

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2024
NAME OF PROVIDER OR SUPPLIER  Ohio Valley Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Nicolette Road Parkersburg, WV 26104	
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>50801</p> <p>Based on observation and staff interview the facility failed to provide a safe, clean, comfortable and homelike environment for Resident #21. This was a random opportunity for discovery. Resident Identifier: #21. Facility Census: 42.</p> <p>Findings included:</p> <p>a) Resident #21</p> <p>An observation on 08/25/24 at 11:45 AM, of Resident # 21's room found the wallpaper had horizontal strips torn from it along the wall from the bathroom door to the window.</p> <p>During an interview on 08/27/24 at 9:20 AM, with Corporate [NAME] President (CVP) #107, CVP #107 confirmed the wallpaper was torn in Resident #21's room.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 515181	If continuation sheet Page 1 of 14

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45171</p> <p>Based on record review and staff interview the facility failed to ensure all admitting diagnosis were reflected on the Preadmission Screening and Resident Review (PASRR). This was true on two (2) of four (4) PASRRs reviewed during the Long-Term Care Survey Process. Resident identifiers: #36 and #21. Facility Census: 42</p> <p>Findings included:</p> <p>a) Resident #36</p> <p>On 08/26/24 at 3:27 PM a record review found Resident #36 was admitted on [DATE] with an admitting diagnosis of: Unspecified Dementia with Psychotic disturbance, Psychosis and Major Depressive Disorder.</p> <p>Review of the PASRR which was submitted on 03/15/22 reflected Resident #36 had a diagnosis of Alzheimer's, multi-infarct, senile dementia but did not have a diagnosis of psychosis or major depressive disorder.</p> <p>This was confirmed during an interview on 08/26/24 at 3:30 PM with Social Worker #58 when she agreed the admitting diagnosis of psychosis and major depressive disorder should have been on the PASRR .</p> <p>b) Resident #21</p> <p>On 08/27/24 a record review found Resident #21 had the following diagnoses:</p> <p>Unspecified Psychosis, Onset date 06/02/22</p> <p>Unspecified Mood disorder, Onset date 06/02/22</p> <p>Major Depressive Disorder, Onset date 05/31/22</p> <p>Review of the PASSR dated 08/27/24 found the following medical diagnoses were not identified on the PASSR:</p> <p>Major Depressive Disorder</p> <p>The above information was confirmed with the Admissions Director (AD) on 08/28/24 at 11:41 AM. The AD agreed the additional medical diagnosis should have been on the PASRR.</p> <p>50801</p>

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<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>45171</p> <p>Based on record review and staff interview the facility failed to comply with the Medical Power of Attorneys' (MPOA) wishes regarding administration of immunizations. This was true for two (2) of six (6) immunizations reviewed during the long term care survey process. Resident identifiers: #35 and #36. Facility Census: 42</p> <p>Findings included:</p> <p>a) Resident #35</p> <p>On 08/26/24 at 1:27 PM, a record review found Resident #35 received a COVID vaccine without consent.</p> <p>Review of the Medication Administration Record shows Resident #35 received Comirnaty 2023-24 (12y up) (COVID vac 2023-24) Suspension; 30 mcg/0.3 ml, administered 0.3 ml intramuscular COVID vaccine on 02/02/24 by Registered Nurse (RN) #24.</p> <p>A progress note dated 01/05/24 at 5:52 PM states Spoke with the POA son (name) regarding upcoming vaccines. Consented to RSV, Prevnar 20 (pneumonia) and Shingrix (Shingles) but no COVID vaccines were to be given This progress note was initiated and signed by RN #24.</p> <p>The MPOA was notified of the administration of the COVID vaccine, as well as the Physician. According to the Incident Report and the reporting documentation to Office of Health Facility Licensure &amp; Certification (OHFLAC) there were no adverse reactions. A new order was received from the Physician to monitor the resident for any changes in condition.</p> <p>The facility provided education to the nursing staff of ensuring consents were on record for any immunizations administered. The Vaccination Consent form was redesigned in April 2024 to reflect consent or declination of all vaccines offered on one page to simplify the review of the Resident or responsible parties wishes. This was addressed in the Quality Assurance Performance Improvement QAPI meeting as well.</p> <p>The above findings were confirmed with the Administrator and the Manager Quality RN #69 on 08/27/24 at 2:15 PM.