STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515188	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindside Healthcare Center	10797 Seneca Trail South Lindside, WV 24951

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 42120 Based on resident interview, staff interview and record review, the facility failed to ensure the right to make choices about aspects of life that is important to one (1) of three (3) residents reviewed for choices. Specifically, Resident #35 was not given showers when requested or the choice. Resident identifiers: #19, and #35. Facility census: 54. Findings included: a) Resident #35 During an interview with Resident #35 on 08/19/24 at 2:44 PM, she stated she never received her shower when she prefered. Resident #35 continued to say that she would like to have showers at least every other day. Medical record review revealed, Resident #35's shower schedule was on Saturday, Sunday, Monday, Wednesday, and Thursday on day shift. A review of the 06/07/24 Quarterly Minimum Data Set (MDS), found the resident's brief interview for mental status was fifteen (15). A continued review of Resident #35s ADL documentation found; she was not receiving showers as scheduled. On 08/21/24 at 3:37 PM during an Interview with Assistant Director of Nursing (ADON) stated that they have been working with staff and trying to get resident showers when they prefer. She verified Resident #35 was not getting her showers as scheduled. b) Resident #19 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Lindside Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10797 Seneca Trail South Lindside, WV 24951	

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with, Resident #19 on 08/19/24 at 2:28 PM, the resident stated she had been accustomed to taking a shower every day throughout her life. However, since she had been at the long-term care facility, her shower schedule had been limited to Mondays and Wednesdays. She mentioned that this restriction was due to the shower rooms being reserved for men on Tuesdays and Fridays. The resident expressed her preference for daily showers, and stated that if it were possible, she would prefer to have a shower every day. She went on to state, I know that Tuesdays and Fridays are set aside for men, but I don't understand why I can't get a shower on the other days of the week. Resident's Medical Power of Attorney (MPOA), who was also present during the interview. The MPOA said Resident #19 was meticulous about her cleanliness. She revealed that she had voiced her concerns, about the showers, to the nursing staff on two previous occasions. Document review on 08/19/24 at 2:44 PM of Resident #19's Annual Minimum Data Set (MDS) assessments revealed just one (1) assessment for Section F - Preferences for Routine & Activities on 11/21/23. Resident's answer to the question How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Her response had been very Important. A review of the shower logs revealed that Resident #19 had received approximately three (3) showers a week. Showers were recorded for the following days during the month of July 2024: 07/13/24 (Saturday) 07/15/24 (Monday) 07/17/24 (Wednesday) 07/20/24 (Saturday) 07/22/24 (Monday) 07/24/24 (Wednesday) 07/27/24 (Saturday) 07/28/24 (Sunday) 07/29/24 (Monday) 07/31/24 (Wednesday) Document review further revealed that, for the month of August 2024, she had received showers on: 8/01/24 (Thursday) 08/03/24 (Saturday) 08/05/24 (Monday) (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/07/24 (Wednesday) 08/10/24 (Saturday) 08/12/24 (Monday) 08/15/24 (Thursday) 08/17/24 (Saturday) 08/19/24 (Monday) At 2:56 PM on 08/19/24, during an interview with Nursing Assistants (NA) #36 and #90 they stated that they always tried to accommodate residents' requests. However, due to having only one shower room, staffing constraints, and a high number of residents scheduled for showers, they confirmed that it was not always possible for them to do so. During an interview, on 08/22/24 at approximately 3:30 PM, with the Executive Director (ED) #29, she revealed a shower schedule dated 08/21/24. Showers were scheduled for Resident #19 on Sundays, Mondays, Wednesdays, Thursdays, and Saturdays.

