

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50801</p> <p>Based on resident observation, resident interview, and staff interview the facility failed to ensure Resident #54 was treated with dignity and respect. This was true for one (1) of seven (7) residents reviewed for the care area of dignity during the long term care survey process. Resident identifier: #54. Facility census: 60.</p> <p>Findings include :</p> <p>A) Resident #54</p> <p>On 4/29/24 at 1:44 PM, Resident #54 was observed with long chin hairs which needed to be removed. An interview with Resident #54 on 4/30/24 at 4:10 PM, confirmed she did not like having chin hair and she would like it removed.</p> <p>The Director of Nursing was present during the resident interview and agreed her chin hair needed removed. She stated she would do that now.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>50552</p> <p>Based on record review and staff interview the facility failed to inform the resident or resident representative, in advance, by the physician or other practitioner or professional, of the risks and benefits of the proposed use of an antipsychotic medication. This was true for one (1) of five (5) sampled residents in the long term survey process. Resident identifier: #36. Facility census: 60</p> <p>Findings include:</p> <p>a) Resident #36</p> <p>On 05/01/24 at 12:42 PM, a review of Resident #36's medical record noted Resident #36 was receiving an antipsychotic medication Risperidone which was ordered 03/07/24. Upon further review it was noted there was no documentation education related to the risks and benefits of the antipsychotic medication was provided to Resident #36's healthcare decision maker prior to the resident being started on the medication.</p> <p>On 05/01/24 at approximately 2:00 PM, an interview was conducted with the Director of Nursing who acknowledged the education related to the risks and benefits of the use of the antipsychotic medication was not completed prior to the medication being started.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>50801</p> <p>Based on record review and staff interview the facility failed to issue a beneficiary notification within appropriate time frames. This was true for one (1) of three (3) residents reviewed for beneficiary notifications during the long term care survey process. Resident identifier # 111. Facility Census 60.</p> <p>Findings include:</p> <p>A) Resident #111</p> <p>A review of Resident #111's medical record on 05/01/24 found her last covered day of Medicare services was 12/14/23. A review of her notice of medicare non-coverage (nomnc) Centers for Medicare and Medicaid Services (CMS) form 10123 found it was issued to the responsible party on 12/14/23. The form indicated the appeal needed to be filed on 12/13/23 which was one day before the responsible party was notified. This made the appeal process inaccessible to the residents responsible party.</p> <p>An interview with the Nursing Home Administrator on 05/01/24 at 10:30 AM, confirmed Resident # 111's NOMNC was not issued two (2) days prior to her last covered day as required.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650</p> <p>Based on observations and staff interviews the facility failed to ensure the residents were provided a safe, functional, sanitary, and comfortable homelike environment. This was evident by soiled equipment, holes in walls and a dirty bathroom. These were random opportunities of discovery during the long term care survey process and had the potential to affect a limited number of residents. Resident Room Identifiers: room [ROOM NUMBER]A, Room # A14B, and Room #B14. Census: 60.</p> <p>Findings Include:</p> <p>a) room [ROOM NUMBER]A</p> <p>On 04/29/24 at 12:37 PM, during a tour of the facility, room [ROOM NUMBER]A was identified to have a piece of equipment in the bathroom which appeared to be soiled on the platform where you would place your feet to stand.</p> <p>On 04/29/24 at 12:40 PM, during an interview with Licensed Practical Nurse (LPN) # 45 and LPN #65, the equipment was identified to be a turn and positioning device the resident stands on to be assisted to turn. LPN #45 stated the platform to stand on was filthy. Neither LPN #45 nor LPN #65 were aware of what the cleaning requirements were for this equipment.</p> <p>On 04/30/24 at 11:50 AM, during an interview with the Administrator, the Policies and Standard Procedures for Infection Control Practices for Maintenance Department, Category noted to be Nursing, was provided. It was identified under the Procedures outlined in Section V. Maintenance and repair of equipment used for resident care that the equipment will be cleaned by staff or housekeeping for visible contaminated blood or other body fluids. The Administrator acknowledged the equipment was not properly cleaned and sanitary for the residents use.