STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E150	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
War Memorial Hospital	1 Healthy Way Berkeley Springs, WV 25411

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795 Based on interviews and record reviews during a recertification survey on 10/16/24, the facility did not ensure timely notification to the physician of Resident's significant weight loss. This is true for one (1) of three (3) Resident's reviewed for weight loss. Resident identifiers: Resident #2. Facility census: 15. Findings included: a) Resident #2 Resident #2 had diagnoses of Polyosteoarthritis, Heart failure, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, Type 2 diabetes, hypertension, and age-related physical debility. Record review on 10/15/24 at approximately 2:18 PM revealed the following: Resident had been weighed on 08/06/24 at 11:58 AM, and the weight recorded as 218.2 pounds. A nursing note on 08/07/24 at 10:28 PM by Licensed Practical Nurse (LPN) #21, which stated: Resident alert and oriented to person, place, time and situation. Speech clear. Resident able to make her needs known. Resident independent, set-up to supervision for ADL's, has been requiring staff assistance on occasion with ADLs depending on ability that day. Resident able to feed herself meals after tray set up. Resident wears upper and lower dentures. Resident takes care of her own dentures. Denies oral pain or discomfort at this time. No issues with chewing or swallowing noted. Resident continent of bladder and bowel but does have occasional incontinence episodes. Resident has bilateral hearing aids but usually does not wear them. Resident wears PRN oxygen at 2L via nasal cannula to maintain oxygen saturations above 92%. Resident walks with rollator walker independently in room and hallway. Has been using wheelchair for longer distances at times depending on ability that day. Resident participates with unit activities. Enjoys watching television, playing Bingo and participates with some unit activities. A nursing note on 08/08/24 at 6:50 PM by Registered Nurse (RN) #1 which stated: (continued on next page)

