

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2024
NAME OF PROVIDER OR SUPPLIER  Hampshire Center		STREET ADDRESS, CITY, STATE, ZIP CODE  260 Sunrise Boulevard Romney, WV 26757	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>49465</p> <p>Based on observation, and staff interview, the facility failed to provide privacy to residents when providing assistance for showers. This was a random opportunity for discovery during the Survey process. Resident identifier #8. Facility Census 62.</p> <p>Findings Included:</p> <p>a) Resident #8</p> <p>An observation on 08/12/24 at 9:45 AM, of the shower room located on hall 200 revealed the shower room had no lock or in use signage. Noticing there was no sign or lock the Surveyor knocked on the door. There was no answer, so the Surveyor entered the shower room.</p> <p>Further observation of the shower room revealed Nurse Aide (NA) #38 standing undressing Resident #8, who only had a brief on at this time.</p> <p>During an interview on 08/12/24 at 9:50 AM, NA #59, Stated, We just usually knock. I agree there isn't much privacy.</p> <p>During an interview on 08/12/24 at 10:00 AM, The Administrator stated, Well, us who work here know when shower time is. We just usually know when it is in use.</p> <p>The Administrator confirmed that there was no lock on the door, or in use signage.</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
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49465</p> <p>Based on record review, and staff interview, the facility failed to do a complete and thorough investigation on a possible resident to resident altercation resulting in death. This failed practice had the potential to affect more than a limited number of residents. Resident identifiers #63 and #35. Facility Census 62.</p> <p>Findings Included:</p> <p>a) Resident # 63</p> <p>A record review on 08/13/24 at 9:00 AM, of Resident # 63's E Interact Change in Condition dated 01/20/24 read as follows:</p> <p>Another resident grabbed at this resident's sleeve and this resident lost balance and fell down. Resident landed on buttocks and the staff member caught head in hands before hitting the floor. Four staff members witnessed the fall.</p> <p>Further record review revealed another E Interact Change in Condition form dated 02/14/24 that read as follows:</p> <p>Found resident on floor in room [ROOM NUMBER], blood noted from back of head. Helmet, elbow pads, and hip pads on. 911 called, neck supported by nurse. Helmet removed.</p> <p>Further Record review revealed an Interdisciplinary team (IDT) note that lists staff in attendance and reads as follows:</p> <p>Resident found on floor by staff in room [ROOM NUMBER]. Helmet, elbow pads and hip pads in place as ordered when found. Bleeding noted underneath the helmet. Helmet removed by staff and neck supported by nurse. Blood noted on the floor from the posterior head wound. 911 called and the resident was transported immediately via ambulance to (local hospital named). Resident returned from hospital with a CVA and cerebral hemorrhage diagnosis. Resident has 4 staples to the back of head with minimal bleeding noted. Resident now on comfort care due to decline in condition . No response to stimuli noted. Several interventions were removed from the care plan due to resident state. Most interventions do not apply to resident currently due to recent diagnosis.</p> <p>According to the (5) five day follow up Resident #36 passed away from the head injury on 02/16/24.</p> <p>b) Resident #35</p> <p>A record review on 08/13/24 at 9:10 AM of Resident #35's E Interact Change in Condition form dated 01/20/24 reads as follows:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident saw another resident attempting to converse with a third resident. This resident attempted to stop another resident from conversing with the third. She grabbed the sleeve of the resident attempting conversation. That resident lost balance and fell . Four staff members witnessed an altercation.</p> <p>Further record review revealed an E Interact Change in Condition form dated 02/15/24 that reads as follows:</p> <p>Another resident was observed on the floor in Resident #35's room on 02/24/24. Resident #35 originally reported to staff She fell . Later Resident #35 stated to staff I did it, thief [sic] Staff did not witness the incident. Neither resident demonstrates capacity. Other resident was transferred to hospital for evaluation.</p> <p>A review of the (5) five day follow up on the incident Resident # 35 was put on 15 minute checks for 72 hours.</p> <p>c) The investigation</p> <p>A review of the five day followup on 08/13/24 at 12:30 PM, revealed that no staff or residents had been interviewed for the incident resulting in death.</p> <p>During an interview On 08/14/24 at 1:00 PM, The Director of Nursing stated, There were no witnesses. The residents shared a bathroom and we are assuming she came in through the bathroom door. Neither resident could tell us what happened. When the surveyor asked why staff was not interviewed, The DON stated, Because no one saw the fall. I was told by the corporate to put the Change in Condition in for (Resident #35 named) just because she had said that and I guess for precaution.</p>		