</p> <p>b) Room A14-B</p> <p>During an observation on 04/29/24 at 11:23 AM, two holes in the wall were observed behind the B bed in room [ROOM NUMBER] on the A-wing, The holes were observed on each side of the over the bead light.</p> <p>A Staff interview on 04/30/24 at 4:20 PM, with the Administrator confirmed the over head light had been replaced and the holes from the previous light remained in the wall. I will have these fixed as soon as possible, thank you.</p> <p>c) B14</p> <p>On 04/29/24 at 12:24 PM, the bathroom for room B14 was observed and a brown substance was smeared on the floor by the toilet. An additional observation of the bathroom for room B14 was made on 04/29/24 at 11:30 AM, found the same brown substance on the floor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/24 at 11:40 AM, the director of plant maintenance confirmed the floor needed cleaned. He indicated the room should be cleaned daily.</p> <p>49751</p> <p>50801</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171</p> <p>Based on record review and staff interview, the facility failed to ensure Resident #30 was free from abuse which includes freedom from resident to resident altercations and #16 was free from inappropriate language from a staff member. This is true for two (2) of two (2) residents reviewed during the survey.</p> <p>This will be cited as past non compliance because the facility identified what had happened and took immediate steps to correct the failure to ensure it does not reoccur. All components of the of plan of correction were completed prior to this survey beginning.</p> <p>This did occur and because Resident #30 did not have the cognitive ability to indicate how this affected her the reasonable person standard was applied. A reasonable person would suffer psychosocial harm from being hit by another resident residing in the same facility as her therefore this will be cited as actual harm at past non compliance for Resident #30. Resident #16 voiced to staff that hearing the nurse aide using profanity about caring for her made her upset also resulting in actual harm for Resident #16. Resident Identifier: #30 and #16. Facility Census: 195.</p> <p>Findings Include:</p> <p>a) Resident #30</p> <p>On 04/30/24 at 11:00 AM, a record review was completed for Resident #30. The record review found a documented incident which occurred on 03/28/24 at 3:00 PM. A witnessed allegation of Resident #57 hitting Resident #30 in the left eye was reported by the Activities Director #54. This was also witnessed by two (2) guests.</p> <p>Resident #30 was admitted to the facility on [DATE]. The resident had the following diagnoses:</p> <ul style="list-style-type: none"> - Alzheimer's disease with late onset - Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbances - Hypertensive chronic kidney disease with Stage 1 through stage 4 chronic kidney disease or unspecified kidney disease - Chronic kidney disease, Stage 4 (Severe) - Anemia in Chronic Kidney disease - Primary generalize osteoarthritis - Essential primary hypertension <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Atherosclerotic heart disease of native coronary artery without angina pectoris - Type 2 diabetes mellitus with diabetic chronic kidney disease - Iron deficiency anemia secondary to blood loss (chronic) - Other seasonal allergic rhinitis - Vitamin D deficiency, unspecified - Major Depressive Disorder, Recurrent, moderate. - Insomnia due to medical condition - Generalize anxiety disorder. - Muscle weakness (generalized) - History of falling - Type 2 diabetes mellitus with hyperglycemia - Dysphagia, oral phase - Personal history of COVID-19 - Hypotension, unspecified - Personal history of (healed traumatic fracture of the right hip - Slow transit constipation <p>The Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed on 04/30/24 at 12:30 PM. The Brief Interview of Mental Status (BIMS), found under section C, a score of -04- (four), which indicates moderate cognitive impairment. The resident does not have capacity according to the Physicians Determination of Capacity form dated 03/02/23 and has a resident representative in place.</p> <p>On 04/30/24 at 01:45 PM, a review of the facility reportable was completed. The review found a reportable dated 03/28/24. The incident took place on 03/28/24 at approximately 3:00 PM. The allegation was Resident #57 hit Resident #30 in the left eye. The incident was reported to the Physician by the Activities Director #54 who witnessed the incident. The reportable was faxed to all appropriate state agencies.</p> <p>The investigation started immediately on 03/28/24. A written statement was obtained from the Activity Director #54 who states she was talking to (Resident #57) concerning his eye and (Resident #30) pointed at him and he hit her in the left eye. There were two (2) guest that also witnessed the incident. Their statements were #1 he was talking and just hit her in the face, witness #2 it looked like an accident, he went to push away her hand and accidentally hit her in the face.