

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515194	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2025
NAME OF PROVIDER OR SUPPLIER Maplewood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 Maplewood Drive Bridgeport, WV 26330	
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>Based on record review and staff interview the facility failed to ensure the resident and/or resident representative were afforded the right to participate in the care planning process with all required members of the interdisciplinary team. This was true for two (2) of two (2) sampled residents reviewed during a complaint survey. Resident Identifiers: #6 and #75. Facility Census: 74.</p> <p>Findings Include:</p> <p>a) State Agency Complaint</p> <p>The state agency received a complaint on 11/18/24 which indicated the following:</p> <p>The complainant was contacted by the facility's Social Worker about a care plan meeting for her mom. She said that the social worker normally only contacts her the day before or the day of the meeting but on this occasion, she did contact her a few days prior. This was helpful because she wanted to review her mom's care plan prior to the meeting.</p> <p>The complainant stated the social worker was the only staff member present on the care plan meeting that was held on the phone. She said she knew there was no interdisciplinary team there when this was going on.</p> <p>b) Facility's Process for Care Plan Meetings</p> <p>A review of the facility's process for Care Plan Meetings found the following:</p> <p>.5. The following team members will be present during the care plan meeting: A clinical representative, Dietary, Social Services, Activities, and therapy . 12. A care plan note must be created at the time of the meeting to include the brief discussion of the meeting, concerns, follow up etc. This note should include a list of all who attended the meeting, both from the resident/ representative and facility staff. The note can be found in PCC under progress notes.</p> <p>c) Resident #75</p> <p>A review of Resident #75's medical record found she had the following care plan meetings with the following attendees:</p> <p>-- 07/25/24 Attendees: Social Services and Activities</p> <p>(continued on next page)</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-- 10/24/24 Attendees: Social Services, Activities and Responsible Party.</p> <p>-- 01/23/25 Attendees: Social services and Responsible party.</p> <p>d) Resident #6</p> <p>A review of Resident #6's medical record found the resident had the following care plan meetings with the following attendees:</p> <p>-- 05/16/24 Attendees Social Services and activities.</p> <p>-- 06/27/24 Attendees: Social Services and Activities</p> <p>-- 08/15/24 Attendees: Social Services and Activities.</p> <p>-- 11/14/24 Attendees Social Services and Responsible party.</p> <p>-- 02/13/25 Attendees: Social Services, Activities and Son</p> <p>-- 02/20/25 Attendees: Social Services and Activities</p> <p>e) Staff Interviews</p> <p>An interview with the Nursing Home Administrator on the afternoon of 05/08/25 confirmed the IDT team was not participating in the care plan meetings. She indicated the social worker was in charge of scheduling and coordinating the meetings and she did not realize they were not participating like they should. The Director of Nursing (DON) also present during the interview stated she would send a floor nurse to the meetings to represent nursing because they would know the resident the best and have the best input. Both agreed the only participating members were social services and activities who shared an office.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to implement their abuse prohibition policy in regards to identifying and reporting all allegations of abuse and/or neglect. The facility failed report all allegations of abuse and or neglect to required agencies within the required time frames. This was a random opportunity for discovery and was true for 13 residents for a total of 15 allegations. Resident Identifiers; Resident #4, #50, #54, #16, #60, ##32, #33, #29, #73, #68, #76, #77, and #78. Facility Census: 74.</p> <p>Findings Include:</p> <p>a) Policy Review</p> <p>A review of the facility;s policy Titled: [NAME] Virginia Abuse, neglect, and Misappropriation Policy with an effective date of 10/17/24 found the following:</p> <p>.Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, visitors, and staff or others but has not yet been investigated and, if verified, could be noncompliance with the federal requirements related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source, and misappropriation of resident property VII. Reporting of incidents and Facility Response. 1. All alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported to the executive director immediately. 2. The executive director/designee will report appropriate incidents to OHFLAC&it; APS, The regional Ombudsman, and other local authorities including but not limited to local law enforcement iff appropriate, as required by state law.