STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515187	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health Care Center	315 Courthouse Rd. Princeton, WV 24740

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 49751 Based on observation and staff interview the facility failed to provide a dignified dining experience by not serving residents sitting together at the same time. This was a random opportunity for discovery and had the potential to affect a minimal number of residents in the facility. Facility Census: 114 Resident Identifiers: #14, #52, #106 Findings Include: On 05/08/24 at 12:20 PM in the South Dining room Resident #52 and #106 were observed setting together and Table one (1) and Resident #14 observed setting to herself at Table two (2). Further observation on 05/08/24 at 12:25 PM revealed Resident #52 was served first at table one (1) then Resident #14 was served at table two (2) at 12:26 PM. Resident #106 waited Three minutes at table one(1) while Resident #52 ate. Resident #106 was served at 12:29 PM. Staff interview was conducted on 05/08/24 at 12:33PM with Certified Nursing Assistant (CNA) #168 asking why Resident #14 was served before Resident #106 CNA #168 stated because there was a mix up with the ticket and did not want Resident #14's food to get cold. During Staff interview with the Administrator on 05/08/24 at 1:00 PM the Administrator confirmed Resident #106 should have been served with/after Resident #52 and not had to wait to be served while the other resident sitting at the same table ate their food.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 49650 Based on medical record review and staff interview the facility failed to ensure an informed consent was obtained for a psychotropic medication. This was true for one (1) of five (5) residents reviewed for unnecessary medication during the long term care survey. Resident identifier: #43 Census: 114. Findings included: a) Resident #43 On 05/07/24 at 12:50 PM during a medical record review for Resident #43, it was identified that the resident was prescribed aripiprazole 20 mg tablet for inappropriate sexual behaviors related to unspecified psychosis not due to a substance or known physiological condition. During this medical record review an informed consent for psychotropic medication use could not be identified for the use of aripiprazole 20 mg tablet. On 05/07/24 at approximately 2:45 PM during an interview with the Director of Nursing (DON), the DON agreed that the psychotropic medication aripiprazole 20 mg did not have an informed consent for psychotropic medication use and that she would have this corrected.

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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. 49465 Based on observation, record review and staff interview the facility failed to ensure residents' information was protected. This failed practice was found true for (1) one of (1) one resident looked at for privacy during the Long-Term Care Survey Process. Resident Identifiers #19. Facility Census 114. Findings include: a) Resident #19 An observation on 05/06/24 at 11:15 AM, found a sign posted behind Resident #19's bed that read: (Resident # 19 name) has an allergy to Latex.} Further observation found that the sign was visible from the hallway when the door and curtain were open. A record review on 05/08/24 at 1:00 PM, revealed that Resident #19 was in fact allergic to Latex. On 05/08/24 at 2:30 PM, a review of the facilities policy titled {Confidentiality of Personal and Medical Records}, number (8) eight reads: Paper notes or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons. During an interview on 05/08/24 at 4:00 PM, the Administrator confirmed that the sign infringed on Resident #19's privacy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on observation and staff interviews the facility failed to provide a clean, comfortable, and homelike environment. A strong unpleasant odor was observed when entering a resident's room. This was a random opportunity for discovery during the long-term care survey process. Room Identifier: room [ROOM NUMBER]. Census: 114. Findings included: a) room [ROOM NUMBER] During a tour of the 200 hall on 05/06/24 at approximately 11:15 AM a strong unpleasant odor was observed when entering room [ROOM NUMBER]. During a tour of the 200 hall on 05/06/24 at 03:05 PM a strong unpleasant odor was again observed when entering room [ROOM NUMBER]. Licensed Practical Nurse (LPN) #91 was asked to help identify the odor in the room. LPN #91 stated that one of the residents will place her soiled undergarments in bags and put them in drawers and that may be what the smell is. She stated she would have the staff help check for what the odor is from and get it cleaned up. During a tour of the 200 hall on 05/07/24 at 09:06 AM a strong unpleasant odor was still present in room [ROOM NUMBER]. During an interview at this time with the DON, she agreed the room smelled bad and she would have someone come in to clean it. During an interview with the Administrator on 05/07/24 at 03:15 PM, she stated they had identified the smell to be coming from the packaged thermal air conditioner (PTAC) unit and was replacing the unit. During an interview with the Administrator on 05/08/24 at approximately 04:30 PM, she stated that the room still had a strong unpleasant odor and that they would continue to work on identifying the cause and correcting it.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45171 Based on record review and staff interview, the facility failed to ensure residents were free from abuse which included misappropriation of medication. This was true for three (3) of three (3) residents reviewed during the survey. Resident identifiers: #10, #20, #81. Facility Census: 114. 