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45173</p> <p>Based on record review and staff interview, the facility failed to implement an intervention regarding pressure ulcers for Resident #54 and implement an intervention of wearing personal protective equipment (PPE) for Resident #50. This was true for two (2) of 16 residents reviewed during the survey process. Resident Identifiers: #54 and #50. Facility Census: 62.</p> <p>Findings Included:</p> <p>a) Resident #54</p> <p>On 08/13/24 at 11:00 AM, a record review was completed for Resident #54. The review found the resident was receiving wound care for an unstagable pressure ulcer on the left heel. The care plan was reviewed regarding the wound care and pressure ulcer. The care plan listed an intervention of assist resident in turning and repositioning every 1 (one) hrs (hours) and PRN (as needed).</p> <p>The Director of Nursing (DON) was interviewed regarding this intervention on 08/13/24 at 1:00 PM. At this time, the DON was asked where is the documentation of the one (1) hour turning and repositioning? The DON stated, there is no documentation to verify this intervention was completed.</p> <p>b) Resident #50</p> <p>On 08/14/24 at 5:07 PM, an observation of Nurse Aide (NA) #71 and NA #17 entering room [ROOM NUMBER] without wearing the appropriate PPE for enhanced barrier precautions for Resident #50 due to an indwelling medical device (feeding tube). At this time, the resident stated, he needed changed. When a resident is under enhanced barrier precautions, the nurse aides should have worn a gown and gloves while performing high contact activities.</p> <p>On 08/14/24 at 5:11 PM, both NA #71 and #17 were asked, Isn't the resident on enhanced barrier precautions? NA #17 stated, no .there isn't a cart in front of his door. Signage was posted on the door stating enhanced barrier precautions were in place.</p> <p>On 08/14/24 at 5:35 PM, the DON was notified. The DON stated, they know there is only one cart on each hallway .they know.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to update a care plan regarding an actual fall for Resident #42. This was true for one (1) of three (3) residents reviewed during the survey process. Resident Identifier: #42. Facility Census: 62.</p> <p>Findings Included:</p> <p>a) Resident #42</p> <p>On 08/14/24 at 9:20 AM, a record review was completed for Resident #42. The review found the resident had an actual fall on 07/10/24 due to the bathroom floor being slippery from powder which is being used with another resident who shares the bathroom. The care plan was reviewed at this time. The care plan focus area stated, Resident is at risk for falls, R/T (related to) Weakness, Osteoarthritis, Chronic Pain, HTN (hypertension). The need for assistance with ADLs, (activities of daily living) use of meds (medications) that could cause drowsiness/dizziness.</p> <p>On 08/14/24 at 9:48 AM, the Director of Nursing was notified the care plan had not been revised to show an actual fall had occurred on 07/10/24. The DON stated, the care plan has not been revised to show an actual fall.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49465</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, record review, and staff interview, the facility failed to provide Activities of Daily Living (ADL) care to dependent residents. This failed practice was found true for (1) one of (4) four residents reviewed for ADL care during the survey process. Resident identifier #50. Facility Census 62.</p> <p>Findings Included:</p> <p>a) Resident #50</p> <p>During an Observation on 08/14/24 at 5:00 PM, Resident #50's call light came on.</p> <p>Further observation at 5:10 PM, shows Resident #50's call light continues to be on.</p> <p>During an interview on 08/14/24 at 5:15 PM, Resident #50 stated, I need changed, I feel wet.</p> <p>An observation on 08/14/24 at 5:16 PM, shows Nurse Aide (NA) #71 and NA #17 entering Resident #50's room. The NA's asked Resident #50 what he needed. Resident #50 stated, I want changed NA #17 stated, I'll be back in a few minutes with your tray. The call light was then turned off and NA #71 and #17 walked out of the room.</p> <p>At 5:18 PM, the surveyor intervened and asked NA #71 what Resident #50 needed? NA #71 stated, Oh, I didn't hear what he said, he usually wants coffee.