with Regional Director #86 and Corporate Nurse #85 confirmed the PASARR for Resident #20 did not contain a diagnosis of Schizoaffective Disorder. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>31826<br><br>Based on record review and staff interview, the facility failed to develop and/or implement a care plan for 1:1 visits, a diagnosis for Schizoaffective Disorder, Bed Rails, Wander Guard, Trauma and Dementia diagnosis, Fall Interventions, and Tube Feeding. This was true for eight (8) of 16 sampled residents reviewed during the long term care survey process. Resident identifiers: 36, 33, 7, 25, 48, 20, 213, and 31 Facility census: 55<br><br>Findings include:<br><br>a) Resident #36<br><br>On 03/26/24 at 10:15 AM the Activity Director Provided a 1:1 list stating Resident #36 was to have 1:1 visits daily.<br><br>A record review on 03/26/24 at 11:00 AM of Resident #36's care plan revealed Resident #36 was not care planned to receive daily 1:1 visits.<br><br>On 03/26/24 at 11:36 AM during a staff interview with the Administrator, it was confirmed the care plan did not include Resident #36's 1:1 visits with activities.<br><br>b) Resident # 33<br><br>On 03/26/24 at 10:15 AM the Activity Director Provided a 1:1 list stating Resident #33 was to have 1:1 visits daily.<br><br>A record review on 03/26/24 at 11:00 AM of Resident #33's care plan revealed Resident #33 was not care planned to receive daily 1:1 visits.<br><br>On 03/26/24 at 11:36 AM during a staff interview with the Administrator, it was confirmed the care plan did not include Resident #33's 1:1 visits with activities.<br><br>C) Resident #7<br><br>On 03/26/24 at 10:15 AM the Activity Director Provided a 1:1 list stating Resident #7 was to have 1:1 visits daily.<br><br>A record review on 03/26/24 at 11:00 AM of Resident #7's care plan revealed Resident #7 was not care planned to receive daily 1:1 visits.<br><br>On 03/26/24 at 11:36 AM during a staff interview with the Administrator, it was confirmed the care plan did not include Resident #7's 1:1 visits with activities.<br><br>d) Resident #25<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/26/24 at 10:15 AM the Activity Director Provided a 1:1 list stating Resident #25 was to have 1:1 visits daily.<br><br>A record review on 03/26/24 at 11:00 AM of Resident #25's care plan revealed Resident #25 was not care planned to receive daily 1:1 visits.<br><br>On 03/26/24 at 11:36 AM during a staff interview with the Administrator, it was confirmed the care plan did not include Resident #25's 1:1 visits with activities.<br><br>e) Resident #48<br><br>On 03/26/24 at 10:15 AM the Activity Director Provided a 1:1 list stating Resident #48 was to have 1:1 visits daily.<br><br>A record review on 03/26/24 at 11:00 AM of Resident #48's care plan revealed Resident #48 was not care planned to receive daily 1:1 visits.<br><br>On 03/26/24 at 11:36 AM during a staff interview with the Administrator, it was confirmed the care plan did not include Resident #48's 1:1 visits with activities.<br><br>f) Resident # 20<br><br>On 03/27/24 at 10:03 AM a record review on Resident #20 found the Pharmacy recommendations on 01/05/24 revealed the FNP (Family Nurse Practitioner) had a note stating to add medical diagnosis of Schizoaffective Disorder and Bipolar Disorder.<br><br>Further record review on 03/27/24 showed Schizoaffective Disorder was not in the care plan<br><br>On 03/27/24 at 11:00 AM a staff interview with Corporate Nurse #85, confirmed the Diagnosis for Schizoaffective Disorder was not on Care plan<br><br>G1) Resident #213<br><br>At approximately 9:30 AM on 03/26/24, an observation of bed rails on Resident #213's bed was made while investigating accident hazards.<br><br>At approximately 10:00 AM on 03/26/24, a review of the care plan for Resident #213 was conducted. During the review, it was noted Resident #213 was not care planned to have bed rails on their bed.<br><br>At approximately 1:41 PM on 03/27/24, an interview was conducted with the Director of Nursing (DON). During the interview, the DON acknowledged the bed rails were on Resident #213's bed and they were missing from the care plan.<br><br>G2) Resident #213<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At approximately 3:30 PM on 03/25/24, a review of the care plan for Resident #213 was conducted. During the review, it was noted Resident #213 had a focus of At risk for impaired psychosocial wellbeing related to history of trauma and/or trauma related symptoms. The following interventions were put into place: Same sex caregiver, removal of clothing slowly, remove from areas where smoking is permitted or cook outs occur.<br><br>At approximately 11:30 AM on 03/26/24, an interview was conducted with the Administrator and Corporate RN (CRN) #85 concerning the care plan for Resident #213. The Administrator stated the facility has no caregivers of the same sex as Resident #213 employed. CRN #85 stated We can't offer same sex caregivers to the resident because we don't have them. The Administrator and CRN #85 confirmed the focus and interventions listed, but could not verify the cause of the trauma or the reason for the interventions listed in Resident #213's care plan.<br><br>At approximately 1:55 PM on 03/26/24, an interview was conducted with Social Services Designee (SSD) #30. During the interview, SSD #30 stated I know Resident #213 was in a car accident when they were younger but that is the only trauma I know of. When asked about the interventions in place (same sex caregiver, removal of clothes slowly, remove from areas where smoking is permitted or cook outs occur), SSD #30 stated I didn't put these in here. I'm not sure who did it or why they are here.<br><br>G3) Resident #213<br><br>At approximately 3:30 PM on 03/25/24, a record review was conducted for Resident #213. It was noted Resident #213 had the following diagnosis: Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbances.<br><br>Upon review of the care plan for Resident #213, it was determined there was no focus, goal, or intervention in the care plan that mentioned dementia.<br><br>At approximately 1:41 PM on 03/27/24, an interview was conducted with the Director of Nursing (DON). During the interview, the DON confirmed the diagnosis and the absence of dementia from Resident #213's care plan.<br><br>h) Resident #31<br><br>A review of Resident #31's medical record on 03/26/24 found a fall intervention of bed bolsters to bed at all times.<br><br>An observation with the Director of Nursing (DON) and Registered Nurse #85 on 03/26/24 at 10:18 AM confirmed Resident #31's bed bolsters were not in place as directed by his care plan.<br><br>i) Resident #36<br><br>A review of Resident #36's care plan on the morning of 03/27/24 found the following care plan interventions related to the use of a feeding tube:<br><br>-- Administer flushes per medical providers order.<br><br>-- Check for placement and residuals per policy.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -- Provide tube feeding per medical provider orders.<br><br>-- Secure tube to prevent dislodging.<br><br>An observation of medication administration for Resident #36 began on 03/27/24 beginning at 1:10 PM found Licensed Practical Nurse (LPN ) #35 was preparing medication for Resident #36. LPN #35 stated, I am giving medication to (Name of Resident #36) this is her noon and 2:00 PM medication. LPN #35 was asked to read each medication as she was pulling them from the medication cart. LPN #35 indicated she was giving the following medication:<br><br>1. Isosource 1.5<br><br>2. Haldol Tablet five (5) milligrams<br><br>3. Midodrine 10 milligrams<br><br>4. Norco 5-325 milligrams<br><br>5. Baclofen 10 milligrams<br><br>LPN #35 crushed the Haldol, Midodrine, Norco, and baclofen all together. She stated, I have to crush them because they are administered in her feeding tube.<br><br>LPN #35 took Resident #36 to her room and began the medication administration at 1:20 PM on 03/27/24. At this time it was noted the feeding tube was not secured to the residents abdomen as directed in the care plan.<br><br>LPN #35 poured the crush medication into a cup. She then added 200 milliliters (mls) of tap water to the medication. LPN #35 then attached the syringe to the feeding tube and began pouring the water with the medication into the syringe. The syringe became disconnected and some of the water and medication leaked onto Resident #36's shirt. LPN #35 then reattached the syringe and continued to pour the water and medication into the syringe. LPN #35 poured all the water into the tube except for 20 milliliters left in the bottom of the cup. An observation of the remaining water found there was medication still left in the water as evidenced by particles of the medication still floating in the water and settled in the bottom of the cup.<br><br>LPN #35 then poured about 250 mls of the isosource into the syringe. Once all the Isosource was emptied out of the cup she told the resident thank you and confirmed she was finished administering the medication. She confirmed there was 20 mls of water with medication in it still left in the cup.<br><br>Resident #36 had the following orders:<br><br>-- May give medications via enteral tube. May combine all medications unless contraindicated. Flush with 30 mls of water before and after medication administration every shift, The 30 ML flush was omitted and not completed by LPN #35. Therefore the intervention to administer flushes per medical order was not implemented.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -- To verify function of an enterable tube prior to feeding or prior to medication administration: Check gastric residual volume (GRV) prior to each use. If residual is greater than 150 mls, hold feeding/medications and notify medical provider for further instruction. LPN #35 failed to check the gastric residual volume (GRV). This was omitted. The intervention to check placement and residual was also not implemented.<br><br>-- Water for enteral flush Give 120 ml via peg - tube three times a day for hydration. LPN #35 omitted this 120 ml flush. Again the intervention to provide flushes per the medical provider order was not implemented.<br><br>At 1:45 PM on 03/27/24 the Director of Nursing was notified of the above errors made by LPN #35, and no further information was provided.<br><br>49467<br><br>49751 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>31826<br><br>Based on record review, observation and staff interview the facility failed to revise Resident #36's care plan when the use of a vest for positioning was discontinued. This was true for one (1) of 16 sampled residents. Resident Identifier: #36. Facility Census: 55.<br><br>Findings include:<br><br>a) Resident #36<br><br>A record review of Resident #36's care plan on 03/26/24 found the following intervention related to Activities of Daily Living (ADL) performance, Up in high back tilt wheelchair with pommel cushion and vest for positioning.<br><br>An observation of Resident #36 on 03/25/24 and 03/27/24 found the resident was up in the wheelchair but was not wearing a vest as directed in her care plan.<br><br>An interview with Nurse Aide #64 at 12:58 PM on 03/27/24 confirmed the resident did not have a vest in place. Nurse Aide #64 stated, She use to have one but we have not used that with her for sometime now.<br><br>An interview with the Director of Nursing (DON) on 03/27/24 at approximately 2:00 PM found the resident no longer used the vest. She indicated, it had messed up so they switched it to the seat belt. She agreed the care plan needed to be revised. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>31826<br><br>Based on record review and staff and resident interview, the facility failed to complete neurological assessments after a fall for Resident #213 and #31, failed to notify the physician of hyperglycemia results for Resident #8, and to administer medication per physician's order for Resident #49. This was true for four (4) out of four (4) residents reviewed for quality of care during the survey process. Resident identifiers: #213, #31, #8, #49. Facility census: 55.<br><br>Findings included:<br><br>a) Resident #213<br><br>At approximately 10:00 AM on 03/27/24, a record review was conducted for Resident #213 concerning falls at the facility. Upon review, it was determined neurochecks were incomplete for Resident #213 following multiple falls.<br><br>For a fall at 5:15 PM on 10/20/23, the daily fourth check was not completed.<br><br>For a fall at 6:35 PM on 12/26/23, the daily second and daily third checks were not completed. The daily fourth check was completed on 03/15/24.<br><br>For a fall at 7:00 PM on 02/14/24, the fourth one-hour check was documented taking place at 02/14/24 at midnight. The neuro check should have taken place at midnight on 02/15/24.<br><br>For a fall at 7:00 PM on 02/14/24, the second four-hour check to be completed at 8:00 AM on 02/15/24, was completed on 03/11/24.<br><br>For a fall at 7:00 PM on 02/14/24, the third four-hour check to be completed at 12:00 PM on 02/15/24, was completed on 03/11/24.<br><br>For a fall at 7:00 PM on 02/14/24, the fourth four-hour check to be completed at 4:00 PM on 02/15/24, was completed on 03/11/24.<br><br>For a fall at 7:00 PM on 02/14/24, the third daily check to be completed at 04:00 PM on 02/18/24, was completed on 03/24/24.<br><br>For a fall at 7:00 PM on 02/14/24, the fourth daily check to be completed at 04:00 PM on 02/19/24, was incomplete.<br><br>For a fall at 11:45 PM on 03/24/24, the first one-hour check was entered for 03/24/24 at 12:30 AM.<br><br>For a fall at 11:45 PM on 03/24/24, the second one-hour check was entered for 03/24/24 at 1:30 AM.<br><br>For a fall at 11:45 PM on 03/24/24, the fourth one-hour check was entered for 03/24/24 at 2:30 AM.<br><br>For a fall at 11:45 PM on 03/24/24, the first four-hour check was not completed.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | For a fall at 11:45 PM on 03/24/24, the first daily check was not completed.<br><br>An interview with the Director of Nursing (DON) on 03/27/24 at 1:41 PM confirmed the neurochecks for Resident #213 were incomplete.<br><br>b) Resident # 8<br><br>A review of Resident #8's medical record on 03/26/24 found a physician order which indicated if Resident #8's blood sugar was greater than 350 mg/dl the physician was to be notified.<br><br>A review of the resident's blood sugars from 08/01/23 to current found the following dates when the resident's blood sugar was greater than 350:<br><br>-- 08/05/23 at 9:38 PM blood sugar was 483.<br><br>-- 08/07/23 at 9:35 PM blood sugar was 385.<br><br>-- 08/16/23 at 9:00 PM blood sugar was 363.<br><br>-- 08/22/23 at 9:00 PM blood sugar was 359.<br><br>-- 08/23/23 at 5:00 PM blood sugar was 482.<br><br>-- 08/25/23 at 9:00 PM blood sugar was 408.<br><br>-- 09/08/23 at 5:00 PM blood sugar was 405.<br><br>-- 09/14/23 at 9:00 PM blood sugar was 382.<br><br>-- 09/19/23 at 9:00 PM blood sugar was 467.<br><br>-- 12/21/23 at 9:00 PM blood sugar was 442.<br><br>-- 02/06/24 at 5:00 PM blood sugar was 429.<br><br>-- 02/09/24 at 5:00 PM blood sugar was 400.<br><br>-- 03/09/24 at 5:00 PM blood sugar was 399.<br><br>-- 03/11/24 at 5:00 PM blood sugar was 458.<br><br>-- 03/19/24 at 11:00 am blood sugar was 359.<br><br>During an interview with the Director of Nursing (DON) on 03/26/24 at 3:21 PM she was asked to provide documentation to show the physician was notified of Resident #8's elevated blood sugars on the aforementioned dates.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In the morning of 03/27/24 the DON was asked if she was able to find any evidence the physician was notified of Resident #8's elevated blood sugars, and she confirmed she was not.<br><br>c) Resident #31<br><br>A review of Resident #31's medical record on 03/27/24 found Resident #31's neurological assessments were not always completed as ordered. The following neurological assessments were missing the following assessments:<br><br>-- Neurological Assessment with an effective date of 08/23/23 was missing the following checks:<br><br>- Daily First<br><br>- Daily Second and<br><br>- Daily Fourth.<br><br>-- Neurological Assessment with an effective date of 09/02/23 was missing the following checks:<br><br>- 4 hour 4th<br><br>- Daily 1st<br><br>- Daily 3rd<br><br>-- Neurological Assessment with an effective date of 09/24/23 was missing the following checks:<br><br>- 4 hour 4th<br><br>- Daily 1st<br><br>- Daily 2nd<br><br>- Daily 3rd<br><br>- Daily 4th<br><br>-- Neurological Assessment with an effective date of 12/10/23 had the following incomplete checks:<br><br>-Daily Fourth.<br><br>-- Neurological Assessment with an effective date of 01/06/24 were missing the first daily check.<br><br>An interview with the Director of Nursing (DON) at 2:55 PM on 03/27/24 confirmed the neurological assessments were not completed.<br><br>d) Resident #49<br><br>(continued on next page) |

