

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Belmont Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 506 Riverview Road Belmont, WV 26134	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50801</p> <p>Based on record review and staff interview the facility failed to ensure professional standards of practice were followed in regards to completing neurological assessments following a fall. This was true for one (1) of 25 residents reviewed during the long term care survey process. Resident Identifier: Resident #13. Facility Census: 60.</p> <p>Findings included:</p> <p>a) Resident #13</p> <p>A review of Resident #13's medical records found the resident suffered a fall on 07/08/24, 09/20/24, and 10/19/24. After each fall neurological assessments were indicated and initiated. However, these neurological assessments were not completed as required.</p> <p>During an interview with the Director of Nursing (DON) on 10/23/24 at 1:05 PM, she acknowledged the neurological assessments were incomplete after the falls dated 07/08/2024, 09/20/2024, and 10/19/2024 .</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49467</p> <p>Based on observation and staff interviews, the facility failed to store, prepare, and serve food in a safe and sanitary manner by not removing dented cans from service. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Facility census: 60.</p> <p>Findings include:</p> <p>A) Dented cans</p> <p>At approximately 11:50 AM on 10/21/24, during a tour of the kitchen, three (3) dented cans were placed on the shelf alongside cans intended for service. Two (2) cans contained corn and one (1) can contained sliced peaches.</p> <p>At approximately 11:53 AM on 10/21/24, Culinary Aide (CA) #38, stated they were the cook for the day due to the Dietary Manager (DM) being out of the facility, and acknowledged the dents in the cans, and they should have been removed from the shelves with the other cans meant for service.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>50551</p> <p>Based on record review and staff interview, the facility failed to maintain a correct capacity form for Resident #23 and failed to correctly document dates and times of neurochecks for Resident #13. Resident identifiers: #23 and #13. Census: 60</p> <p>Findings included:</p> <p>a) Resident #23</p> <p>A review of Resident #23's records on 10/21/24 at 7:18 PM revealed the following:</p> <p>Physician's Determination of Capacity Form dated 06/05/24 documented the resident did not have capacity to make his own medical decisions with duration being long term due to inability to process information and disorientation caused by a cerebral vascular accident.</p> <p>Physician's Determination of Capacity Form dated 8/30/24 expressed the resident had capacity to make his own medical decisions and was signed by only one physician.</p> <p>During an interview with the Administrator on 10/22/24 at 12:05 PM she acknowledged her understanding in order to restore capacity to a resident who has been deemed incapacitated you must have 2 (two) physician's signatures. She acknowledged, there was only one signature for Resident #23 to restore capacity but the physician had planned to re-evaluate as it was done in error and does not believe resident to have capacity to make his own medical decisions. She also acknowledge that resident's care plan had been updated to state that resident had capacity when it should not have been.</p> <p>b) Resident #13</p> <p>A review of Resident #13's medical record found Resident #13's neurological assessments dated 09/09/24 had incorrect dates and signature times documented.</p> <p>On 10/23/24 at 1:05 PM, during an Interview with the Director of Nursing, #23, she acknowledged the signatures and dates in the documentation of the neuro checks for Resident #13's fall on 09/09/24 were incorrect.</p> <p>50801</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50795</p> <p>Based on observation and interview, the facility failed to maintain effective infection control practices in the laundry room. Additionally, facility staff failed to adhere to infection control policies and protocols while providing catheter care. Resident Identifier: #44. Facility Census: 60.</p> <p>Findings included:</p> <p>a) Laundry Room</p> <p>During an inspection of the laundry room with Executive Director (ED) #6 on 10/22/24, at approximately 3:55 PM, discarded mop heads with a brown substance on them, were observed in the laundry sink. Additionally, several towels with brown stains were observed on top of a bin near the sink. Multiple covered, empty bins, for storing soiled items were available and lined up against the opposite wall. ED #6 confirmed soiled items should not be in the sink, or on top of the bins. The presence of uncovered soiled items increases the risk of contamination for all items in the laundry room.</p> <p>b) Resident #44</p> <p>Catheter care for Resident #44 was observed on 10/23/24 at approximately 1:12 PM. This surveyor had requested Licensed Practical Nurse (LPN) #9's presence during the procedure. LPN #9 introduced Nurse Aide (NA) #53, and stated catheter care would be performed by NA #53.</p> <p>Resident #44 was under Enhanced Barrier Precautions (EBP), and the sign outside the resident's room noted this.</p> <p>NA #53 entered Resident #44's room wearing gloves but did not don additional personal protective equipment (PPE) or perform hand hygiene before proceeding. She closed the room door and pulled a screen to provide privacy for the resident. NA #53 informed the resident she would be performing catheter care, and then proceeded to undo the resident's brief.</p> <p>Without changing her gloves or performing hand hygiene, NA #53 gathered her supplies and began the procedure. She used moistened soapy towels to clean the catheter from the meatus forward. As she continued, she discarded each used towel on the floor. After she finished cleaning the catheter, she re-fastened the resident's brief, collected the soiled towels from the floor, and placed them in a trash bag.</p> <p>Once the procedure was complete, NA #53 again failed to discard her gloves or perform hand hygiene. She then went on to empty the catheter bag, and measured the volume of urine, still without changing her gloves or performing hand hygiene.</p> <p>LPN #9 expressed her shock at NA #53's failure to adhere to infection prevention protocols. She confirmed NA #53 did not follow the facility's EBP policy, or infection control procedures. LPN #9 mentioned she would take a moment to speak with NA #53 and provide a 'teachable moment' as soon as she exited the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>50795</p> <p>Based on observation and interview, the facility failed to ensure that residents had a means of contacting their caregivers through a call system that was accessible to them while in their bed, or other sleeping accommodations within their room. Resident Identifiers: #46 and #38.</p> <p>Facility Census: 60.</p> <p>Findings included:</p> <p>a) Resident #46</p> <p>During an interview with Resident #46 on 10/21/24 at approximately 1:51 PM, the resident stated she needed to speak to a staff member. She looked around and was unable to locate her call light. Resident then stated, I'll wait for someone to come. Upon being notified the resident needed help, Licensed Practical Nurse (LPN) #51 arrived and confirmed the call light was on the floor below the resident's bed, and inaccessible to the resident.</p> <p>LPN #51 confirmed that the call light was out of the reach of the resident and stated, Well that is a problem! LPN #51 then retrieved the call light and placed it next to the resident, and attended to the resident's needs.</p> <p>b) Resident #38</p> <p>An observation of Resident #38 on 10/21/24 at 1:45 pm, found the residents call light was not within the residents reach.</p> <p>An interview with Licensed Practical Nurse (LPN) #9, at 1:48 pm on 10/21/24, confirmed Resident # 38 was unable to reach his call light.</p> <p>50801</p>		