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	515188	A. Building B. Wing	08/21/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43340 Based on record review and staff interview the facility failed to notify the representative/family of an acute hospitalization . This was true for two (2) out of three (3) residents reviewed for the care area of hospitalization during the Long-Term Care Survey process. Resident identifier: Resident #20. Facility census 54. Findings included: a) Resident #20 A record review, completed, on 08/20/24 at 7:09 PM, revealed Resident #20 had capacity to make his own medical decisions. Record review also revealed Resident #20 was transferred to the hospital on 02/16/24. A Nurses Note, dated 02/16/2023 at 10:41 PM, noted that Resident #20 had informed the nurse he was not feeling well and that he just wanted to go to the hospital. The physician was notified and new orders were received to send resident to the emergency room for evaluation. There was no evidence resident's daughter was notified. Section E. Key Contacts of the eInteract Transfer form, dated 02/16/24, listed resident as his own Resident Representative. There was no evidence resident's daughter / representative / next of kin / emergency contact was notified of transfer. During an interview, on 08/21/24 at 4:02 PM, the Assistant Director of Nursing (ADON) reported the facility could not produce evidence Resident #20's daughter/ representative / emergency contact was notified. The ADON acknowledged that even though resident was mentally competent, his designated resident representative or family, as appropriate, should have been notified of significant changes in the resident's health status because the resident may not have been able to notify them personally, especially in the case of sudden illness.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50552 Based on record review and staff interview the facility failed to implement the facility Policy and Procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation by failing to thoroughly investigate incidents of abuse between residents. The facility failed to obtain statements from staff who were working at the time of the incident. Furthermore, the facility failed to assess and interview like residents of the facility. This failed practice was true for three (three) of 5 (five) residents reviewed for abuse. Resident identifiers: #30, #54, and #1. Facility census: 54. Findings included: a) Resident #30 On 08/21/24 at approximately 10:00 AM, a review of the Facility Reported Incident (FRI) dated 07/26/24 was conducted revealing that on the morning of 07/26/24 at 10:30 AM. Licensed Practical Nurse (LPN) #82 witnessed Resident #207 pat Resident #30's mid section through his clothing. Further review of this investigation revealed 3 (three) statements which are typed as written and read as follows: Statement from LPN #82: I witnessed Resident #207 touching Resident #30 on his genital area outside his pants. I immediately removed Resident #207 from Resident #30. Administrator walking down hall during incident. She made Social Worker (SW) aware. Statement from Resident #30: I don't remember that. Statement from Resident #207: I did not do that. Further review of this investigation revealed there were no statements obtained from other staff working and that no other resident's were assessed or interviewed. In addition, a review of the policy and procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation was conducted revealing that when conducting an investigation of abuse, the facility will obtain statements from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. On 08/21/24 at 12:00 PM, an interview was conducted with the facility SW. At this time, the SW acknowledged that she had not interviewed and obtained statements from other staff working on 07/26/24, nor had other residents who may have had contact with Resident #207 been interviewed or assessed. In addition, the SW acknowledged she had not followed the policy and procedure. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Resident #54 On 08/20/24 at 09:05 AM, a review of the Facility Reported Incident (FRI) dated 07/17/24, for Resident #54 was conducted revealing that on the night of 07/17/24 at 11:30 PM, Resident #54 was seen in the activity room with Resident #39 by Licensed Practical Nurse (LPN) #98. Resident #39 was massaging Resident #54's neck. LPN #98 asked Resident #39 to stop. Resident #54 was crying and said Resident #39 had asked to touch her all day on the butt and thigh. On 08/21/24 at approximately 10:00 AM, review of this investigation revealed 3 (three) statements which are typed as written and read as follows: Statement from LPN #98: Nurse saw Resident #39 rubbing Resident #54's shoulders. Resident #39 redirected to his room. Resident #39 went to his room and to bed. Resident #54 stated Resident #39 tried to touch her earlier in the day. Statement from Resident #54 (which was obtained by a face to face interview with Resident #54 and written by facility Social Worker (SW)): Resident #54 stated, that man was rubbing my shoulders. My mom told me that a man should never touch me unless it's my doctor. When asked if it happened any other time, Resident #54 stated that Resident #39 patted her leg twice while sitting on couch watching TV. Resident #53 stated she went to bingo and Resident #39 asked her is she was a kid or retarded. Statement from Resident #39 (which was obtained by a face to face interview with Resident #39 and written by facility SW): I was trying to console that lady, she was crying. Resident #39 acknowledged he probably shouldn't touch people without permission. Further review of this investigation revealed there were no statements obtained from other staff working and that no other resident's were assessed or interviewed. In addition, a review of the policy and procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation was conducted revealing that when conducting an investigation of abuse, the facility will obtain statements from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. On 08/21/24 at 12:00 PM, an interview was conducted with the facility SW. At this time, the SW acknowledged that she had not interviewed and obtained statements from other staff working the night of 07/17/24, nor had other residents who may have had contact with Resident #39 been interviewed and assessed. In addition, the SW acknowledged the allegation Resident #54 made that Resident #39 asked to touch her all day on the butt was not addressed in the investigation and she had not followed the policy and procedure. c) Resident #1 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/24 at approximately 10:00 AM, a review of the Facility Reported Incident (FRI) dated 10/20/2024 was conducted revealing that on the evening of 10/20/2024 at 18:15 PM, Licensed Practical Nurse (LPN) #85 's written report of the allegation which is typed as written and reads as folllows: Resident #1 was hit resident by Resident #301 on the left side of the face multiple times and on the back of the head. DON made aware. Resident # 301 was sent to hospital for evaluation. On 08/21/24 at approximately 10:00 AM, review of this investigation revealed 2 (two) statements dated 10/21/23, which are typed as written and read as follows: Resident #1: That woman hit me. That woman mean. Resident # 20: That woman hit him. I saw it Further review of this investigation revealed there were no statements obtained from other staff working and that no other resident's were assessed or interviewed. On 08/21/2024 at 11:42 AM, an interview was conducted with the Director of Social Services. At this time, she acknowledged that she had not interviewed and obtained statements from other staff working the night of 10/20/24, nor had she interviewed other residents who may have had contact with Resident #301. A review of the policy and procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation was conducted revealing that when conducting an investigation of abuse, the facility will obtain statements from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses.