</p> <p>b) Grievance Forms review for the previous 12 months.</p> <p>A review of the facility's filed grievances for the previous 12 months on 05/07/25 found the following allegations of abuse and/or neglect contained on the grievance forms:</p> <p>-- 05/29/24 Resident # 4 grievance voiced during the resident council and read as follows:resident stated CNA (First Name of Nurse Aide (NA) #56) yelled at her for pushing her call bell resident states w/c is dirty.</p> <p>-- 06/24/24 Resident #76's family voiced this grievance to the DON , Hospice and Social Services and it read as follows: yesterday residents wife found him undressed from the waist down. His shirt had not been changed for several days. He had food from his tray and BM up his back. Also a staff member was going up the hall yesterday saying loudly quit ringing your bells. and residents and families could hear this. would like to have range of motion provided.</p> <p>-- 06/28/24 Resident #77's family reported this grievance to social services and it read as follows, Family came to see her Wednesday and she was dirty and in the dame hospital gown se had been in on Monday when she got here. Please be sure she has her cochlea implant in to talk with her. She is also known to lay it on bed and it could get lost, staff needs to make sure it is not in her bed if she isn't wearing it and it isn't in he charger.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-- 07/06/24 Resident #54 grievance voiced by the residents family unsure who the grievance was reported too and read as follows: I would like to see if my mom's depend can be checked more often I have came everywhere day Thursday and Saturday and she was soaked through.</p> <p>-- 07/16/24 Resident #16 grievance voiced to the social worker and read as follows: timeliness of call bell response. they took her whistle away from her. She stated that she needed to go to the bathroom at 6:00 am a few days ago and staff came in and told her that they couldn't do it right now because they were passing breakfast trays.</p> <p>-- 08/06/24 Resident #54 grievance voiced by the residents family the concern was voiced to social services and read as follows, 'activities told social services followed up with the family who was visiting today. (First Name of Resident #54) daughter (First name of Resident #54's daughter) state (First Name of Resident #54) was so wet when she got here there was urine dripping down into her shoes. When Social service spoke with her she said she had already talked to the aide.</p> <p>-- 09/04/24 Resident #32 grievance voiced by family to social services which read as follows: Resident's daughter stated her mother told her that the CNA (First Name of NA #56) didn't change her sheet which was wet as the result of her using the bed pan. (First name of Nurse Aide #56) told her it wasn't wet and she didn't have time to change it. (First name of unidentified Staff) came in and said she would get someone to change her. She then stated (First name of two more staff members who no longer work at the facility) came in and put a thicker sheet over her wet sheet and that (First Name of Staff who no longer works at the facility) jerked her nightgown in the process. She said (First Name of Staff who no longer works at the facility) had told her mother a few das before she wasn't going to be caring for her anymore. She also said that (First Name of Staff) told her that [NAME] liked her.</p> <p>-- 09/28/24 Resident #60's family member voiced a concern to social services which read as follows: Expressed concern over mothers knee being bruised. They documented on the concern is was unknown how the injury occurred and the resolution was the NP (nurse practitioner) looked at her knee and confirmed it was healing.</p> <p>-- 10/08/24 Resident #78's family reported to nursing/social services the following grievance, daughter feels the stage 2 on (First Name of Resident #78)'S bottom is related to the staff leaving her up in her wheelchair last night to sleep because her bed had not been made.</p> <p>-- 10/28/24 Resident #33 voiced this grievance to social services and it read as follows: Resident came to social services and stated that another female resident was in her room and going through her belongings, when she told her to stop the other resident grabbed her neck and put her hand over (First Name of Resident #33) face. (First Name of Resident #33) said it did not cause her any pain or injury.</p> <p>-- 10/28/24 - Resident #29 reported the grievance to social services and it read as follows: Resident told the nurse, (First and Last Name of Registered Nurse #31) that there was a girl on night shift that came in and woke her up and startled her. She was tall with long blonde hair. She said she was husky not fat nor thin and tall like an amazon. She was rude and pulled her arm.