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| | 515164 | A. Building<br>B. Wing | 03/27/2024 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/25/24 at 1:50 PM Resident #49 expressed concern that he had been having trouble getting his Trulicity (an injectable diabetes medicine that helps control blood sugar levels). Resident stated, I've started it, stopped it and then started it again because they can't get it.<br><br>Record review showed an order for Trulicity Subcutaneous Solution Pen-injector 0.75 MG/0.5ML (Dulaglutide). Inject 0.75 mg subcutaneously one time a day every Wed for Diabetes. Order start date 01/15/24.<br><br>Review of Resident #49's Medication Administration Record (MAR) showed four (4) of the ten (10) ordered doses were not administered since the medication has been ordered.<br><br>Review of the Electronic Medication Administration Record Note (EMAR) notes showed the following dates to have been omitted:<br><br>1/31/2024 1:38 PM EMAR note text stated: Trulicity Subcutaneous Solution Pen-injector 0.75 MG/0.5ML. Inject 0.75 mg subcutaneously one time a day every Wednesday for Diabetes Medication not available. Called Pharmacy to reorder. Will be available on evening medication run.<br><br>2/7/2024 at 9:34 AM EMAR note text stated: Trulicity Subcutaneous Solution Pen-injector 0.75 MG/0.5ML. Inject 0.75 mg subcutaneously one time a day every Wednesday for Diabetes awaiting from pharmacy.<br><br>2/28/2024 at 10:57 AM EMAR note text stated: Trulicity Subcutaneous Solution Pen-injector 0.75 MG/0.5ML. Inject 0.75 mg subcutaneously one time a day every Wednesday for Diabetes Medication not available will contact pharmacy.<br><br>3/13/2024 at 10:41 AM Electronic Medication Administration Record Note (EMAR) text stated: Trulicity Subcutaneous Solution Pen-injector 0.75 MG/0.5ML. Inject 0.75 mg subcutaneously one time a day every Wednesday for Diabetes. Awaiting order from pharmacy.<br><br>03/27/24 at 10:30 AM the Director of Nursing (DON) verified the missed doses of the Trulicity medication for Resident #49. The DON stated, We have been having a hard time getting the Trulicity. I will contact the Nurse Practitioner and see if we can get the order changed to something else.<br><br>40595<br><br>49467 |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40595<br><br>Based on observation, family interview, staff interview and record review the facility failed to provide toenail care to Resident #29. This failed practice was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident identifier: #29. Facility census: 55.<br><br>Findings included:<br><br>a) Resident #29<br><br>On 03/25/24 at 12:30 PM Resident #29's husband stated he would like to get her toenails cut. They [facility staff] told him she wasn't eligible, and no one has ever come back to do anything else about it. The resident's toenails on both feet were observed to be thick, yellow in color and curled over top the ends of the toes on both feet.<br><br>Record review showed no grievance or concerns for toenail care.<br><br>Resident #29 was admitted to the facility on [DATE].<br><br>On 03/26/24 at 2:02 PM electronic health records Licensed Practical Nurse (LPN) #19 stated they have to sign up for [name of contracted services company] then if they are eligible, they can get the services. If they are not eligible, they also have a local podiatrist in town that can see them. LPN #19 verified they should have services provided regardless of if they qualify. LPN #19 further stated the Licensed Social Worker (LSW) takes care of the [name of contracted services company] services.<br><br>On 03/26/24 at 2:51 PM the Licensed Social Worker (LSW) stated I sent the referral for [person at referral base] at [name of contracted services company] after the family requested toenails to be trimmed. [name of contracted services company] don't offer the services to Resident #29 due to resource amount. The family went through a Medicaid advisor. On 3/15/24 I received email back that resident was not eligible [name of contracted services company]. Nurses usually would usually take it from there. To be honest have not followed up on it anymore.<br><br>On 03/26/24 at 3:30 PM the Director of Nursing (DON) observed Resident #29's toenails in the presence of resident family members. The family reiterated the request to have the toenails trimmed. The DON stated, This is something my staff wouldn't be comfortable with due to the condition and thickness and of the toenails. I will follow up and see where we are at with outside services.<br><br>Record review showed the following progress note post surveyor intervention:<br><br>On 03/27/2024 at 3:06 PM Nurses Note stated received return call from [local podiatry office] and was notified that a packet must be completed to obtain an appointment. Referral packet completed and faxed with fax confirmation received. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>31826<br><br>Based on record review and staff interview the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. Resident #31 did not have his fall interventions in place. The facility to failed to implement fall interventions for Resident #213 regarding his risk for elopement. This was true for two (2) of the 16 sampled residents. Resident identifiers: #31 and #213. Facility Census: 55.<br><br>Findings Include:<br><br>a) Resident #31<br><br>A review of Resident #31's medical record on 03/26/24 found a fall intervention of bed bolsters to the bed.<br><br>An observation with the Director of Nursing (DON) and Registered Nurse #85 on 03/26/24 at 10:18 AM confirmed Resident #31's bed bolsters were not in place as directed by his care plan.<br><br>b) Resident #213<br><br>At approximately 3:30 PM on 03/25/24, a review of the care plan for Resident #213 was conducted. During the review, it was noted Resident #213 was care planned to have a wanderguard device on their leg and wheelchair due to wandering behaviors and a history of elopement.<br><br>At approximately 10:30 AM on 03/26/24, a review of orders for Resident #213 was conducted. During this review, it was discovered Resident #213 did not have orders for a wanderguard device until 03/25/24, following surveyor intervention.<br><br>At approximately 10:30 AM a wandering observation tool completed by the facility on 03/04/24 was reviewed. This assessment stated the resident did not have a history of wandering or elopement. A progress note was reviewed from 10/06/23 at 12:23 PM stating the resident cut off their wanderguard device with a butterknife and exited the facility through the front door.