</p> <p>b) Resident #36</p> <p>On 08/26/24 at 1:26 PM, a record review found Resident #36 received a Shingrix (Shingles) vaccine on 07/22/24 by Manager Quality RN #69.</p> <p>Additional record review shows Resident #36's Medical Power of Attorney signed a declination of the Shingrix (Shingles) vaccine on 06/24/24.</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 - Few</p>	<p>The MPOA was notified as well as the Physician. According to the review of the Incident Report and the reporting documentation to Office of Health Facility Licensure &amp; Certification (OHFLAC) there were no adverse reactions. A new order was received from the Physician to monitor the resident for any changes in condition.</p> <p>The facility provided education to the nursing staff of ensuring the right resident prior to administering any medication.</p> <p>On 08/27/24 at 9:10 AM during an interview with the Director of Nursing she stated the nurse confused Resident #36 with another resident with a similar last name but residing on a different hall. It was confirmed at this time that the vaccine should not have been administered.</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 and staff interview, the facility failed to maintain a safe and accident free environment as possible regarding the disposal of razors. This was a random opportunity for discovery and had the potential to affect no more than an isolated number of residents. Resident Identifier: #43. Facility Census: 42.</p> <p>Findings included:</p> <p>a) Resident #43</p> <p>On 08/25/24 at 10:55 AM, an observation was made of two (2) used disposable razors laying in the soap dish in the shower in Resident #43's bathroom.</p> <p>On 08/25/24 at 10:58 AM, Nurse Aide (NA) # 35 was notified. NA #35 stated, let me get rid of those.</p> <p>On 08/25/24 at 11:16 AM, the Administrator was notified and confirmed the two (2) used disposable razors should not be left in the shower.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31826</p> <p>Based on record review and staff interview the facility failed to ensure Resident #5 maintained acceptable perimeters of nutrition by not implementing recommendations made by the registered dietician. This was true of one (1) of two (2) residents reviewed for the care area of nutrition during the long term care survey process. Resident identifier: #5. Facility Census: 42.</p> <p>Findings included:</p> <p>a) Resident #5</p> <p>A review of Resident #5's medical record on 08/27/24 at 1:30 PM revealed a nutritional assessment dated [DATE] which included the following recommendation: .protein added to meals to encourage healing. Further review of the resident's record found the following care plan intervention: Encourage foods high in protein &amp; offer protein supplements as ordered. This intervention was added to the care plan on 01/31/24.</p> <p>Further review of Resident #5's medical record found protein was not added to the resident's meals and no nutritional supplements to increase protein intake were added to the resident's physician orders.</p> <p>At 2:30 PM on 08/27/24 the Director of Nursing (DON) acknowledged orders for nutritional recommendations had not been implemented appropriately.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to ensure annual performance reviews were completed for nursing staff. This was true for four (4) of five (5) staff members reviewed under the care area of sufficient and competent nurse staffing. Facility Census: 42.</p> <p>Findings Include:</p> <p>a) Annual Performance Reviews</p> <p>On 08/27/24 at 3:00 PM, a review of the staff employment files was completed. The review found the annual performance evaluations were not completed for the following nurse aides (NAs):</p> <p>-NA #71</p> <p>-NA #50</p> <p>-NA #72</p> <p>-NA #14</p> <p>On 08/28/24 at approximately 9:45 AM, the Administrator was notified of the missing evaluations. The Administrator stated, we will be working on this.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to monitor behaviors and/or side effects for residents prescribed psychotropic medications. This was true for three (3) of five (5) residents reviewed under the care area of unnecessary medications. Resident Identifiers: #43, #21 and #5. Facility Census: 42.</p> <p>Findings Include:</p> <p>a) Resident #43</p> <p>On 08/27/24 at 12:35 PM, a record review was completed for Resident #43. The review found the resident had three psychiatric diagnoses; Unspecified Dementia, Bipolar Disorder and Depression. The resident was prescribed Risperdal (antipsychotic medication) 2mg (milligram) daily for bipolar disorder. The review also, found no documentation regarding the monitoring of behaviors for the resident who was receiving an antipsychotic medication.