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-- 11/11/24 Resident #50 voiced to the social worker and read as follows: Resident does not like an evening CNA She would prefer not to have her care for her at night. Resident stated the CNA had previous lied about thing she said (First Name of Resident #50) had said to her. She stated the aide is loud and did not change her brief on several occasions.</p> <p>-- 01/21/25 Resident #73's family voiced this grievance to social services and it read as follows: Social Service was informed that the resident had a concern from over the weekend. When Social Service talked with her, (First name of Resident #73) expressed concern over how she felt an aide was rough with her when cleaning up a bowel movement midday on 01/19/25. She couldn't remember the staff members name.</p> <p>-- 04/01/25 Resident #68 reported the grievance to social services and it read as follows: "They were outside my door at about 1:30 last night and they were being very ;loud. They were talking loudly and singing loudly. Yesterday (first Name of NA #56) got (first name of Resident #68's roommate) up to sit in the hall and go to the dining room. They didn't get her back to bed until 12:30 last night. (First Name of Nurse Aide no longer working at facility) put her back to bed and there was a girl with her in training. They also didn't change me till 5:00 am (Name of day shift aide #56) changed me before she left.</p> <p>-- 04/03/25 Resident #16 voiced by the residents family to to social services an read as follows: stated that the other night around shift change her mother was put on the toilet and the bathroom door was closed as well as the room door. No one came back for a half hour (First Name of Resident #16) was banging on the wall for assistance. A friends came to visit and found her in this situation and notified staff.</p> <p>A review of the facility's reportable log for the same time frame found none of the allegations noted above were on the log.</p> <p>An interview with the Nursing Home Administrator (NHA) on 05/07/25 at 6:02 PM confirmed if they were not on the log they were not reported. She stated she would double check and provide them had they been reported. The allegations were reviewed with the NHA and she agreed they needed to be reported. She assumed the social worker had done it.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and staff interview the facility failed to report all allegations and five (5) day follow up reports of abuse and or neglect to required agencies within the required time frames. This was a random opportunity for discovery and was true for 13 residents for a total of 16 allegations. Resident identifiers: #4, #50, #54, #16, #60, #32, #33, #29, #73, #68, #76, #77, and #78 Facility census: 74.</p> <p>Findings include:</p> <p>a) A review of the facility's filed grievances for the previous 12 months on 05/07/25 found the following allegations of abuse and/or neglect contained on the grievance forms:</p> <p>-- 05/29/24 Resident # 4 grievance voiced during the resident council and read as follows: resident stated CNA (First Name of Nurse Aide (NA) #56) yelled at her for pushing her call bell resident states w/c is dirty.</p> <p>-- 06/24/24 Resident #76's family voiced this grievance to the DON , Hospice and Social Services and it read as follows: yesterday residents wife found him undressed from the waist down. His shirt had not been changed for several days. He had food from his tray and BM up his back. Also a staff member was going up the hall yesterday saying loudly quit ringing your bells and residents and families could hear this. would like to have range of motion provided.</p> <p>-- 06/28/24 Resident #77's family reported this grievance to social services, and it read as follows, Family came to see her Wednesday and she was dirty and in the dame hospital gown se had been in on Monday when she got here. Please be sure she has her cochlea implant in to talk with her. She is also known to lay it on bed and it could get lost, staff needs to make sure it is not in her bed if she isn't wearing it and it isn't in he charger.</p> <p>-- 07/06/24 Resident #54 grievance voiced by the resident's family unsure who the grievance was reported too and read as follows: I would like to see if my mom's depend can be checked more often I have came everywhere day Thursday and Saturday and she was soaked through.</p> <p>-- 07/16/24 Resident #16 grievance voiced to the social worker and read as follows: timeliness of call bell response. they took her whistle away from her. She stated that she needed to go to the bathroom at 6:00 am a few days ago and staff came in and told her that they couldn't do it right now because they were passing breakfast trays.</p> <p>-- 08/06/24 Resident #54 grievance voiced by the resident's family the concern was voiced to social services and read as follows, 'activities told social services followed up with the family who was visiting today. (First Name of Resident #54) daughter (First name of Resident #54's daughter) state (First Name of Resident #54) was so wet when she got here there was urine dripping down into her shoes. When Social service spoke with her she said she had already talked to the aide.