<br><br>At approximately 1:41 PM on 03/27/24, an interview was conducted with the Director of Nursing (DON). During the interview, the DON confirmed the care plan intervention for a wanderguard device due to wandering behaviors. The DON acknowledged the orders for the wanderguard device were not being entered until 03/25/24.<br><br>49467 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>31826<br><br>Based on observation, record review and staff interview the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of the enteral feeding tube unless unavoidable. Resident Identifier: Resident #36. Facility Census: 55.<br><br>Findings Include:<br><br>a) Resident #36<br><br>An observation of medication administration for Resident #36 began on 03/27/24 beginning at 1:10 PM found Licensed Practical Nurse (LPN ) #35 was preparing medication for Resident #36. LPN #35 stated, I am giving medication to (Name of Resident #36) this is her noon and 2:00 PM medications. LPN #35 was asked to read each medication as she was pulling them from the medication cart. LPN #35 indicated she was giving the following medication:<br><br>1. Isosource 1.5<br><br>2. Haldol Tablet five (5) milligrams<br><br>3. Midodrine 10 milligrams<br><br>4. Norco 5-325 milligrams<br><br>5. Baclofen 10 milligrams<br><br>LPN #35 crushed the Haldol, Midodrine, Norco, and baclofen all together. She stated, I have to crush them because they are administered in her feeding tube.<br><br>LPN #35 took Resident #36 to her room and began the medication administration at 1:20 PM on 03/27/24. LPN #35 poured the crush medication into a cup. She then added 200 milliliters (mls) of tap water to the medication. LPN #35 then attached the syringe to the feeding tube and began pouring the water with the medication into the syringe. The syringe became disconnected and some of the water and medication leaked onto Resident #36's shirt. LPN #35 then reattached the syringe and continued to pour the water and medication into the syringe. LPN #35 poured all the water into the tube except for 20 milliliters left in the bottom of the cup. An observation of the remaining water found there was medication still left in the water as evidenced by particles of the medication still floating in the water and settled in the bottom of the cup.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN #35 then poured about 250 mls of the isosource into the syringe. Once all the Isosource was emptied out of the cup she told the resident thank you and confirmed she was finished administering the medication. She confirmed there was 20 mls of water with medication in it still left in the cup. LPN #35 failed to flush the feeding tube with water after administering Resident #36's isosource. LPN #35 also failed to the check gastric volume residual (GVR) before beginning the medication administration and enteral feeding.<br><br>a) Resident #36<br><br>An observation of medication administration for Resident #36 began on 03/27/24 at 1:10 PM. Licensed Practical Nurse (LPN ) #35 was preparing medication for Resident #36. LPN #35 stated, I am giving medication to (Name of Resident #36) this is her noon and 2:00 PM medication. LPN #35 was asked to read each medication as she was pulling them from the medication cart. LPN #35 indicated she was giving the following medication:<br><br>1. Isosource 1.5<br><br>2. Haldol Tablet five (5) milligrams<br><br>3. Midodrine 10 milligrams<br><br>4. Norco 5-325 milligrams<br><br>5. Baclofen 10 milligrams<br><br>LPN #35 crushed the Haldol, Midodrine, Norco, and baclofen all together. She stated, I have to crush them because they are administered in her feeding tube.<br><br>LPN #35 took Resident #36 to her room and began the medication administration at 1:20 PM on 03//27/24.<br><br>LPN #35 poured the crush medication into a cup.<br><br>She then added 200 milliliters (mls) of tap water to the medication.<br><br>LPN #35 then attached the syringe to the feeding tube and began pouring the water with the medication into the syringe.<br><br>The syringe became disconnected and some of the water and medication leaked onto Resident #36's shirt.<br><br>LPN #35 then reattached the syringe and continued to pour the water and medication into the syringe.<br><br>LPN #35 poured all the water into the tube except for 20 milliliters left in the bottom of the cup.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation of the remaining water found there was medication still left in the water as evidenced by particles of the medication still floating in the water and settled in the bottom of the cup.<br><br>LPN #35 then poured about 250 mls of the Isosource into the syringe.<br><br>Once all the Isosource was emptied out of the cup she told the resident thank you and confirmed she was finished administering the medication.<br><br>She confirmed there was 20 mls of water with medication in it still left in the cup.<br><br>Resident #36 had the following orders:<br><br>1. May give medications via enteral tube. May combine all medications unless contraindicated. Flush with 30 mls of water before and after medication administration every shift, The 30 ML flush was omitted and not completed by LPN #35.<br><br>2. To verify function of an enterable tube prior to feeding or prior to medication administration: Check gastric residual volume (GRV) prior to each use. If residual is greater than 150 mls, hold feeding/medications and notify medical provider for further instruction. LPN #35 failed to check the gastric residual volume (GRV). This was omitted.<br><br>3. Baclofen Tablet 10 mg due at 2:00 PM. LPN #35 failed to administer this medication in its entirety.<br><br>4. Isosource 1.5 250 ml due at 12:00 PM. This medication was administered an hour and half late.