</p> <p>During an interview on 08/14/24 at 5:40PM, The Director of Nursing (DON) stated, They know better than that. The DON confirmed that Resident #50 should have been provided incontinence care when he needed it.</p> <p>A record review on 08/14/24 at 6:00 PM, revealed a care plan that reads as follows:</p> <p>Focus:</p> <p>Resident requires assistance for ADL care related to CVA with monoplegia, weakness, left BKA, left knee contracture, arthritis,</p> <p>Goal:</p> <p>Will be limited assist with 2 or more ADLs by next review.</p> <p>Interventions:</p> <p>Encourage resident participation with ADL care. See ADL flowsheets for current level of support provided. Independent with eating and locomotion. Extensive to dependent with bathing. Extensive with transfers. Limited to extensive with remaining ADLs. Independent to extensive with toileting. Not currently walking.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident has a left knee contracture.</p> <p>Stand on weaker side of resident (left) when assisting with ADLs or other activities.</p> <p>Bed rail(s) used as an enabler.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465</b></p> <p>Based on observation, record review and staff interview, the facility failed to provide an ongoing program of activities to meet the needs and interest of the residents. This was a random opportunity for discovery during the survey process. Resident identifier #36. Facility Census 62.</p> <p>Findings Included:</p> <p>a) Resident #36</p> <p>An observation on 08/12/24 at 12:20 PM, showed Resident #36 eating her lunch in a common area in front of the nurses station.</p> <p>Further observation showed Resident #36 continuing to sit in the common area in front of the nurse's station with no television and/or music on at 1:30 PM, 1:45 PM, 2:25 PM and 3:00 PM.</p> <p>An observation on 08/13/24 at 8:30AM showed Resident #36 eating her breakfast in a common area in front of the nurses station.</p> <p>Further observation of Resident #36 at 10:00AM revealed Resident #36 crying in the common area in front of the nurses station. No Television/music was on at this time.</p> <p>Resident #36 continues to be in the common area at 11:00 AM and still appears to be upset.</p> <p>Resident #36 was eating her lunch in the common area at 12:25 PM.</p> <p>Further observation on 08/13/24 of Resident # 36 showed her asleep in her wheelchair in the common area in front of the nurses station from 1:30 PM to 3:30 PM</p> <p>A record review on 08/13/24 at 12:00 PM, of Resident #36's activity care plan reads as follows:</p> <p>Focus:</p> <p>Resident exhibits or is at risk for limited and/or meaningful engagement related to: Cognitive loss/dementia.</p> <p>Goal:</p> <p>Resident will increase level of participation in activities as evidenced by: increased socialization, increased verbalization of satisfaction in involvement, increased attendance and participation.</p> <p>Intervention:</p> <p>( Resident #36 name ) prefers to be called [NAME].</p> <p>Encourage ( Resident #36 name) participation in activity preferences such as church service.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide (Resident #36 name) with opportunities for choice during care/activities to provide a sense of control.</p> <p>Provide and review calendar/daily flow with [NAME]/patient/family to identify interests and preferences.</p> <p>Invite and assist patient, as needed, to activities of interest.</p> <p>Establish a relationship with ( Resident # 36 name) using informal conversations and/or small groups to foster resident trust and an environment where resident feels comfortable expressing interests and participating in activity.</p> <p>Encourage family/friend's support and involvement in facility based activities and opportunities</p> <p>Provide appropriate cueing through physical prompt, physical assist, verbal direction, etc.) to enable successful participation in activity.</p> <p>Remove physical barriers that prevent [NAME] from participating in daily routines and/or preferred activities.</p> <p>Further record review of Resident #36's Minimum Data Set (MDS) section F, with an Assessment Reference Date (ARD) of 03/08/24 was marked it is important to resident to participate in group activities and that it is important for resident to do things with groups of people.</p> <p>A record review of the MDS section F with an ARD of 07/08/24 is marked not assessed for the entire section.</p> <p>A review of Resident #36's activity participation records for the months of 06/2024, 07/2024, and 08/2024 shows there are a lot of A's to show active participation in individual activities Resident #36 is not physically or cognitively able to participate in. Such as the following:</p> <p>Exercise/sports/walking/wheeling.