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Activities Director #54 immediately separated the residents and summoned the Physician which was in house and was instructed to place a cold compress on her eye. Resident #57 was placed on one on one (1:1) until he was able to be transferred to a local hospital for evaluation. He has since been discharged from the facility.</p> <p>The alleged perpetrator, Resident #57 has the following medical diagnosis:</p> <ul style="list-style-type: none"> - Epilepsy, unspecified, not intractable, without status epileptics. - Anoxic brain damage, not elsewhere classified. - Difficulty walking - Muscle weakness (generalized) - Unspecified mood (affective) disorder - Impulse disorder - Intermittent explosive disorder - Asthma - Non surgical orthopedic/musculoskeletal - Essential hypertension - Unilateral primary osteoarthritis, right hip - Type 2 diabetes without complications - Bipolar disorder - Moderate intellectual disabilities - Unspecified hearing loss, bilateral - Mixed hyperlipidemia - Presence of artificial right eye - Pain in right knee <p>Resident #57's Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed on 04/30/24 at 12:40 PM. The Brief Interview of Mental Status (BIMS), found under section C, a score of 12 (twelve), which indicates moderately cognitive impairment. The resident does not have capacity according to the Physicians Determination of Capacity form dated 02/20/23 and has a resident representative in place.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/24 at approximately 3:30 PM, the Administrator provided a copy of the Abuse Abatement Plan dated 03/2/24. The Abatement Plan states the following:</p> <p>Resident's Head to toe assessment completed 03/28/24</p> <p>Resident's Pain assessment complete. 03/28/24</p> <p>Resident's MD (medical doctor) and RP (resident representative) notification of incident. 03/28/24</p> <p>Resident Social services referral. 03/28/24</p> <p>Care plan reviewed- 04/30/24</p> <p>All agencies and police notified of incident. 03/28/24</p> <p>Identification of Others:</p> <p>All competent residents in the facility were interviewed for any concerns of being safe or if their needs were being met. No residents voiced any concerns of their safety or of their needs not being met. Head to toe skin assessments were conducted on residents residing in the facility who are unable to be interviewed. No additional residents were identified to have any unknown skin issues.</p> <p>A further review of Resident #30's record indicated a head to toe assessment and a pain assessment were completed on 03/28/24. Based on the residents mental status the facility was able to confirm the witnessed incident at the time of the incident. The completed assessments by nursing staff documented no indication the resident had any physical injuries and the resident did not have any signs or symptoms to indicate pain. There were continued skin assessments completed weekly since the incident. The Resident is scheduled Tylenol 650 mg twice a day for osteoarthritis pain. She has denied pain since the incident. Pain assessments are completed twice a day and a pain observation tool was completed on 03/28/24 based on the incident.</p> <p>An interview was conducted on 05/02/24 at 11:15 AM with the Administrator and the Director of Nursing (DON). Both the Administrator and the DON confirmed the incident which involved Resident #30 did happen as reported. The Administrator, also stated Resident #57 has been discharged from this facility to a more suitable facility for his mental capacity.</p> <p>b) Resident #16</p> <p>On 04/29/24 at 11:00 AM, a record review was completed for Resident #16. The record review found an allegation of the resident hearing a Certified Nursing Assistant (CNA) use profanity in front of Resident #16 and stating CNA #83 doesn't want to care for Resident #16.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/29/24 at 10:30 AM, a review of the facility reportable's was completed. The review found a reportable dated 02/19/24 by the administrator. The incident took place on 02/18/24 . The allegation was CNA #83 stated, , If I knew how much fucking work (he) had to do, he wouldn't have taken this fucking job. Resident #16 heard the statement be made in the doorway of Resident #16's room. Resident #16 reported this to staff stating CNA #83 uses profanity often and I don't care for it and do not want him caring for her. The report was faxed to all appropriate state agencies and investigation started.</p> <p>The CNA #83 was placed on unpaid suspension following the incident on 02/18/24. Multiple witness statements were obtained by other staff members regarding the incident from 02/18/2024 through 02/21/24. The witness statements reviewed stated CNA #83 did say what he said in front of Resident #16.