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. Findings included: a) Resident #10 Resident #10 had a narcotic medication borrowed for another resident five (5) times in the month of January, 2024. This was discovered when management performed an in house audit on 02/19/24. The facility reported it to the appropriate agencies on 02/19/24 and the five (5) day follow up was faxed on 02/22/24. The investigation started immediately on 02/19/24 at approximately 12:30 PM. A verbal and written statement was obtained from Licensed Practical Nurse (LPN) #104. The verbal statement relayed the nurse felt she had borrowed the medication for pain management and felt she had the best interest of the resident in pain at that time of judgement. The written statement states, I have borrowed medications in the past but have since been educated not to borrow any medications. On 02/19/24 Licensed Social Worker (LSW) #129 interviewed Resident #10. The resident was very pleasant, denies any needs and voiced no concerns. No mental anguish or distress noted during the visit. Education: A review of staff education was completed on 05/07/24 at approximately 09:00 AM. All staff signatures were obtained and included all employed nurses. The staff signatures were verified via the staff roster. System Change: New hires will be provided with education: Narcotics are not to be borrowed for any reasons. If a resident is scheduled a narcotic and you do not have it, first check with med dispense system. If the narcotic is not available in the med dispense then you are to contact pharmacy to see if they can send it or get it sent to back up pharmacy. If they are unable to send the narcotic from main pharmacy or to the back up pharmacy, you are to call the physician to see if there is another medication option available. If you are unable to get into the med dispense system you need to contact Staff Development Coordinator (name typed) to have him assist you. Please make sure to document every attempt to obtain the medication. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 05/08/24 at approximately 10:00 AM with the Administrator and the Director of Nursing (DON). Both the Administrator and the DON confirmed the incident which involved Resident #10, #20 and #81 did happen as reported. The Administrator also stated Resident #10 did not miss any doses of her medication due to this finding. b) Resident #20 Resident #20 had a narcotic medication borrowed for another resident one (1) time in the month of July, 2023. This was discovered when management performed an in house audit on 02/19/24. The facility reported it to the appropriate agencies on 02/19/24 and the five (5) day follow up was faxed on 02/23/24. The investigation started immediately on 02/19/24 at approximately 12:30 PM. Two written statements were obtained from Licensed Practical Nurse (LPN) #63. They read (1) The reason a medication was borrowed due to the fact I was unable to obtain from pharmacy at time medication was dye because back up does not bring narcotics and was unable to obtain medication from med dispense due to med dispense not working correctly. (2) I did also receive education on not borrowing medications and correct way to obtain medications. On 02/19/24 Licensed Social Worker (LSW) #129 interviewed Resident #20. The resident was pleasantly confused, He was talkative but did nod off to sleep throughout the visit. Resident appeared to be comfortable by this LSW's observation. No needs voiced during visit. No mental anguish or distress noted. Education: A review of staff education was completed on 05/07/24 at approximately 09:00 AM. All staff signatures were obtained and included all employed nurses. The staff signatures were verified via the staff roster. System Change: New hires will be provided with education: Narcotics are not to be borrowed for any reasons. If a resident is scheduled a narcotic and you do not have it, first check with med dispense system. If the narcotic is not available in the med dispense then you are to contact pharmacy to see if they can send it or get it sent to back up pharmacy. If they are unable to send the narcotic from main pharmacy or to the back up pharmacy, you are to call the physician to see if there is another medication option available. If you are unable to get into the med dispense system you need to contact Staff Development Coordinator (name typed) to have him assist you. Please make sure to document every attempt to obtain the medication. An interview was conducted on 05/08/24 at approximately 10:00 AM with the Administrator and the Director of Nursing (DON). Both the Administrator and the DON confirmed the incident which involved Resident #10, #20 and #81 did happen as reported. The Administrator also stated Resident #20 did not miss any doses of her medication due to this finding. c) Resident #81 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #81 had a narcotic medication borrowed for another resident two (2) times in the month of January, 2024. This was discovered when management performed an in house audit on 02/19/24. The facility reported it to the appropriate agencies on 02/19/24 and the five (5) day follow up was faxed on 02/21/24. The investigation started immediately on 02/19/24 at approximately 12:30 PM. A verbal and written statement was obtained from Licensed Practical Nurse (LPN) #176. The verbal statement relayed the nurse felt she had borrowed the medication for pain management and felt she had the best interest of the resident in pain at that time of judgement. The written statement states, (Resident names) have the same order for (narcotic name). Medication would have been borrowed if (resident name) didn't have any left. Aware this is not the protocol, it is to look in the Pyxis, if there isn't any, contact Registered Nurse (RN) on call, then proceed to contact (Physician name) and pharmacy of needed. On 02/19/24 Licensed Social Worker (LSW) #129 interviewed Resident #81. The resident was friendly with LSW. She did not answer many questions asked except for ones she replied yeah to. Resident carrying what appeared to be some of her clothing. Was encouraged to rest and put clothing in her room. She did sit on bed and smiled at LSW. No needs acknowledge. No mental anguish or distress observed during visit. Education: A review of staff education was completed on 05/07/24 