FOIA Data Base - The Law Office of Jeffrey J. Downey Serving clients in Washington D.C., Virginia and Maryland

Care Haven Center (skilled nursing facility)

2720 Charles Town Road Martinsburg,
WV 25401

If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.
Phone: 703-564-7318; email: jdowney@jeffdowney.com

Facility Characteristics:

- Nursing Facility with 68 beds
- Operational Control – Genesis Healthcare LLC
- Facility Website - http://www.genesishcc.com/CareHaven
- Legal Business Name – 2720 Charles Town Road Operations LLC
- The For-profit corporation is partially owned by Genesis WV Holdings LLC
- As of 2019 Care Haven Center was evaluated as a three-star facility on Medicare.gov

Researching Nursing Homes:

A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The West Virginia Department of Health and Human Resources, Office of Health Facility Licensure & Certification inspects nursing homes including Care Haven Center in Martinsburg, West Virginia. Periodically they do inspections as complaint surveys which should be public record. You can write to the Office of Health Facility Licensure and Certification, 408 Leon Sullivan Way, Charleston, WV 25301

You may fax at (304) 558-2515 to file a complaint or via phone to (304) 558-0050. The Hotline number is 1-800 442-2888

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

Disclaimer: Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPIs. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here. Researchers should independently research this facility to determine the current state of survey findings and deficiencies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	515178	A. BUILDING B. WING	**03/22/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE HAVEN CENTER	**2720 CHARLES TOWN ROAD MARTINSBURG, WV 25401**

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 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to provide the residents and/or responsible parties with written summaries of the residents' baseline care plans which were developed within forty-eight (48) hours of admission. This was evident for four (4) of five (5) sampled residents. Resident identifiers: #61, #16, #5, #6. Facility census: 59. Findings included: a) Resident #61 Review of the medical record on 03/20/18 found this resident first came to the facility on [DATE], and had some baseline care planning done in the first forty-eight (48) hours of admission. There was no evidence that the resident and/or the responsible party was provided a written summary of the baseline care plan, and/or a copy of the baseline care plan. Further review of the medical record found he lacked capacity to make medical decisions. Review of the State operation manual (SOM) found that residents and/or their responsible parties must receive a written summary of the baseline careplan that was developed within forty-eight (48) hours of the resident's admission. At a minimum, this summary must include initial goals, summary of medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, physician's orders [REDACTED]. During an interview with the director of nursing (DON) and registered nurse clinical reimbursement coordinator (CRC) Employee #44 on 03/20/18 at 10:09 a.m., they said their initial care plan is always a verbal summary rather than a written summary. They said they try to conduct their first post-admission patient-family conference within seventy-two (72) hours of admission. They said when the twenty-one (21) day care plan is completed, they give the resident and/or responsible party the option of having a copy of the care plan if they want one. On 03/20/18 at 11:30 a.m., E#44 provided a copy of their post-admission patient-family conference form which was dated 02/07/18, which was sixteen (16) days after admission. The resident attended this meeting, but not the family. An interview was completed with the licensed social worker (LSW) on 03/22/18 at approximately noon, while in the presence of the DON and E#44. They agreed the resident first came to the facility on [DATE]. The LSW said she reached out to the family representative on 01/31/18, but found that the telephone was out of service. The LSW said she found another telephone number on a particular document in the medical record and called that number. She said there was no answer, so she left a message on the voicemail. The LSW said on 02/07/18 they held the family conference, and included the family representative by telephone. Employee #44, the DON, and the LSW showed that they began the initial baseline care plan within 48 hours of admission with goals, and that they added to it all along. They were all in agreement that they have not been giving copies of the baseline care plan, or a written summary of the baseline care plan, that identifies goals and services, to their residents and/or representatives. b) Resident #16 Review of the medical record on 03/20/18 found this resident first came to the facility on [DATE], and had some baseline care planning done in the first forty-eight (48) hours of admission. There was no evidence that the resident and/or the responsible party was provided a written summary of the baseline care plan, and/or a copy of the baseline care plan. Further review of the medical record found although he had capacity to make medical decisions, he experienced episodes of confusion. During an interview with the director of nursing (DON) and registered nurse clinical reimbursement coordinator (CRC) Employee #44 on 03/20/18 at 10:09 a.m., they said their initial care plan is always a verbal summary rather than a written summary. They said they try to conduct their first post-admission patient-family conference within seventy-two (72) hours of admission. They said when the twenty-one (21) day care plan is completed, they give the resident and/or responsible party the option of having a copy of the care plan if they want one. On 03/20/18 at 11:30 a.m., E#44 provided a copy of the post-admission patient-family conference from which was dated 03/01/18, which was seventy-two (72) hours after admission. The resident and the family attended this meeting. There was no evidence that the resident and/or the family who attended was offered a written summary of the baseline care plan. An interview was conducted with the resident on 03/20/18 at 2:00 p.m. He said he has never received a written summary or copy of his baseline care plan that he was aware of. A telephone call was also made at this time to the family member who attended the 03/01/18 family conference. Upon inquiry, he said he has never been given a written summary or copy of the baseline care plan. An interview was completed with the licensed social worker (LSW) on 03/22/18 at approximately noon, while in the presence of the DON and E#44. They agreed the resident first came to the facility on [DATE]. Employee #44, the DON, and the LSW showed that they began the initial baseline care plan within 48 hours of admission with goals, and that they added to it all along. They were all in agreement that they have not been giving copies of the baseline care plan, or a written summary of the base line care plan, that identifies goals and services, to their residents and/or representatives. c) Resident #5 Review of the medical record on 03/20/18 found this resident first came to the facility on [DATE], and had some baseline care planning done in the first forty-eight (48) hours of admission. There was no evidence that the resident and/or the responsible party was provided a written summary of the baseline care plan, and/or a copy of the baseline care plan. Further review of the medical record found that he lacked capacity to make medical decisions due to dementia. During an interview with the director of nursing (DON) and registered nurse clinical reimbursement coordinator (CRC) Employee #44 on 03/20/18 at 10:09 a.m., they said their initial care plan is always a verbal summary rather than a written summary. They said they try to conduct their first post-admission patient-family conference within seventy-two (72) hours of admission. They said when the twenty-one (21) day care plan is completed, they give the resident and/or responsible party the option of having a copy of the care plan if they want one. On 03/20/18 at 11:30 a.m., E#44 provided a copy of the post-admission patient-family conference from which was dated 02/09/18, which was eight (8) days after admission. The resident and the family attended this meeting. There was no

