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

**Trinity Health Care of Logan** 1000 West Park Avenue Logan, WV 25601

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; e[mail: jdowney@jeffdowney.com](mailto:jdowney@jeffdowney.com)

Facility Characteristics:

* Nursing Facility with 120 beds
* Operational Control – Trinity Health Care Services Inc
* Legal Business Name – Trinity Health Care Services of Logan Inc
* The For-profit corporation is partially owned by Trinity Health Care Services Inc.
* As of April 2019, Trinity Health Services remains on Medicare’s Special Focus Facility list, which requires more frequent health and safety inspections.

**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 Trinity Health Care of Logan in Logan, 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 NPls. 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.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515178** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **03/22/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CARE HAVEN CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **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:   1. 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 care plan 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.   1. 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.   1. 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.

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 515178 If continuation sheet Page 1 of 3

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515178** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **03/22/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CARE HAVEN CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **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  F 0656  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0686  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0880  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (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.  **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.  **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.  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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Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 515178 If continuation sheet Page 2 of 3

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515178** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **03/22/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CARE HAVEN CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **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 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. | | | |

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Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 515178 If continuation sheet Page 3 of 3

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515178** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **02/14/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CARE HAVEN CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **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 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:   1. 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.   1. 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 (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.

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 515178 If continuation sheet Page 1 of 1

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0550  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0558  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0561  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**  Based on resident interview, family interview, staff interview and record review, the facility failed to maintain residents' dignity by placing them a public area with inappropriate attire. This was found for two (2) of six (6) residents reviewed for the care area of dignity. Resident identifiers: #5 and #26. Facility census 107.  Findings included:   1. Resident #5   During an interview on 06/05/18 at 10:05 AM, Resident #5 said she went to dinner with her roommate at 6:00 PM on 05/18/18. Resident #5 said after dinner when they returned to their room, the staff would not let them back in the room due to pest control treatment. Resident #5 said staff showered her and her roommate and made them wear a hospital gown afterwards. She further stated the staff made them sit in the lounge until around 11:00 PM while only wearing a hospital gown. Resident #5 was tearful throughout the interview. She stated that her and her roommate are fearful to leave leave the room at the same  time now because they do not want what happened on 05/18/18 to happen again.  During a phone interview on 05/05/18 at 10:25 AM with a family member of Resident #5, she revealed her mother called her the night of 05/18/18 at almost 11:00 PM. She stated her mother was extremely upset and tearful because they made her wear a hospital gown instead of your own clothes and sit in the lounge this way until 10:00 PM.  An incident report filed by this resident's family member was made on 05/21/18. This report was filled out by Social Worker #6. This was not signed by family or the resident. This incident of alleged abuse was not reported to West Virginia Adult Protective Services nor the Office of Health Facility Licensure and Certification until 06/05/18 during this survey.   1. Resident #26   During an interview on 06/05/18 at 10:05 AM, Resident # 26 agreed she and her roommate were not allowed back into their room after going the dining room for dinner on 05/18/18. She said it was about 11:00 PM, before they were allowed back let them back in their room. She said that, she was not happy about it and did not appreciate having to set in their lounge in a  hospital gown in front of everyone.  A report form, Adult Protective Services Mandatory Reporting Form was completed and reported to the West Virginia Department of health and Human Resources, on 06/11/18 at 3:05 PM. by Social Worker #6.  During an interview with Administrator on 06/12/18 at 4:00 PM, he said,this incident should have never happened. Someone overreacted over a bug from outside and thought it was a bedbug. I just live over the hill if they would have called me it would have never happened.  .  **Reasonably accommodate the needs and preferences of each resident.**  Based on observation, staff interview, and resident interview, it was determined the facility failed to ensure a resident received services with reasonable accommodation of their individual needs. This was found for one (1) of twenty (20)  residents randomly observed during the initial pool process of the Long-Term Care Survey Process (LTCSP). Resident #89, who has the ability to use the call light, did not have access to their call light. This practice had the potential to affect  an isolated number of residents. Resident identifier: #89. Facility census: 107. Findings included:  a) Resident #89  Interview with Resident #89, on 06/05/18 at 10:25 AM, revealed the resident was lying on her bed and complained to this surveyor of having a headache and hurting all over. This surveyor asked the resident if she had told the nurse that she needed something for pain. Resident #89 said, No, not yet. The resident started feeling with her fingers along the left upper side of her mattress and bed railing. When asked what she was looking for, the resident said, I can't find my call light button. This surveyor told the resident, I will get a nurse for you.  At 10:33 AM on 06/05/18, this surveyor stepped out into the hall as LPN#38 was walking by. At the request of this surveyor LPN#38 went in to check on Resident #89. This surveyor asked LPN#38 where the call light was. LPN#38 after looking around saw the call light on the floor and picked it up and attached it to bed by clipping it to the mattress.  On 06/07/18 at 11:19 AM an interview with the Director of Nurses (DON), revealed she was not aware Resident #89's call light had been found in the floor. The DON stated the resident likes to make up her own bed and things, and probably removed it that morning herself and laid it in the floor. The DON indicated the resident was known to remove the call light, and  didn't really use the call light, but would come out to the nurse's station herself to get things.  A random observation on 06/12/18 at 11:38 AM revealed Resident #89's call light was again lying on the floor out of the reach of the resident. Resident #89 was observed reaching and feeling for something along the left upper side of her  mattress and bed railing. Resident #89 then got up out of bed and started walking toward the door and stopped when she saw this surveyor at the door. This surveyor asked the resident if the surveyor could come in and ask her a few questions.  Resident #89 agreed, and when asked where she was going at the time the surveyor came to her room, the resident replied, I needed to find a nurse, so I can get something for a head ache. When asked why the resident does not call for a nurse with her call light button, the resident said, I don't know where it is, I can't find it. A staff Valet (QA#63) was observed  outside in the hallway and was requested to come into Resident #89's room to find the residents call light button. Staff Valet (QA#63) came into the room and found the call light button lying on the floor against the wall at the head of the resident's bed. Staff Valet (QA#63) picked the call light button off floor and clipped it on the mattress sheet. Staff Valet (QA#63) agreed the call light was to be in reach of the resident not lying on the floor.  **Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.**  Based on resident interview, medical record review, and staff interview, the facility failed to ensure residents had the right to make choices about aspects of life in the facility significant to the resident. The facility failed to honor the bathing frequency preferences for five (5) of six (6) residents reviewed for the care area of choices and activities of | | | |