</p> <p>On 08/27/24 at 2:00 PM, the Director of Nursing (DON) was interviewed regarding the monitoring of behaviors. The DON stated, I don't have any documentation for behavior monitoring .I added it.</p> <p>b) Resident #21</p> <p>A review of Resident #21's medical record found they were prescribed Celexa, an antidepressant medication , Wellbutrin an antidepressant medication and Zyprexa an antipsychotic medication.</p> <p>The medical record was void of any behavior monitoring related to the use psychotropic medications for Resident #21.</p> <p>In an interview with the Director of Nursing (DON) on 08/27/24 at 2:30 PM, she confirmed they have not been monitoring for behaviors for Resident #21.</p> <p>c) Resident #5</p> <p>A review of Resident #5's medical record on 08/27/24 at 2:15 PM revealed, Trazodone was prescribed for an improper diagnosis of G47.00 : Insomnia, unspecified. There was no documentation of monitoring for side effects associated with this psychotropic medication. The medical record was also void of any behavioral monitoring related to the use of trazadone.</p> <p>On 08/27/24 at 2:15 PM, the Director of Nursing (DON) was notified of the issue. Upon their return at approximately 2:30 PM, the DON acknowledged the facility did not monitor for side-effects or behaviors related to the use of trazadone.</p> <p>49466</p> <p>50801</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>45173</p> <p>Based on record review, resident interview and staff interview, the facility failed to ensure resident safety for medication administration. Resident Identifiers: #3 and #13. Facility Census: 42.</p> <p>The state agency notified the Nursing Home Administrator of the immediate jeopardy at 4:30 PM on 08/26/24. The facility submitted a plan of correction (POC) at 6:09 PM. At 6:25 PM, the POC was accepted by the state agency. The state agency verified the POC was implemented by conducting staff interviews and the immediate jeopardy was abated at 10:15 AM on 08/27/24.</p> <p>Findings Include:</p> <p>a) On 08/25/24 at approximately 11:25 AM, the resident was interviewed regarding receiving the wrong medication on 07/01/24. Resident #3 responded, I don't even know what medication I take, there is probably eight (8) or nine (9) of them.</p> <p>On 08/26/24 at 11:30 AM, a review of the facility's reportables regarding medication errors was completed. The review found two (2) events occurred for two (2) different residents on 07/01/24 and 08/20/24. Resident #3 was administered the following medications in error: Norco 7.5/325mg (opiate for pain), Xanax 0.25mg (anti-anxiety) and Metoprolol 37.5mg (hypertension). Resident #13 was administered Lyrica 150mg (anticonvulsant used for pain control). Neither Resident #3 nor Resident #13 were ordered the medications that were administered.</p> <p>On 08/26/24 at 11:50 AM, the Director of Nursing (DON) was interviewed regarding these events. The DON stated, The first event was a seasoned nurse, Registered Nurse (RN) #85 .the second event was LPN #94, who was on orientation with LPN #105.</p> <p>The DON stated, There really isn't an excuse for the mistake RN #85 made, and the reason the event happened with LPN #94 is the seasoned nurse (LPN #105) was not with LPN #94 when the medication was administered.</p> <p>On 08/26/24 at 12:20 PM, the DON stated, a disciplinary write-up and re-education regarding the rights of medication administration was provided to RN #85, at which time, the same education was provided to all nurses. LPN #94 was re-educated regarding the rights of medication administration as well.</p> <p>On 08/26/24 at 2:00 PM, the sign-in sheets dated for 07/05/24 and 07/23/24 were reviewed. Of the 25 nurses employed by the facility, only 18 signed the acknowledgement sheets of attendance.</p> <p>On 08/26/24 at 3:30 PM, Resident #13 was interviewed regarding the medication error. The resident stated, I knew something was wrong when they told me about taking my vitals all night. The nurse was scared, and she told me she was sorry for giving the wrong medication .I was afraid of what might happen to me .this has never happened</p> <p>before.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The state agency notified the Nursing Home Administrator of the immediate jeopardy at 4:30 PM on 08/26/24. The facility submitted a plan of correction (POC) at 6:09 PM. At 6:25 PM, the POC was accepted by the state agency. The state agency verified the POC was implemented by conducting staff interviews and the immediate jeopardy was abated at 10:15 AM on 08/27/24.