STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E154	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main Street Care	115 Summers Hospital Road, Suite 300 Hinton, WV 25951

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45173 Based on record review and staff interview, the facility failed to provide a transfer form and notify the State Ombudsman of a transfer to an acute care facility for Resident #30. This was true for one (1) of three (3) residents reviewed under the care area of hospitalization s. Resident identifier: #30. Facility Census: 32. Findings Included: a) Resident #30 On 08/20/24 at 9:55 AM, a record review was completed for Resident #30. The review found the resident was transferred to an acute care hospital on 06/25/24 for an unwitnessed fall. The resident was noted with a large knot and bruising to the back of the head. The following progress note dated 06/25/24 at 2:03 PM stated, Resident found lying in the floor beside of her bed. Resident stated she, fell on her head. Full body assessment completed. Hematoma with bruise observed to back of resident's head. Neuro (Neurological) checks initiated. (Name of facility physician) and POA notified via phone. Resident transferred to the emergency room for evaluation. The review, also, found no transfer form in the medical record and the State Ombudsman was not notified of the transfer. On 08/20/24 at 2:30 PM, the Assistant Director of Nursing (ADON) was notified of the transfer form not being found as well as the State Ombudsman notification. On 08/20/24 at 2:35 PM, the ADON stated, we send note summaries to the acute care facility and the State Ombudsman is not notified unless the resident is admitted . No further information was obtained during the survey process.

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

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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. 45173 Based on record review and staff interview, the facility failed to provide a bed hold notice for Resident #30 after a fall. This was true for one (1) of three (3) residents reviewed under the care area of hospitalization s. Resident Identifier: #30. Facility Census: 32. Findings Included: a) Resident #30 On 08/20/24 at 9:55 AM, a record review was completed for Resident #30. The review found the resident was transferred to an acute care hospital on 06/25/24 for an unwitnessed fall. The resident was noted with a large knot and bruising to the back of the resident's head. The following progress note dated 06/25/24 at 2:03 PM states, Resident found lying in the floor beside of her bed. Resident stated she fell on her head. Full body assessment completed. Hematoma with bruise observed to back of resident's head. Neuro (Neurological) checks initiated. (Name of facility physician) and POA notified via phone. Resident transferred to the emergency room for evaluation. The review, also, found a bed hold notice had not been provided to the resident. The bed hold notice provided by the facility was dated for 07/23/23. On 08/20/24 at 2:30 PM, the Assistant Director of Nursing (ADON) was notified that a bed hold notice was not completed for this transfer to an acute care facility. On 08/20/24 at 2:35 PM, the ADON stated, we use the bed hold notice which is signed upon admission to the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on record review and staff interview, the facility failed to complete an accurate Minimum Data Set (MDS) regarding a fall for Resident #30. This was true for one (1) of two (2) residents reviewed under the care area of falls. Resident Identifiers: #30. Facility Census: 32. Findings Included: a) Resident #30 On 08/20/24 at 9:55 AM, a record review was completed for Resident #30. The review found the resident was transferred to an acute care hospital on 06/25/24 for an unwitnessed fall. The resident was noted with a large knot and bruising to the back of the head. The following progress note dated 06/25/24 at 2:03 PM states, Resident found lying in the floor beside of her bed. Resident stated she fell on her head. Full body assessment completed. Hematoma with bruise observed to back of resident's head. Neuro (Neurological) checks initiated. (Name of facility physician) and POA notified via phone. Resident transferred to the emergency room for evaluation. The review, also, found an inaccurate MDS dated [DATE]. Section J noted the resident had no falls. Although, the resident was noted to have a fall on 06/25/24. On 08/20/24 at 2:30 PM, the Assistant Director of Nursing (ADON) was notified of the inaccurate MDS. The ADON stated, I will get that corrected right away. No further information was obtained during the survey process.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49751 Based on observations and staff interview, the facility failed to protect residents from possible hazards, by leaving five (5) medicine cups of Triamcinolone acetonide cream 0.1% at the bedside. This was a random opportunity for discovery and had the potential to affect a limited number of residents residing in the facility. Resident identifier: #13. Facility census: 31. Findings included: a) Resident #13 On 08/19/24 at 3:43 PM during an interview with Resident #13, this surveyor observed five (5) small medication cups on Resident #13's bedside table with white creamy substance in it. On 08/19/24 at 12:59 PM the Assistant Director of Nursing (ADON) stated, It is Triamcinolone acetonide Cream 0.1% for Resident #13's face. During an interview on 08/20/24 at 10:06 AM the Director of Nursing (DON) stated that they do not have an order for Resident #13 to self administer the medication or have it by the bedside.