

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 83 Little Kanawha Pkwy Elizabeth, WV 26143	

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 - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50552</p> <p>Based on record review and staff interview, the facility failed to ensure advanced directives were implemented for Resident #133. This was true for one (1) of three (3) residents reviewed during the survey.</p> <p>This will be cited as past non-compliance because the facility identified what had happened and took immediate steps to correct the failure to ensure it does not reoccur. All components of the plan of correction were completed prior to this survey beginning.</p> <p>This did occur, and was substantiated by the facility as occurring. Resident #133 had completed a Physician Order for Scope of Treatment (POST) form, indicating her wishes to be a full code therefore this will be cited as past non-compliance. Facility census: 32. Resident identifiers: Resident #133.</p> <p>Findings included:</p> <p>a) Facility</p> <p>On [DATE] at 02:25 PM, a record review was completed for Resident #133 which revealed the following progress notes, (typed as written):</p> <p>[DATE] 22:00 Health Status Note</p> <p>Note Text: Resident resting in bed with O2 (oxygen) in place at 2L/nc; HOB elevated 30 degrees; she told CNA that she was having some trouble breathing, and felt nauseated; CNA alerted this nurse, and placed pulse ox on; this nurse checked resident at 22:15 and found her not breathing, no pulse, pupils fixed and nonreactive, extremities cold to touch, torso rigid; color yellow, pale; sternal rub, shaking resident, calling her name were ineffective; monitored VS x 5 min with no signs of life; NOC and Administrator notified; call to family who requested to come in to see resident; call to Provider at 2300 who gave order to not attempt CPR and pronounce resident deceased .</p> <p>[DATE] 23:20 COMMUNICATION</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Note Text: Call to family to let them know of resident passing; (granddaughter) very upset and gave phone to husband; family requesting to come in to see resident; stated they would be here in ,d+[DATE] min; family arrived at MN; this nurse relayed sequence of events and interventions by staff; (granddaughter) voiced understanding; family expressed wishes for [NAME] Funeral Home and wants to wait until they arrive; family boxed up some personal items (pictures, glasses, hearing aids, jewelry), and stated they would probably donate some items to this facility; awaiting Funeral Home arrival.</p> <p>Further review of Resident #133's medical record revealed Resident #133 had completed a POST which indicated her wishes for Cardiopulmonary Resuscitation (CPR), including mechanical ventilation, defibrillation and cardioversion with full treatments and a time limited trail of 14 days of medically assisted nutrition but no surgically placed tubes.</p> <p>In addition, Resident #133's physician's orders and care plans were reviewed which revealed the following:</p> <p>Physician's order:</p> <p>Full Code- Full interventions. Medically assisted nitration for a limited trail of 14 days but no surgically placed tubes. Active [DATE]</p> <p>Care plan:</p> <p>Focus:</p> <p>West Virginia (WV) Advanced Directives: full code, full treatments. Provide medically assisted nutrition time limited trail of 14 days but no surgically placed tubes.</p> <p>Goal:</p> <p>Wishes will be honored through next review.</p> <p>Interventions:</p> <p>Full Code.</p> <p>Review advanced directives with resident/family yearly and as needed.</p> <p>On [DATE] at 03:15 PM, a review of the facility reportable incident (FRI) was completed. The review of this FRI, dated [DATE], revealed that Resident #133 was observed to be nonresponsive upon staff entering Resident #133's room. Resident #133 was noted to be cold to touch, rigid, with yellow pale skin tone. Resident #133 was noted to have a full code status in the medical record. Resident #133's physician was notified of Resident #133's status including above findings and the order was given to not begin CPR due to signs of death.</p> <p>The investigation started immediately on [DATE]. A statement was obtained from all staff on duty the night of [DATE] which included the following statements:</p> <p>b) Nurse Aide (NA) #46</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>NA #46 stated that at 10:00 PM, NA #46 went to change Resident #133. Resident #133 voiced having trouble breathing. NA #46 states she elevated the position of Resident #133's head of bed, Resident #133 voiced being nauseous. NA #46 states she went and told RN #53 what Resident #133 had voiced. NA #46 stated that she got the vital pole and put the pulse oximetry on Resident #133 noting an oxygen saturation of 94%. NA #46 told Resident #133 she was going to leave the pulse oximetry on Resident #133 for a few minutes and come back to check on her. NA #46 reports at 10:15 PM, when NA #46 re-entered Resident #133's room that RN #53 was in there at this time with Resident #133's medications. NA #46 stated that she told RN #53 was not breathing and voiced that Resident #133's skin color appeared to be yellowish-pale color. NA #46 states RN #53 began sternal rubs and Resident #133 was cold to touch. NA #46 states she continued to check for a pulse with no pulse found.</p> <p>c) RN #53</p> <p>RN #53 stated that on [DATE] around 10:00 PM, Resident #133 had been resting in bed with oxygen in place at two (2) liters per minute via nasal cannula with the head of bed elevated to 30 degrees. RN #53 stated Resident #133 had expressed to NA #46 that she was having some trouble breathing and felt nauseated. RN # 53 stated NA #46 alerted her and that NA #46 had placed the pulse oximeter on Resident #133 RN #53 stated that she checked Resident #133 at 10:15 PM and found Resident #133 not breathing, no pulse, pupils fixed and non-reactive, extremities cold to touch, torso rigid, color yellow and pale. RN # 53 stated she began sternal rubs, shaking Resident #133, calling Resident #133's name, which was ineffective. RN #53 stated Resident #133's vital signs were monitored for five (5) minutes with no signs of life. RN #53 stated she attempted to call the nurse on call and administrator with no answer initially. RN #53 stated she called Resident #133's family who requested to come in and see Resident #133. RN #53 also stated she made a call to Resident #133's physician, who gave orders to not attempt CPR and pronounced Resident #133 deceased .