<br><br>5. Haloperidol give 5 mg via peg tube three times a day due at 2:00 PM, LPN #35 failed to administer this medication in its entirety.<br><br>6. Norco oral tablet 5-325 mg. Give 1 tablet by mouth every eight hours due at 2:00 PM. LPN #35 failed to administer this medication in its entirety.<br><br>7. Water for enteral flush Give 120 ml via peg - tube three times a day for hydration. LPN #35 omitted this 120 ml flush.<br><br>At 1:45 PM on 03/27/24 the Director of Nursing was notified of LPN #35 failing to flush the tube and failing to check the GVR before administering medications and enteral feeding and no further information was provided. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>49467<br><br>Based on record review and staff interview, the facility failed to properly assess Resident #213 for the use of bed rails. This was true for one (1) of one (1) residents reviewed for bed rails during the long term care survey process. Resident identifier: 213. Facility census: 55.<br><br>Findings include:<br><br>A) Resident #213<br><br>At approximately 09:30 AM on 03/26/24, an observation of bed rails on Resident #213 ' s bed was made while investigating accident hazards.<br><br>At approximately 10:00 AM on 03/26/24, a review of the care plan for Resident #213 was conducted. During the review, it was noted that Resident #213 was not care planned to have bed rails on their bed.<br><br>At approximately 10:15 AM on 03/26/24, a bed evaluation provided by Corporate RN (CRN) #85 stated the resident had interest in bed rails. However, there was no bed rail safety evaluation completed for the resident.<br><br>CRN #85 confirmed there was no bed rail safety evaluation done on Resident #213. CRN #85 stated There ' s not a bed rail safety evaluation here for that resident. I don ' t even know what a bed rail safety evaluation is. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>31826<br><br>Based on observation, staff interview and record review the facility failed to ensure Licensed Practical Nurse (LPN) #35 had the appropriate nurse competencies to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of the enteral feeding tube unless unavoidable. LPN #35 did not administer medications and or feedings to Resident #36 via the enteral tube in a correct manner. The facility was unable to show LPN #35's competencies and skills regarding feeding tube care was reviewed upon her hire to the facility in January of 2024. Resident identifier: #36. Facility census: 55.<br><br>Findings included:<br><br>a) Resident #36<br><br>An observation of medication administration for Resident #36 began on 03/27/24 beginning at 1:10 PM found Licensed Practical Nurse (LPN ) #35 was preparing medication for Resident #36. LPN #35 stated, I am giving medication to (Name of Resident #36) this is her noon and 2:00 PM medications. LPN #35 was asked to read each medication as she was pulling them from the medication cart. LPN #35 indicated she was giving the following medication:<br><br>1. Isosource 1.5<br><br>2. Haldol Tablet five (5) milligrams<br><br>3. Midodrine 10 milligrams<br><br>4. Norco 5-325 milligrams<br><br>5. Baclofen 10 milligrams<br><br>LPN #35 crushed the Haldol, Midodrine, Norco, and baclofen all together. She stated, I have to crush them because they are administered in her feeding tube.<br><br>LPN #35 took Resident #36 to her room and began the medication administration at 1:20 PM on 03/27/24.<br><br>LPN #35 poured the crush medication into a cup. She then added 200 milliliters (mls) of tap water to the medication.<br><br>LPN #35 then attached the syringe to the feeding tube and began pouring the water with the medication into the syringe.<br><br>The syringe became disconnected and some of the water and medication leaked onto Resident #36's shirt.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN #35 then reattached the syringe and continued to pour the water and medication into the syringe.<br><br>LPN #35 poured all the water into the tube except for 20 milliliters left in the bottom of the cup.<br><br>An observation of the remaining water found there was medication still left in the water as evidenced by particles of the medication still floating in the water and settled in the bottom of the cup.<br><br>LPN #35 then poured about 250 mls of the isosource into the syringe. Once all the Isosource was emptied out of the cup she told the resident thank you and confirmed she was finished administering the medication.<br><br>She confirmed there was 20 mls of water with medication in it still left in the cup. LPN #35 failed to flush the feeding tube with water after administering Resident #36's isosource. LPN #35 also failed to the check gastric volume residual (GVR) before beginning the medication administration and enteral feeding.<br><br>At 1:45 PM on 03/27/24 the Director of Nursing was notified of LPN #35 failing to flush the tube and failing to check the GVR before administering medications and enteral feeding and no further information was provided.<br><br>At 5:00 PM on 03/27/24 the facility was asked to provide the nursing competencies which were performed with LPN #35 upon her hire to the facility. The facility provided several competencies which were completed with LPN #35 but non were related to care and services required for residents who have and enteral feeding tube. This was reviewed with the Director of Nursing (DON) at 5:56 PM on 03/27/24 and no further information was provided. |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>49467<br><br>Based on record review and staff interview, the facility failed to notify the physician of a change in baseline behaviors immediately, for a resident with dementia. This was true for one (1) of three (3) residents reviewed for dementia care during the long-term care survey process. Resident identifier: #213. Facility census: 55.