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49751 Based on record review and staff interview, the facility failed to have a Registered Nurse (RN) in the facility for at least eight (8) hours on weekends. This failed practice had the potential to affect all residents residing in the facility. Facility census: 31. a) RN weekend staffing During a record review on 08/21/24 it was revealed that the facility did not have an RN working on weekends in the facility. A review of the schedule revealed there was no RN working on 07/06/24, 07/07/24, 07/13/24, 07/14/24, 07/20/24, 07/21/24, 07/27/24, 07/28/24. In addition, there was no RN coverage on 08/03/24, 08/04/24 and 08/11/24. On 08/21/24 at 1:36 PM the Director of Nursing (DON) stated she and the Assistant Director of Nursing (ADON) were on call and can be at the facility with in seven (7) to fifteen minutes, however they did not work in the facility on weekends. At approximately 2:00 PM on 08/21/24 the facility's Administrator stated they have an agreement with the hospital and if the on-call is not available then the emergency room RN will come up to the unit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 45173 49465 Based on record review and staff interview, the facility failed to provide side effect monitoring for Psychotropic medications. This failed practice was found true for (5) five of (5) five residents reviewed for unnecessary medications during the Long-Term Care Survey Process. Resident identifiers #8, #10, #29, #6, and #30. Facility Census: 31. Findings Included: a) Resident #8 A record review on 08/20/24 at 10:01 AM, revealed that Resident #8 is prescribed the following Psychotropic medications: Alprazolam oral tablet 0.5 Milligrams (MG) Give (1) one tablet by mouth two times a day related to anxiety disorder. Depakote oral tablet delayed release 250 MG Give (1) one tablet by mouth one time a day related to anxiety disorder. Effexor XR oral capsule extended release 24 hour 75 MG Give (1) one capsule by mouth one time a day related to anxiety disorder. Seroquel oral tablet 50 MG Give (1) one tablet by mouth (3) three times a day related to delirium due to known physiological conditions. Further record review of Resident #10's Medication Administration Record (MAR), and Treatment Administration Record (TAR) for the months of 06/24, 07/24, and 08/24 shows no side effect monitoring for psychotropic medications. During an interview on 08/20/24 at 11:17 AM, the Director of Nursing (DON) stated, We do monitor for behaviors, we look at them every day but we do not document that we monitor for side effects. b) Resident #10 A record review on 08/20/24 at 10:01 AM, revealed that Resident #10 is prescribed the following Psychotropic medications: Xanax Tablet 0.25 Milligrams (MG) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give (1) one tablet by mouth two times a day related to generalized anxiety disorder. Zoloft Tablet 100 MG Give (1) one tablet by mouth at bedtime related to other specified depressive disorder. Risperdal tablet 0.5 MG Give (1) one tablet by mouth two times a day related to vascular dementia with behavioral disturbance. Further record review of Resident #10's MAR, and TAR for the months of 06/24, 07/24, and 08/24 shows no side effect monitoring for psychotropic medications. During an interview on 08/20/24 at 11:17 AM, the DON stated, We do monitor for behaviors, we look at them every day but we do not document that we monitor for side effects. c) Resident #6 A record review on 08/20/24 at 11:00 AM, revealed that Resident #6 is prescribed the following Psychotropic medications: Seroquel oral tablet 50 MG Give (1) one tablet by mouth (3) three times a day related to delirium due to known physiological conditions. Further record review of Resident #6's MAR, and TAR for the months of 06/24, 07/24, and 08/24 shows no side effect monitoring for psychotropic medications. During an interview on 08/20/24 at 11:17 AM, the DON stated, We do monitor for behaviors, we look at them every day but we do not document that we monitor for side effects. d) On 08/21/24 at 11:21 AM a record review for unnecessary medications was completed for Resident #29. The review found the resident was prescribed Donepezil hydrochloride, DULoxetine HCl, Mirtazapine, and Mirtazapine. The review found there was no monitoring of side-effects for these psychotropic medications. On 08/20/2024 at 11:17 AM the Assistant Director of Nursing (ADON) was notified. The ADON stated, we monitor for behaviors and we look at them every day, but we do not document that we monitor side-effects. e) Resident #30 On 08/20/24 at 10:00 AM, a record review for unnecessary medications was completed for Resident #30. The review found the resident was prescribed Risperdal, an antipsychotic; Trazodone and Paxil, antidepressants. The review found there was no monitoring of side effects for these psychotropic medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/20/24 at 11:17 AM, the ADON was notified. The ADON stated, we monitor for behaviors and we look at them every day; but we do not document that we monitor for side effects. 49466 49751