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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. 50552 Based on record review and staff interview the facility failed to timely report allegations of suspected abuse between residents timely within the 2 (two) hour window to the appropriate State Agency. This failed practice was true for 2 (two) of 5 (five) residents reviewed for abuse. Resident Identifiers: Resident #39, Resident #01 and Resident #207. Facility Census: 54. Findings include: a) Resident #39 On 08/21/24 at approximately 10:00 AM, a review of the Facility Reported Incident (FRI) dated 06/18/24 was conducted revealing that on the morning of 06/13/24 during the afternoon Licensed Practical Nurse (LPN) #71 reported that Resident #207 appeared to be touching the private are of Resident #39. LPN #71 stated she immediately separated the residents and re-directed each of them. During the review of this FRI, it was noted the allegation type selected was sexual abuse, which according to the reporting requirements of the Office of Health Facility Licensure and Certification Long Term Care Nursing Home Program must be reported to the appropriate state agency within 2 hours of occurrence. This allegation of sexual abuse was noted to occur on 06/13/24, however it was not reported until 06/18/24, which is outside of the reporting requirements referenced above. In addition, facility Policy and Procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation was reviewed, revealing that if the events that cause an allegation involve abuse and/or serious bodily injury, the self-report must be made immediately, but not later than 2 hours after the allegation is made. On 08/21/24 at approximately 01:30 PM, an interview was conducted with the Administrator at which time she acknowledged the facility failed to follow the reporting requirements set forth by Office of Health Facility Licensure and Certification Long Term Care Nursing Home Program , in addition to the facility Policy and Procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation . 50801 b) Resident #1 On 08/21/24 at approximately 10:00 AM, a review of the Facility Reported Incident (FRI) dated 10/20/2024 was conducted revealing that on the evening of 10/20/2024 at 6:15 PM, Licensed Practical Nurse (LPN) #85's documented that Resident #1 was hit on the left side of the face multiple times by Resident #301. TheFaxed record of Adult Protective Services Mandated Reporting Form was not sent until 10:28 PM to The Office Of Health Facilities Certification And Licensure (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Faxed Record of Adult Protective Services Mandated Reporting Form was not sent until 10:37 PM to Adult Protective Services, On 08/21/2024 at 11:42 AM, in an interview with The Director of Social Services, she confirmed the resident to resident abuse occurred and it was not reported in the 2 hour window for reporting.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 50552 Based on record review and staff interview the facility failed to thoroughly investigate thoroughly investigate 2 (two) instances of resident-to-resident sexual abuse and one instance of resident-to-resident physical abuse by failing to obtain statements from staff who were working at the time of the incidents, furthermore the facility failed to assess and interview like residents of the facility. This failed practice was true for 3 (three) of 5 (five) residents reviewed for abuse. Resident identifiers: #30, #54, #1 and #39. Facility Census: 54. Findings included: a) Resident #30 On 08/21/24 at approximately 10:00 AM, a review of the Facility Reported Incident (FRI) dated 07/26/24 was conducted revealing that on the morning of 07/26/24 at 10:30 AM, Licensed Practical Nurse (LPN) #82 witnessed Resident #207 pat Resident #30's mid section through his clothing. Further review of this investigation revealed 3 (three) statements which are typed as written and read as follows: Statement from LPN #82: I witnessed Resident #207 touching Resident #30 on his genital area outside his pants. I immediately removed Resident #207 from Resident #30. Administrator walking down hall during incident. She made Social Worker (SW) aware. Statement from Resident #30: I don't remember that. Statement from Resident #207: I did not do that. Further review of this investigation revealed there were no statements obtained from other staff working and that no other resident's were assessed or interviewed. In addition, a review of the policy and procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation was conducted revealing that when conducting an investigation of abuse, the facility will obtain statements from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. On 08/21/24 at 12:00 PM, an interview was conducted with the facility SW. At this time, the SW acknowledged that she had not interviewed and obtained statements from other staff working 07/26/24, nor had other residents who may have had contact with Resident #207. In addition, the SW acknowledged she had not followed the policy and procedure. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Resident #54 On 08/20/24 at 09:05 AM, a review of the Facility Reported Incident (FRI) dated 07/17/24, for Resident #54 was conducted revealing that on the night of 07/17/24 at 11:30 PM, Resident #54 was seen in the activity room with Resident #39 by Licensed Practical Nurse (LPN) #98. Resident #39 was massaging Resident #54's neck. LPN #98 asked Resident #39 to stop. Resident #54 was crying and said Resident #39 had asked to touch her all day on the butt and thigh. On 08/21/24 at approximately 10:00 AM, review of this investigation revealed 3 (three) statements which are typed as written and read as follows: Statement from LPN #98: Nurse saw Resident #39 rubbing Resident #54's shoulders. Resident #39 redirected to his room. Resident #39 went to his room and to bed. Resident #54 stated Resident #39 tried to touch her earlier in the day. Statement from Resident #54 (which was obtained by a face to face interview with Resident #54 and written by facility Social Worker (SW)): Resident #54 stated that man was rubbing my shoulders. My mom told me that a man should never touch me unless it's my doctor. When asked if it happened any other time, Resident #54 stated that Resident #39 patted her leg twice while sitting on couch watching TV. Resident #53 stated she went to bingo and Resident #39 asked her is she was a kid or retarded. Statement from Resident #39 (which was obtained by a face to face interview with Resident #39 and written by facility SW): I was trying to console that lady, she was crying. Resident #39 acknowledged he probably shouldn't touch people without permission. Further review of this investigation revealed there were no statements obtained from other staff working and that no other resident's were assessed or interviewed. In addition, a review of the policy and procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation was conducted revealing that when conducting an investigation of abuse, the facility will obtain statements from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. On 08/21/24 at 12:00 PM, an interview was conducted with the facility SW. At this time, the SW acknowledged that she had not interviewed and obtained statements from other staff working the night of 07/17/24, nor had other residents who may have had contact with Resident #39. In addition, the SW acknowledged the allegation Resident #54 made that Resident #39 asked to touch her all day on the butt was not addressed in the investigation and she had not followed the policy and procedure. 50801 c) Resident #1 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/24 at approximately 10:00 AM, a review of the Facility Reported Incident (FRI) dated 10/20/2024 was conducted revealing that on the evening of 10/20/2024 at 18:15 PM, Licensed Practical Nurse (LPN) #85 's written report of the allegation which is typed as written and reads as folllows: Resident #1 was hit resident by Resident #301 on the left side of the face multiple times and on the back of the head. DON made aware. Resident # 301 was sent to hosipital for evaluation. On 08/21/24 at approximately 10:00 AM, review of this investigation revealed 2 (two) statements dated 10/21/23, which are typed as written and read as follows: Resident #1: That woman hit me. That woman mean. Resident # 20: That woman hit him. I saw it Further review of this investigation revealed there were no statements obtained from other staff working and that no other resident's were assessed or interviewed. On 08/21/2024 at 11:42 AM, an interview was conducted with the Director of Social Services. At this time, she acknowledged that she had not interviewed and obtained statements from other staff working the night of 10/20/24, nor had she interviewed other residents who may have had contact with Resident #301. A review of the policy and procedure entitled, [NAME] Virginia Abuse, Neglect and Misappropriation was conducted revealing that when conducting an investigation of abuse, the facility will obtain statements from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42120 Based on medical record review and staff interview, the facility failed to provide evidence a resident/resident's representative was provided a written Notice of Transfer for an acute hospital transfer. The facility also failed to provide evidence that a copy of the Notice of Transfer was sent to the Ombudsman. This was true for three (3) out of four (4) hospital transfers reviewed during the long-term care process. This had the potential to affect all residents being transferred or discharged . Resident identifiers: #20, #38, and #29. Facility census: 54. Findings included: a) Resident #29 Medical Record review on 08/21/24 revealed resident #29 was discharged to the hospital on 08/13/24. Subsequent review of Resident #29's medical record showed it did not contain documentation that the Notice of Transfer or Discharge was provided to the Resident Representative, or the Ombudsman was notified of the discharges on 08/13/24. On 08/21/24 at 5:58 PM during an interview the Administrator verified, there was no evidence that the Notice of Transfer or Discharge was completed and provided to the Resident's Representative for the discharges on 08/13/24. The Administrator also confirmed the Ombudsman was not notified of the discharges on 08/02/24. b) Resident #20 A medical record review was completed on 08/21/24 at 9:14 AM. The record review revealed Resident #20 was transferred to the hospital on 02/16/24. The record did not reflect the resident/resident's representative was provided a Notice of Transfer. During an interview with the Administrator on 08/21/24 at approximately 4:40 PM, the Administrator reported the correct Notice of Transfer/Discharge was not provided to resident upon transfer. c) Resident #38 A medical record review was completed on 08/21/24 at 9:53 AM. The record review revealed Resident #38 was transferred to the hospital on 11/16/23. The record did not reflect the resident/resident's representative was provided a Notice of Transfer, nor did the record reflect the Notice of Transfer was sent to the Ombudsman. During an interview with the Administrator on 08/21/24 at approximately 4:40 PM, the Administrator reported the correct Notice of Transfer / Discharge was not provided to resident upon transfer. (continued on next page)

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	515188	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindside Healthcare Center	10797 Seneca Trail South Lindside, WV 24951

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43340

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 42120 Based on medical review and staff interview, the facility failed to provide the resident/resident representative notice of the bed hold policy when Resident #29 was transferred to a local hospital. This was true for one (1) of three (3) residents reviewed for transfers. Resident identifier: #29. Facility census: 54. Findings included: a) Resident #29 Medical Record review on 08/21/24 revealed Resident #29 was discharged to the hospital on 08/13/24. Continued review of Resident #29's medical record showed it did not contain documentation that the resident or the resident's representative received a copy of the bed hold policy at the time of transfer. In addition, there was no documentation in the medical record of contacting the resident / resident representative regarding the bed hold policy. In an interview with the Administrator on 08/21/24 at 5:58 PM, the Administrator confirmed there was no documentation regarding staff notifying the resident/resident representative of the bed hold policy for the hospital transfer on 08/13/24.

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NAME OF PROVIDER OR SUPPLIER: Lindside Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 10797 Seneca Trail South Lindside, WV 24951	

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on record review, resident, and staff interview. The facility failed to assist dependent Residents with activities of daily living (ADL's) in accordance with the Residents assessed needs for care. This is true for one (1) of three (3) residents reviewed for ADL care. Resident identifiers: #108. Facility census: 54. Findings included: a) Resident #108 During an interview, on 08/19/24 at 1:02 PM, Resident #108 stated she had never had a bath / shower or had her hair washed since she was admitted . A record review revealed Resident #108 was admitted to the facility on [DATE]. Continued review found no documentation of bathing from 08/14/24 through 08/21/24. On 08/21/24 at 3:37 PM during an Interview with Assistant Director of Nursing (ADON) stated that they have been working with staff and trying to get resident showers when they prefer. She verified Resident #108 was not getting her showers as scheduled. 50795