at approximately 09:00 AM. All staff signatures were obtained and included all employed nurses. The staff signatures were verified via the staff roster. System Change: New hires will be provided with education: Narcotics are not to be borrowed for any reasons. If a resident is scheduled a narcotic and you do not have it, first check with med dispense system. If the narcotic is not available in the med dispense then you are to contact pharmacy to see if they can send it or get it sent to back up pharmacy. If they are unable to send the narcotic from main pharmacy or to the back up pharmacy, you are to call the physician to see if there is another medication option available. If you are unable to get into the med dispense system you need to contact Staff Development Coordinator (name typed) to have him assist you. Please make sure to document every attempt to obtain the medication. An interview was conducted on 05/08/24 at approximately 10:00 AM with the Administrator and the Director of Nursing (DON). Both the Administrator and the DON confirmed the incident which involved Resident #10, #20 and #81 did happen as reported. The Administrator also stated Resident #81 did not miss any doses of his medication due to this finding.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50801 Based on Record review and staff interview the facility failed to notify the Ombudsman of resident #45's discharge to the hospital.This was true for one (1) of one(1) residents reviewed for the carrier of hospitalization . Resident identifier; #45. Facility census: 114. Findings include: A) Resident #45 A record review found The resident was discharged to the hospital 12/06/2024 at 12:48 pm. Interviewed Social Worker on 05/06/2024 to ask if the ombudsman was notified of resident discharge to the hospital and she said yes but could not provide verification of that notification.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 49650 The facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid. The PASARR was not resubmitted for residents with newly evident or possible serious mental disorder. This was true for two (2) of six (06) residents PASARR reviewed during the long term care process. This had the ability to affect a limited number of residents. Resident Identifier: Resident #67, Resident #80; Census: 114. Findings Included: a) Resident #67 During a medical record review on 05/07/24 at 11:02 AM for Resident #67, the PASARR was dated 05/04/22. Further record review of the residents diagnosis identified an updated diagnosis of delusions due to known physiological condition dated 5/06/22. No further PASARR's were identified to have been completed for this diagnosis dated 05/06/22. On 05/07/24 at 02:46 PM during an interview with Social Worker #129 she stated she did not have an updated PASARR for the diagnosis of delusions due to known physiological condition dated 5/06/22 and that she would need to complete one.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 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 five (5) residents reviewed for the PASARR care area. Resident identifiers: #80, #1, Facility Census: #114 Findings included: (a) Resident #80 During a record review on 05/07/24, Resident #80's medical record revealed admitting diagnosis for 06/16/22 (admitted) included the following: -unspecified Psychosis not due to a substance or known physiological condition According to the Diagnosis Report provided by the facility and the PASARR submitted 10/12/22 the PASARR did not reflect this admitting medical diagnosis. In an interview with the Social Services/Admissions Director #129 on 05/08/24 at 08:39 AM, it was verified the PASARR should have reflected the Psychosis Disorder upon the admitted [DATE]. 49650

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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. 39043 Based on record review and staff interview, the facility failed to develop a complete and accurate comprehensive care plan for two (2) of 34 residents reviewed in the long-term care survey sample. Resident identifiers: #115, #67. Facility census: 114. Findings included: a) Resident #115 Review of Resident #115's comprehensive care plan showed the resident had been living at the facility since 2022. On 02/15/24, the resident was discharged to a family members' home. The resident had diagnoses of traumatic brain disorder and dementia. A physician's note written on 02/12/24 indicated the resident had received discharge planning and assistance from a state agency. The discharge summary written on 02/15/24 indicated delivery of durable medical equipment and home health agency visits were arranged prior to discharge. An appointment was also made with the resident's primary care provider and an Adult Protective Services (APS) referral was made. Review of Resident #115's comprehensive care plan showed no focus was developed regarding discharge planning. A focus written on 11/17/22 and resolved on 11/30/23 indicated the resident was residing in the facility for long-term care. However, no updated focus was developed relating to discharge planning for the resident to be discharged to a family member's home. On 05/08/24 at 4:00 PM, Registered Nurse (RN) Case Manager #151 stated the state agency had been working with Resident #115's family for a couple of months to arrange discharge. RN Case Manager #151 confirmed no focus relating to the resident's discharge planning had been developed on the resident's comprehensive care plan. No further information was provided through the completion of the survey process. 49650 b) Resident #67 During a medical record review on 05/07/24 at 06:00 PM for Resident #64, the diagnosis of a psychotic disorder with delusions due to known physiological condition was identified. The diagnosis of a psychotic disorder with delusions due to known physiological condition was dated 05/06/22. Further review of the resident's medical record did not identify a care plan for the diagnosis of the psychotic disorder with delusions due to known physiological condition diagnosis dated 05/06/22. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 10:24 AM During an interview with DON and Social Worker (SW) #129, the DON acknowledged the care plan for the diagnosis of Psychotic disorder with delusions due to known physiological conditions had not been developed and requested that the SW #129 make those corrections.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49650 Based on observation, medical record review and staff interview, the facility failed to revise the residents comprehensive care plan. Residents had one-on-one (1:1) interventions put in place without being care planned or being care planned timely. This was a random opportunity for discovery during the long term care survey process. Resident identifiers: #47, #75 and #101. Census: 114. Findings included: a) Resident #47 On 05/06/24 at 11:13 PM Resident #47 was observed to be sitting in her room with an apparent black eye. A staff member was observed at this time to be sitting in the room with the resident. On 05/07/24 at approximately 12:15 PM Resident #47 was observed to have a staff member sitting with her in her room. 05/07/24 at 07:45 PM during a medical record review, Resident #47 nursing note dated 05/03/24 identified that the resident had a fall as she was observed sitting in front of toilet in bathroom on floor, resident assessed for injuries noted to have skin tear to behind left ear and left side of face near chin, noted to have bump forming on top of left eyebrow noted to have purple coloring, resident started on neuro checks per facility protocol, vitals wnl. resident alarms in place and functioning. Resident denies any pain or discomfort. will continue to observe. On 05/07 at 08:00 PM during a medical review of the residents care plan for the focus it is noted that the resident is high risk for falls referenced to confusion, deconditioning and poor safety awareness. It also states that the resident often turns alarms off. The goal is identified for Resident #47 to be free of major injury through the review date of 07/31/24. Further review of the care plans, the intervention of a 1:1 sitter was not identified. On 05/08/24 at approximately 10:43 AM during an interview with the DON, she stated that Resident #47 has a 1:1 sitter as an intervention for her recent fall on 05/03/24. She further stated that the Interdisciplinary Team (IDT) determines if it is appropriate for the 1:1 sitter intervention and they did not get a physician order for this. The DON further agreed that the resident care plan does not include the 1:1 intervention and stated she would have that completed. 50552 b) Resident #75 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a facility tour on 05/06/24 at approximately 2:50 PM, it was noted Resident #75 had a Health Team Aide (HTA) sitting at her bedside. At that time, an interview with Resident #75 and the HTA #136 was conducted. HTA #136 revealed she was providing one on one care to Resident #75 and that a HTA sat with Resident #75 24 hours a day providing this service. When asked why, HTA #136 responded, I am not sure, I think she had a fall a while back. HTA #136 was unable to tell me when the one on one was initiated or how long it was to continue. Resident #75 was unable to provide further information. On 05/08/24 at 12:00 PM, a review of Resident #75 medical record was conducted revealing documentation of one on one care dating back to 09/18/23. Further review of Resident #75 record revealed a behavioral care plan with an intervention which read provide one to one observation as needed with an initiation date of 05/03/24. On 05/08/24 at 1:40 PM an interview with the Quality Assurance Nurse (QAN) was conducted. During this interview QAN acknowledged Resident #75's care plan had not been revised in a timely manner to reflect changes. 50801

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. 49650 The facility failed to create and sustain an environment that humanizes and individualizes each resident's quality of life as they were not provided a person-centered care to honor and support the residents individual preference, choices, values and beliefs. This was a random opportunity for discovery during the long term survey process. This had the ability to affect a limited number of resident's. Resident identifiers: #75, #47, #101. Facility census: 114. Findings include: a) During a facility tour on 05/06/24 at approximately 2:50 PM, it was noted Resident #75 had a Health Team Aide (HTA) sitting at her bedside. At that time, an interview with Resident #75 and the HTA #136 was conducted. HTA #136 revealed that she was providing one on one care to Resident #75 and that a HTA sat with Resident #75 24 hours a day providing this service. When asked why, HTA #136 responded, I am not sure, I think she had a fall a while back. HTA #136 was unable to tell me when the one on one was initiated or how long it was to continue. Resident #75 was unable to provide further information. On 05/08/24 at 12:00 PM, a review of Resident #75 medical record was conducted revealing documentation of one on one care dating back to 09/18/23, at which time she was noted to have had a fall. Resident #75 was sent to the hospital for evaluation after the fall with no injuries noted. Next, on 09/18/23 it was noted in a nurses note Resident #75 had a one on one sitter. A review of Resident #75's care plan for falls revealed no one on one sitter intervention initiated. However, a review of Resident #75's behavioral care plan revealed a one on one sitter intervention initiated on 05/03/24. Further review of Resident #75's physician's orders noted no physician's order for a one on one sitter. On 05/08/24 at approximately 10:43 AM during an interview with the DON, she stated Resident #75 has a one on one sitter as an intervention for her frequent falls. She further stated the Interdisciplinary Team (IDT) determines if it is appropriate for the one on one sitter intervention and they did not get a physician order for this nor does the facility have a policy related to this. When asked how the facility determines the length of time the one on one sitter intervention remains in place, the DON stated the IDT reviews each resident receiving one on one sitters to determine if the intervention is still appropriate, however they do not document this review. On 05/08/24 at approximately 11:45 AM an interview with the facility Social Worker (SW) was conducted. The SW verbalized she does not routinely assess the psychosocial well-being of residents receiving one on one sitters, stating There is no time frame set in stone, if they need something or there is a reportable I will assess them. The SW was unable to provide documentation she had assessed Resident #75's psychosocial well-being related to the one on one sitter. b) Resident #47 On 05/06/24 at 11:13 PM Resident #47 was observed to be sitting in her room with an apparent black eye. A staff member was observed at this time to be sitting in the room with the resident. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/24 at approximately 12:15 PM Resident #47 was observed to have a staff member sitting with her in her room. 05/07/24 at 07:45 PM during a medical record review, Resident #47 nursing note dated 05/03/24 identified that the resident had a fall as she was observed sitting in front of toilet in bathroom on floor, resident assessed for injuries noted to have skin tear to behind left ear and left side of face near chin, noted to have bump forming on top of left eyebrow noted to have purple coloring, resident started on neuro checks per facility protocol, vitals within normal limits. Resident alarms in place and functioning. Resident denies any pain or discomfort. will continue to observe. On 05/07 at 08:00 PM during a medical review of the residents care plan for the focus it is noted that the resident is high risk for falls referenced to confusion, reconditioning and poor safety awareness. It also states that the resident often turns alarms off. The goal is identified for Resident #47 to be free of major injury through the review date of 07/31/24. Further review of the care plans, the intervention of a 1:1 sitter was not identified. On 05/08/24 at approximately 10:43 AM during an interview with the DON, she stated that Resident #47 has a 1:1 sitter as an intervention for her recent fall on 05/03/24. She further stated that the Interdisciplinary Team (IDT) determines if it is appropriate for the 1:1 sitter intervention and they did not get a physician order for this. The DON further agreed that the resident care plan does not include the 1:1 intervention and stated she would have that completed. On 05/08/24 at approximately 11:15 AM during an interview with the DON, she stated that the IDT team had not met yet to discuss Resident #47's fall or the continued usage of the 1:1 sitter as a fall intervention. She further stated that they are scheduled to meet on 05/09/24. 50552 50801

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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. 49650 The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to obtain the physicians order for one on one (1:1) interventions. This was a random opportunity of discovery during the long term care survey process. This had the ability to affect a limited number of residents. Resident Identifiers; Resident #47, Resident #75, and Resident #101. Facility Census: 114. Findings Included: a: Resident #47 On 05/06/24 at 11:13 PM Resident #47 was observed to be sitting in her room with an apparent black eye. A staff member was observed at this time to be sitting in the room with the resident. On 05/07/24 at approximately 12:15 PM Resident #47 was observed to have a staff member sitting with her in her room. 05/07/24 at 07:45 PM during a medical record review, Resident #47 nursing note dated 05/03/24 identified that the resident had a fall as she was observed sitting in front of toilet in bathroom on floor, resident assessed for injuries noted to have skin tear to behind left ear and left side of face near chin, noted to have bump forming on top of left eyebrow noted to have purple coloring, resident started on neuro checks per facility protocol, vitals within normal limits. resident alarms in place and functioning. Resident denies any pain or discomfort. will continue to observe. On 05/07 at 08:00 PM during a medical review of the residents care plan for the focus it is noted that the resident is high risk for falls referenced to confusion, reconditioning and poor safety awareness. It also states that the resident often turns alarms off. The goal is identified for Resident #47 to be free of major injury through the review date of 07/31/24. Further review of the care plans, the intervention of a 1:1 sitter was not identified. On 05/08/24 at approximately 10:43 AM during an interview with the DON, she stated that Resident #47 has a 1:1 sitter as an intervention for her recent fall on 05/03/24. She further stated that the Interdisciplinary Team (IDT) determines if it is appropriate for the 1:1 sitter intervention and they did not get a physician order for this. She stated that the IDT team has not met yet to review this fall but would be meeting on Thursday 05/09/24. 50552 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) During a facility tour on 05/06/24 at approximately 2:50 PM, it was noted Resident #75 had a Health Team Aide (HTA) sitting at her bedside. At that time, an interview with Resident #75 and the HTA #136 was conducted. HTA #136 revealed, she was providing one on one care to Resident #75 and a HTA sat with Resident #75 24 hours a day providing this service. When asked why, HTA #136 responded, I am not sure, I think she had a fall a while back. HTA #136 was unable to tell me when the one on one was initiated or how long it was to continue. Resident #75 was unable to provide further information. On 05/08/24 at 12:00 PM, a review of Resident #75 medical record was conducted revealing documentation of one on one care dating back to 09/18/23, at which time she was noted to have had a fall. Resident #75 was sent to the hospital for evaluation after the fall with no injuries