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on record review, resident interviews, and staff interviews, the facility failed to adequately deploy nursing staff across all shifts to properly care for residents and their safety. This was found to be true for 15 (fifteen) of 15 calendar days. Facility census: 74.</p> <p>Findings included:</p> <p>Nurse staffing postings review revealed the following:</p> <p>11/02/24:</p> <p>Facility census: 74</p> <p>LPN on night shift: 3</p> <p>CNA on night shift: 2</p> <p>CNA/resident ratio: 1:37 (one CNA for every 37 residents)</p> <p>11/03/24:</p> <p>Facility census: 74</p> <p>LPN on night shift: 4</p> <p>CNA on night shift: 3</p> <p>CNA/resident ratio: 1:25</p> <p>11/07/24:</p> <p>Facility census: 73</p> <p>LPN on night shift:3</p> <p>CNA on night shift: 5</p> <p>CNA/resident ratio: 1:11</p> <p>11/09/24:</p> <p>Facility census: 74</p> <p>LPN on night shift:3</p> <p>CNA on night shift: 4</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>CNA on night shift: 3</p> <p>CNA/resident ratio: 1:25</p> <p>03/09/25:</p> <p>Facility census: 76</p> <p>LPN on night shift:3</p> <p>CNA on night shift: 3</p> <p>CNA/resident ratio: 1:25</p> <p>03/25/25:</p> <p>Facility census: 77</p> <p>LPN on night shift: 2</p> <p>CNA on night shift: 3</p> <p>CNA/resident ratio: 1:25</p> <p>03/26/25:</p> <p>Facility census: 77</p> <p>LPN on night shift:2</p> <p>CNA on night shift: 5</p> <p>CNA/resident ratio: 1:15</p> <p>03/27/25:</p> <p>Facility census: 77</p> <p>LPN on night shift: 4</p> <p>CNA on night shift: 4</p> <p>CNA/resident ratio: 1:19</p> <p>04/02/25:</p> <p>Facility census: 76</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Maplewood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1081 Maplewood Drive Bridgeport, WV 26330	

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>LPN on night shift: 2</p> <p>CNA on night shift: 3</p> <p>CNA/resident ratio: 1:25</p> <p>04/05/25</p> <p>Facility census: 77</p> <p>LPN on night shift: 2</p> <p>CNA on night shift: 3</p> <p>CNA/resident ratio: 1:25</p> <p>A review of the current facility assessment, under the Section of staffing, states according to their acuity, 4-6 nurse aides are needed on night shift, along with 2-3 licensed nurses.</p> <p>During the morning of 05/07/25 during interviews with Resident #4, #50, and #38 these three residents complained of staffing shortages on night shifts and the long waits for responding to their call lights.</p> <p>During an interview NA #37 on 05/07/25 at approximately 9:50 PM, when asked after if she felt there was sufficient staffing on nights to properly care for residents, she responded, No, most nights we have 3 aides for all these residents, one in each wing. When asked if she was able to get all her tasks done before the end of shift, she stated no, unfortunately. When asked if she had any concerns that she wanted to share, she stated, I just feel this place is going downhill, several staff have left over the last few months.</p> <p>During an interview with LPN #38 on 05/07/25 at approximately 10:12 PM, she stated, I do not feel there is sufficient staff on nights. I frequently have to help the aides, and it is difficult for me to get all my documentation completed.</p> <p>Staffing information and time/attendance reports were reviewed with the NHA on 05/07/25 at 4:40 PM.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>Based on record review and staff interview, the facility failed to post nurse staffing with accurate information reflecting the actual hours worked, and total hours worked by category for nursing.</p> <p>This was true for 14 (fourteen) of 15 (fifteen) calendar days reviewed. The facility also failed to accurately reflect Facility census:75</p> <p>Findings included:</p> <p>A) Record review</p> <p>11/02/24: Nurse Staffing Report recorded a total of 191.50 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 221.88 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>11/03/24: Nurse Staffing Report recorded a total of 337 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 227.5 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>11/07/24: Nurse Staffing Report recorded a total of 240.5 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 260.5 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>11/09/24: Nurse Staffing Report recorded a total of 307 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 244.75 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>11/10/24: Nurse Staffing Report recorded a total of 283.5 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 240 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>12/25/24: Nurse Staffing Report recorded a total of 249.5 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 222.5 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>12/31/24: Nurse Staffing Report recorded a total of 298 