</p> <p>The five (5) day follow up investigation was submitted by SSD #84 on 02/23/24 Allegation of abuse (verbal and psychosocial) made by the resident to the nurse Conclusion it was determined the resident overheard CNA using profanity, which was validated by staff members who also heard the profanity. The statement made by CNA #83 left the resident upset and no longer wanting CNA #83 caring for them.</p> <p>CNA #83 agreed making the statement, however stated he did not use profanity. CNA #83 states he knew this interview was coming and he would no longer be working at the facility he resigned.</p> <p>SSD #84 concluded an investigation stating Resident #16 was not continuing to be in psychological distress knowing CNA #83 no longer works at this Long-Term Care Facility.</p> <p>On 02/21/24 CNA #83 resigned during investigation of verbal abuse by using profanity in front of Resident #16 when contacted about the investigation his response was I have been waiting for this call and didn't come into work anyway because I am quitting down there.</p> <p>Upon being hired to this facility CNA #83 had completed Elder Abuse: The Elder Justice Act training, Preventing, Recognizing, and Reporting Abuse training on 02/07/24.</p> <p>49751</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>31826</p> <p>Ensure each resident receives an accurate assessment.</p> <p>Based on medical record review and staff interviews the facility failed to accurately encode the residents Minimum Data Set (MDS) upon discharge. This was true for one (1) of two (2) resident discharges reviewed during the long term care survey process. Resident Identifier: Resident #59. Facility Census: 60.</p> <p>Findings Include:</p> <p>a) Resident #59</p> <p>On 4/30/24 at 6:45 PM during a medical record review for Resident #59, there were no notes identified for the anticipated discharge of Resident #59 prior to the discharge occurring on 03/21/24. A review of the miscellaneous documents identified the Notice of Medicare Non-Coverage that was verbally reviewed with Resident #59's son on 03/15/24. Upon further review of the residents record, the discharge summary dated 03/21/24 was completed by all required departments. The discharge summary did include but was not limited to the notification of the need to follow up with attending physician in 2 weeks, medication list, and the discharge goals of St Mary's home health.</p> <p>On 04/30/24 at 10:40 AM, during an interview with Unit Manager Licensed Practical Nurse (UM LPN) #65, she stated that the MDS Coordinator was currently off but she remembered that the residents son had worked with the staff on the discharge process but then he had come to get her one day before the date they had originally planned for. She stated she felt it had to do with financial issues. She further stated she felt that because he came before the planned date is why it was marked as unplanned.</p> <p>On 04/30/24 at 11:38 AM, during an interview with Regional Director of Finance # 82, she confirmed the cut letter and provided the letter of determination that Resident #59 had won her appeal dated 03/18/24. She further stated that there was nothing financially in the system that would indicate the discharge to be due to financial reasons.</p> <p>On 04/30/24 at approximately 11:45 AM, during an interview with the Administrator, he agreed that everything identified in regards to this discharge indicates that the discharge was planned and the MDS was not encoded correctly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>45171</p> <p>Based on record review and staff interview the facility failed to ensure a resident's Preadmission Screening and Resident Review (PASARR) reflected the diagnoses sheet for a newly diagnosed mental illness. This was true for three (3) of four (4) residents reviewed for the PASARR care area. Resident Identifiers: #26, #41, and #52 Facility Census: 60</p> <p>Findings Include:</p> <p>(a) Resident #26</p> <p>During a record review on 04/29/24, Resident #26 medical record review revealed admitting diagnosis for 09/08/22 (admitted) included the following:</p> <ul style="list-style-type: none"> -Schizoaffective disorder <p>According to the Diagnosis Report provided by the facility the following diagnoses were added during Resident #26 stay. A review of the PASAAR submitted 03/01/23, there was no new PASARR submitted to reflect this admitting medical diagnosis (Schizoaffective disorder) or the following new diagnosis of:</p> <ul style="list-style-type: none"> - Major Depressive Disorder 07/13/23 - Mild cognitive impairment of uncertain or unknown etiology 02/06/23 - Delusional Disorder 11/20/22 - Paranoid Personality Disorder 11/20/22 - Bipolar Disorder (history of) 10/20/22 <p>In an interview with the Director of Nursing on 04/30/24 at 3:36 PM, it was verified the new diagnoses were not submitted on a PASARR.