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.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0561  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 1)  daily living. Resident identifiers: #17, #8, #49, #11, #26. Facility census: 107. Findings included:  a) Resident #17  During an interview on 06/05/18 at 7:29 AM, Resident #17 stated she would like to be bathed more often. She stated she received two (2) bed baths a week, but she would like to receive four (4) or five (5) bed baths a week. Resident #17 stated she has requested more frequent baths, but her preference has not been honored.  The Nurse Aide (NA) and Activities Supervisor were interviewed on 06/07/18 at 3:02 PM. The NA and Activities Supervisor stated residents are bathed or showered every three (3) days. Upon admission, the residents are assigned to day one, two,  or three bathing/showering day. The NA and Activities Supervisor stated she develops the daily bathing/showering schedule based on the bathing/showering day that was assigned to the resident upon admission. If a resident refuses a bath or shower on his or her day, the resident can request the bathing/shower on another day. However, men and women have separate days for showering in the shower room.  Review of the bathing task report for 03/14/18 through 06/07/18 revealed Resident #17 did not receive baths every three days. The bathing task report revealed the following information:  --03/14/18 - Resident was not bathed  --03/15/18 - Resident was not bathed  --03/16/18 - Resident was not bathed  --03/17/18 - Resident was not bathed  --03/18/18 - Resident was bathed  --03/19/18 - Resident was not bathed  --03/20/18 - Resident was not bathed  --03/21/18 - Resident was not bathed  --03/22/18 - Resident was not bathed  --03/23/18 - Resident was not bathed  --03/24/18 - Resident was bathed  --03/25/18 - Resident was not bathed  --03/26/18 - Resident was not bathed  --03/27/18 - Resident was bathed  --03/28/18 - Resident was not bathed  --03/29/18 - Resident was not bathed  --03/30/18 - Resident was bathed  --03/31/18 - Resident was not bathed  --04/01/18 - Resident was not bathed  --04/02/18 - Resident was bathed  --04/03/18 - Resident was not bathed  --04/04/18 - Resident was not bathed  --04/05/18 - Resident was not bathed  --04/06/18 - Resident was not bathed  --04/07/18 - Resident was not bathed  --04/08/18 - Resident was bathed  --04/09/18 - Resident was not bathed  --04/10/18 - Resident was not bathed  --04/11/18 - Resident was bathed  --04/12/18 - Resident was not bathed  --04/13/18 - Resident was not bathed  --04/14/18 - Resident was not bathed  --04/15/18 - Resident was not bathed  --04/16/18 - Resident was not bathed  --04/17/18 - Resident was bathed  --04/18/18 - Resident was not bathed  --04/19/18 - Resident was not bathed  --04/20/18 - Resident refused bathing  --04/21/18 - Resident was not bathed  --04/22/18 - Resident was not bathed  --04/23/18 - Resident was not bathed  --04/24/18 - Resident was not bathed  --04/25/18 - Resident was not bathed  --04/26/18 - Resident was not bathed  --04/27/18 - Resident was not bathed  --04/28/18 - Resident was not bathed  --04/29/18 - Resident was bathed  --04/30/18 - Resident was not bathed  --05/01/18 - Resident was not bathed  --05/02/18 - Resident was not bathed  --05/03/18 - Resident was not bathed  --05/04/18 - Resident was not bathed  --05/05/18 - Resident was bathed  --05/06/18 - Resident was not bathed  --05/07/18 - Resident was not bathed  --05/08/18 - Resident was not bathed  --05/09/18 - Resident was not bathed  --05/10/18 - Resident was not bathed  --05/11/18 - Resident was bathed  --05/12/18 - Resident was not bathed  --05/13/18 - Resident was not bathed  --05/14/18 - Resident refused bathing  --05/15/18 - Resident was not bathed  --05/16/18 - Resident was not bathed  --05/17/18 - Resident was bathed  --05/18/18 - Resident was not bathed  --05/19/18 - Resident was not bathed  --05/20/18 - Resident was bathed  --05/21/18 - Resident was not bathed  --05/22/18 - Resident was not bathed  --05/23/18 - Resident was bathed  --05/24/18 - Resident was not bathed  --05/25/18 - Resident was not bathed  --05/26/18 - Resident was bathed  --05/27/18 - Resident was not bathed  --05/28/18 - Resident was not bathed  --05/29/18 - Resident was not bathed  --05/30/18 - Resident was not bathed  --05/31/18 - Resident was not bathed | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0561  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 2)  --06/01/18 - Resident was bathed  --06/02/18 - Resident was not bathed  --06/03/18 - Resident was not bathed  --06/04/18 - Resident was bathed  --06/05/18 - Resident was not bathed  --06/06/18 - Resident was not bathed  --06/07/18 - Resident was bathed  During an interview on 06/07/18 at 3:02 PM, the RNA and Activities Supervisor stated she was not aware Resident #17 would like bathed more than twice a week. The RNA and Activities Supervisor stated residents can be bathed as many times a week as they would like. She was informed Resident #17 was not even bathed every three days, and had an eight (8) day period when the bathing task report stated she did not receive or did not refuse a bath. The RNA and Activities Supervisor stated bathing may have been performed but not documented by the RNA staff.  During an interview on 06/11/18 at 11:12 AM, the Director of Nursing (DON) was informed Resident #17 would like bed baths four (4) or five (5) times a week, but review of the medical record revealed the resident had not even received bed baths  two (2) times a week. The DON was informed Resident #17 had gone up to eight (8) days without receiving or refusing a bed bath according to documentation on the bathing task report. The DoN had no comment regarding the matter.  b) Resident #8  On 06/05/18 at 07:56 AM, an interview with Resident #8 revealed the resident likes his showers in the morning. The resident said he had just moved back from the East wing to the West wing. Resident #8 said he did not like it on the East wing, but they at least had their showers in the morning. When asked if he had told anyone at the facility his preference for morning showers, Resident #8 said he had told the Nurse Aid Supervisor (NA#7) the one who makes the shower schedule, many times that he would like his showers in the morning and told other NAs. When asked what he was told when he requested morning showers, Resident #8 replied NA#7 said he could not have it changed around because it's too big a hassle. Resident #8 said some NAs will go ahead and help him have a shower when he wants it, but others grumble and carry on, it's not worth even asking.  An interview with Nursing Aid (NA#43), on 06/07/18 at 10:24 AM, revealed the resident likes his showers in the morning, but he is on the evening shift schedule for every three (3) days. When asked when the resident wants his showers, NA#43 said,  He likes them in the morning, but when he moved back to the West wing an evening shift slot was the only one opened. When asked how showers are done at the facility, NA#43 said, (Name of Nurse Aid Supervisor (NA#7)) sets up the shower schedule, we have to follow. NA#43 explained showers are given to a resident every three (3) days, not on any set day, they are  simple scheduled every three (3) days. When asked how a NA would know if a resident refused or actually had a shower three   1. days before showing up on the schedule. NA#43 shrugged her shoulders (implying she didn't know) and said, All I know is we just go by the schedule, name (NA Supervisor) takes care of that. NA#43 stated, Resident #8 has come to her and asked to be fitted in on mornings, and NA#43 said, We know that is when he likes his showers, so I try to fit him in mornings when I can, but that is not often.   Review of electronic shower records, on 06/07/18 at 02:15 PM, revealed in the electronic record the NAs had the option to either mark 'Yes' or 'No' the resident had a shower. Resident #8's last documented shower was on 06/03/18 at 10:29 PM, four   1. days prior to the day of this review. So far in the month of June, the resident has had two (2) opportunities for a shower and only receive one (1) shower, four (4) days prior to his last shower.   The date of the last documented shower prior to 06/03/18 was 05/28/18 at 10:50 AM, six (6) days between showers. The date of the last documented shower prior to 05/28/18 was 05/23/18 at 6:27 PM, five (5) days between showers. The next two (2) recorded showers were three (3) days apart (05/20/18 at 7:26 AM and 05/17/18 at 3:42 PM). The date of the last documented shower prior to 05/17/18 was 05/11/18 at 1:56 PM, six (6) days between showers. The date of the last documented shower prior to 05/11/18 was 05/05/18 at 7:17 AM, six (6) days between showers. In the month of (MONTH) the resident had ten (10) opportunities for a shower and only had six (6) showers.  The date of the last documented shower prior to 05/05/18 was 04/29/18 at 5:16 PM, six (6) days between showers. The date of the last documented shower prior to 04/29/18 was 04/26/18, three (3) days apart. The date of last documented shower prior  to 04/26/18 was 04/20/18 at 1:49 PM, six (6) days between showers. The next two (2) recorded showers were three (3) days apart (04/17/18 at 3:10 PM and 04/14/18 at 11:23 AM and 10:06 PM). The date of the last documented shower prior to 04/14/18 was 04/08/18 at 5:00 PM, six (6) days between showers. The date of the last documented shower prior to 04/08/18 was  04/01/18 at 10:40 AM, seven (7) days between showers. In the month of April, the resident had ten (10) opportunities for a shower and only had seven (7) showers.  On 06/07/18 at 03:02 PM an interview with Nursing Assistant Supervisor (NA#7) revealed NA#7 denied knowing Resident #8's preference was to have showers in the morning, but agreed the resident use to have his showers in the mornings. NA#7 said showers are given to all the residents every three (3) days, either on the men's or the women's shower day, and NA#7 said  she makes up the shower schedule. Nursing Assistant Supervisor (NA#7) told the surveyors she thought the residents did get their showers every three (3) days. NA#7 said if there were any lapses of days showing a shower was missing in the record, it was probably just an error in documentation. The NAs must have just forgotten to document. The electronic record allowed NAs the option to either mark 'Yes' or 'No' the resident had a shower.  c) Resident #49  On 06/05/18 at 04:21 PM, Resident #49 indicated she did not always get her showers, she said it had been three (3) days since her last shower and she would like one now. When asked if she had told anyone she would like a shower, Resident #49 said, I think they don't want to fool with me, so I won't ask them.  Interview with NA#48, on 06/11/18 at 04:00 PM, revealed the resident needs limited assistance with showers. NA#48 was not aware when the resident had her last shower and did not know of a time when the resident refused a shower. NA#48 stated, We go by the shower schedule, that's when we give their showers.  Review of electronic shower records, on 06/12/18 at 03:32 PM, revealed in the electronic record the NAs had the option to either mark 'Yes' or 'No' the resident had a shower.  Resident #49's last documented shower was on 06/10/18, and the only other shower in (MONTH) was three (3) days prior on 06/07/18. So far in the month of June, the resident had four (4) opportunities for showers and only two (2) showers.  The date of the last documented shower prior to 06/07/18 was 05/26/18, twelve (12) days between showers. The date of the last documented shower prior to 05/26/18 was 05/23/18 at 6:27 PM, three (3) days between showers. The date of the last documented shower prior to 05/23/18 was 05/11/18, twelve (12) days between showers. The date of last documented shower prior to 05/11/18 was 05/05/18, six (6) days between showers. In the month of (MONTH) the resident had ten (10) opportunities for a shower and only had four (4) showers.  The date of the last documented shower prior to 05/05/18 was 04/30/18, five (5) days between showers. The date of the last documented shower prior to 04/30/18 was 04/17/18, thirteen (13) days between showers. The date of last documented shower prior to 04/17/18 was 04/14/18, three (3) days between showers as scheduled. The date of the last documented shower prior to 04/14/18 was 04/08/18, six (6) days between showers. The date of last documented shower prior to 04/08/18 was 04/02/18, six (6) days between showers. In the month of April, the resident had ten (10) opportunities for a shower and only had five  (5) showers.  