noted. Next, on 09/18/23 it was noted in a nurses note Resident #75 had a one on one sitter. A review of Resident #75's care plan for falls revealed no one on one sitter intervention initiated. However, a review of Resident #75's behavioral care plan revealed a one on one sitter intervention initiated on 05/03/24. Further review of Resident #75's physician's orders noted no physician's order for a one on one sitter. On 05/08/24 at approximately 10:43 AM during an interview with the DON, she stated that Resident #75 has a one on one sitter as an intervention for her frequent falls. She further stated that the Interdisciplinary Team (IDT) determines if it is appropriate for the one on one sitter intervention and they did not get a physician order for this nor does the facility have a policy related to this. When asked how the facility determines the length of time the one on one sitter intervention remains in place, the DON stated the IDT reviews each resident receiving one on one sitters to determine if the intervention is still appropriate, however they do not document this review. 50801

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465 Based on record review and staff interview the facility failed to provide services for Post Traumatic Stress Syndrome (PTSD). This failed practice was found true for (1) one of (3) three residents looked at for mood and behavior during the Long-Term Care Survey Process. Resident identifier #76. Facility Census: 114. Findings included: a) Resident # 76 A record review on 05/06/24 at 1:06 PM, of the Minimum Data Set (MDS), Section I, revealed that Resident #76 had PTSD. A record review on 05/08/24 at 11:00 AM, revealed the following trauma related care plan initiated on 10/31/21: Focus: (Resident #76 name) has a Trauma history relating to a car accident that left him badly injured [AGE] years ago. He has had two major strokes and two brain aneurysms. He lost his son due to a heart attack three years ago. He has a strained relationship with his living son and is close with a grandson. He worked as a social worker for many years at DHHR. No triggers reported. Goal: (Resident #76 name) will not have an increase in adverse symptoms related to trauma history through next review. Interventions: * Be patient and reassuring with (Resident # 76 name). * Encourage positive visits with friends/family. * Ensure (Resident #76 name) feels safe during care, offering reassurance as needed. * (Resident #76 name) enjoys being outdoors, pet visits, black and white movies. Engage in activities of comfort. * (Resident #76 name) is of the Christian faith. Provide spiritual guidance/materials as needed. * Identify any possible triggers to past trauma such as people, places, sounds, smells, objects, time of day. * Report any mood changes to the provider. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Use communication /picture boards when interacting with (Resident # 76 name). Further record review showed that Resident # 76, last Trauma Informed Care Assessment was completed on 10/31/21 and revealed that he had (5) five out of 13 life events for PTSD. No triggers had been identified at this time. During an interview on 05/08/24 at 1:30 PM with the Director of Nursing (DON), she confirmed that resident #76's MDS was marked for PTSD and the last Trauma Informed Care Assessment that she could find was dated 10/31/21. She further stated, I will see what is going on with that. Further record review on 05/08/24 at 2:00 PM, revealed an Activity Progress Note dated 03/27/24 that has the following documentation within the note: Resident tends to get frustrated when he is unable to communicate his needs/wants and will refuse to talk to you at times. He has had periods of tearfulness. Further record review revealed a Nurses note dated 03/27/24 that reads: Spoke with (Psychiatric doctor name) about (Resident #76 name) tearfulness and increased depression. He ordered an increase in Rexulti from 0.5mg to 1 mg daily. No follow-up notes were found to indicate if the medication increase was effective. During this record review it was found that Resident # 76 had no mention of anyone working with him for his possible triggers of PTSD, only notes that the medications were increased due to tearfulness. No further information was provided by the end of the survey.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 49650 Based on observation and staff interview, the facility failed to ensure the Daily Staffing Posting information was accurate and current. The Daily Staffing Posting Form was not posted in a prominent place readily accessible to residents and visitors; the Daily Staffing Posting Form did not accurately reflect the direct care staff; and the Daily Staffing Posting Form did not identify the actual number of staff and or the actual hours worked. This was identified during the long-term care survey process of reviewing the sufficient and competent nursing staff. This has the potential to affect potential to affect more than a limited number of residents and visitors. Identifiers: Accurate and current data of direct care, Accurate and current date of actual numbers of staff and or the actual hours worked; and the Daily Staffing Posting Form was not posted in a prominent place readily accessible to residents and visitors. Facility Census: 114. Findings included: a) Accurate and current data- direct care staff On 05/07/24 at approximately 10:15 AM during a review of the Daily Staffing Posting Forms with the Administrator it was identified that the total number of Registered Nurses (RN's) for direct care staff was more than one (1) eight (8) hour shift daily. The Administrator stated that the Registered Nurses with administrative duties are added to this number of RN direct care staff because they help with the floor staff throughout the day. 