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

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident with increased weakness and dyspnea with exertion. Resident is experiencing some confusion and states she feels shaky. Upon assessment, resident's vital signs WNL for resident. Blood glucose is 319. Resident does have tremors to hands and is having difficulty staying awake, even while conversing with staff. Lung sounds diminished to right side; fine crackles auscultated to left base. Resident required 2 staff assist to ambulate from the bathroom and reported fear of falling due to weakness. [Physician] was notified of change in condition. New orders for ER evaluation. POA, called and updated. POA and resident agreeable to transfer to ER. A note by LPN #21 on 08/08/24 at 7:00 PM which stated: Resident left floor via wheelchair with staff to ER. A follow up note on 08/08/24 at 10:26 PM by LPN #21 which stated: Spoke with ER nurse, resident admitted to (local hospital). MPOA, made aware. A note on 08/12/2024 at 10:23 AM by RN #5 which stated: Resident returned to unit via wheelchair on 2L portable oxygen from (local hospital) unit. VS were taken and are WNL for resident. Last BM reported on 8/11. Bowel sounds active in all 4 quads. Resident lung sounds are clear. Bilateral lower leg swelling +1 pitting edema noted. Resident c/o right knee pain 6/10 that is alleviated with Tylenol. Multiple bilateral arms bruising due to blood draws and IVs. Resident is currently sitting in recliner with call bell in reach. POA notified of residents return to unit. Plan of care ongoing. Resident's weight upon re-admission to the facility on [DATE] at 10:08 AM was documented as 201.4 pounds. This was a loss of 16.8 pounds in six (6) days, which correlates to a 7.7% weight change. During an interview with the Director of Nursing (DON) #34 on 10/16/24 at approximately 10:55 AM, she revealed a patient weighing policy. Review of the policy revealed that residents were to be re-weighed if resident's weight had increased or decreased by five (5) pounds, per physician's order, or at the request of the RN or Dietitian. Record review further revealed that facility staff were compliant with the policy. Resident #2 was re-weighed multiple times on 08/12/24: At 10:45 AM, her weight was again recorded as 201.4 pounds. At 11:15 AM she had been weighed once again and her weight was recorded as 201.4 pounds. On 08/13/24 at 10:31 AM resident's weight was recorded as 201.6 pounds. A progress note on 08/16/24 at 6:24 PM by DON #34 stated: (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident] triggered for significant change in status (decline) in urinary incontinence this assessment period. On state assessment, [Resident] triggered for significant change in status (decline) in mood this assessment period. [Resident] has episodes of bladder incontinence and mood fluctuates from day to day and times throughout the day, therefore, will not complete a significant change in status this assessment period. During the seven days look back period (ARD 08/02/24), POC documents [Resident] as independent for bed mobility, transfer, toilet use, and supervision for eating. [Resident] was occasionally incontinent of bladder and always continent of bowel this assessment period. [Resident] has no behavior problems. [Resident] has no pressure injuries. Skin is intact. Current weight is 217.6 pounds (08/01/2024). [Resident] attends activities of her choosing and also participates in self-directed activities (television, music, crocheting, talking on the phone). [Resident] had no falls this assessment. [Resident's] family (son and family) live out of state and are supportive. [Resident] has no concerns for care conference and does not wish to participate in care conference. Letter regarding care conference was mailed to MPOA, with no response back. [Resident] requested a copy of her care plan be mailed to her MPOA, per pre request, a copy of care plan was mailed to [Resident's] MPOA. [Resident's] plan of care will continue. A review of Resident #2's care plan revealed the following note: NUTRITIONAL STATUS: [Resident] has the potential for nutritional problem related to Obese II BMI. Diet order Regular Consistency/Regular Diet with regular liquids. [Resident] has Type II Diabetes. Date Initiated: 03/18/19 Revision on: 08/16/24 GOALS: [Resident] will be free from any sign/symptoms of hyperglycemia through next review date. Date Initiated: 06/05/18 Revision on: 06/07/19 Target Date: 11/07/24 [Resident] will be free from any sign/symptoms of hypoglycemia through the next review date. Date Initiated: 06/05/18 Revision on: 06/07/19 Target Date: 11/07/24 [Resident] will have no complications related to Diabetes through the next review date. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 06/05/18 Revision on: 06/07/19 Target Date: 11/07/24 [Resident] will maintain adequate nutritional status as evidenced by maintaining weight within +/- 5%, no s/sx of malnutrition, and consuming at least 76-100% of each meal daily through the next review date. Date Initiated: 06/05/18 Revision on: 06/07/19 Target Date: 11/07/24 INTERVENTIONS: Administer medications (Lantus Insulin, 20 units SQ at bedtime x 1 week) as ordered. Monitor for adverse effects and effectiveness. Notify MD as indicated. Date Initiated: 08/13/24. Dietician offered education to resident due to excessive snacking at times, [Resident] declined education. She verbalized I know exactly what I am doing. Dietician will provide education to [Resident] as requested or indicated. Date Initiated: 03/18/19. Record review revealed a dietitian's note on 09/03/24 at 1:36 PM by Dietitian #27 which stated: Weight loss verified after re-weight. Significant weight loss noted. Current weight on 9/2/24 204.6 Lbs -5.0% change [Comparison Weight 8/6/2024, 218.2 Lbs. -6.2%, -13.6 Lbs] Discussed POC with RN and [Resident] who are aware of weight loss. During recent acute care hospitalization , they removed fluid. Weight loss was expected. Skin intact at this time. No concerns noted during morning meal rounds. Feeds herself. Normally consumes 100 % of meals. An attempt was made to interview the Dietitian #27 on 10/16/24 at approximately 5:18 PM. The dietitian was not available for interview at that time. Further record review revealed no physician's orders, or progress notes, documenting or addressing the weight loss. An interview with RN #5 on 10/16/24 at approximately 8:55 AM revealed that she was aware of Resident #2's weight loss. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview with DON #34 on 10/16/24 at approximately 1:55 PM, she was asked whether she could produce any record that the facility notified the physician of the resident's 16.8-pound weight loss. DON #34 stated that she would review the facility records. At approximately 3:30 PM on 10/16/24 the DON #34 produced a handwritten physician's order dated 08/13/24 concerning Resident #2's diagnosis, and treatment, but did not refer to the resident's weight loss. She stated That's all I've got.