d) Resident #26  During an interview on 06/05/18 at 9:41 AM, Resident #26 said she asked for a shower last week and was told its men's day, and she would have to wait until her next scheduled day to shower, then was told she missed her shower date yesterday. She said they do not like to shower me because I need help. She said the staff that has told her that is Nursing Assistant (NA) #40, and #50 most recently. She said that she was sent to the doctor without being washed up down here (pointing to her genital area) and said she was so embarrassed. She became tearful and said, I stunk up the whole room while they put that thing up my privates. She said it was almost two weeks she had not had a shower when this happened. She said she felt like they were punishing her because one night she told them she did not feel well and was tried and would shower in the morning. She stated that the next morning and days after she was told,It's men's day or it's not your day to shower! She  said she has had to call her brothers for help before.  During an interview on 06/05/18 at 1:30 PM, with Nursing Assistant/ Supervisor #7 stated that any resident can have a shower whenever they want. She said that the residents are to be showered every three days, and yes, they do have men days and | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0561  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 3)  women days. Sometimes they have men or women's days back to back, like men/men/women or women/women/men.  During an interview on 06/07/18 at 8:53 AM, Nursing Assistant/Supervisor #7 said that residents can get showers anytime they want except during meal time.  During an interview on 06/07/18 at 3:02 PM, Nursing Assistant/Supervisor #7 was asked about shower days. She said the residents have a shower schedule for every three days alternating mens day and womens day sometimes mens day or womens day can be back to back. She could not explain how the shower schedule was made or who determined who gets a shower. Her only answer was,This is the way we have always done it!  Review of shower records received 06/7/18 at 2:54 PM, from Assistant Director of Nursing (DON) # 23, for this resident listed days showered/bathed as follows;  --04/04/18 at 2:29 PM - showered  --04/05/18 at 7:17 AM - not showered  --04/05/18 at 11:20 PM - not showered  --04/06/18 at 10:32 AM - not showered  --04/06/18 at 11:24 PM - not showered  --04/07/18 at 7:36 AM - not applicable  --04/07/18 at 6:56 PM - not showered  --04/08/18 at 10:39 AM - not applicable  --04/08/18 at 4:52 PM - not showered  --04/09/18 at 9:39 AM - not showered  --04/09/18 at 4:40 PM - not showered  --04/10/18 at 9:53 AM - showered six days apart  --04/10/18 at 11:01 PM - not showered  --04/11/18 at 12:53 AM - not showered  --04/11/18 at 7:08 PM - not showered  --04/12/18 at 11:52 AM - not showered  --04/12/18 at 9:52 PM - not applicable  --04/13/18 at 10:16 AM - showered three days apart  --04/13/18 at 8:41 PM - not showered  --04/14/18 at 12:00 PM - not showered  --04/14/18 at 3:44 PM - not showered  --04/15/18 at 2:29 PM - not showered  --04/15/18 at 4:41 PM - not showered  --04/16/18 at 2:15 PM - showered three days apart  --04/16/18 at 3:34 PM - not showered  --04/17/18 at10:28 AM - not showered  --04/17/18 at 3:52 PM - not showered  --04/18/18 at 2:29 PM - not showered  --04/18/18 at 6:42 PM - not showered  --04/19/18 at 1:36 PM - showered three days apart  --04/19/18 at 8:55 PM - not applicable  --04/20/18 at 11:00 AM - not showered  --04/20/18 at 3:50 PM - not showered  --04/21/18 at 2:12 PM - not showered  --04/21/18 at 4:29 PM - not showered  --04/22/18 at 2:29 PM - not showered  --04/22/18 at 4:38 PM - not showered  --04/23/18 at 7:16 AM - not applicable  --04/23/18 at 5:06 PM - not showered  --04/24/18 at 9:12 AM - not showered  --04/24/18 at 6:47 PM - not showered  --04/25/18 at 10:44 AM - not showered  --04/25/18 at 3:28 PM - not showered  --04/26/18 at 10:46 AM - not showered  --04/26/18 at 7:39 PM - not applicable  --04/27/18 at 2:29 PM - not showered  --04/27/18 at 3:52 PM - not showered  --04/28/18 at 2:29 PM - not showered  --04/28/18 at 9:15 PM - not showered  --04/29/18 at 12:14 PM - not showered  --04/29/18 at 5:03 PM - not showered  --04/30/18 at 2:29 PM - resident not available (at doctor's appointment)  --04/30/18 at 6:30 PM - not showered  --05/01/18 at 2:29 PM - showered 12 days apart  Nursing note dated 02/19/18 at 8:53 PM note staff offered to give resident shower d/t her refusal on previous day states no I'm tired ill just wait until tomorrow explained to resident that the next day would not be her scheduled day and she may have to wait until weds states that's fine I'll just wash off at the sink thank you  Review of nursing notes dated on 02/20/18 at 8:54 AM the note revealed (typed as written):  --resident to desk states, I've been waiting forever for a shower explained to this resident the cna's (nurse aides) would attempt to get her in shower sometime today d/t several residents were already receiving showers at time of request. resident states, well I'm sick of never getting a shower reminded resident that she had refused X3 when 3 different cna's attempted to take to shower previous evening resident then said well I'll just go wait let me know when i can get one. Nursing noted dated 04/30/18 at 4:34 PM revealed resident returned to facility from (local hospital after having a colonoscopy) via gurney.  e) Resident #11  On 06/05/18 at 9:36 a.m., the resident expressed concern she had not received a shower in a long time. According to the resident she was upset over this practice, she wanted a shower a least every three (3) days.  Review of the electronic medical record documentation, regarding resident bathing with Employee #7, the registered nursing assistant/activities supervisor, at 3:14 p.m. on 06/07/18, found the following information:  The electronic medical record required nursing assistants to answer the question, Was resident bathed/showered this shift? Staff could respond with yes, no, not applicable or resident refused.  E #7 said it is the facility expectation is all residents are offered a shower every three (3) days. Residents are allowed to refuse the activity.  Documentation of the bathing activity from 05/01/18 to 06/06/18 found the following dates when the documentation did not support bathing activity every three (3) days:  Resident #11 was bathed on 05/21/18 the next bathing activity occurred on 05/27/18- a period of five (5) days between bathing activity.  Bathing was provided on 05/27/18, the next bathing activity occurred on 06/05/18 - a period of nine (9) days between bathing. The bathing activity was recorded in the electronic medical record as occurring at 10:02 p.m. on 06/05/18. Therefore, when the resident stated at 9:36 a.m. on 06/05/18 she had not received a shower in a long time, she had not received a shower for the past nine (9) days.  E #7 confirmed the staff did not document the resident refused bathing during these time periods.  At 10:59 a.m. on 06/11/18, the above information was discussed with the Director of Nursing (DON). The DON said, She (referring to the resident) would normally tell me if she didn't get a shower but she didn't tell me. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0561 | (continued... from page 4)  At the close of the survey at 5:30 p.m. on 06/12/18, no further information was provided to validate the resident received her bathing activity every three (3) days per her preference and facility practice.  **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**  Based on resident interview, staff interview and policy review, the facility failed to provide a reasonable protection of the residents' property from loss or theft. This was true for four (4) out of seven (7) residents reviewed for the care area of personal property. For Resident identifiers: #5, #44, #26 and #8. Facility census 107.  Findings included:   1. Review of Facility policy   Resident Personal Property Dated (MONTH) 24, (YEAR) required the following:  --The resident and/or family representative will be notified of the loss or breakage of personal items.  --Any loss or breakage of a resident's personal item will be properly documented on a complaint form by the social worker or designee and then referred to the facility administrator.  --The lost or broken items will be investigated.  --If the investigation identifies misappropriation of patient property, refer to the abuse and neglect policy.  --Results of the investigation will be given to the resident or representative and documented.   1. Resident #44   During an interview on 06/05/18 at 8:53 AM, Resident #44 said she had clothes, a Bible and a green clock that sings Christmas songs missing. States she told Nurse Aide/ Nurse Aide Supervisor (NAS) #7 but nothing was replaced.  During an interview on 06/07/18 at 8:30 AM, NAS #7 said they replace her clock but do not know about the Bible. She was asked if a report was made, she replied, no. Upon record review no reports about these complaints were found in the record or other location.  During an interview on 06/07/18 at 2:44 PM, NAS #7 she said that the facility is always buying things for this resident and all the residents. She provided the facility policy for resident personal property. She also gave various papers with  copies of Walmart receipts with items circled with many of the same items on the list and some hand-written list for mileage reimbursements nothing to do with any of the missing or replacement of items. She could not provide any proof of the items Resident # 44 reported missing being found or replaced.   1. Resident #5   During an interview on 06/05/18 at 9:58 AM, Resident #5 said staff go through her stuff and she had had things missing. Tearful she said she cannot leave her room because thing come up missing. She said,After the incident where the staff bombed (pest control) my room and would not let me and her (her roommate) back in their room. More stuff has come up missing. She stated her daughter does her laundry, but the staff still take all her clothes to the laundry and ruined them.  Things that are missing are bras, snack cakes, pop and a small amount of money (a dollar or some change).  During a phone interview with the Resident's daughter on 06/05/18 at 10:25 she said that did have 29 outfits to start with and she now has only 19 remaining in her possession.  During an interview on 06/07/18 at 8:34 AM, NAS #7 said, I don't know anything about, the missing clothes. However, she provided a Walmart receipt for this resident. She denied any reports being made or investigations being done.  During an interview on 06/07/18 at 10:29 AM, Social Worker (SW) #6 stated she was not aware of the missing items nor the fact the resident was afraid to leave her room because of ongoing issues with missing property. She said that NAS#7 said they could get her a lock for her cabinet.   1. Resident #26   During an interview on 06/05/18 at 10:29 AM, Resident #26 said she has had many clothes missing, cookies, snack cake, pop and perfume. She stated that she had reported to NAS #7 and had to hide her stuff or not leave her room.  During an interview on 06/07/18 at 8:37 AM, NAS #7 said that she always replaced the items, but did not have any documentation to show what and when items were replaced.  During an interview on 06/07/18 at 10:21 AM, SW #6 said she has never been told about this resident missing anything.   1. Resident #8   Interview with Resident #8, on 06/05/18 at 07:53 AM, revealed the resident had lost many personal items at different times, more than he could count. Resident #8 said he had been a resident the last two (2) years and has had many things missing. When asked if there was anything recent, the resident said about four (4) months ago a T shirt with a pig on it that he really liked. When asked what the facility said they would do about it, the resident replied, Name of NA/Activities  Supervisor (NA#7) said they would see what they could do, but did not do anything. Resident #8 said, If you got any jewlery they'll get it. I don't leave anything lying around.  