STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515178	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Haven Center	2720 Charles Town Road Martinsburg, WV 25401

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42120 Based on observation, and staff interview the facility failed to treat each resident with respect and dignity regarding meal service. This was a random opportunity for discovery. Resident identifier: #119. Facility census: 64. Findings included: b) Resident #119 An observation on 09/03/24 at 2:26 PM of Resident #119 lying in bed with her noon meal tray sitting on bed side table not opened. During a second observation of the meal service on 09/03/24 at 2:43 PM revealed Nurse Aide (NA) #12 was standing over Resident #119 feeding her in bed. During an interview on 09/03/24 at 2:45 PM the Director of Nursing confirmed NA #12 was standing over Resident #119 feeding her at this time. The DON corrected NA #12 at this time.

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

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43340 Based on record review and staff interview, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) form to one (1) of three (3) residents reviewed for the facility's beneficiary protection notification practice during an annual survey. This failure placed the resident at risk of not being informed of her rights prior to the end of Medicare Part A covered services. Resident identifier: #25. Facility census: 64. Findings included: a) Resident #25 On 09/06/24 at 8:36 AM, a review was completed regarding the beneficiary protection notification liability notices given for Resident #25 who remained at the facility following her last covered day of Medicare Part A services: Resident #25 began Medicare Part A skilled services on 08/15/24. The last covered day of Part A service was 08/28/24. Notice of Medicare Non-Coverage (NOMNC) was signed and dated on 06/26/24. No SNF ABN form was provided. Review of Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice on Non-coverage (SNF ABN) Form CMS-10055 (2018) denoted Medicare requires Skilled Nursing Facilities to issue the SNF ABN to Medicare beneficiaries prior to providing care that Medicare usually covers, but may not pay for because the care is: - not medically reasonable and necessary; or - considered custodial. On 09/06/24 at 9:45 AM, Clinical Reimbursement Coordinator #58 acknowledged the facility failed to provide SNF ABN form to Resident #25 to her last covered day of Medicare Part A skilled services.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 49466 Based on record review and staff interview, the facility failed to protect the personal privacy and confidentiality of residents ' medical records. This was true for two (2) residents as a random opportunity for discovery. Resident identifiers: #47 and #59. Facility census: 64. Findings included: a) At 2:30 PM on 9/4/24, the surveyor discovered that pharmacist medication regimen review paperwork dated 8/28/24 (entitled PharMerica Recommendation maintain current dose Citalopram .pdf) containing Resident #59's name and medication information was scanned into Resident #47's medical record. Further record review revealed that the same document had been scanned into resident #59's record. The two residents' respective medication reviews were included on a single printed sheet, and medical records did not redact the name before the document was scanned in. On 09/04/24 at 2:50 PM, the surveyor informed the Director of Nursing (DON) who reviewed the record and confirmed that the record, as present, contained the combined personal health information of Resident #47 and #59.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42120 Based on record review and staff interview, the facility failed to report alleged violation related to, neglect, or abuse, and report the results of all investigation to the proper authorities within prescribe time-frames. This was a random opportunity for discovery. Resident identifier: #8. Facility census: 64. Findings include: a) Resident #8 An investigation of a Facility Reported Incident of abuse that accrued on 03/23/24 revealed that the Incident was not reported to appropriate agencies until 04/05/24. Continued record review found multiple statements from Registered Nurses #47 and #39 and Nurse aide #13 stating they witnessed Nurse Aide # 74 clap her hands and yell at Resident #8 on 03/23/24. During an interview with the Administrator and Director of Nursing on 09/05/24 at 2:32 PM they verified the incident on 03/23/24 for Resident #8 was not reported within prescribe time-frames. It was also verified that all employees at the facility were mandatory reporters.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to develop and implement a comprehensive person-centered care plan for Resident #15 that was trauma-informed and would allow Resident #15 to attain or maintain his highest practicable physical, mental, and psychosocial well-being. This was true for one (1) of three (3) residents reviewed for the diagnosis of Post Traumatic Stress Disorder (PTSD). Resident identifier: #15. Facility census: 64. Findings included: a) Resident #15 A record review, completed on 09/04/24 at 2:52 PM, revealed Resident #15 was admitted to the facility on [DATE] with a PTSD diagnosis. Review of Resident #15's Care Plan revealed the following: Focus: [Resident #15] has the potential to exhibit signs or symptoms of anxiety or depression r/t (related to) a dx (diagnosis) of Post Traumatic Stress Disorder. Goal: [Resident #15] will be free of signs or symptoms of depression or anxiety throughout next review. Interventions: -Provide a calm, quiet, well-lit environment -Explain all care, including procedures (one step at a time), and the reason for performing the care before initiating. -Social Service visits to provide support, as needed and/or requested by resident/patient During an interview on 09/05/24 at 2:00 PM, Social Worker #62 reported she did not know the reason for Resident's PTSD diagnosis. Social Worker #62 reported she recognized she did not have possible PTSD triggers care planned or appropriate staff interventions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42120 Based on staff interview and medical record review the facility failed to ensure Resident #92 received assistance with meals. This was true for one (1) of (1) residents reviewed for nutrition. Resident identifier #119. Facility census: 64. Findings included: a) Resident #119 An observation on 09/03/24 at 2:26 PM the lunch tray was sitting in front of resident, she was not eating, no assistance was offered. An bservation of the meal service on 09/04/24 at 1:24 PM revealed a tray set up in front of Resident #119 with food spillage all over her. She was trying to drink her sherbet. She had her phone receiver laying in the middle of her tray. During an interview with the Director of Nursing (DON) on 09/04/24 at 1:28 PM she verified Resident #119 was an assist with meals. At this time the DON went to get Resident #119 assistance.