</p> <p>b) Resident #41</p> <p>On 04/30/24 at 11:00 AM, a review of Resident #41's medical record noted a new diagnosis of bi-polar disorder was added on 09/15/20. Resident #44's Preadmission Screening and Resident Review form (PASARR) was last completed on 08/28/20. No level II was needed.</p> <p>On 04/30/24 at 11:15 AM, an interview was conducted with the Director of Nursing who acknowledged the facility failed to resubmit a new PASARR to the state-designated mental health authority promptly when Resident #41 was diagnosed with a change in his mental status.</p> <p>c) Resident #52</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review on 04/30/24 at 2:04 PM, it was found Resident #52 was diagnosed with Major Depressive disorder on 06/06/23.</p> <p>Further record review revealed Resident # 52's last Preadmission Screening and Resident Review (PASSAR) was completed on 01/20/23, and a diagnosis of Major Depressive disorder was not indicated.</p> <p>During an interview on 05/01/24 at 12:30PM, with the Director of Nursing (DON), she confirmed a new PASSAR had not been completed for Resident #52.</p> <p>50552</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171</p> <p>Based on record review and staff interview the facility failed to ensure a resident's Preadmission Screening and Resident Review (PASARR) reflected the diagnoses sheet for pre admission diagnoses. This was true for two (2) of four (4) residents reviewed for the PASARR care area. Resident Identifiers: #26, #14, Facility Census: #60</p> <p>Findings Include:</p> <p>(a) Resident #26</p> <p>During a record review on 04/29/24, Resident #26 medical record revealed admitting diagnosis for 09/08/22 (admitted) included the following:</p> <ul style="list-style-type: none"> -Schizoaffective disorder <p>According to the Diagnosis Report provided by the facility and the PASARR submitted 03/01/23 the PASARR did not reflect this admitting medical diagnosis.</p> <p>In an interview with the Director of Nursing on 04/30/24 at 03:36 PM, it was verified the PASAAR should have reflected the Schizoaffective disorder upon the admitted [DATE].</p> <p>(b) Resident #14</p> <p>During a record review on 04/29/24, Resident #14's medical record revealed an admitting diagnosis for 05/25/23 (admitted) included the following:</p> <ul style="list-style-type: none"> - Bipolar Disorder - Mild Cognitive Impairment of Uncertain or Unknown Etiology <p>According to the Diagnosis Report provided by the facility and the PASARR submitted 05/23/23 by a local hospital, the PASARR did not reflect these admitting medical diagnosis.</p> <p>In an interview with the Director of Nursing on 04/30/24 at 03:36 PM, it was verified the PASAAR should have reflected the Bipolar Disorder and Mild Cognitive Impairment of Uncertain or Unknown Etiology upon the admitted [DATE].</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50552</p> <p>Based on record review and staff interview the facility failed to develop and implement the individualized comprehensive care plan for bowel and bladder continence. This was true for one (1) of two (2) residents reviewed for the care area of bowel and bladder continence during the long term survey process. Resident Identifiers: Resident #2. Facility Census: 60.</p> <p>Findings Included:</p> <p>a) Resident #2</p> <p>On 04/30/24 at 11:20 AM, a record review of Resident #2's medical record revealed a diagnosis of urinary incontinence. Upon further record review it was noted a Urinary Incontinence Assessment was completed dated 12/22/23 noting Resident #2 was functioning incontinent requiring a toileting program titled Check and Change. During a review of Resident #2's current care plan, it was identified the facility failed to develop or implement an individualized comprehensive care plan for this diagnosis.</p> <p>During an interview with the Director of Nursing on 05/01/24 at approximately 9:30 AM, the Director of Nursing acknowledged Resident #2 had not been care planned for her urinary incontinence diagnosis as she should have been.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49465</p> <p>Based on observation, resident interview, staff interview, and record review the facility failed to provide care and services in accordance with professional standards of practice by not providing timely medical treatment for a foot injury. This was true for one (1) of 29 sampled residents reviewed during the long term care survey process. Resident identifier #52. Facility Census 60.</p> <p>Findings Include:</p> <p>a) Resident # 52</p> <p>During an interview on 04/29/24 at 1:02 PM, Resident #52 who has a Brief Interview for Mental Status (BIMS) of (8) eight stated, I fell in January at my house and came here due to a broken hip. Yesterday my walker fell on the other foot, it hurt. Now I can't walk on either side. I told the nurse and she looked at it when it happened, but no one has done anything since.