On 06/07/18 at 08:55 AM, during an interview with NA/Activities Supervisor NA#7 was asked what was done about Resident #8's missing shirt. NA#7 replied, I got all his receipts. Later NA#7 brought this surveyor copies of nine (9) different  receipts, with various dates, from Wal-mart listing many different items. Some of the items were circled. NA#7 could not provide a record of what all Resident #8 had actually missing to compare the receipts to. NA#7 agreed that she would have  to develop a different way to track missing items and their replacement. NA#7 acknowledged review of documentation brought to this surveyor could not distinguish whether Resident #8's had all of his missing items replaced.  **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record, Incident/Accident reports, Complaints/Grievances and Reportable reports, staff interview, resident interview and review of the facility's abuse policy, the facility failed to ensure each resident was free from abuse and neglect. Additionally, the facility failed to not use verbal, mental, sexual or physical abuse, or involuntary seclusion.  This deficient practice caused actual harm for Residents #89, #99, #26 and #5. This deficient practice had the potential to affect more than an isolated number. Resident identifiers: #89, #99, #26, #11, #71, #5, #44, #58, #4, #212, #114. Facility  census: 107. Findings included:  a) Resident #89   1. Review of Resident #89's medical records found an annual Minimum Data Set (MDS) with an Assessment reference date (ARD) of 11/07/17. This MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 for   severe cognitive impairment. Resident # 89's [DIAGNOSES REDACTED]. Severe confusion was noted with poor safety awareness with a history of falls. Resident #89 required the physical assistance of one person with bathing/showering. Resident #89  was noted as always continent of bowel and bladder functions. Requiring only supervision with most Activities of Daily living except bathing and personal hygiene.   1. A review of the Incident/Accident reports found on 02/01/18 at 10:20 AM found an incident occurred in the shower room. The incident description was as follows: Called to shower room per staff. Resident sitting in floor in shower room.   Resident noted to have a complaint of pain in left wrist. Left wrist noted to be swollen at this time. Resident has no other complaints of pain. No redness or bruising noted at this time. Resident was unable to give description states, My wrist is really hurting me. Resident noted to be holding left wrist at this time. Resident was transferred to nearby hospital and was diagnosed with [REDACTED].  A review of statements by the two (2) nurse aides (NA) present in the shower room found:  --Statement by Employee #56, NA read: I was showering (Resident #89's name) with another staff member in the shower room. As I turned to get a piece of clothing the resident got up and tried to walk by herself and lost her footing and fall the  other staff member (Employee #43, NA) tried to catch her but wasn't quick enough then got (Employee #32, licensed practical | | | |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Some |
| F 0584 |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Some |
| F 0600 |
| **Level of harm -** Actual harm |
| **Residents Affected -** Some |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0600  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 5) nurse (LPN) name.  --Statement by Employee #43, NA read: I was assisting another staff member in showering resident (Resident #89). As the other staff member turned to get a piece of the resident's clothing. Resident got up unassisted. She lost her footing. I  tried to catch her but I was too late.   1. Review of the significant change MDS with an ARD of 05/09/18 found the resident has had a decline in her activities of daily living (ADL) and has more episodes of incontinence. Resident remains alert to person only and continues to have poor safety awareness secondary to impaired cognitive status.   This indicates following the incident on 02/01/18 resulting in a fractured left wrist, Resident #89 has experienced a decline in her ADL status and incontinence status.   1. On 02/02/18 at 11:00 AM an in-service was provided on Proper showering techniques the following was included, Maintain a face-to-face contact when possible, stay with resident during the entire process . do not leave residents alone while   bathing or showering .  This indicates actual harm for Resident #89 due to leaving the resident unsupervised and out of reach while in the shower resulting in a fall acquired fracture and pain.  b) Resident #99   1. Review of the reportable allegation of abuse found a report for Resident #99, dated 05/23/18 at 1:34 AM, this report read Resident told reporter (Employee #6, Social Worker (SW) that she was trying to get out the door to smoke. She tried to get a lighter out of the alleged perpetrator's pocket. While trying to get the resident back into the building, it was alleged   that (Employee #59, licensed practical nurse (LPN) grabbed Resident #99's right hand and squeezed her fingers hard causing pain. Resident #99 stated, It hurt real bad. I thought she had broken it.  Review of statements found:  --Statement by the alleged perpetrator, Employee #59, LPN read: On 05/23/18 at 11:34 AM, Resident #99 was trying to exit through the back door, as I was trying to redirect the resident. The resident was moving wheelchair back into facility the resident grabbed the door frame. I slid my hand under her wrist to guide it backwards. The resident started putting her  hand in my pockets, when I asked her not to. At which time resident became agitated and stated, She was going out and we couldn't stop her. then she turned her wheelchair and propelled her self-down the hallway muttering and cursing.  --Statement by the nurse whom examined the resident, Employee #23, RN read: This nurse was on East wing, approached by SW and asked to assess (Resident #99's) hand. Resident sitting in her room in her wheelchair at bedside with remote in hand.  This nurse asked her if something occurred, she stated, Yes, I don't remember if it was yesterday or today. I was going outside to smoke. I opened the door, I know all the codes. Somebody grabbed my chair, it jerked me backwards. I couldn't go forward or backwards. I saw the girl's lighter in her pocket and I grabbed it. She grabbed my hand and squeezed it real  hard. It hurt bad. I thought she broke it. I continued to assess the resident's right hand, this is the hand that was squeezed .   1. Only statements obtained was the perpetrator, Employee #59, LPN and Resident #99. Employee #23, registered nurse (RN) provided a statement with her assessment of Resident 99's injuries (she did not observe the incident). 2. Interview with Resident #99, on 06/05/18 at 9:15 AM, she stated, The staff punishes me with not letting me smoke with the other residents due to I feed the cats my leftover food and cat food that I have bought. They say all kinds of stuff to me,   they mock me and they take the food I have for the cats and throws it in the trash can in front of me and says, Ha,Ha. They  grab my wheelchair and prevent me from moving and jerks my chair backwards at times. Employee #59 squeezed my hand/fingers one time so hard I thought she broke it. The resident appeared distraught and upset as she recalled these incidents.  This deficient practice has caused Resident #99 actual psychosocial and physical harm which caused mental anguish, pain, intimidation, punishment, and humiliation.  c) Resident #11  1) Review of Complaint/Concern log found a complaint for Resident #11 dated 03/14/18 and made by the resident's family. The concern stated, (DON's name) received a call from (Name of resident's family) on 03/14/18. Also, another family member was also on the call. The family stated, I want to report abuse. Nurse Aide (NA) #46, is pulling out resident's hair. The  family member stated, I have reported this to Employee #23, RN and nothing is been done. The family goes on to say they do not want NA #46 taking care of her as they feel mistreatment by NA #46 is a retaliation due to some criminal activity by residents and NA #46's family.  A review of the statements found:  --Statement by Director of Nursing (DON) #18, NA #7 and Registered Nurse (RN) dated at 2:00 PM on 03/14/18, statement read: Employee #23, NA #7 and myself (DON) went to the residents room. I asked her if she was happy here and she stated, No, I want to go to Williamson. I asked her if everyone is good to her and she stated, They take my stuff. I asked her if anyone  has done anything mean to her and she stated, No. I asked her if anyone had smacked her or hit her she stated, No. I asked  her if NA #7, RN #23 or myself (DON) had ever pulled her hair and she stated, No. She denied anyone being mean to her and stated they take care of her.  --Statement by Employee #46, NA, the alleged perpetrator read: I was putting the resident (Resident #11) to bed after the last smoke break. The resident became combative and I asked the nurse (No name mentioned) to assist me with the resident.  She continued hitting and scratching me. We got her in bed and I was removing her jewelry and the necklace pulled her hair. I told her, I was sorry and she said, She was fine and told me to put her stuff on the table.  d) Resident #71   1. A review of the Complaint log found a complaint dated 03/28/18. This complaint was from Resident #71 and was made to the DON. This complaint read: (Resident's name) made a complaint that the staff got her up at 4 am to take a shower. 2. No statements or investigation could be found. After this surveyors intervention it was determined by the staff this was an allegation of neglect/abuse.   e) Resident #44  Review of the grievance/concern forms for the last year found three (3) concern/allegations:  1) Allegation #1: On 06/08/17, Resident #44 reported that Licensed Practical Nurse (LPN) #36 did not give her medication to her. The resident reported this to RN #123, who informed the DON. Social Worker (SW) #124 and DON spoke with the resident separately concerning her allegation. Resident denies the allegation of abuse, neglect or anyone treating her in a mean  manner. She stated she does not like her nurse because she crushes her medicine. On 06/22/17, resident is no longer receiving medication crushed.  Review of the statements found:  I explained that I could not give a medication without an order from the physician and again I explained I would contact the physician regarding residents request. I attempted to explain the parameters for Tylenol toxicity due to the resident currently had an order for [REDACTED]. At this time, RN #123 states well you are well within your limits and what could Tylenol hurt? This writer attempted to let Rn #123 know of resident's drug seeking behaviors but that again one of us would contact the physician and let her know the residents request.  Statement by Employee #16, LPN on 06/01/17 at 17:40 (5:40 pm): A resident went up to (Employee #123's name) and told her she had a temperature of 99 degrees. The RN came out and told the nurse to give her two (2) Tylenol. Staff attempted to explain  to the RN we could not give medication without a physician's orders [REDACTED].#116 two (2) Tylenol. Resident stated she had a temperature of 99 degrees. Staff again attempted that we could not give it. This nurse took RN into the office and attempted to give some of the resident's history with being told I was just an LPN and that she had been a nurse for [AGE] years. Rn became loud to the point that it was almost a scream cutting this nurse off.  Statement by Employee #36, LPN on 06/06/17 at approximately 15:10 (3:10 pm) While sitting at nurse's station attempting to complete paperwork to send a resident to hospital. RN #123 is noted to approach the nurse's station and state, I need drugs this writer informed her that I would be with her in just a minute as I was on the telephone attempting to transfer a  resident to the hospital. RN #123 states, I wasn't speaking to you, I was speaking to Employee #57, nurse assistant (NA). This writer explained if you are referring to Resident #214's antibiotic then I am his nurse and Employee #57, NA cannot help you. Then Rn #123 stated, I apparently, I didn't make myself clear I was speaking to Employee #57, NA. Again, this writer explained I was the resident's nurse and would get the medication for her in a minute that I am in the process of sending someone to the hospital. RN #123 stated, Obviously, you don't seem to understand that I am not speaking to you. At this time, this writer went into the med room and got the said antibiotic and handed it to the RN #123. RN #123 walks off. | | | |