</p> <p>It is also marked individual activity for watching or listening to TV/Movies when surveyors made multiple observations of none of these activities being provided.</p> <p>Further record review of Resident #36's MDS with an ARD of 07/08/24, section C shows a Brief Interview of Mental Status (BIMS) score of 3. Section GG reveals that Resident #36 is not able to propel herself in the wheelchair.</p> <p>During an interview on 08/14/24 at 2:38 PM, the Activity Director (AD) stated, There are days where she (Resident #36), thinks someone is out to get her. Her participation has gone down. I do have her on the forget me not group. But she didn't come today.</p> <p>She confirmed, Resident #36 had been sitting in the common area across from the nurses station for (2) two days.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45173</p> <p>Based on observation, record review and staff interview, the facility failed to follow physician's orders regarding wound care for Resident #9 and #36, follow a physician's order regarding adaptive equipment for Resident #8, and completing an intervention per the physician for a possible resident to resident altercation for Resident #35. This was true for three (3) of 16 residents reviewed during the survey process. Resident Identifiers: #9, #36, #8 and #35. Facility Census: 62.</p> <p>Findings Included:</p> <p>a) Resident #9</p> <p>On 08/13/24 at 10:30 AM, a record review was completed for Resident #9. The review found physician's orders were not being followed regarding treatments, including wound care. The following physician's orders were not completed on the following dates:</p> <p>--Clotrimazole-Betamethasone External Cream 1-0.05% apply to affected area topically every day shift for itching.</p> <p>--06/20/24</p> <p>--07/02/24</p> <p>--07/10/24</p> <p>--Hydrocortisone External Cream 1% apply to affected areas topically every day and evening shift for itching/rash.</p> <p>--06/20/24</p> <p>--07/02/24</p> <p>--07/10/24</p> <p>Kerlix Gauze Roll Large Miscellaneous apply to peri-anal topically every days shift for surgical wound. Moisten with saline and pack wound. Cover with bordered gauze.</p> <p>--06/20/24</p> <p>--07/02/24</p> <p>--07/10/24</p> <p>Lidocaine External Cream 3% apply to affected area topically every day shift for pain.</p> <p>--06/20/24</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review on 08/14/24 at 10:30 AM of Resident # 35's E Interact Change in Condition form dated 02/15/24 revealed, she had a possible altercation with another resident. The (5) five day follow up revealed, she was put on 15 minute checks for 72 hours.</p> <p>Further record review showed, the 15 minute checks were completed on 02/15/24 and 02/16/24 but no 15 minute checks could be found for 02/17/24.</p> <p>On 08/14/24 at 11:00 AM, The DON confirmed, the 15 minute checks for Resident #35 had not been completed for the full 72 hours.</p> <p>49465</p>		

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NAME OF PROVIDER OR SUPPLIER  Hampshire Center		STREET ADDRESS, CITY, STATE, ZIP CODE  260 Sunrise Boulevard Romney, WV 26757	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>45173</p> <p>Based on observation, resident interview and staff interview, the facility failed to provide appropriate treatment to prevent further decrease in range-of-motion for Resident #11. This was a random opportunity for discovery. Resident Identifier: #11. Facility Census: 62.</p> <p>Findings Included:</p> <p>a) Resident #11</p> <p>On 08/14/24 at 3:30 PM, an interview was held with Resident #11. During the interview, Resident #11 stated, I had my shower earlier and they didn't put my splint on my hand (right).</p> <p>On 08/14/24 at 4:00 PM, a record review was completed for Resident #11. The review found a physician's order stating, SoftPro resting hand splint (WHFO) (wrist/hand/finger orthosis) to be applied to right hand in the morning, when patient is in her wheelchair, and to be removed in the evening, at bedtime. Skin checks to be performed pre/post WHFO application two times a day.</p> <p>On 08/14/24 at 5:04 PM, an additional observation of Resident #11 was made. The resident did not have the resting splint on her right hand.</p> <p>On 08/14/24 at 5:07 PM, an interview was held with Nurse Aide (NA) #71. The NA was asked, does the resident normally wear a splint on her right hand? NA #71 stated, she usually doesn't wear one.</p> <p>On 08/14/24 at 5:09 PM, Registered Nurse (RN) #41 confirmed the resident does have a physician's order for the splint to be applied to the right hand.</p> <p>On 08/14/24 at 5:30 PM, the Director of Nursing (DON) was notified. The DON confirmed the resident should be wearing the splint to the right hand to prevent further decrease in range-of-motion.