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49465 Based on record review and staff interview, the facility failed to provide side effect monitoring for Psychotropic medications. This failed practice was found true for (5) five of (5) five residents reviewed for unnecessary medications during the Long-Term Care Survey Process. Resident identifiers #8, #10, #29, #6, and #30. Facility Census: 31. Findings Included: a) Resident #8 A record review on 08/20/24 at 10:01 AM, revealed that Resident #8 is prescribed the following Psychotropic medications: Alprazolam oral tablet 0.5 Milligrams (MG) Give (1) one tablet by mouth two times a day related to anxiety disorder. Depakote oral tablet delayed release 250 MG Give (1) one tablet by mouth one time a day related to anxiety disorder. Effexor XR oral capsule extended release 24 hour 75 MG Give (1) one capsule by mouth one time a day related to anxiety disorder. Seroquel oral tablet 50 MG Give (1) one tablet by mouth (3) three times a day related to delirium due to known physiological conditions. Further record review of Resident #10's Medication Administration Record (MAR), and Treatment Administration Record (TAR) for the months of 06/24, 07/24, and 08/24 shows no side effect monitoring for psychotropic medications. During an interview on 08/20/24 at 11:17 AM, the Director of Nursing (DON) stated, We do monitor for behaviors, we look at them every day but we do not document that we monitor for side effects. b) Resident #10 A record review on 08/20/24 at 10:01 AM, revealed that Resident #10 is prescribed the following Psychotropic medications: Xanax Tablet 0.25 Milligrams (MG) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give (1) one tablet by mouth two times a day related to generalized anxiety disorder. Zoloft Tablet 100 MG Give (1) one tablet by mouth at bedtime related to other specified depressive disorder. Risperdal tablet 0.5 MG Give (1) one tablet by mouth two times a day related to vascular dementia with behavioral disturbance. Further record review of Resident #10's MAR, and TAR for the months of 06/24, 07/24, and 08/24 shows no side effect monitoring for psychotropic medications. During an interview on 08/20/24 at 11:17 AM, the DON stated, We do monitor for behaviors, we look at them every day but we do not document that we monitor for side effects. c) Resident #6 A record review on 08/20/24 at 11:00 AM, revealed that Resident #6 is prescribed the following Psychotropic medications: Seroquel oral tablet 50 MG Give (1) one tablet by mouth (3) three times a day related to delirium due to known physiological conditions. Further record review of Resident #6's MAR, and TAR for the months of 06/24, 07/24, and 08/24 shows no side effect monitoring for psychotropic medications. During an interview on 08/20/24 at 11:17 AM, the DON stated, We do monitor for behaviors, we look at them every day but we do not document that we monitor for side effects. d) On 08/21/24 at 11:21 AM a record review for unnecessary medications was completed for Resident #29. The review found the resident was prescribed Donepezil hydrochloride, DULoxetine HCl, Mirtazapine, and Mirtazapine. The review found there was no monitoring of side-effects for these psychotropic medications. On 08/20/2024 at 11:17 AM the Assistant Director of Nursing (ADON) was notified. The ADON stated, we monitor for behaviors and we look at them every day, but we do not document that we monitor side-effects. e) Resident #30 On 08/20/24 at 10:00 AM, a record review for unnecessary medications was completed for Resident #30. The review found the resident was prescribed Risperdal, an antipsychotic; Trazodone and Paxil, antidepressants. The review found there was no monitoring of side effects for these psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/20/24 at 11:17 AM, the ADON was notified. The ADON stated, we monitor for behaviors and we look at them every day; but we do not document that we monitor for side effects.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49465 Based on observation and staff interview, the facility failed to maintain cleanliness of the air conditioning vents blowing into the kitchen. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 31. Findings Included: a) Kitchen The initial tour of the facility kitchen on 08/19/24 at 12:16 PM, revealed (7) seven vents in the window blowing over the (3) three compartment sink and into the open area of the kitchen where food is prepared and served that were covered in dust and a black substance. During an interview on 08/19/24 at 12:21 PM, the Food and Nutrition Contact (FNC) #14 stated, The maintenance department takes them down for us and we clean them. Yes, I agree. It is time to get that done The FNC confirmed that the vents were dirty and covered in a black substance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45173 Based on observation and staff interview, the facility failed to maintain an appropriate infection control program for storage of clean linen. This was a random opportunity for discovery. Facility Census: 32. Findings Included: a) Linen Cart On 08/20/24 at 10:42 AM, a tour of the unit was completed. During the tour, a linen cart with clean linen was observed uncovered on the top and sides. On 08/20/24 at 10:46 AM, the Assistant Director of Nursing (ADON) was notified and observed the clean linen cart which was uncovered. The ADON stated, I'll take care of this.