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| F 0600  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 6)  Statement by Employee #36, LPN on 06/08/17 at approximately 18:45 (6:45 pm) Front door alarm sounds and this writer proceeds up to the front to check for safety and reset the alarm. I proceeded out to the parking lot to be sure that no residents  were in the parking lot unattended. For further safety, this writer walked around building to be sure the parking lot and surrounding areas were clear. This writer then proceeded to the west wing to check with nursing staff to be sure all residents were accounted for.  Upon entering front hall of the east wing (Employee #123, RN name) was noted to be standing at the nurses station with the Medication Administration Report (MAR) for the A section opened. This writer enters the nurses station to begin charting on the computer when Employee #123, RN states, You did not give (Resident #44' name) her meds today. At this time this writer states, yes I did. Employee #123, RN then states, Well, I don't think you did. She told me you didn't. I explained to the  RN that the resident has hoarding behaviors, refusal of medications and false accusations. The RN then states, Well if she says you didn't give the medication, as far as I concerned you didn't. RN proceeds to state, There are no initials in the  box (referring to the MAR). Then asked, Is 0900 9am or pm. At this time, I stated 0900 is 9am and I have been checking my MAR to be sure all of my finger sticks and etc. has been documented. RN then states, Well, apparently you did not learn anything in nursing school, you are to sign medication out when you give them, therefore, as far as I am concerned you did not give her medication and that is abuse. At no time did the RN allow me to see which area of MAR that she was referring  to and nor did she know the resident had been found with a [MEDICATION NAME] (pain medication) in her bra. While attempting to explain this resident's behavior the RN became loud and she pointed her finger in this writers face and saying, Where  were you when I was looking for you. I explained I was assessing the situation with the door alarm going off and being sure there was no elopement, while she sat in the office not responding.  She (RN) continued to point finger in this writer's face. This writer states, please get your finger out of my face. RN states, you need to get in the office to continue this conversation. This writer informed the RN , I will not go to a  private area to hold a conversation with you alone. You are pointing your finger in my face and approached me here in front of my peers and other residents. So, I will not go to a private area with you if you want to speak to me I will do it in  front of the DON only. At this time, the RN looks to her right where several staff as well as residents in the hallway. The RN then states, (Employee #57, NA name) go to the office. At this time this writer explained that the NA was a union representative but as a union employee I did not wish to have her present to speak with the RN without the DON in the building due to her aggressive tone with me. RN states, Well, we will see about this I am calling the DON. At no time during this shift did this RN look at any other MAR located on the east wing or any other resident's MAR regarding medications or administration. But the RN stated, Well she is my family and I will take care of this.  Statement by Employee #125, SW read, On 06/09/17, I spoke with resident, (Resident #44's Name), regarding allegations a nurse made that the resident was not getting her medications. (Resident #44's name) came to my office in private and I asked her if any nurse failed to give her medications to her. The resident stated, No, I get my medication but she makes me take them crushed and I don't like that. I then looked in the resident's chart to verify that the resident had an  physician's orders [REDACTED]. There was a fact an order stating that the resident was to receive crushed meds. I explained this to the resident and she stated her understanding.  Statement by Employee #60. LPN read, On 06/11/17, I worked the A hallway on the west wing and (Employee #39, LPN name) worked B hallway. She came to me with a [MEDICATION NAME] (pain medication) in a cup and asked me to waste it with her.  She  stated she had popped it out in error when pulling a residents medicine, Medication was wasted. We counted at the end of shift and a [MEDICATION NAME](pain med) was signed out by Employee #39 for 06/11/17 at 9 pm and count was correct.   1. Allegation #2: Resident #44 reported an allegation of neglect on 06/12/17 to RN #123. RN #123 reported teh allgeation to   the Nursing Home Administrator and DON. The allegation made by the resident was not given her medication by LPN #123. LPN #123 went to the resident's room to confront the resident by reportedly saying, Since you told on me now your medication  will be crushed and I will give them to you in the hallway.  Employee #124, social worker (SW) talked with resident regarding the allegations and resident denies the allegation. The resident continues to deny any issues with staff being mean to her. She continues to be upset about her medications being crushed.  A review of the statements found:  --Statement by Employee #44, RN, made on 06/12/17 at 5:35 p.m.: While doing skin assessments, patient in room [ROOM NUMBER]-  (Resident #112, Name) called me into her room. She asked me if I was a nurse and I told her yes. Resident stated she did not receive her 9 pm meds last night. I asked her did she know what med, she stated little blue pill (pain pill-  [MEDICATION NAME]). I told her I would check the MAR (Medication Administration Record), it may have been not available. I checked the MAR and the medication ([MEDICATION NAME]) had been signed out with the initials of (Employee #39, LPN). I went  back into Resident #112's room with Employee #125, Graduate Nurse (GN). What month is it? she stated, June. I asked the year, she stated, (YEAR). I asked her who was the President, she said, Trump. I asked her if she was mistaken, she said,  No, I check my pills, my pain pill is the little blue pill and it wasn't there. And I asked the nurse (Employee #39) about it and she told she didn't have it and that they would give it at 12:00 a.m. She went on to tell me several nurses about it and nobody came to see her.  --Statement by Employee #49, NA read: On (MONTH) 12, (YEAR) (time ineligible) I was putting (Name of Resident #76) in bed. The wife of Resident #76 was in the room. Employee #124, RN came in the room to do an assessment on the resident. The RN #124 started talking to the resident's wife about an incident that happened on east hallway. She told the wife it involved  Resident #44 and Employee #36, LPN. She said she was in the bathroom and heard everything between Resident #44 and LPN #36.  She told the wife she had took it to the Administrator and the DON. She told the wife she had screen shot all the nurses whom had been notified. She said they were that the facility was trying to get rid of her and that she reported it to the  state. On (MONTH) 20, (YEAR) the wife of Resident #76 was told by RN #124 this morning she had received her letter from the state and they were investigated.  --Statement by Employee #41, NA, written on 06/12/17 read: I witnessed a resident come up to the RN and asked about her medicine, The RN came up to the nurse's station and asked where the nurse was at. The RN started looking through the medicine book and when the LPN came back to the nurse's station the RN asked the LPN about the resident's medicine and the  MAR book. The RN was telling the LPN she must have not learned anything or she would have signed the book when she gave the resident meds. RN points at LPN and asked her to come to the office. LPN asked the RN to stop pointing her finger in her  face. The RN said I'm not pointing in your face.  --Statement by Employee #125, SW, written on 06/12/17 read: On 06/12/17, SW spoke with (Resident #44's name), regarding allegations the LPN #36 had not gave her medications and that she came into her room and stated, Since you told on me now your meds will be crushed and I will give it to you in the hall. Resident #44 denies that this was said and also says,  Nobody has been mean to me here but I don't like that nurse (LPN #36) because she crushes my meds.  --Statement by Employee #127, NA written on 06/12/17 read; I witnessed Resident #44 go into the DON's office and told RN #124 she had not had any of her medicine all day. The RN looked at the MAR and the book had holes in it where the LPN had  not signed the MAR. The LPN assured the RN she had gave the meds but had not signed the MAR. The RN's and the LPN's voices kept getting louder.   1. Allegation #3: A review of the concern/grievance log found a statement on 06/20/17 at approximately 9:00 AM, NA #58 entered Resident #44's room to find her roommate some clothes, this resident had her roommates pants on. I came out and got my nurse (LPN #36) to assist me. The housekeeper and I was standing in the closet doorway and Resident #44 exited the bathroom holding the clothes. The resident threw the pants and hit LPN #36 in the side of head and then openly smacked her across the face knocking her glasses off. I attempted to get the resident away from the nurse and calm her down. The   resident started yelling at the nurse stating, I am going to have your job [\*\*\*] . I dare you to hit me queer.  --Statement by Employee #36, LPN dated 06/20/17 at 9:15 am read: Upon entering Resident #44's room I found the resident had her roommates pants on. This writer, NA and Housekeeper were standing in the doorway of this resident's room when she exited the bathroom striking this nurse in left side of face multiple times screaming, (RN #124) and I are going to have  your job [\*\*\*] . I dare you to hit me I'm calling RN #124 and she will beat your face in. This writer exited the room and notified the supervisor of this resident's behaviors and notified the physician with new orders to administer [MEDICATION NAME] 20 milligrams (mg) intramuscularly (IM) now for agitation. Power of attorney (POA) notified and made aware of residents room change from east to west wing.  --Statement by Employee #125, SW read: On 06/20/17, I talked with Resident #44, to discuss her recent behaviors against LPN | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0600  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 7)  #36. I asked (Resident #44) why she hit LPN#36 and the resident stated the nurse was discrimating against her. I then asked her why she felt LPN #36 was discriminating against her and she stated, She crushes my medicine and RN #124 told me it was discrimation. I then asked the resident why she called the LPN #36 a queer. She at first denied calling her a queer but  later she said, RN #124 told me that she was married to a girl so what would you call her. I told the resident that she could not act that way toward a staff member regardless of her personal opinion. The resident states understanding.  f) Residents in room [ROOM NUMBER] on 06/19/17  1) A review of grievance/concern book found an incident, in which, occurred between RN #124 and Employee NA #54 on 06/19/17 at 9:30 PM.  Review of the statements found:  --Statement by Employee #124, RN read, On 06/19/17 at around 9:30 pm I went to find who had Resident #117 to do a skin assessment. The NAs stated that NA #54 had Resident #117. I went into room [ROOM NUMBER]and pecked on the door, when I entered the room I said, Good I need to do (Resident #118's skin assessment and you have her undressed. NA #54 said, Why  you want to look at her ass. I asked him what he meant by that and he said, I don't have time for this. I told him I needed him to help me turn Resident #117 on her side for a skin assessment that I had already did everything but her buttock and back. NA #54 stated, I have more patients to do and you treat NAs and nurses like were dirt under her feet. I told him that wasn't true and I hadn't even talked to him before, that I was told to get help turning the patients and he kept saying you never asked. I asked again for help and he refused. I told him I was going to write him up for insubordination and he stated, I am getting a union representative. As I came down the hall I stated, I hate it when people are smart asses.  Statement by Employee #54, NA read: I was on west wing and was in room [ROOM NUMBER] assisting the residents in getting ready for bed, when RN #124 came into the room and told me that I was to come to room [ROOM NUMBER]. I asked her to give me a minute, she then told me that she needed me to do it now. I told her she needed to give me a minute. I asked her if she  needed to look at their butt. She then told me I was getting wrote up for insubordination. I never refused to help. I told  her to give me a minute. Then she yelled at me and called me a smartass. She stated she was the RN and that meant I would do as I am told and not question her. She pulled her name badge at my face and said that is what this means.  g) Resident #58   1. A review of the Complaint/Grievance book found a concern by Resident #58. This allegation was reported to Employee #125, SW on 01/23/18.   Concern: Resident reports that she doesn't know how to take the Employee #43, NA on evening shift. NA sometimes. She takes good care of me but she likes to joke and sometimes doesn't know how to take her. She makes me anxious. Interventions: NA #43 received a written warning. The resident no longer has the NA as her caregiver.   1. No further statements, investigation or intervention could be located.   h) Resident #4   1. A review of the complaint/grievance book found a concern by Resident #4. This allegation was reported to SW #6 on 06/01/18.   Concerns noted by Resident #4's family read: Still not getting coffee at all meals. Staff were mocking the resident Help at the west wing nurses' station. One NA would not give the NA caring for Resident #4 the proper size of diapers. Wednesday, pm shift. The resident was lying angled in her bed. She couldn't get to her tray to eat. She had a bowl of peaches in her  bed with her. She needs pulled up to the tray to eat her meals. Residents name is not over her bed it is a different residents' name.  Interventions: Coffee is being served at all meals. Diaper issue is resolved. Resident will eat in day lounge (sitting upward).   1. No further statements could be located.    1. Complaint made by the Ombudsman 2. A review of the complaint/grievance book found a concern by the Ombudsman. This allegation was reported to SW #6 on 05/15/18.   Concern: I had more complaints of staff being rude to residents. One employee (NA) was huffing and puffing and complaining because they were short staffed and everyone was acting crazy. After the visitor reported this a resident spoke up and  reported a nurse who is mean and hateful and this nurse had to shut up and quit talking so much. The NA said that is her personality. There is one employee that is hateful as the devil; when one resident asked for a drink and another asked if there was church tonight; she yelled and was hateful to both residents. Please address this issue with your staff.   1. This surveyor was provided a copy of an in-service for Ethical behavior and Unethical behavior conducted on 05/16/18 by the Administrator. 2. No further statements could be located. 3. Resident #114    1. Review of Resident #114's medical records found the resident was admitted on [DATE].   Care Plan initiated; Resident is a 53yr. old female-Diagnosis: [REDACTED]. Staff supervises meals, assists as needed. She is noted to take food from other resident's trays. Easily agitated. Diet Regular NAS with lidded cups for safety. Weight 102#  --below IBW range (123#-149#) She feeds herself meals--often uses her fingers to eat --likes sweets and snack foods. No teeth or dentures.   * 1. Progress notes found the following incident/altercations involving resident-to-resident:   --10/18/2017 at 08:28 - Resident noted to be up walking around day lounge throwing food on the floor and taking food from other resident's trays.  --10/19/2017 at 18:00 - Resident up and ambulating in day lounge throwing her shoes across room pushing furniture against resident's wheelchairs. staff sits down with resident to assist with meal resident then gets up and proceeds to remove food from her brother's tray. when attempting to redirect resident begins hitting self in head and slamming fists on wall,  offered activities, fluids and snacks with staff to monitor for safety.  --11/6/2017 at 18:00 - Another resident was calling out to resident and calling her names. Resident became agitated and grabbed other resident's hair and pulled hard. Residents were separated by staff. Vital signs unable to be obtained due to resident was agitated.  --11/9/2017 at 21:46 - Late Entry: Note: resident has been noted to be up wandering in other resident's rooms, taking food and drinks off resident's dinner trays this shift requiring redirection numerous times.  --11/27/2017 at 07:59 - Resident up ambulating in day lounge removing food from other resident's trays requiring redirection numerous times. resident becomes agitated and begins hitting self in head. attempts to take resident to room for  self-soothing.  --12/7/2017 at 13:20 - Resident in day lounge at this time alert and nonverbal skin clean dry warm to touch resident noted to hit her head on the walls and glass numerous times this shift , staff makes attempts to redirect this resident , with no positive results noted , this resident noted to be grabbing other residents chairs in the day lounge and halls x 4 this  shift staff attempts to redirect this resident to the day lounge resident placed in chair at which time resident proceeds to kick and hit staff numerous times along with attempting to hit her head on tables and chairs in the day lounge , staff remains with resident at this time.  --12/7/2017 at 17:40 - Resident continues to be aggressive to staff along with continues to hit her head on the walls and windows, with each attempt to redirect this resident from getting upset and pushing another resident's wheelchair.  --12/12/2017 at 09:35- Resident is noted to be standing at the nurse's station grabbing other resident w/c as they pass x 1 this shift along with getting notably agitated x 1 at nurse station then enters the day lounge door and began to push and shake another residents merri walker resident assisted to room via staff now to self-soothing.  --2/14/2018 at 15:21 - Resident was agitated and shoving tray tables and tables in dining area. when this nurse enters dining area to calm her down another resident stated that you smashed my hand remover other resident near nurse's station for further evaluations.  --2/27/2018 at 10:30 - RNA states that Resident was in DL and ran over and grabbed another female resident by the hair and got ahold of her left breast. No injuries were noted to either resident. The residents were separated.  --3/16/2018 at 16:40 - Nurse called to day lounge this resident grabbed another resident by arm and struck him on his chest. staff separated residents and redirected this resident verbally and assisted to sit on couch to watch the television. vital  signs refused now. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0600  **Level of harm -** Actual harm  **Residents Affected -** Some  F 0609  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 8)  --3/26/2018 at 15:56 - Reported via staff that resident has been noted to get in bed with roommate now, resident removed from roommate's bed. Will continue to monitor resident  --3/26/2018 at 16:30 - Resident has been noted to run up and grab another resident's mobile device now. Resident's separated now. Both residents assessed, no injuries to either resident. Will continue to monitor.  --3/26/2018 at 17:00 - Called to resident's room via staff, resident is lying in roommate's bed, with roommate in the floor bedside bed. Tries to re-direct resident to correct bed now. Resident cooperated with success of redirection.  --3/26/2018 at 17:30 - Reported via staff that resident went up to another resident that was in a w/c, grabbed his arms and put her head down as if she was (TRUNCATED)  **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record, Incident/Accident reports, Complaints/Grievances and Reportable reports, staff interview, resident interview and review of the facility's abuse policy, the facility failed to ensure each allegation of alleged or acutal  abuse and neglect to the State Survey Agency and Adult Protective Services. This deficient practice caused actual harm for Residents #89, #99, #26 and #5. This deficient practice had the potential to affect more than an isolated number. Resident identifiers: #89, #99, #26, #11, #71, #5, #44, #58, #4, #212, #114. Facility census: 107.  Findings included:  a) Resident #89   1. Review of Resident #89's medical records found an annual Minimum Data Set (MDS) with an Assessment reference date (ARD) of 11/07/18. This MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 for   severe cognitive impairment. Resident # 89's [DIAGNOSES REDACTED]. Severe confusion was noted with poor safety awareness with a history of falls. Resident #89 required the physical assistance of one person with bathing/showering. Resident #89  was noted as always continent of bowel and bladder functions. Requiring only supervision with most Activities of Daily living except bathing and personal hygiene.   