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 220 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>02/26/25: Nurse Staffing Report recorded a total of 191 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 220.75 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>03/08/25: Nurse Staffing Report recorded a total of 190.5 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 190.5 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03/09/25: Nurse Staffing Report recorded a total of 187.5 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 209.25 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>03/25/25: Nurse Staffing Report recorded a total of 231 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 211.25 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>03/26/25: Nurse Staffing Report recorded a total of 218 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 255 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>03/27/25: Nurse Staffing Report recorded a total of 242 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 249.25 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>04/02/25: Nurse Staffing Report recorded a total of 177.5 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 192.75 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>04/05/25: Nurse Staffing Report recorded a total of 199.5 hours worked for RNs, LPNs, and Certified Nurse Aides. Time and attendance report records a total of 204.5 hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>Additionally, an observation of the posted nursing staffing report on 05/07/25 reported 12 Certified Nurse Aides were supposed to be working evening shift (3:00 PM - 11:00 PM). An on-site visit at the facility on 05/07/25 at approximately 9:45 PM, revealed that were in actuality only 5 Certified Nursing Aides working that shift.</p> <p>B) Staff interview</p> <p>Staffing information and time/attendance reports were reviewed with the NHA on 05/07/25 at 4:40 PM. The NHA indicated a lack of awareness on how the data was accumulated and the lack o accuracy of the data.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure each resident received medically related social services. The facility failed to assist the residents in the assertion of their right related to being free from abuse and or neglect and comprehensive person-centered care planning. This was random opportunity for discovery and has the potential to affect more than a limited number of residents. Resident identifiers: #75, #6, #77, #4, #54, #16, #32, #60, #78, #33, #29, #50, #73, #68, and #16. Facility Census: 74.</p> <p>Findings include:</p> <p>a) A review of the SOM found medically related social services include Advocating for residents and assisting them in the assertion of their rights within the facility in accordance with &sect;483.10, Resident Rights, &sect;483.12, Freedom from Abuse, Neglect, and Exploitation, &sect;483.15, Transitions of Care, &sect;483.20, Resident Assessments (PASARR), and &sect;483.21, Comprehensive Person-Centered Care Planning.</p> <p>b) Care Plan with Interdisciplinary Team</p> <p>1) State Agency Complaint</p> <p>The state agency received a complaint on 11/18/24 which indicated the following:</p> <p>Complainant was contacted by the facility's Social Worker about a care plan meeting for her mom. She said that the social worker normally only contacts her the day before or the day of the meeting but on this occasion, she did contact her a few days prior. This was helpful because she wanted to review her mom's care plan prior to the meeting.</p> <p>The complainant stated the social worker was the only staff member present on the care plan meeting that was held on the phone. She said she knew there was no interdisciplinary team there when this was going on.</p> <p>2) Facility's Process for Care Plan Meetings</p> <p>A review of the facility's process for Care Plan Meetings found the following:</p> <p>.5. The following team members will be present during the care plan meeting: A clinical representative, Dietary, Social Services, Activities, and therapy . 12. A care plan note must be created at the time of the meeting to include the brief discussion of the meeting, concerns, follow up etc. This note should include a list of all who attended the meeting, both from the resident/ representative and facility staff. The note can be found in PCC under progress notes.</p> <p>3) Resident #75</p> <p>A review of Resident #75's medical record found she had the following care plan meetings with the following attendees:</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-- 07/25/24 Attendees: Social Services and Activities</p> <p>-- 10/24/24 Attendees: Social Services, Activities and Responsible Party.</p> <p>-- 01/23/25 Attendees: Social services and Responsible party.</p> <p>4) Resident #6</p> <p>A review of Resident #6's medical record found the resident had the following care plan meetings with the following attendees:</p> <p>-- 05/16/24 Attendees Social Services and activities.