	evidence that the resident and/or the family who attended was offered a written summary of the baseline care plan. An interview was completed with the licensed social worker (LSW) on 03/22/18 at approximately noon, while in the presence of the DON and E#44. They agreed the resident first came to the facility on [DATE]. Employee #44, the DON, and the LSW showed that they began the initial baseline care plan within 48 hours of admission with goals, and that they added to it all

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	515178	A. BUILDING B. WING	**03/22/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE HAVEN CENTER	**2720 CHARLES TOWN ROAD MARTINSBURG, WV 25401**

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

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	continued... from page 1) along. They were all in agreement that they have not been giving copies of the baseline care plan, or a written summary of the base line care plan, that identifies goals and services, to their residents and/or representatives. d) Resident #6 Review of the medical record on 03/20/18 found this resident first came to the facility on [DATE], and had some baseline care planning done in the first forty-eight (48) hours of admission. There was no evidence that the resident and/or the responsible party was provided a written summary of the baseline care plan, and/or a copy of the baseline care plan. Further review of the medical record found that he was deemed to have capacity to make medical decisions. During an interview with the director of nursing (DON) and registered nurse clinical reimbursement coordinator (CRC) Employee #44 on 03/20/18 at 10:09 a.m., they said their initial care plan is always a verbal summary rather than a written summary. They said they try to conduct their first post-admission patient-family conference within seventy-two (72) hours of admission. They said when the twenty-one (21) day care plan is completed, they give the resident and/or responsible party the option of having a copy of the care plan if they want one. On 03/20/18 at 11:30 a.m., E#44 provided a copy of the post admission patient family conference from which was dated 03/09/18, which was seven (7) days after admission. The resident and the family attended this meeting. There was no evidence that the resident and/or the family was offered a written summary of the baseline care plan. An interview was conducted with the resident on 03/20/18 at noon. Upon inquiry, he shook his head to signify that he has never received a written summary or copy of his care plan that he was aware of. An interview was completed with the licensed social worker (LSW) on 03/22/18 at approximately noon, while in the presence of the DON and E#44. They agreed the resident first came to the facility on [DATE]. Employee #44, the DON, and the LSW showed that they began the initial baseline care plan within 48 hours of admission with goals, and that they added to it all along. They were all in agreement that they have not been giving copies of the baseline care plan, or a written summary of the base line care plan, that identifies goals and services, to their residents and/or representatives.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** Based on medical record review and staff interview, the facility failed to develop a care plan focus and goals for a resident admitted with urinary incontinence. This was evident for one (1) of five (5) sampled residents. Resident identifier: #61. Facility census: 59. Findings included: a) Resident #61 The medical record was reviewed on 03/20/18. Review of the activities of daily living (ADL) flow sheets for (MONTH) and (MONTH) (YEAR) found that all of the documentation showed incontinence of urine. Review of the admission minimum data set (MDS) with assessment reference date (ARD) 01/29/18, found nursing assessed him as frequently incontinent of urine. Review of the care plan found there was no focus or goals pertaining to this resident's problem of urinary incontinence. An interview was completed with clinical reimbursement coordinator (CRC) registered nurse Employee #44 (E#44) at 9:25 a.m. on 03/22/18. She reviewed the care plan and the ADL flow sheets and the initial nursing assessment. She said this resident was incontinent of urine at the time of admission, and throughout his stay. She said the admission nursing assessment contained information that he was frequently incontinent of urine. She said in the ADL look-back period of seven (7) days prior to the 01/29/18 MDS, he was incontinent of urine on all shifts for all seven (7) days except for one shift which was left blank. She said because of the one (1) blank entry, and the nursing assessment information, she assessed him on the initial MDS as frequently incontinent of urine rather than as always incontinent of urine. E#44 referred to page twenty-eight (28) of the care plan related to the resident being at risk for skin breakdown as related to immobility. She stated, usually I put incontinence. I don't know why I didn't put it there. She agreed the care plan should have identified the problem area of urinary incontinence, along with person-centered goals and interventions related to the urinary incontinence, and it was not done.