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 was reviewed 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 agreed that the RN staffing total and the RN total hours worked were not accurate. b) Accurate and current data-actual number of staff and staff hours worked. During a record review of the Staffing Posting Forms for 04/14/24, 04/21/24, 04/23/24, 05/01/24 and 05/04/24 and the Detail Hours Overview report of actual hours worked, the following staffing inaccuracies were identified; *04/14/24- -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number of Certified Nursing Assistant (CNA) direct care staff was as nine (9) CNA and the total number of hours as 103.5. The Detail Hours Overview report identified the actual total number of CNA direct care was 10 and the actual total number of hours was 112.0. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*04/21/24 -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number of LPN hours was 64. The Detail Hours Overview report identified the actual total number of hours for LPN was 61.5. -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified CNA total number of hours identified was 126.5. The Detail Hours Overview report identified the actual total number of hours was 135.75. *04/23/24 -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number Registered Nurse (RN) staff was eight (8) and the total number of hours identified was 64. The Detail Hours Overview report identified the actual total number of RN staff was one (1) and the actual total hours was identified as 8 (eight). -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number of LPN staff was eight (8) and the total number of hours identified was 56. The Detail Hours Overview report identified the actual total number of LPN staff was six (6) and the actual total hours was identified as 63.75. -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number of CNA staff was eight (8) and the total number of hours identified was 134.5. The Details Hours Overview report identified the actual total number of CNA staff was 20 and the actual total hours was identified as 161.25. -The Daily Staffing form day shift 07:00 PM - 07:00 AM identified the total number of LPN staff was five (5) and the total number of hours identified was 52. The Detail Hours Overview report identified the actual total number of LPN staff was four (4) and the actual total hours was identified as 42.5. -The Daily Staffing form day shift 07:00 PM - 07:00 AM identified the total number of CNA staff was nine (9) and the total number of hours identified was 96. The Details Hours Overview report identified the actual total number of CNA staff was 10 and the actual total hours was identified as 116.75. *05/01/24 -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number Registered Nurse (RN) staff was eight (8) and the total number of hours identified was 64. The Detail Hours Overview report identified the actual total number of RN staff was one (1) and the actual total hours was identified as eight (8). -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number of LPN staff hours identified was 62. The Detail Hours Overview report identified the actual total number of LPN staff hours was identified as 64.75. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number of CNA staff was 22 and the total number of hours identified was 201. The Details Hours Overview report identified the actual total number of CNA staff was 22 and the actual total hours was identified as 209.25. -The Daily Staffing form day shift 07:00 PM - 07:00 AM identified the total number of LPN staff hours identified was 48. The Detail Hours Overview report identified the actual total number of LPN staff hours was identified as 46.25. -The Daily Staffing form day shift 07:00 PM - 07:00 AM identified the total number of CNA staff hours was 103.5. The Details Hours Overview report identified the actual total number of CNA staff hours was as 107. *05/04/24 -The Daily Staffing form day shift 07:00 AM - 07:00 PM identified the total number of CNA staff was nine (9) and the total number of hours identified was 103.5. The Details Hours Overview report identified the actual total number of CNA staff was 12 and the actual total hours was identified as 142.75. -The Daily Staffing form day shift 07:00 PM - 07:00 AM identified the total number of CNA staff was nine (9) and the total number of hours identified was 96.5. The Details Hours Overview report identified the actual total number of CNA staff was 10 and the actual total hours were identified as 114.75. On 05/08/24 at approximately 01:43 PM during an review of the inaccuracies of the Daily Staffing Form with the Administrator, she agreed that the Daily Staffing form reviewed did not reflect the total number of staff or the actual hours worked by the staff. c) Daily Staffing Posting Form not posted in a prominent place readily accessible to residents and visitors. On 05/08/24 at approximately 01:47 PM during an interview with the Administrator it was identified that the Daily Staffing Posting form was not posted in a prominent place readily accessible to residents and visitors. The Administrator agreed that the Daily Staffing Posting form is to be posted in a prominent place readily accessible to residents and visitors.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 39043 Based on record review and staff interview, the facility failed to obtain laboratory services as ordered by the physician. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifier: #80. Facility census: 114. Findings included: a) Resident #80 Review of Resident #80's physician's orders showed an order for the laboratory test hemoglobin A1c (HgbA1-c) to be performed every six (6) months. HgbA1-c testing measures the average blood sugar level over the past three (3) months. Resident #80 was on a medication, Ziprasidone (Geodon) for psychosis, that can elevate blood sugar levels. Review of Resident #80's laboratory results showed HgbA1-c testing had last been performed on 09/07/23. On 05/08/24 at 1:17 PM, the Director of Nursing (DON) confirmed Resident #80's HgbA1-c testing had not been performed every six (6) months as ordered. She stated a HgbA1-c test would be obtained for the resident today. No further information was provided through the completion of the survey.