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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. 50552 Based on record review and staff interview the facility failed to follow a physician's order to be notified of blood sugar greater than 400 for Resident #23. This was true for 1 (one) of 1 (one) residents reviewed for the Long Term Care Survey Process. Facility census: 54. Resident identifier: #23. Findings included: a) Resident #23 On 08/19/24 at 03:48 PM, a record review was conducted for Resident #23 revealing orders for the following: Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 48 unit subcutaneously one time a day for DM 2 Obtain blood sugar at 6 AM and PM. Notify physician if blood glucose less than 60 or over 400 two (2) times a day for diabetes On 08/20/24 at 03:06 PM, a review was conducted of Resident #23's progress notes and Medication Administration Record (MAR) revealing the following documentation: 1. 08/03/2024 5:46 PM - Medication Administration Note Note Text: Obtain blood sugar at 6 AM and PM. Notify physician if blood glucose less than 60 or over 400. 2. 08/01/2024 16:38 Nurses Note Note Text: BS 455. Left message with NP. Awaiting message/call back. Had sweets the facility carnival this afternoon. In addition, no further documentation was noted that the Physician or Nurse Practitioner (NP) called back and was notified. On 08/20/24 at 03:30 PM, a review of Resident #23's care plan was conducted which revealed the following: Resident has diabetes Disease process Resident will be able to articulate potential complications of not following prescribed regimen Observe for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath, stupor, coma. Report any abnormal findings to medical provider, resident / resident representative. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe for s/sx of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, blurred speech, lack of coordination, staggering gait. Report any abnormal findings to medical provider, resident / resident representative. Obtain and monitor lab / diagnostic studies, as ordered. Report abnormal findings to medical provider, resident / resident representative. Obtain blood sugars per orders. Report abnormal findings to medical provider, resident / resident representative. On 08/21/24 at 11:39 AM, an interview was conducted with the Assistant Director of Nursing (ADON) acknowledged the Physician and/or NP had not been made aware of blood sugar outside of parameters.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on record review, resident, and staff interview. The facility failed to ensure that a resident received the treatment and care in accordance with professional standards of practice in regard to monitoring pain levels. This was true for three (3) of five (5) residents reviewed for pain during the Long-Term Survey Process. Resident Identifier: #26, #29, and #157. Facility census: 54. Findings included: a) Resident #29 Medical record review revealed Resident #29 had a broken hip. The resident had a physician orders for pain management. The oder was for Acetaminophen Oral Tablet (Acetaminophen). Give 500 mg by mouth every six (6) hours as needed for pain. The order stated, Do not exceed 3000mg total dose in a 24-hour period from any medication with a state date 08/02/24. A continued review of Medication Administration Record (MAR) revealed: --08/13/24 at 8:06 AM pain level 8 - Acetaminophen 500 mg tablet given. --08/14/24 at 7:09 AM pain level 8 - Acetaminophen 500 mg tablet given. An interview on 08/21/24 at 5:12 PM with Assistant Director of Nursing (DON), she confirmed Resident #29's Pain medication did not have perameters, and she was not receiving pain medication per nursing standards. b) Resident #26 During an interview on 08/19/24 at 2:42 PM Resident #29 stated that he has a good bit of pain. Medical record review revealed Resident #26's physician orders for pain management: --Acetaminophen Oral Tablet (Acetaminophen), Give 2 tablet by mouth every 8 hours as needed for pain with a start date 02/28/24. --Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 1 tablet by mouth every 6 hours as needed for pain, with a start date 06/29/24. Continued review found no parameters were on the pain management orders. A continued review of Medication Administration Record (MAR) revealed: --06/03/24 at 7:28 AM pain level 3- Oxycodone HCL tablet given. --06/03/24 at 3:37 PM pain level 3 - Oxycodone HCL tablet given. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--06/08/24 at 7:25 AM pain level 3 - Oxycodone HCL tablet given. --06/08/24 at 8:27 PM pain level 3 - Oxycodone HCL tablet given. --06/09/24 at 7:33 AM pain level 3 - Oxycodone HCL tablet given. --06/13/24 at 8:15 PM pain level 3 - Oxycodone HCL tablet given. --06/17/24 at 7:20 AM pain level 3 - Oxycodone HCL tablet given. --06/18/24 at 7:12 AM pain level 3 - Oxycodone HCL tablet given. --06/22/24 at 7:40 AM pain level 3 - Oxycodone HCL tablet given. --07/06/24 at 7:35 AM pain level 3 - Oxycodone HCL tablet given. --07/06/24 at 8:19 PM pain level 3 - Oxycodone HCL tablet given. --07/07/24 at 7:27 AM pain level 3 - Oxycodone HCL tablet given. --07/13/24 at 7:26 AM pain level 4 - Oxycodone HCL tablet given. --07/14/24 at 7:39 PM pain level 3 - Oxycodone HCL tablet given. --07/22/24 at 6:46 AM pain level 4 - Oxycodone HCL tablet given. --07/23/24 at 6:47 AM pain level 4 - Oxycodone HCL tablet given. --08/13/24 at 8:06 AM pain level 2 - Oxycodone HCL tablet given. --08/14/24 at 7:09 AM pain level 4 - Oxycodone HCL tablet given. Subsequent review revealed no acetaminophen tablets were given from 06/01/24 through 08/21/24. Also, no milligram was noted on the ordered acetaminophen. An interview on 08/21/24 at 3:21 PM with Assistant Director of Nursing (DON), she confirmed Resident #26's pain medication did not have perameters, and he was not receiving pain medication per nursing standards. 