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45173</p> <p>Based on observation, record review, resident interview and staff interview, the facility failed to ensure the resident environment, over which it has control, was as free from accident hazards as possible. This was a random opportunity for discovery. Resident Identifier: #9. Facility Census: 62.</p> <p>Findings Include:</p> <p>a) Resident #9</p> <p>On 08/12/24 at 9:00 AM, the initial interview was held with Resident #9. Observations made during the interview, found multiple medications sitting on the over-the-bed table and laying on the resident's bed. Resident #9 was asked, are you allowed to have these medications in your room? The resident responded, it is okay .it is no big deal.</p> <p>On 08/12/24 at 9:28 AM, Registered Nurse (RN) #41 entered into the resident's room. RN #41 was asked, why does the resident have medication laying around his room? RN #41 stated, I don't know why the medication is in here .I didn't know anything about it.</p> <p>On 08/12/24 at 9:40 AM, the Director of Nursing (DON) was interviewed regarding the medication found in Resident #9's room. The DON stated, We don't know what he has .his family brings it in .we offered a lock box but we have to keep a key and (Resident's name) refused .</p> <p>On 08/12/24 at 9:55 AM, the Administrator was interviewed regarding the medication found in the resident's room. The Administrator stated, (Name of Resident) is a difficult resident .he does what he wants .I am banned from his room.</p> <p>The medications found in the resident's room on 08/12/24 at 9:00 AM are as follows:</p> <ul style="list-style-type: none"> <li>-- One (1) Incruse Ellipta Inhaler</li> <li>--Two (2) Advair Inhalers</li> <li>--Two (2) Mucinex Nasal Sprays</li> <li>--One (1) bottle of Visine Eye Drops</li> <li>--One (1) tube of Absorbine Muscle Rub</li> <li>--One (1) roll on bottle of Biofreeze</li> <li>--One (1) bottle of Liquid Antidiarrheal Medication</li> <li>--One (1) bottle of Gas X</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>After further review of the medical record, the resident did not have a physician's orders for any of the above medications. An interview was held with the DON on 08/13/24 at approximately 1:00 PM. The DON stated, I have talked with the physician and he is not going to give physician's orders for the medication found in the resident's room. The physician feels the resident has enough as needed medication available. The DON was asked, are there any wanderers in the facility? The DON stated, Name of Resident #48. The DON was then asked, do you not feel this is a safety issue? The DON stated, no (the Name of Resident #9) would not allow anyone to take anything out of his room. The DON was then asked, how would a resident who is unable to ambulate stop an ambulatory resident? The DON stated, he would not allow it.</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>49465</p> <p>Based on record review, and staff interview, the facility failed to prevent significant unintended weight loss for Resident #8. This failed practice was found true for (1) of (3) residents reviewed for weight loss during the survey process. Resident identifier: #8. Facility Census 62.</p> <p>The State Agency (SA) determined harm was caused to Resident #8 when significant unintended weight loss occurred of 11.6 percent within 60 days. The failure to identify a decrease in meal intake, which resulted in a significant unintended weight loss from failure to document all meall intake and not providing physician ordered fortified snacks.</p> <p>Findings included:</p> <p>a) Resident #8</p> <p>A record review on 08/12/24 at 10:00AM revealed the following weights for Resident #8:</p> <p>7/28/24 106.6 pounds (Lbs)</p> <p>7/24/24 108.7 Lbs</p> <p>6/23/24 119.5 Lbs</p> <p>6/19/24 114.5 Lbs</p> <p>6/3/24 114.0 Lbs</p> <p>5/24/24 120.4 Lbs</p> <p>5/24/24 120.4 Lbs</p> <p>Further record review showed a note by the Registered Dietician (RD) on 07/25/24 with the following recommendations:</p> <p>Re-weight, fortified pudding daily at 2:00PM.</p> <p>The fortified pudding daily at 2:00PM was ordered by the physician on 07/26/24 .</p> <p>Further record review of Resident #8's Medicine Administration Record (MAR) for the month of August 2024 revealed Resident #8 did not receive her fortified pudding (4) out of 12 days.</p> <p>An observation on 08/12/24 at 2:30PM, found Resident #8 asleep with no fortified pudding in her room.</p> <p>(continued on next page)</p>		