1. A review of the Incident/Accident reports found on 02/01/18 at 10:20 AM found an incident occurred in the shower room. The incident description was as follows: Called to shower room per staff. Resident sitting in floor in shower room.   Resident noted to have a complaint of pain in left wrist. Left wrist noted to be swollen at this time. Resident has no other complaints of pain. No redness or bruising noted at this time. Resident was unable to give description states, My wrist is really hurting me. Resident noted to be holding left wrist at this time. Resident was transferred to nearby hospital and was diagnosed with [REDACTED].  A review of statements by the two (2) nurse aides (NA) present in the shower room found:  --Statement by Employee #56, NA read: I was showering (Resident #89's name) with another staff member in the shower room. As I turned to get a piece of clothing the resident got up and tried to walk by herself and lost her footing and fall the  other staff member (Employee #43, NA) tried to catch her but wasn't quick enough then got (Employee #32, licensed practical nurse (LPN) name.  --Statement by Employee #43, NA read: I was assisting another staff member in showering resident (Resident #89). As the other staff member turned to get a piece of the resident's clothing. Resident got up unassisted. She lost her footing. I  tried to catch her but I was too late.   1. Review of the significant change MDS with an ARD of 05/09/18 found the resident has had a decline in her activities of daily living (ADL) and has more episodes of incontinence. Resident remains alert to person only and continues to have poor safety awareness secondary to impaired cognitive status.   This indicates following the incident on 02/01/18 resulting in a fractured left wrist, Resident #89 has experienced a decline in her ADL status and incontinence status.   1. On 02/02/18 at 11:00 AM an in-service was provided on Proper showering techniques the following was included, Maintain a face-to-face contact when possible, stay with resident during the entire process . do not leave residents alone while   bathing or showering .   1. This incident was not reported as potential neglect until 06/12/18 (after surveyor intervention). The Social Worker (SW)   and the Director of Nursing (DON) agreed the NAs were neglectful by stepping away from the resident, whom has poor safety awareness due to impaired short term and long term memory.  This indicates actual harm for Resident #89 due to leaving the resident unsupervised and out of reach while in the shower resulting in a fall acquired fracture and pain.  b) Resident #99   1. Review of the reportable allegation of abuse found a report for Resident #99, dated 05/23/18 at 1:34 AM, this report read Resident told reporter (Employee #6, Social Worker (SW) that she was trying to get out the door to smoke. She tried to get a lighter out of the alleged perpetrator's pocket. While trying to get the resident back into the building, it was alleged   that (Employee #59, licensed practical nurse (LPN) grabbed Resident #99's right hand and squeezed her fingers hard causing pain. Resident #99 stated, It hurt real bad. I thought she had broken it.  Review of statements found:  --Statement by the alleged perpetrator, Employee #59, LPN read: On 05/23/18 at 11:34 AM, Resident #99 was trying to exit through the back door, as I was trying to redirect the resident. The resident was moving wheelchair back into facility the resident grabbed the door frame. I slid my hand under her wrist to guide it backwards. The resident started putting her  hand in my pockets, when I asked her not to. At which time resident became agitated and stated, She was going out and we couldn't stop her. then she turned her wheelchair and propelled her self-down the hallway muttering and cursing.  --Statement by the nurse whom examined the resident, Employee #23, RN read: This nurse was on East wing, approached by SW and asked to assess (Resident #99's) hand. Resident sitting in her room in her wheelchair at bedside with remote in hand.  This nurse asked her if something occurred, she stated, Yes, I don't remember if it was yesterday or today. I was going outside to smoke. I opened the door, I know all the codes. Somebody grabbed my chair, it jerked me backwards. I couldn't go forward or backwards. I saw the girl's lighter in her pocket and I grabbed it. She grabbed my hand and squeezed it real  hard. It hurt bad. I thought she broke it. I continued to assess the resident's right hand, this is the hand that was squeezed .   1. This allegation was submitted to Adult Protective Service (APS) on 05/24/18 only. Was not faxed to all of the other required agencies until 05/30/18. Only statements obtained was the perpetrator, Employee #59, LPN and Resident #99. Employee #23, registered nurse (RN) provided a statement with her assessment of Resident 99's injuries (she did not observe the incident). 2. Interview with Resident #99, on 06/05/18 at 9:15 AM, she stated, The staff punishes me with not letting me smoke with the other residents due to I feed the cats my leftover food and cat food that I have bought. They say all kinds of stuff to me,   they mock me and they take the food I have for the cats and throws it in the trash can in front of me and says, Ha,Ha. They  grab my wheelchair and prevent me from moving and jerks my chair backwards at times. Employee #59 squeezed my hand/fingers one time so hard I thought she broke it. The resident appeared distraught and upset as she recalled these incidents.  This deficient practice has caused Resident #99 actual psychosocial and physical harm which caused mental anguish, pain, intimidation, punishment, and humiliation.  c) Resident #11  1) Review of Complaint/Concern log found a complaint for Resident #11 dated 03/14/18 and made by the resident's family. The concern stated, (DON's name) received a call from (Name of resident's family) on 03/14/18. Also, another family member was also on the call. The family stated, I want to report abuse. Nurse Aide (NA) #46, is pulling out resident's hair. The  family member stated, I have reported this to Employee #23, RN and nothing is been done. The family goes on to say they do not want NA #46 taking care of her as they feel mistreatment by NA #46 is a retaliation due to some criminal activity by residents and NA #46's family.  A review of the statements found:  --Statement by Director of Nursing (DON) #18, NA #7 and Registered Nurse (RN) dated at 2:00 PM on 03/14/18, statement read: Employee #23, NA #7 and myself (DON) went to the residents room. I asked her if she was happy here and she stated, No, I | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0609  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 9)  want to go to Williamson. I asked her if everyone is good to her and she stated, They take my stuff. I asked her if anyone has done anything mean to her and she stated, No. I asked her if anyone had smacked her or hit her she stated, No. I asked  her if NA #7, RN #23 or myself (DON) had ever pulled her hair and she stated, No. She denied anyone being mean to her and stated they take care of her.  --Statement by Employee #46, NA, the alleged perpetrator read: I was putting the resident (Resident #11) to bed after the last smoke break. The resident became combative and I asked the nurse (No name mentioned) to assist me with the resident.  She continued hitting and scratching me. We got her in bed and I was removing her jewelry and the necklace pulled her hair. I told her, I was sorry and she said, She was fine and told me to put her stuff on the table.  2) This alleged allegation of abuse/neglect was not reported till 06/15/18 after this Surveyor's inquiry.  d) Resident #71   1. A review of the Complaint log found a complaint dated 03/28/18. This complaint was from Resident #71 and was made to the DON. This complaint read: (Resident's name) made a complaint that the staff got her up at 4 am to take a shower. 2. No statements or investigation could be found. After this surveyors intervention it was determined by the staff this was an allegation of neglect/abuse. This was submitted on 06/05/18 to the proper agencies.   e) Resident #44  Review of the grievance/concern forms for the last year found three (3) concern/allegations:   1. Allegation #1: On 06/08/17, Resident #44 reported that Licensed Practical Nurse (LPN) #36 did not give her medication to her. The resident reported this to RN #123, who informed the DON. Social Worker (SW) #124 and DON spoke with the resident separately concerning her allegation. Resident denies the allegation of abuse, neglect or anyone treating her in a mean   manner. She stated she does not like her nurse because she crushes her medicine. On 06/22/17, resident is no longer receiving medication crushed.  Review of the statements found:  Statement by Employee #36, LPN, made on 06/01/17 at approximately 1700 (5pm): (Employee #123, RN's name) approached nurse's station and stated, who is (Resident #116's name) nurse? Myself as well as another LPN were sitting at desk when RN #123  states, she needs Tylenol, I explained to RN #123 that this resident did not have a current RX (prescription) for Tylenol.  RN #123 states, well you need to give her some Tylenol again I explained, we can call the doctor and ask but most generally she doesn't give Tylenol for a temperature of 99 degrees. Rn #123 states, well I said to give it to her. I explained that I  could not give a medication without an order from the physician and again I explained I would contact the physician regarding residents request. I attempted to explain the parameters for Tylenol toxicity due to the resident currently had  an order for [REDACTED]. At this time, RN #123 states well you are well within your limits and what could Tylenol hurt? This writer attempted to let Rn #123 know of resident's drug seeking behaviors but that again one of us would contact the physician and let her know the residents request.  Statement by Employee #16, LPN on 06/01/17 at 17:40 (5:40 pm): A resident went up to (Employee #123's name) and told her she had a temperature of 99 degrees. The RN came out and told the nurse to give her two (2) Tylenol. Staff attempted to explain  to the RN we could not give medication without a physician's orders [REDACTED].#116 two (2) Tylenol. Resident stated she had a temperature of 99 degrees. Staff again attempted that we could not give it. This nurse took RN into the office and attempted to give some of the resident's history with being told I was just an LPN and that she had been a nurse for [AGE] years. Rn became loud to the point that it was almost a scream cutting this nurse off.  Statement by Employee #36, LPN on 06/06/17 at approximately 15:10 (3:10 pm) While sitting at nurse's station attempting to complete paperwork to send a resident to hospital. RN #123 is noted to approach the nurse's station and state, I need drugs this writer informed her that I would be with her in just a minute as I was on the telephone attempting to transfer a  resident to the hospital. RN #123 states, I wasn't speaking to you, I was speaking to Employee #57, nurse assistant (NA). This writer explained if you are referring to Resident #214's antibiotic then I am his nurse and Employee #57, NA cannot help you. Then Rn #123 stated, I apparently, I didn't make myself clear I was speaking to Employee #57, NA. Again, this writer explained I was the resident's nurse and would get the medication for her in a minute that I am in the process of sending someone to the hospital. RN #123 stated, Obviously, you don't seem to understand that I am not speaking to you. At this time, this writer went into the med room and got the said antibiotic and handed it to the RN #123. RN #123 walks off.  