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure it followed physician's orders for treatment changes when a Stage I pressure ulcer evolved into a Stage II pressure ulcer. This was evident for one (1) of five (5) sampled residents, and one (1) of two (2) residents with documented Stage II pressure ulcers. Resident identifier: #61. Facility census: 59. Findings included: a) Resident #61 The medical record was reviewed on 03/20/18. This resident first came to the facility on [DATE]. According to the skin integrity reports dated 01/22/18 he had a Stage I to the coccyx/buttocks, a Stage I to the left heel, and a Stage I to the right heel. Nursing completed weekly skin assessments on 01/22/18, 01/29/18, 02/05/18, 02/12/18, and 02/19/18, and there were no changes assessed for either heel. On the day of admission, and throughout his stay at the facility, the physician ordered sure prep to both heels each night and as needed for redness. Nursing completed weekly skin assessments of the coccyx on 01/22/18, 01/29/18, 02/05/18, and 02/12/18. There were no changes assessed in the Stage I to the coccyx. Each time nursing described it as spread diffusely. On the day of admission, and through 02/18/18, the physician ordered protective cream to the bilateral buttocks and coccyx every shift related to redness. The weekly skin assessment dated [DATE] assessed that the reddened coccyx developed a small opened area measuring 0.8 centimeters (cms) by 0.2 cms by 0.1 cm., and it was now deemed a Stage 2 pressure ulcer. A physician's order dated 02/18/18 directed to cleanse the Stage 2 pressure ulcer on the coccyx with wound cleanser, apply hydrogel, cover with adhesive [MEDICATION NAME], and change every three (3) days and prn (as needed). Review of the treatment administration record (TAR) found there were blank spaces left open on 02/18/18 and on 02/21/18 to document the treatment for [REDACTED]. However, there was no evidence on the TAR that the treatment was completed on either of those dates, or anytime in February.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	On 03/22/18 at 8:30 a.m., the director of nursing (DON) provided copies of the progress notes from 02/16/18 through the date of discharge on 02/22/18. Review of the progress notes found no mention of the change in treatment orders for the Stage 2 pressure ulcer, and found no mention that the new treatment orders were completed. During an interview with the DON on 03/22/18 at 8:30 a.m. she agreed there was no evidence on the TAR on either 02/18/18 or on 02/21/18 to support that the new treatment order for the Stage 2 pressure ulcer was done. She agreed there was no documentation in the nurse progress notes about the worsening of the pressure ulcer from Stage I to Stage II, or of the change in treatment ordered by the physician on 02/18/18. **Provide and implement an infection prevention and control program.**

	Based on observation, staff interview, and policy review, the facility failed to maintain its infection control program to help prevent the potential transmission of organisms and disease to the extent possible over which it had control. When providing incontinence care to a resident, a nursing assistant threw soiled linens and a used incontinence product directly onto the floor in the resident's room. Resident identifier: #49. Facility census: 59. Findings included: a) Resident #49 Observation on 03/22/18 at 09:20 a.m. found the door to this resident's room was open, and his privacy curtain was pulled around his bed. On the floor between his bed and his room-mate's bed lay a disposable brief that was folded numerous times,

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	515178	A. BUILDING B. WING	**03/22/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE HAVEN CENTER	**2720 CHARLES TOWN ROAD MARTINSBURG, WV 25401**

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	continued... from page 2) a blue plastic pad that looked like chux incontinence pad, and soiled linens which included washcloths and a towel. At this time, nursing assistant #15 (E#15) pushed back the privacy curtain. E#15 picked up the disposable items from the floor and placed them into a clear plastic trash bag, then picked up the soiled linens from the floor and placed them into another clear plastic bag. E#15 carried the two (2) bags down the hall to the soiled utility room. An interview was conducted with the director of nursing (DON) on 03/22/18 at 9:45 a.m. She said nursing is supposed to bag linens and used incontinence products in plastic bags, then take them to the soiled utility room. She said nursing staff know not to throw those contaminated items onto the floor. On 03/22/18 at 10:20 a.m. the DON provided a copy of their infection control policy on linen handling, the purpose of which was to provide effective containment and reduce potential for cross-contamination from soiled linen. She said the same was true for the disposal of trash and incontinence products. The DON said she has already begun staff re-education on infection control measures related to disposal of briefs and soiled linen.