</p> <p>-- 06/27/24 Attendees: Social Services and Activities</p> <p>-- 08/15/24 Attendees: Social Services and Activities.</p> <p>-- 11/14/24 Attendees Social Services and Responsible party.</p> <p>-- 02/13/25 Attendees: Social Services, Activities and Son</p> <p>-- 02/20/25 Attendees: Social Services and Activities</p> <p>5) Staff Interviews</p> <p>An interview with the Nursing Home Administrator on the afternoon of 05/08/25 confirmed the IDT team was not participating in the care plan meetings. She indicated the social worker was in charge of scheduling and coordinating the meetings and she did not realize they were not participating like they should. The Director of Nursing (DON) also present during the interview stated she would send a floor nurse to the meetings to represent nursing because they would know the resident the best and have the best input. Both agreed the only participating members were social services and activities who shared an office.</p> <p>c) Abuse Reporting</p> <p>1) Grievance Forms review for the previous 12 months.</p> <p>A review of the facility's filed grievances for the previous 12 months on 05/07/25 found the following allegations of abuse and/or neglect contained on the grievance forms:</p> <p>-- 05/29/24 Resident #4 grievance voiced during the resident council and read as follows: resident stated CNA (First Name of Nurse Aide (NA) #56) yelled at her for pushing her call bell resident states w/c is dirty.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-- 06/24/24 Resident #76's family voiced this grievance to the DON , Hospice and Social Services and it read as follows: yesterday residents wife found him undressed from the waist down. His shirt had not been changed for several days. He had food from his tray and BM up his back. Also a staff member was going up the hall yesterday saying loudly quit ringing your bells. and residents and families could hear this. would like to have range of motion provided.</p> <p>-- 06/28/24 Resident #77's family reported this grievance to social services, and it read as follows, Family came to see her Wednesday and she was dirty and in the dame hospital gown se had been in on Monday when she got here. Please be sure she has her cochlea implant in to talk with her. She is also known to lay it on bed and it could get lost, staff needs to make sure it is not in her bed if she isn't wearing it, and it isn't in the charger.</p> <p>-- 07/06/24 Resident #54 grievance voiced by the resident's family unsure who the grievance was reported too and read as follows: I would like to see if my mom's depend can be checked more often I have came everywhere day Thursday and Saturday and she was soaked through.</p> <p>-- 07/16/24 Resident #16 grievance voiced to the social worker and read as follows: timeliness of call bell response. they took her whistle away from her. She stated that she needed to go to the bathroom at 6:00 am a few days ago and staff came in and told her that they couldn't do it right now because they were passing breakfast trays.</p> <p>-- 08/06/24 Resident #54 grievance voiced by the residents family the concern was voiced to social services and read as follows, 'activities told social services followed up with the family who was visiting today. (First Name of Resident #54) daughter (First name of Resident #54's daughter) state (First Name of Resident #54) was so wet when she got here there was urine dripping down into her shoes. When Social service spoke with her she said she had already talked to the aide.</p> <p>-- 09/04/24 Resident #32 grievance voiced by family to social services which read as follows: Resident's daughter stated her mother told her that the CNA (First Name of NA #56) didn't change her sheet which was wet as the result of her using the bed pan. (First name of Nurse Aide #56) told her it wasn't wet and she didn't have time to change it. (First name of unidentified Staff) came in and said she would get someone to change her. She then stated (First name of two more staff members who no longer work at the facility) came in and put a thicker sheet over her wet sheet and that (First Name of Staff who no longer works at the facility) jerked her nightgown in the process. She said (First Name of Staff who no longer works at the facility) had told her mother a few das before she wasn't going to be caring for her anymore. She also said that (First Name of Staff) told her that [NAME] liked her.</p> <p>-- 09/28/24 Resident #60's family member voiced a concern to social services which read as follows: Expressed concern over mothers knee being bruised. They documented on the concern is was unknown how the injury occurred and the resolution was the NP (nurse practitioner) looked at her knee and confirmed it was healing.</p> <p>-- 10/08/24 Resident #78's family reported to nursing/social services the following grievance, daughter feels the stage 2 on (First Name of Resident #78)'S bottom is related to the staff leaving her up in her wheelchair last night to sleep because her bed had not been made.