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42120 Based on medical record review, observation, and staff interview, the facility failed to ensure one (1) residents received treatment and care in accordance with professional standards of practice. Resident identifier: #30. Facility census: 64. Findings included: a) Resident #30 A record review on 09/05/24 at approximately 8:00 AM, revealed nurses documenting Blood pressure (BP) being taken in the right arm. Further record review revealed the resident had a Physician order which stated, Do not take B/P in the right arm, with an order date of 08/14/24. Continued record review on 09/05/24 shows resident having orders - Dialysis port location: right upper chest. - Monitor hemodialysis catheter site 2 lumens, right upper chest for signs and symptoms infection, edema, bleeding, and upon return from dialysis. Notify primary care physician and dialysis unit if there are signs and symptoms of infection. If catheter site is bleeding apply pressure for 15 minutes and notify MD/physician if bleeding does not stop, every shift and as needed. Do Not Change End Caps. On 09/05/24 at 9:52 AM a call was placed to Resident #30's dialysis center revealed the order for no BP in right arm did not come from the dialysis center or Neurologist. There is no reason to not take B/P in right arm from them. It was stated that mapping, or shunt / fistula placement has not taken place yet. On 09/05/24 at 10:32 AM, The Director of Nursing stated that the order was put in place just for precautions and would not hurt him if the B/P was taken in the right arm. The (DON) also stated, The orders and care plan should have been followed to not take a B/P in the left arm.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42120 Based on staff interview and medical record review the facility failed to ensure Resident #92 received assistance with meals. This was true for one (1) of (1) residents reviewed for nutrition. Resident identifier #119. Facility census: 64. Findings included: a) Resident #119 An observation on 09/03/24 at 2:26 PM the lunch tray was sitting in front of resident, she was not eating, no assistance was offered. An bservation of the meal service on 09/04/24 at 1:24 PM revealed a tray set up in front of Resident #119 with food spillage all over her. She was trying to drink her sherbet. She had her phone receiver laying in the middle of her tray. During an interview with the Director of Nursing (DON) on 09/04/24 at 1:28 PM she verified Resident #119 was an assist with meals. At this time the DON went to get Resident #119 assistance.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 42120 Based on medical record review and staff interview the facility failed to ensure one (1) of one (1) residents reviewed for nutrition received the correct therapeutic diet. Resident #119. Facility census: 64. Findings included: a) Resident #119 A record review on 09/04/24 at 11:45 AM found, two (2) conflicting orders for a diet: --2 gm Sodium (2g Na) diet, Dysphagia Advanced texture, Standard Thin Liquids consistency diet. Order date 09/02/24. --2 gm Sodium (2g Na) diet, Regular Texture, Standard Thin Liquids consistency diet. Order date 8/26/2024. An interview 09/04/24 at 1:28 PM the Director of Nursing (DON) verified Resident #119 had two (2) different diet orders on her active chart. The DON stated that they should have discontinued the regular texture diet out of the active orders.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 42120 Based on observations, record review, resident interview, and staff interview, the facility failed to maintain regularly scheduled mealtimes. This had the potential to affect all residents that get their nutrition from the kitchen. Facility census: 64. Findings Included: a) Dining Observation An observation on 09/03/24 at 12:30 PM revealed the lunch meal had not been served. 16 residents were in the dining room waiting for their meal. A review of the posted mealtimes found that the lunch meal was scheduled to start at 12:15 PM daily. An interview with Nurse Aide #29 on 09/03/24 at 12:44 PM revealed the lunch meal was late most days. During an interview, on 09/03/24 at 12:56 PM, Certified Dietary Manager (CDM) verified the noon meal was not served on time. She stated breakfast was late so they could not start on time for the lunch meal. Continued observation on 09/03/24 found drinks were not served until 1:05 PM, upon inquiry by the surveyor. Observation continued to find the first tray was served in the dining room at 1:20 PM.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42120 Based on observation and staff interview the facility failed to serve food in accordance with professional standards for food serve safety. This had the ability to effect more than a limited number of residents. Facility census: 64. Findings included: a) Initial Kitchen Tour During the initial kitchen tour on 09/03/24 at 1:20 PM an observation of tray service found the Dietary Manager (DM) dipping food with gloved hands, touching and opening hamburger buns, touching serving scoops, the plate warming cart, the counter, bowls, bowl rack, and the environment around the service area. Continued observation found The DM using the plate lifter to get the plates from the warmer and when not in use, suction the plate lifter to the countertop. During an interview at 09/03/24 1:35 PM the DM stated that she only cleans the top counter after breakfast, lunch and dinner. The DM confirmed that suctioning the plate lifter to the countertop could cause germs to be spread. She also verified that she was touching the surrounding environment and the resident's hamburger buns without changing her gloves.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 43340 Based on record review and staff interview, the facility failed to maintain accurate records on two (2) out of 22 sampled residents in the Long-Term Care Survey Process. Resident identifiers: #64 and #119. Facility census: 64. Findings included: a) Resident #64 A record review, completed on 09/05/24 at 7:30 PM, revealed resident had been hospitalized on [DATE] and had not returned to the facility. There was also a nurse practitioner (NP) note, dated on 6/25/2024 at 10:52 PM, that listed the date of service (date of NP visit at the facility) as 06/25/24. Details of the note were, She is seen resting to bed with no grimaces or s/s (signs and symptoms of) pain. She was recommended hospice by oncology however declined. Labs and meds reviewed. She continues rehab for weakness. This shift increased weakness reported with general declines. The note indicated the NP had spent 46 minutes total meeting with resident and reviewing resident's chart. During an interview, on 09/06/24 at 10:05 AM, the Director of Nursing (DON) reported there was an error with the date of service listed in the chart. The DON further explained it was a telehealth vist that was made on 06/19/24 prior to Resident #64 going to the hospital.