<br><br>Findings include:<br><br>At approximately 3:30 PM on 03/25/24, a record review was conducted for Resident #213. It was noted Resident #213 had the following diagnosis: Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbances.<br><br>On 03/22/24, Resident #213 returned from a local behavioral health facility for behaviors. Upon review of behavioral monitoring task sheets, it was determined the resident had worsening behaviors and the physician was not notified until surveyor intervention for an Immediate Jeopardy (IJ) situation, on 03/25/24. The behaviors noted from the task sheets were:<br><br>03/23/24 at 11:18 AM-Kicking others, physically aggressive toward others, cursing at others, express frustration/anger at others, screaming at others, threatening others, disruptive sounds, entering other resident's room/personal space, agitated, anxious, restless, elopement, exit seeking, refusing care, wandering. Redirection was attempted and behaviors were unchanged.<br><br>03/24/24 at 12:26 AM- Express frustration/anger at others, entering other residents' room/personal space. Redirection was attempted and the behaviors were unchanged.<br><br>03/24/24 at 3:02 PM- Grabbing others, kicking others, pushing others, physically aggressive towards others, accusing of others, cursing at others, express frustrations/anger at others, threatening others, disrobing in public, entering other residents' room/personal space, public sexual acts, repetitive motions, rummaging, spitting, agitated, anxious, restless, elopement, exit seeking, insomnia, not sleeping, pacing, wandering, withdrawn/isolating. Redirection was attempted and the behavior worsened.<br><br>03/24/2024 at 10:57 PM- Physically aggressive towards others, express frustration/anger towards others, threatening others, entering other residents' room/personal space, agitated, wandering. Redirection attempted-behaviors unchanged.<br><br>At approximately 1:41 PM on 03/27/24, an interview was conducted with the Director of Nursing (DON). During the interview, the DON confirmed the physician was not notified of the resident's behaviors until after surveyor intervention. |

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|---|---|---|---|
| | 515164 | A. Building<br>B. Wing | 03/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wyoming Healthcare Center | 236 Warrior Way<br>New Richmond, WV 24867 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>31826<br><br>Based on observation, record review and staff interview the facility failed to ensure the facility's medication error rate was five (5) percent or less. The facility's medication error rate was 16.67 percent. Resident identifier: Resident #36. Facility census: 55.<br><br>Findings include:<br><br>a) Resident #36<br><br>An observation of medication administration for Resident #36 began on 03/27/24 at 1:10 PM. Licensed Practical Nurse (LPN ) #35 was preparing medication for Resident #36. LPN #35 stated, I am giving medication to (Name of Resident #36) this is her noon and 2:00 PM medication. LPN #35 was asked to read each medication as she was pulling them from the medication cart. LPN #35 indicated she was giving the following medication:<br><br>1. Isosource 1.5<br><br>2. Haldol Tablet five (5) milligrams<br><br>3. Midodrine 10 milligrams<br><br>4. Norco 5-325 milligrams<br><br>5. Baclofen 10 milligrams<br><br>LPN #35 crushed the Haldol, Midodrine, Norco, and baclofen all together. She stated, I have to crush them because they are administered in her feeding tube.<br><br>LPN #35 took Resident #36 to her room and began the medication administration at 1:20 PM on 03//27/24.<br><br>LPN #35 poured the crush medication into a cup.<br><br>She then added 200 milliliters (mls) of tap water to the medication.<br><br>LPN #35 then attached the syringe to the feeding tube and began pouring the water with the medication into the syringe.<br><br>The syringe became disconnected and some of the water and medication leaked onto Resident #36's shirt.<br><br>LPN #35 then reattached the syringe and continued to pour the water and medication into the syringe.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN #35 poured all the water into the tube except for 20 milliliters left in the bottom of the cup. An observation of the remaining water found there was medication still left in the water as evidenced by particles of the medication still floating in the water and settled in the bottom of the cup.<br><br>LPN #35 then poured about 250 mls of the Isosource into the syringe. Once all the Isosource was emptied out of the cup she told the resident thank you and confirmed she was finished administering the medication. She confirmed there was 20 mls of water with medication in it still left in the cup.<br><br>Resident #36 had the following orders:<br><br>1. May give medications via enteral tube. May combine all medications unless contraindicated. Flush with 30 mls of water before and after medication administration every shift, The 30 ML flush was omitted and not completed by LPN #35.<br><br>2. To verify function of an enterable tube prior to feeding or prior to medication administration: Check gastric residual volume (GRV) prior to each use. If residual is greater than 150 mls, hold feeding/medications and notify medical provider for further instruction. LPN #35 failed to check the gastric residual volume (GRV). This was omitted.<br><br>3. Baclofen Tablet 10 mg due at 2:00 PM. LPN #35 failed to administer this medication in its entirety.<br><br>4. Isosource 1.5 250 ml due at 12:00 PM. This medication was administered an hour and half late.<br><br>5. Haloperidol give 5 mg via peg tube three times a day due at 2:00 PM, LPN #35 failed to administer this medication in its entirety.<br><br>6. Norco oral tablet 5-325 mg. Give 1 tablet by mouth every eight hours due at 2:00 PM. LPN #35 failed to administer this medication in its entirety.