43340 c) Resident #157 During an interview on 08/19/24 at 3:21 PM, Resident #157 stated he received PRN (as needed) oxycodone for pain management. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review was completed on 08/20/24 at 8:51 PM. Resident #157 was admitted to the facility on [DATE]. A review of the August 2024 Medication Administration Record (MAR) revealed the following order: Oxycodone Hcl Oral Tablet 5 MG. Give 1 tablet by mouth every 4 hours as needed for pain. Additionally, the August MAR revealed the following dates and times Resident #157 was given oxycodone one (1) time for pain rated at 0 and eight (8) times for mild pain rated between 1-2: -08/05/24 at 9:15 PM for a Pain Level of 2 -08/07/24 at 10:25 PM for a Pain Level of 1 -08/08/24 at 5:40 AM for a Pain Level of 0 -08/09/24 at 2:05 PM for a Pain Level of 2 -08/10/24 at 00:59 AM for a Pain Level of 2 -08/12/24 at 4:35 PM for a Pain Level of 2 -08/13/24 at 00:30 AM for a Pain Level of 2 -08/14/24 at 8:46 PM for a Pain Level of 1 -08/18/24 at 10:45 AM for a Pain Level of 2 Subsequently, the numeric pain rating scale (NPRS) was reviewed. It is a 0-10 scale that is often used by clinicians to assess pain intensity in clinical settings. On the scale, 0 means no pain and 10 means the worst pain imaginable. The NPRS can be administered verbally or graphically, and patients can complete it themselves. The NPRS is often categorized into the following ranges: No pain: 0 Mild pain: 1-3 Moderate pain: 4-6 Severe pain: 7-10 During an interview, on 08/21/24 at 3:02 PM, the ADON was asked how a nurse would know it was OK to administer the ordered oxycodone for pain. She responded the resident would be asked to rank their pain. The ADON was then asked if any pain level was reported, would the oxycodone be ordered. The ADON stated that oxycodone is typically utilized for more severe pain. When the above-mentioned dates where oxycodone was administered for a pain between 0 - 3 were reviewed with the ADON, she reported the nurses should have called the physician to question if he wanted to prescribe a different medication for a lesser level of pain.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50795 Based on observation, interviews with facility staff, and a review of facility policy and procedures, it was determined that the facility failed to follow acceptable infection control practices that controlled, or prevented, the spread of infection. This practice had the potential to affect all residents that reside in the facility. Facility Census: 54. Findings included: a) Water Management On 08/23/24 at 3:34 PM, during a review of water management, it was discovered that the facility lacked a Water Management Plan. Additionally, there was no text and flow documentation available that detailed the facility's water system, including control points where Legionella control measures, like dead leg water flushes, were required. During a face-to-face interview with Executive Director (ED) #29 on 08/23/24 at 3:52 PM, she stated that she was not aware of the requirement for a text and flow description of the water system. The Regional Director of Clinical Operations (RDCO) #110 overheard the conversation and mentioned that the facility's Emergency Management Plan should contain this information. However, upon review of the Emergency Management Plan, no water management plan or description of the water system was found. At approximately 4:50 PM on 08/23/24, the ED #29 came into the conference room, and referring to the water management plan, stated, we don't have it. b) Laundry Services On 08/23/24 at approximately 2:30 PM, this surveyor requested an inspection of the laundry room from Laundry Aide (LA) #96. At that time, LA #96 was rolling a cart of clean laundry down the corridor, for delivery to residents, and asked for a few minutes to finish delivering the laundry. This surveyor agreed, and waited until the delivery was completed. In the soiled laundry room, a washing machine was found with pillows piled on top of it. LA #96 stated that the washing machine was also not in use due to a breakdown and expressed confusion about the pillows being on top of it. LA #96 reported coming in to work at 2:00 PM, and immediately beginning to deliver laundry to the residents. She confirmed that the pillows should not be on top of the washing machine and stated that all items in the soiled laundry room were supposed to be in the bins.