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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. 49751 Based on observation and staff interview the facility failed to ensure cooking/serving pans were completely dry before storing them on the shelf wet nesting. Wet nesting occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow. Hot/Cold compress pack was stored in the resident pantry refrigerator where cold snacks are stored. This failed practice was found during the initial kitchen tour during the Long-Term Care Survey and had the potential to affect more than a minimal number of residents residing in the facility. Facility Census: 114 Findings Include: a) wet nesting During the initial Kitchen tour on 05/06/24 at 11:00AM with Certified Dietary Manager (CDM) #132 Pans were stacked under the counter, when one was pulled it was observed to be wet on the right side. CDM #123 confirmed staff should have ensured pans were dry before stacking and storing them. On 05/06/24 at 1:00 PM CDM provided educations signed by staff ensuring dishes are dry when putting them up. b) Hot/Cold compress in pantry refrigerator On 05/06/24 at approximately 12:30 PM during inspection of facility North Pantry surveyor observed in the freezer of the refrigerator a hot-cold pack with a resident's name and room number written on it. During interview with Licensed Practical Nurse (LPN) #22 on 05/06/24 at 12:33PM, LPN #22 confirmed the hot/cold pack should not be in the pantry freezer stating, oh no this should not be here, we have a fridge behind the nurses station for these.

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	515187	A. Building B. Wing	05/08/2024

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Princeton Health Care Center	315 Courthouse Rd. Princeton, WV 24740

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)
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. 49465 Based on Record review and staff interview the facility failed to ensure that the medical record contained the diagnosis of Post Traumatic Stress Syndrome (PTSD) as indicated on the Minimum Data Set (MDS) and that the Physician Order for Selective Treatment (POST) form was complete and accurate. This failed practice was found true for (2) two of 34 residents reviewed for medical record accuracy during the Long-Term Care Survey Process. Resident identifiers #76, #86. Facility Census 114. Findings include: a) Resident #76 A record review on 05/08/24 at 10:19 AM, revealed that Resident #76's MDS with an Assessment Reference Date (ARD) of 03/22/24, Section I, question 16100, is marked yes for PTSD. Further record review showed that Resident #76 did not have PTSD listed for one of his medical diagnoses. He did however; have a care plan for trauma. During an interview on 05/08/24 at 1:30PM with the Director of Nursing (DON), she confirmed that resident #76's MDS was marked for PTSD and it was not on the current diagnosis list. She further stated, I will see what is going on with that. No further information was provided by the end of the survey. 50552 b) Resident #86 During a record review on 05/06/24 at 02:29 PM, a review of Resident #86's medical record revealed a Physician Orders for Scope of Treatment (POST) form that failed to include the contact number of the physician signing the POST order. The 2021 POST form guidance titled, Using the POST Form: Guidance for Health Care Professionals, 2021 edition, available on-line, stated, Failure to provide a contact number may result in the inability to contact the provider regarding any errors in the form completion that need to be addressed. During an interview on 05/06/24 at 09:22 AM with the Social Worker (SW), SW #129 acknowledged that the physicain had not entered his contact number on the POST form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515187	A. Building B. Wing	05/08/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 45171 50552 The facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed practice included: the missed opportunity for hand hygiene was true for 29 of 193 documented hand hygiene observations made by the facility and for 1 (one) of 32 observations made during a medication pass for the medication administration portion of the long term survey process. This failed practice had the potential to affect more than an isolated number of residents. Facility census: 114. Findings included: a) Facility On 05/07/24 at approximately 12:30 PM, a review of the facility Policy and Procedure titled, Infection Prevention and Control Program, section 4, Standard Precautions, dated 12/10/13 with a revision date of 05/18/23, noted the policy read, in part, Hand hygiene shall be performed in accordance with facility's established hand hygiene procedures. Further record review of the facility's Hand Hygiene Observation Tool for the months of February, March and April of 2024 revealed a total of 193 opportunities for hand hygiene with 29 missed opportunities indicating a no answer that hand hygiene was observed as performed. These missed opportunities were noted to occur on the following dates 02/12/24 02/14/24 02/22/24 03/01/24 03/12/24 03/19/24 03/22/24 04/04/24 04/05/24 04/06/24 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	04/24/24 04/29/24 During a staff interview conducted on 5/7/24 at 2:34 PM with the Infection Preventionist (IP), the IP stated There should be immediate education provided for all missed opportunities. When asked to provide documentation of education provided to the employees who had missed opportunities the IP acknowledged she was unable to provide proof that immediate education was performed.