<br><br>7. Water for enteral flush Give 120 ml via peg - tube three times a day for hydration. LPN #35 omitted this 120 ml flush.<br><br>LPN #35 had seven (7) opportunities for medication administration and made seven (7) medication errors. Another surveyor observed 35 medication administration opportunities. This created seven (7) errors out of 45 opportunities for a medication error rate of 16.67 %.<br><br>At 1:45 PM on 03/27/24 the Director of Nursing was notified of the above errors made by LPN #35, and no further information was provided. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>49467<br><br>Based on record review and staff interview, the facility failed to employ qualified dietary staff by failing to have each member of the dietary staff obtain food handlers cards before working in the dietary department. This has the potential to affect more than a limited number of residents. Facility census: 55.<br><br>Findings include:<br><br>A) Culinary Aide (CA) #62<br><br>At approximately 9:00 AM on 03/27/24, an interview was conducted with the Culinary Director (CD). The CD provided a list of employees with food handlers cards. Upon review, it was determined that CA #62 did not have a food handlers card and had been employed in dietary since 01/02/24.<br><br>The CD stated They just work weekends and I never see them, so it has been hard to get them to get the food handlers card.<br><br>According to [NAME] Virginia code S16-2-16, all counties in [NAME] Virginia must require food safety certificates for food employees. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467<br><br>Based on observation and staff interview, the facility failed to store food in a safe and sanitary manner and maintain sanitary equipment. This had the ability to affect more than a limited number of residents. Facility census: 55.<br><br>Findings included:<br><br>a) Temperature logs<br><br>At approximately 11:07 AM on [DATE], during a tour of the kitchen, it was discovered that the breakfast temperature logs were incomplete. [NAME] #59 stated the temperature logs were not done due to new employee training.<br><br>The Culinary Director (CD) confirmed the temperature logs were not done. CD stated the employee must have put the temperature logs on a separate sheet of paper somewhere to show the trainee how to fill out the logs, and just forgot to fill out the logs.<br><br>b) Expired beans<br><br>At approximately 11:15 AM on [DATE], during a tour of the kitchen, a container of pinto beans was discovered in the reach-in refrigerator. The beans were dated [DATE]-[DATE].<br><br>The CD acknowledged the expired beans and stated, I don ' t know why those are still in there but I will throw those away right now.<br><br>c) Microwave<br><br>At approximately 11:43 AM during a tour of the nourishment room, the microwave was observed having grime on the inside, as well as a paper towel with yellow stains on it, stuck to the plate inside the microwave.<br><br>The surveyor asked the CD if the microwave was used to prepare food for the residents in the facility. The CD stated, Yes, they will bring food in here and heat it up for the residents if they ask. I will get that paper towel out of there now. The CD attempted to remove the paper towel and it remained stuck to the plate. The CD was eventually able to remove it.<br><br>d) Can of corn<br><br>At approximately 11:15 AM on [DATE], during a tour of the kitchen, a dented can of corn was observed sitting on the storage rack in the kitchen.<br><br>The CD was informed, and acknowledged, the dented can of corn and stated, I will throw that away right now, it shouldn't have been there. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>45173<br><br>.<br><br>Based on record review and staff interview, the facility failed to maintain an accurate and complete record for two (2) of 16 residents reviewed during the survey process. Residents #19 and #26 did not have an accurate and complete record. Resident #19's record had an incomplete transfer form. Resident #26's record was incomplete in Physician's Scope of Orders for Treatment (POST) form. Resident Identifiers: #19 and #26 . Facility Census: 55.<br><br>Findings Include:<br><br>a) Resident #19<br><br>On 03/26/24 at 11:00 AM, a record review was completed for Resident #26. The review found the resident was transferred to an acute care facility on 03/15/24. However, the transfer form was reviewed, and the date was listed as 01/28/24.<br><br>On 03/26/24 at 11:30 AM, the Administrator and the Corporate Registered Nurse (RN) #85 were notified and confirmed the transfer date on the transfer form was incorrect.<br><br>b) Resident #26<br><br>On 03/26/24 at 10:00 AM, a record review was completed for Resident #26. The review found the Physician's Scope of Orders for Treatment (POST) form was not complete. The POST form was signed by Resident #26 and the Resident Representative. However, the signatures did not have a date for when the POST form was signed. The date was left blank.<br><br>On 03/26/24 at 10:31 AM, the Administrator was notified of the incomplete POST form. The Administrator confirmed the signatures on the POST form were not dated. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>40595<br><br>Based on record review and staff interview the facility failed to have the appropriate members of the quality assessment and assurance committee attend the quarterly meetings. This failed practice had the potential to affect all residents residing at the facility. Facility census: 55.<br><br>Findings included:<br><br>Record Review of the Quality Assurance and Performance Sign in Sheet showed the facility's Medical Director did not attend the second quarter meeting for 2023.<br><br>On 03/27/24 at 3:55 PM the Director of Nursing (DON) verified the medical director was not in attendance at the second quarter meeting in 2023 |