ID: YL1O11

Facility ID: 515178

If continuation sheet Page 3 of 3

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	515178	A. BUILDING B. WING	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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.** Based on observations, staff interviews, review of water temperature logs and policy review, the facility failed to monitor safe water temperatures accurately on 1 of 2 halls (A hall). The facility failed to consistently perform weekly water temperatures for 1 of 2 halls. This had the potential to affect more than an isolated number of residents. Facility census 56. Findings included: a) Accurate monitor of water temperatures Review of water temperature logs, conducted on 02/12/18 at 3:15 PM, revealed on 02/05/18: --A 1 room water temp 119.6 --A 2 room water temp 116.9 --A-5 room water temp 117.1 --A-7 room water temp 118.1 --B-18 room water temp 118.1 During an interview, on 02/12/18 at 12:00 PM, Maintenance Director (MD) #51 stated the facility had problems with mixing valve in (MONTH) and on 02/05/18 installed a new circulating valve in the building to raise water temperatures. The facility had been having problems with cold water complaints since his date of hire 01/08/18. MD #51 stated he and the normal water temperature in resident rooms is to be between 100-110 degrees. During an interview, on 02/12/18 at 3:25 PM, with the Administrator and MD #51 stated the water temperatures were only elevated for a short while. The administrator stated the facility took no precautions to limit resident access to hot water on 02/05/18. The facility provided documentation of water temps done on 02/06/18 and 02/12/18. Water temperatures were within state guidelines. On 02/12/18 at 3:40 PM to 3:45 PM, water temperatures were obtained by MD #51 utilizing a digital thermometer. --Room A 9 was 112. MD #51 stated oh that is hot. --Room A 10 was 114. --Room A 15 was 117 --Shower room (on A hall) was 99.5. At 3:50 PM, MD #51 stated the thermometer was self calibrating. MD #51 stated he had never calibrated the thermometer or changed the batteries since his date of hire. MD #51 was instructed on obtaining a cup of ice mixed with water. The thermometer only dropped to 42 degrees after immersion in ice slurry. At 4:03 PM, Regional Senior VP of Clinical Operations obtained a second thermometer. The thermometer was calibrated in ice slurry. The thermometer dropped to 32 degrees. On 02/12/18 at 4:05 PM, water temperatures were performed by VP of Clinical operations. --Room A 9 water temp was 110 --Room A 10 water temp was 106 --Room A 15 water temp was 100 At 4:15 PM on 02/12/18, MD #51 stated he had turned the mixing valve down. MD #51 stated he had informed the Administrator of his interventions. At 4:20 PM on 02/12/18, Maintenance Assistant (MA) #10 stated he did water temperatures on a weekly basis. MA #10 stated he did not do any more frequent monitoring of water temperatures after the installation of the circulating valve on 02/05/18. MA #10 stated he had never calibrated a thermometer prior to taking water temperatures. MA #10 stated he started to work at the facility on 01/15/18. MA #10 stated he had performed water temperatures since his date of hire which he did not document. MA #10 was unable to provide any evidence that water temperatures had been performed. Review of water temperature logs performed on 02/12/18 at 7:45 PM and 02/13/18 at 5:05 AM revealed water temperatures on both the A hall and B hall and shower room ranged 100 degrees to 109 degrees. Nursing was notified, on 02/12/18 at 8:00 PM that water temperatures were in the safe range. b) Consistent monitoring of water temperatures Review of facility policy entitled Hot Water Temperatures: inspection. revised 06/01/07 stated hot water temperatures will be tested weekly. Process is to conduct tests in at least 3 locations. Inspection forms are to be filed and maintained for one year. Review of water temperature logs revealed water temperatures had not been monitored from 10/02/17 until 01/19/18. During an interview, on 02/12/18 at 3:25 PM, with the Administrator and MD #51 stated the water temperatures were monitored on a weekly basis. The administrator was unaware of the lack of documentation of water temperature inspections performed from 10/02/17 until 01/19/18. The Administrator stated she could provide no further evidence that water temperature inspections had been completed.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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