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F 0692  Level of Harm - Actual harm  Residents Affected - Few	<p>During an interview on 08/12/24 at 2:35 PM, Registered Nurse ( RN) stated, Her pudding usually does not come up with the 2:00 snacks. I don't know why. We sometimes go to the pantry and get her something. She did not have it today.</p> <p>During an interview on 08/12/24 at 3:00 PM, The Certified Dietary Manager (CDM) stated, I don't have access to Point Click Care (PCC), it pulls into my system and this is how I know what snacks to send out.</p> <p>A record review on 08/12/24 at 3:30 PM of the facilities ordered snacks revealed that Resident #8 is not listed to receive a snack.</p> <p>Further record review of Resident # 8's Physician Orders for Scope of Treatment (POST) form revealed under section D (Medically Assisted Nutrition), it is marked to provide feeding through new or existing surgically -placed tubes.</p> <p>During an interview by phone on 08/13/24 at 11:45AM the RD stated, She is aware that she is marked for a feeding tube, but her intakes are still high with monitoring her meal intake and feels some of the weight loss is coming from TSH levels, but feels like they now have that under control</p> <p>During a record review on 08/14/24 at 12:30 PM of Resident #8's meal intake from 06/16/24 to 08/12/24, it revealed that out of a possible 174 meals, 42 of those had no documentation.</p> <p>On 08/14/24 at 2:07 PM, The Director of Nursing (DON) confirmed the meal intakes were not documented properly.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45173</p> <p>Based on record review, resident interview and staff interview, the facility failed to ensure physician's visits were completed every 30 days for the first 90 days for Resident #9. This was a random opportunity for discovery. Resident Identifier: #9. Facility Census: 62.</p> <p>Findings Included:</p> <p>a) Resident #9</p> <p>On 08/12/24 at 9:00 AM, an interview was held with Resident #9. The resident stated, I want to talk to the physician about certain things and I can never see him .it's usually the nurse practitioner .sometimes it's things I want to discuss with a physician.</p> <p>On 08/12/24 at 11:30 AM, a record review was completed for Resident #9. The findings of the review were unclear as to when the facility physician visited the resident versus the nurse practitioner. The DON was asked for a list of the provider's visits to Resident #9. The resident was admitted to the facility on [DATE]. The physician's visits were as follows:</p> <p>--02/22/23</p> <p>--03/22/23</p> <p>--05/25/23</p> <p>--06/22/23</p> <p>--09/10/23</p> <p>--11/26/23</p> <p>--01/21/24</p> <p>The physician's visits were reviewed and found the visit in April, 2023 was not completed by the facility physician.</p> <p>On 08/13/24 at approximately 10:00 AM, the Director of Nursing (DON) was asked for a policy relating to when the facility physician should visit the residents. The information provided for the state of [NAME] Virginia stated the following: the initial visit should have a completed H&amp;P (History &amp; Physical) within 5 (five) days prior to admission or within 72 hours following admission; and the follow up visits should be every 30 days for the first 90 days .</p> <p>On 08/13/24 at 2:00 PM, the DON was notified of the missing physician's visits. The DON stated, I didn't realize the resident was not seen by the physician.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49465</p> <p>Based on observation and staff interview, the facility failed to serve meals at a palatable temperature. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents during the survey process. Resident identifiers #54 and #60. Facility Census 62.</p> <p>Findings Included:</p> <p>a) Food temperatures Resident #53 and #60</p> <p>According to the meal timesheet hall 400 trays were brought out to the hallway at 7:45 AM</p> <p>During an observation on 08/13/24 at 8:00 AM, of hallway 400 it was revealed, Resident #54 and #60 were sitting in the hallway in reclining wheelchairs and their breakfast meal trays were still on the food cart. No staff were noted to be nearby and were down hall 200 passing breakfast trays.</p> <p>Further observation at 8:10AM of hallway 400 showed that Residents #54 and #60's breakfast trays were still on the food cart and no staff were present on the hallway.</p> <p>During an interview on 08/13/24 at 8:25 AM, while Residents #54 and #60's food was still on the meal cart, Nurse Aide (NA) #69 stated, We pass all trays on all halls first and then go back and assist them.</p> <p>During an observation on 08/13/24 at 8:26 AM, The Certified Dietary Manager (CDM) checked the temperature of Resident #54's breakfast tray at the surveyors request. The food temperature was as follows:</p> <p>Puree sausage: 83.3 degrees Fahrenheit (F)</p> <p>Puree pancakes: 90.5 degree F.</p> <p>Oatmeal: 94.1 degrees</p> <p>During an interview on 08/13/24 at 8:30 AM, The CDM stated, Serving temperature should be 145 degrees. I think the danger zone is 41 to 135 degrees. I will get them another tray.