</p> <p>b) Facility's Plan of Correction</p> <p>IJ Abatement Plan</p> <p>1. Resident #3 and Resident #13 were assessed by the Assistant Director of Nursing (ADON) on 8/26/2024 for any further possible adverse outcomes from the medication administration errors that occurred 07/01/24 and 08/20/24.</p> <p>Med Pass observation to be completed by the ADON/ Designee on all current license nurses working this shift beginning on 8/26/24 at 5:30pm. Licensed nurses not available during this timeframe will be completed on their next scheduled shift.</p> <p>2. All current residents of the facility have the potential to be affected.</p> <p>3. The Director of Nursing (DON) will immediately initiate re-education beginning on 8/26/24 at 5:15pm to all licensed nurses that are working and prior to his/her next scheduled shift regarding medication administration process to include the 6 rights of administration to be completed by 9/5/2024. Licensed nurses not available during this timeframe will be provided reeducation including posttest prior to the next scheduled shift by the DON/ designee. New Licensed nurses during orientation will receive education prior to completion of orientation.</p> <p>4. Nurse Med Pass observation will be monitored for 5 residents by the DON/ Designee daily during all shifts x 14 days then monthly during all shifts x 3 months with on-going as indicated by audits and monitoring.</p> <p>The DON/ Designee will present results of medication admission audits or monitoring monthly to the Quality Improvement Committee for any additional follow up and/or in-serving .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to monitor refrigerator temperatures in the medication room on the 300 hall. This was a random opportunity for discovery and has the potential to affect more than a limited number of residents. Facility Census: 42.</p> <p>Findings Include:</p> <p>a) Medication Refrigerator</p> <p>On 08/26/24 at 8:10 AM, a tour of the medication room on the 300 hall was completed. The tour found the medication refrigerator temperatures were not monitored and documented on the following dates:</p> <p>--08/02/24 AM --08/02/24 PM --08/03/24 AM --08/04/24 AM --08/04/24 PM --08/05/24 PM --08/07/24 AM --08/08/24 AM --08/10/24 AM --08/11/24 AM --08/12/24 AM --08/13/24 AM --08/13/24 PM --08/15/24 AM --08/16/24 AM --08/17/24 AM</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--08/17/24 PM</p> <p>--08/18/24 AM</p> <p>--08/18/24 PM</p> <p>--08/19/24 PM</p> <p>--08/21/24 AM</p> <p>--08/22/24 AM</p> <p>On 08/26/24 at 8:18 AM, the Director of Nursing (DON) was notified. The DON stated, the nurse on the 300 hall let me know.</p> <p>b) Facility Policy</p> <p>On 08/26/24 at 8:30 AM, the facility policy entitled, Medication Storage was reviewed. The review found under Procedures #11 the following:</p> <p>Medications requiring refrigeration or temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit) are kept in a refrigerator with a thermometer to allow temperature monitoring.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>50801</p> <p>Based on observation and staff interview the facility failed to ensure Resident #18's call light was within reach. This was true for one (1) of 42 residents currently residing in the facility. Resident identifier: #18. Facility Census: 42.</p> <p>Findings included:</p> <p>a) Resident #18.</p> <p>An observation of Resident #18 on 08/25/2024 at 11:35 AM, found the resident was unable to reach her call bell and therefore could not call for help if and when she needed help.</p> <p>An interview on 8/25/2024 at 11:40 AM, Registered Nurse (RN) #13 confirmed Resident #18's call light was not within the resident's reach.</p>		

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NAME OF PROVIDER OR SUPPLIER  Ohio Valley Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Nicolette Road Parkersburg, WV 26104	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to ensure completion of the required staff education for one (1) of five (5) staff members reviewed under the care area of sufficient and competent nurse staffing. Employee identifier: Nurse Aide (NA) #35. Facility Census: 42.</p> <p>Findings included:</p> <p>a) NA #35</p> <p>On 08/27/24 at 3:00 PM, a review of the staff education was completed. The review found the required staff education was not completed for the following nurse aide (NA):</p> <p>-NA #35</p> <p>On 08/28/24 at approximately 9:45 AM, the Administrator was notified of the missing staff education. The Administrator stated, We will be working on this.</p>		