</p> <p>On [DATE] the Administrator had an additional conversation with RN #53, in which RN #53 stated that when asked why she did not initiate CPR, RN #53 stated that she didn't know why. RN #53 further stated that she was in the mode of pronouncing death and not thinking about CPR. RN #53 stated that was why she was observing for five (5) minutes for signs of life. RN #53 stated because of her assessment, she thought that Resident #133 was gone. When the Administrator asked RN #53 if she thought those observations represented irreversible signs of death, RN #53 stated yes she did. RN #53 stated that she was just trying to do the right thing.</p> <p>On [DATE] the five (5) day follow up investigation was submitted which stated RN #53 was suspended pending investigation and later terminated as a result of the investigation with the allegation having been substantiated.</p> <p>On [DATE] at approximately 9:30 AM, the Administrator provided a copy of the facility plan of action which indicated the following:</p> <p>On [DATE] all staff on duty to be educated on Full Code Protocol and Responding to resident change in condition which was followed by 100% compliance with education of all staff.</p> <p>On [DATE] all staff were re-educated on Full Code Protocol, Responding to resident change in condition, visual aid for clinical algorithm for unresponsive resident and irreversible signs of death with 100% compliance with education of all staff.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In addition, a post test of education is scheduled within one (1) month and six (6) months. This education was added to the orientation process for all newly hired employees also. Two (2) ADHOC (impromptu) Quality Assurance and Performance Improvement meetings were conducted to evaluate the occurrence and review actions, a root cause analysis was performed with the above action plans developed.</p> <p>On [DATE] at approximately 10:00 AM, a review of the staff education was completed in addition to the QAPI meetings. All staff signatures were obtained and were verified via the staff roster.</p> <p>On [DATE] at approximately 10:30 AM, an interview was conducted with the facility Administrator who confirmed the incident which involved Resident #133 did happen as reported.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>50552</p> <p>Based on observation and staff interview, the facility failed to maintain adequate, appetizing temperatures for breakfast foods served in resident rooms. This was a random opportunity for discovery in the Long Term Care Survey process. Resident identifiers: Resident #09, Resident #26. Facility census: 32.</p> <p>Findings included:</p> <p>a) Facility</p> <p>On 09/24/24 at 2:00 PM, a resident council meeting was held. During the meeting, Resident #26 stated Breakfast delivered to our rooms are cold. It just doesn't taste right. At that time, Resident #9 stated, Yes, sometimes our breakfast is cold when they bring it. I don't say anything about it though. They bring me something else if I ask them too.</p> <p>On 09/25/24 at 7:20 AM, an observation was made of breakfast trays being delivered resident rooms. The last tray was taken from the food cart at 7:36 AM and the temperature of the food being served was taken. The following are the temperatures obtained by Dietary Staff #12:</p> <p>Scrambled eggs: 103.5 degrees Fahrenheit (F)</p> <p>Pancakes: 93.8 degrees F</p> <p>Oatmeal: 143 degrees F</p> <p>At that time, Dietary Staff #12 acknowledged the scrambled eggs and pancakes were not within the recommended temperature range of 120 degrees at point of service.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>45171</p> <p>Based on record review and staff interview, the facility failed to ensure all required members of the Quality Assurance and Performance Improvement Committee (QAPI) attend a quarterly meeting as required. Facility Census: 62.</p> <p>Findings Included:</p> <p>a) On 09/25/14 at 11:57 AM record review indicates the facility Quality Assurance Committee meets every second (2nd) Tuesday of each month. The following individuals are listed as individuals that attend:</p> <p>Medical Director</p> <p>Consultant Pharmacists</p> <p>Director of Nursing (DON)</p> <p>Administrator</p> <p>Social Service Director</p> <p>Therapy Director</p> <p>Activities Director</p> <p>Dietary Manager</p> <p>Minimum Data Set (MDS) Nurse</p> <p>Nursing House Supervisor (Infection Preventionist) IP</p> <p>Nursing Unit Manager</p> <p>Business Office Manager</p> <p>Human Resources Director</p> <p>Review of the QAPI meeting sign in sheets for four (4) quarters starting in September 2023, the following information was obtained:</p> <p>March, April, May 2024 - All required members were not present at any meeting this quarter.</p> <p>March, there was no IP present</p> <p>(continued on next page)</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>April, there was no Medical Director or IP present</p> <p>May, there was no IP or Administrator present</p> <p>June, July, August 2024 - All required members were not present at any meeting this quarter.</p> <p>June, there was no IP, no DON and no Medical Director present.</p> <p>July, there was no IP, no DON and no Medical Director present.</p> <p>August, there was no IP present.</p> <p>On 09/25/24 at 1:33 PM the Director of Nursing and the Administrator confirmed there were missing required personnel for two (2) of the four (4) quarterly meetings.</p>		