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-- 10/28/24 Resident #33 voiced this grievance to social services and it read as follows: Resident came to social services and stated that another female resident was in her room and going through her belongings, when she told her to stop the other resident grabbed her neck and put her hand over (First Name of Resident #33) face. (First Name of Resident #33) said it did not cause her any pain or injury.</p> <p>-- 10/28/24 - Resident #29 reported the grievance to social services and it read as follows: Resident told the nurse, (First and Last Name of Registered Nurse #31) that there was a girl on night shift that came in and woke her up and startled her. She was tall with long blonde hair. She said she was husky not fat nor thin and tall like an amazon. She was rude and pulled her arm.</p> <p>-- 11/11/24 Resident #50 voiced to the social worker and read as follows: Resident does not like an evening CNA She would prefer not to have her care for her at night. Resident stated the CNA had previous lied about thing she said (First Name of Resident #50) had said to her. She stated the aide is loud and did not change her brief on several occasions.</p> <p>-- 01/21/25 Resident #73's family voiced this grievance to social services and it read as follows: Social Service was informed that the resident had a concern from over the weekend. When Social Service talked with her, (First name of Resident #73) expressed concern over how she felt an aide was rough with her when cleaning up a bowel movement midday on 01/19/25. She couldn't remember the staff members name.</p> <p>-- 04/01/25 Resident #68 reported the grievance to social services and it read as follows: "They were outside my door at about 1:30 last night and they were being very ;loud. They were talking loudly and singing loudly. Yesterday (first Name of NA #56) got (first name of Resident #68's roommate) up to sit in the hall and go to the dining room. They didn't get her back to bed until 12:30 last night. (First Name of Nurse Aide no longer working at facility) put her back to bed and there was a girl with her in training. They also didn't change me till 5:00 am (Name of day shift aide #56) changed me before she left.</p> <p>-- 04/03/25 Resident #16 voiced by the resident's family to social services an read as follows: stated that the other night around shift change her mother was put on the toilet and the bathroom door was closed as well as the room door. No one came back for a half hour (First Name of Resident #16) was banging on the wall for assistance. A friends came to visit and found her in this situation and notified staff.</p> <p>A review of the facility's reportable log for the same time frame found none of the allegations noted above were on the log.</p> <p>An interview with the Nursing Home Administrator (NHA) on 05/07/25 at 6:02 PM confirmed if they were not on the log they were not reported. She stated she would double check and provide them had they been reported. The allegations were reviewed with the NHA, and she agreed they needed to be reported. She assumed the social worker had done it.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and staff interview, the facility failed to maintain an accurate and complete record for Resident #56. This was true for one (1) of five (5) residents reviewed under the care area of falls. Resident identifier: #56. Facility census: 74.</p> <p>Findings Include:</p> <p>a) Resident #56</p> <p>On 05/07/25 at 12:30 PM, a record review was completed for Resident #56. The review found the resident had been transferred to an acute care facility. The transfer forms were noted with errors as follows:</p> <p>--Transfer date 11/01/24; incorrect date of 09/06/24</p> <p>--Transfer date 11/25/24; incorrect date of 11/01/24</p> <p>--Transfer date 03/04/25; incorrect date of 11/25/24</p> <p>On 05/07/25 at 1:30 PM, the Administrator was notified and confirmed the dates on the transfer forms were incorrect.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review and staff interview, the facility failed to maintain infection control standards Resident #53's urinary catheter. This was a random opportunity for discovery. Resident identifier: #53. Facility Census: 74.</p> <p>Findings include:</p> <p>a) Resident #53</p> <p>On 05/07/25 at 3:24 PM, Resident #53's urinary catheter drainage bag was touching the floor. On 05/07/25 at 3:28 PM, Licensed Practical Nurse (LPN) #55 raised the resident's bed up to keep the urinary catheter drainage bag from touching the floor.</p> <p>On 05/07/25 at 3:35 PM, the Administrator was notified of the infection control breach. The Administrator stated, it should not be touching the floor.</p> <p>On 05/07/25 at 4:20 PM, the facility policy entitled, Catheter Care was reviewed. Section V under the heading of procedure states, Check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back to the bladder. (Typed as written.)</p>