</p> <p>A review of Healthcare services Group Policy titled [Food Distribution] on 08/13/24 at 10:00 AM, number (6) six reads as follows:</p> <p>Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining.</p> <p>Further policy review of the policy titled {Food: Preparation} Number 11, 12 and 13 reads as follows:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11. When hot pureed, ground or diced food drops into the danger zone (below 135 degrees F.), the mechanically altered food must be reheated to 165 degrees F for 15 seconds if holding for hot service.</p> <p>12. When reheating foods will be rapidly heated to 165 degree F. for 15 seconds. If the food is not reheated within (2) two hours it must be discarded.</p> <p>13. All foods will be held at appropriate temperatures, greater than 135 degrees F. (or as state regulation requires) for hot holding, and less than 41 degrees F for cold food holding.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to provide an accurate and complete record for an acute transfer for Resident #9 and meal intake for Resident #8. This was true for two (2) of 16 residents reviewed during the survey process. Resident Identifiers: #9 and #8. Facility Census: 62.</p> <p>Findings Include:</p> <p>a) Resident #9</p> <p>On 08/12/24 at 12:00 PM, a record review was completed for Resident #9. The review found the resident had been transferred to an acute care facility on 02/22/24 . The transfer form listed the date as 07/08/23.</p> <p>On 08/12/24 at 12:30 PM, the Director of Nursing was notified of the incorrect transfer date. The DON stated, I will have to look into this.</p> <p>b) Resident #8</p> <p>During a record review on 08/14/24 at 12:30 PM of Resident #8's meal intake from 06/16/24 to 08/12/24, it revealed that out of a possible 174 meals, 42 of those had no documentation.</p> <p>On 08/14/24 at 2:07PM the Nursing Home Administrator confirmed the meal intakes were not documented properly.</p> <p>49465</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45173</p> <p>Based on observation, staff interview and record review the facility failed to provide an effective infection control program which meets current standards of practice. This failed practice was found true for (3) of (3) residents reviewed for infection control practices during the survey process. Resident identifiers #9, #54, and #50. Facility Census 62.</p> <p>Findings included:</p> <p>a) Resident #9</p> <p>During an observation on 08/12/24 at 9:45 AM, of Resident #9's bathroom revealed (2) two bed pans were in the bathtub, (1) one of the bed pains had small droppings of a brown substance in it and liquid was in the corners. The commode had Urine in it with a black ring around the top of the urine. Mixed vegetables were found on top of the stopper in the sink.</p> <p>During an interview on 08/12/24 at 9:50 AM, Resident #9 stated, They never clean that stuff up. They just come and do it as fast as they can.</p> <p>During an interview on 08/12/24 at 10:00 AM The Director of Nursing (DON) stated, Yes, this shouldn't be like this. I will get it taken care of.</p> <p>b) Resident #54</p> <p>On 08/14/24 at 10:30 AM, wound care was observed for Resident #54 completed by Registered Nurse (RN) #41. During the wound care, RN #41 would complete hand hygiene but then open the bathroom door with bare hands to retrieve gloves. This happened three (3) times during the wound care observation. The first time was after placing a barrier on the over-the-bed table; the second time was after removing the soiled dressing; and lastly, after cleansing the wound.</p> <p>On 08/14/24 at 9:45 AM, RN #41 was advised of the infection control breach. RN #41 stated, I should have had the gloves available so I wouldn't have had to open the bathroom door.</p> <p>On 08/14/24 at 11:00 AM, the Director of Nursing (DON) and the Administrator were notified. The DON stated, she was very nervous.</p> <p>c) Resident #50</p> <p>On 08/14/24 at 5:07 PM, an observation of Nurse Aide (NA) #71 and NA #17 entering room [ROOM NUMBER] without wearing the appropriate personal protective equipment (PPE) for enhanced barrier precautions for Resident #50 due to an indwelling medical device (feeding tube). At this time, the resident stated, he needed changed. When a resident is under enhanced barrier precautions, the nurse aides should have worn a gown and gloves while performing high contact activities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/14/24 at 5:11 PM, both NA #71 and #17 were asked, Isn't the resident on enhanced barrier precautions? NA #17 stated, no .there isn't a cart in front of his door. Signage was posted on the door stating enhanced barrier precautions were in place.</p> <p>On 08/14/24 at 5:35 PM, the DON was notified. The DON stated, they know there is only one cart on each hallway .they know.</p> <p>49465</p>		