</p> <p>An observation on 04/29/24 at 1:03 PM, of Resident #52's right foot revealed dark purple and red bruising on her right big toe and of the toe beside it. The bruising also went down the side and top of her foot.</p> <p>During an interview on 04/29/24 at 1:10 PM, Licensed Practical Nurse (LPN) # 80 stated, I did not work over here yesterday. She has not said anything to me about it today.</p> <p>During an interview on 04/29/24 at 1:13 PM with the Assistant Director of Nursing (ADON), while she was observing Resident # 52's right foot, stated, Yes, we definitely need to get that x-rayed. (Resident # 52 named), do not get up and walk by yourself until we get this x-rayed.</p> <p>A review on 04/29/21 at 1:30 PM, of Resident # 52's medical record revealed that no notes, or incident reports had been charted for Resident # 52 concerning the incident involving the right foot.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>49650</p> <p>Based on observation and staff interview, the facility failed to ensure the Daily Staffing Posting information was accurate and current with the actual direct care hours and the identified direct care staff. This was true for four (4) of five (5) Daily Staffing Posting forms reviewed during the long term care survey process. This had the potential to affect more than a limited number of residents. Days Identified: 04/04/24; 04/05/24; 04/12/24 and 04/18/24. Facility Census: 60.</p> <p>Findings include:</p> <p>a) Inaccuracy of actual direct care hours.</p> <p>On 04/30/24 at 9:30 PM, during a review of 04/04/24, 04/05/24, 04/12/24 and 04/18/24 the total direct care hours posted were compared to the Actual Hours for Direct Care Staff Report document for 04/01/24-04/30/24 calculations. The following inaccuracies were identified.</p> <p>* 04/04/24 - the Daily Staffing Posting form identified the direct care hours to be 176 hours. The Actual Hours for Direct Care Staff document identified the direct care hours to be 147.50. An inaccuracy of 28.5 hours.</p> <p>*04/05/24 - the Daily Staffing Posting form identified the direct care hours to be 172 hours. The Actual Hours for Direct Care Staff document identified the direct care hours to be 152.25. An inaccuracy of 19.75 hours.</p> <p>*04/12/24 - the Daily Staffing Posting form identified the direct care hours to be 172.5 hours. The Actual Hours for Direct Care Staff document identified the direct care hours to be 169.75. An inaccuracy of 2.75 hours.</p> <p>*04/18/24 - the Daily Staffing Posting form identified the direct care hours to be 183.5 hours. The Actual Hours for Direct Care Staff document identified the direct care hours to be 174.50. An inaccuracy of 8.75 hours.</p> <p>On 05/01/24 at approximately 11:15 AM during an interview with the Administrator, he agreed the hours identified on the Daily Staffing Posting were more than the actual reported hours worked.</p> <p>b) Inaccuracy of direct care staffing hours.</p> <p>On 04/30/24 at 09:30 PM, during a review of 04/04/24, 04/05/24, 04/12/24 and 04/18/24 the staff category and total direct care hours posted were reviewed. The following inaccuracies were identified.</p> <p>* 04/04/24 - the Daily Staffing Posting of direct care staffing care hours identified the Registered Nurse Director of Nursing (RN DON) eight (8) hours and two (2) Registered Nurse (RN) with Administrative Duties 16 hours as direct care hours.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>* 04/05/24 - the Daily Staffing Posting of direct care staffing care hours identified the Registered Nurse Director of Nursing (RN DON) eight (8) hours and two (2) Registered Nurse (RN) with Administrative Duties 16 hours as direct care hours.</p> <p>* 04/12/24 - the Daily Staffing Posting of direct care staffing care hours identified the Registered Nurse Director of Nursing (RN DON) eight (8) hours and two (2) Registered Nurse (RN) with Administrative Duties eight 16 as direct care hours.</p> <p>* 04/18/24 - the Daily Staffing Posting of direct care staffing care hours identified the Registered Nurse Director of Nursing (RN DON) eight (8) hours and two (2) Registered Nurse (RN) with Administrative Duties 16 hours as direct care hours.</p> <p>On 05/01/24 at approximately 11:15 AM during an interview with the Administrator, he stated the RN DON hours and the RN's with Administrative hours were on the Daily Staffing Posting form because they do sometimes assist throughout their shift with the daily care of the residents. With a review of the Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6 with the Administrator. This section defines that the Labor Classification/Job Title Reporting shall be based on the employee's primary role and their official categorical title. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of that employee based on their primary role. CMS recognizes that staff may completely shift primary roles in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). The Administrator acknowledged the RN DON hours and the RN's with administrative duties hours should not had been included on the Daily Staffing Posting for direct care staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49465</p> <p>Based on observation, policy review, and staff interview the facility failed to store, and serve food in accordance with professional standards by keeping chocolate milk beyond its expiration date, and by not ensuring all staff were wearing hairnets during the Long-Term Care Survey Process. This failed practice had the potential to affect all resident currently residing in the facility. Facility Census 60.</p> <p>Findings Include:</p> <p>a) Chocolate milk</p> <p>During the initial tour of the kitchen on 04/29/24 at 11:00 AM, ia gallon of chocolate milk was found in the reach-in-refrigerator with approximately 1/4th of the gallon of chocolate milk left in the jug. The expiration on the jug of chocolate milk was 04/26/24.</p> <p>A review of the facilities policy number 019, titled, { Food Storage: Cold Foods}, under policy statements reads as follows:</p> <p>Typed as written</p> <p>All time/temperature control for safety (TCS) foods, frozen, and refrigerated, will be appropriately stored in accordance with guidelines of the FDA food code.</p> <p>The Dietary Corporate Manager (DCM), confirmed that the chocolate milk was out of date.</p> <p>b) Employee #61</p> <p>During the initial tour of the facility's kitchen on 04/29/24 at 11:00 AM, it was found Employee # 61 was washing and putting up dishes and did not have a hairnet on.</p> <p>The DCM confirmed that employee # 61 was not wearing a hairnet.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49751</p> <p>Based on observation, record review, and staff interview the facility failed to ensure a clean, sanitary environment by leaving a bedpan in the floor on the A-Hall room [ROOM NUMBER] restroom, and following policy to test yearly for Legionellosis. This failed practice had the potential to affect more than a minimal number of residents in the facility. Facility Census: 60</p> <p>Findings Include:</p> <p>a) Bepan left in floor</p> <p>Observation on 04/29/24 at 11:28 AM, revealed an uncovered bedpan in bathroom floor.</p> <p>A second observation on 04/29/24 at 1:17 PM showed the bedpan remained on the floor in the bathroom.</p> <p>On 04/30/24 at 9:00 AM, a third observation with the facility Administrator who confirmed the bedpan still remained in the bathroom floor in room A13.</p> <p>b) Water Management/Legionella Plan</p> <p>Legionellosis refers to two clinically and epidemiologically distinct illnesses: Legionnaires disease, which is typically characterized by fever, myalgia, cough, and clinical or radiographic pneumonia and Pontiac fever, a milder illness without pneumonia (e.g., fever and muscle aches). Legionellosis is caused by Legionella bacteria</p> <p>Review of the facility Water Management plan/Legionella Plan on 05/01/24 at 12:35 PM, revealed the last Legionellosis test was done on 9/14/22.</p> <p>Further record review of the Policies and standard procedures showed in Policy #: IC:- on page 8</p> <p>to read Water testing will be performed on an Annual basis and the results of the test to be recorded in the facilities Water Management/Legionella Plan.</p> <p>During a staff interview on 05/01/24 at 1:00 PM with the Administrator confirmed the policy for water testing was not followed and the facility had not had a Lefionella test since 09/14/22.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Wayne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6999 Route 152 Wayne, WV 25570	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>49650</p> <p>Based on observations, family interview and staff interview the facility failed to ensure the residents were provided a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The facility failed to place chairs in the residents rooms for the resident and/or visitors to utilize. This was a random opportunity of discovery during the long term care survey process and had the potential to affect a limited number of residents. Resident Identifier: Resident #12. Census: 60.</p> <p>Findings Include:</p> <p>a) Resident #12</p> <p>On 04/29/24 at 12:56 PM, during an interview with Resident #12, his brother was observed to be sitting half way on the rooms packaged terminal air conditioner (PTAC) unit beside Resident #12's bedside. Resident #12's brother stated, the room never had a chair in it but sometimes he is able to get a fold-up chair if there are any available.</p> <p>On 04/30/24 at 4:10 PM, during an interview with the Administrator, he stated, many rooms does not have chairs and he will replace them. He further acknowledged the rooms should have chairs for residents and visitors to have a functional comfortable homelike environment.</p>