Statement by Employee #36, LPN on 06/08/17 at approximately 18:45 (6:45 pm) Front door alarm sounds and this writer proceeds up to the front to check for safety and reset the alarm. I proceeded out to the parking lot to be sure that no residents  were in the parking lot unattended. For further safety, this writer walked around building to be sure the parking lot and surrounding areas were clear. This writer then proceeded to the west wing to check with nursing staff to be sure all residents were accounted for.  Upon entering front hall of the east wing (Employee #123, RN name) was noted to be standing at the nurses station with the Medication Administration Report (MAR) for the A section opened. This writer enters the nurses station to begin charting on the computer when Employee #123, RN states, You did not give (Resident #44' name) her meds today. At this time this writer states, yes I did. Employee #123, RN then states, Well, I don't think you did. She told me you didn't. I explained to the  RN that the resident has hoarding behaviors, refusal of medications and false accusations. The RN then states, Well if she says you didn't give the medication, as far as I concerned you didn't. RN proceeds to state, There are no initials in the  box (referring to the MAR). Then asked, Is 0900 9am or pm. At this time, I stated 0900 is 9am and I have been checking my MAR to be sure all of my finger sticks and etc. has been documented. RN then states, Well, apparently you did not learn anything in nursing school, you are to sign medication out when you give them, therefore, as far as I am concerned you did not give her medication and that is abuse. At no time did the RN allow me to see which area of MAR that she was referring  to and nor did she know the resident had been found with a [MEDICATION NAME] (pain medication) in her bra. While attempting to explain this resident's behavior the RN became loud and she pointed her finger in this writers face and saying, Where  were you when I was looking for you. I explained I was assessing the situation with the door alarm going off and being sure there was no elopement, while she sat in the office not responding.  She (RN) continued to point finger in this writer's face. This writer states, please get your finger out of my face. RN states, you need to get in the office to continue this conversation. This writer informed the RN , I will not go to a  private area to hold a conversation with you alone. You are pointing your finger in my face and approached me here in front of my peers and other residents. So, I will not go to a private area with you if you want to speak to me I will do it in  front of the DON only. At this time, the RN looks to her right where several staff as well as residents in the hallway. The RN then states, (Employee #57, NA name) go to the office. At this time this writer explained that the NA was a union representative but as a union employee I did not wish to have her present to speak with the RN without the DON in the building due to her aggressive tone with me. RN states, Well, we will see about this I am calling the DON. At no time during this shift did this RN look at any other MAR located on the east wing or any other resident's MAR regarding medications or administration. But the RN stated, Well she is my family and I will take care of this.  Statement by Employee #125, SW read, On 06/09/17, I spoke with resident, (Resident #44's Name), regarding allegations a nurse made that the resident was not getting her medications. (Resident #44's name) came to my office in private and I asked her if any nurse failed to give her medications to her. The resident stated, No, I get my medication but she makes me take them crushed and I don't like that. I then looked in the resident's chart to verify that the resident had an  physician's orders [REDACTED]. There was a fact an order stating that the resident was to receive crushed meds. I explained this to the resident and she stated her understanding.  Statement by Employee #60. LPN read, On 06/11/17, I worked the A hallway on the west wing and (Employee #39, LPN name) worked B hallway. She came to me with a [MEDICATION NAME] (pain medication) in a cup and asked me to waste it with her.  She  stated she had popped it out in error when pulling a residents medicine, Medication was wasted. We counted at the end of shift and a [MEDICATION NAME](pain med) was signed out by Employee #39 for 06/11/17 at 9 pm and count was correct. This allegation of abuse/neglect was never reported to the required state agencies.   1. Allegation #2: Resident #44 reported an allegation of neglect on 06/12/17 to RN #123. RN #123 reported teh allgeation to   the Nursing Home Administrator and DON. The allegation made by the resident was not given her medication by LPN #123. LPN #123 went to the resident's room to confront the resident by reportedly saying, Since you told on me now your medication  will be crushed and I will give them to you in the hallway.  Employee #124, social worker (SW) talked with resident regarding the allegations and resident denies the allegation. The resident continues to deny any issues with staff being mean to her. She continues to be upset about her medications being | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0609  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 10) crushed.  A review of the statements found:  --Statement by Employee #44, RN, made on 06/12/17 at 5:35 p.m.: While doing skin assessments, patient in room [ROOM NUMBER]-  (Resident #112, Name) called me into her room. She asked me if I was a nurse and I told her yes. Resident stated she did not receive her 9 pm meds last night. I asked her did she know what med, she stated little blue pill (pain pill-  [MEDICATION NAME]). I told her I would check the MAR (Medication Administration Record), it may have been not available. I checked the MAR and the medication ([MEDICATION NAME]) had been signed out with the initials of (Employee #39, LPN). I went  back into Resident #112's room with Employee #125, Graduate Nurse (GN). What month is it? she stated, June. I asked the year, she stated, (YEAR). I asked her who was the President, she said, Trump. I asked her if she was mistaken, she said,  No, I check my pills, my pain pill is the little blue pill and it wasn't there. And I asked the nurse (Employee #39) about it and she told she didn't have it and that they would give it at 12:00 a.m. She went on to tell me several nurses about it and nobody came to see her.  --Statement by Employee #49, NA read: On (MONTH) 12, (YEAR) (time ineligible) I was putting (Name of Resident #76) in bed. The wife of Resident #76 was in the room. Employee #124, RN came in the room to do an assessment on the resident. The RN #124 started talking to the resident's wife about an incident that happened on east hallway. She told the wife it involved  Resident #44 and Employee #36, LPN. She said she was in the bathroom and heard everything between Resident #44 and LPN #36.  She told the wife she had took it to the Administrator and the DON. She told the wife she had screen shot all the nurses whom had been notified. She said they were that the facility was trying to get rid of her and that she reported it to the  state. On (MONTH) 20, (YEAR) the wife of Resident #76 was told by RN #124 this morning she had received her letter from the state and they were investigated.  --Statement by Employee #41, NA, written on 06/12/17 read: I witnessed a resident come up to the RN and asked about her medicine, The RN came up to the nurse's station and asked where the nurse was at. The RN started looking through the medicine book and when the LPN came back to the nurse's station the RN asked the LPN about the resident's medicine and the  MAR book. The RN was telling the LPN she must have not learned anything or she would have signed the book when she gave the resident meds. RN points at LPN and asked her to come to the office. LPN asked the RN to stop pointing her finger in her  face. The RN said I'm not pointing in your face.  --Statement by Employee #125, SW, written on 06/12/17 read: On 06/12/17, SW spoke with (Resident #44's name), regarding allegations the LPN #36 had not gave her medications and that she came into her room and stated, Since you told on me now your meds will be crushed and I will give it to you in the hall. Resident #44 denies that this was said and also says,  Nobody has been mean to me here but I don't like that nurse (LPN #36) because she crushes my meds.  --Statement by Employee #127, NA written on 06/12/17 read; I witnessed Resident #44 go into the DON's office and told RN #124 she had not had any of her medicine all day. The RN looked at the MAR and the book had holes in it where the LPN had  not signed the MAR. The LPN assured the RN she had gave the meds but had not signed the MAR. The RN's and the LPN's voices kept getting louder.  This allegation of abuse/neglect was never reported to the required agencies.  3) Allegation #3: A review of the concern/grievance log found a statement on 06/20/17 at approximately 9:00 AM, NA #58 entered Resident #44's room to find her roommate some clothes, this resident had her roommates pants on. I came out and got my nurse (LPN #36) to assist me. The housekeeper and I was standing in the closet doorway and Resident #44 exited the bathroom holding the clothes. The resident threw the pants and hit LPN #36 in the side of head and then openly smacked her across the face knocking her glasses off. I attempted to get the resident away from the nurse and calm her down. The  resident started yelling at the nurse stating, I am going to have your job [\*\*\*] . I dare you to hit me queer.  --Statement by Employee #36, LPN dated 06/20/17 at 9:15 am read: Upon entering Resident #44's room I found the resident had her roommates pants on. This writer, NA and Housekeeper were standing in the doorway of this resident's room when she exited the bathroom striking this nurse in left side of face multiple times screaming, (RN #124) and I are going to have  your job [\*\*\*] . I dare you to hit me I'm calling RN #124 and she will beat your face in. This writer exited the room and notified the supervisor of this resident's behaviors and notified the physician with new orders to administer [MEDICATION NAME] 20 milligrams (mg) intramuscularly (IM) now for agitation. Power of attorney (POA) notified and made aware of residents room change from east to west wing.  --Statement by Employee #125, SW read: On 06/20/17, I talked with Resident #44, to discuss her recent behaviors against LPN #36. I asked (Resident #44) why she hit LPN#36 and the resident stated the nurse was discrimating against her. I then asked her why she felt LPN #36 was discriminating against her and she stated, She crushes my medicine and RN #124 told me it was discrimation. I then asked the resident why she called the LPN #36 a queer. She at first denied calling her a queer but  later she said, RN #124 told me that she was married to a girl so what would you call her. I told the resident that she could not act that way toward a staff member regardless of her personal opinion. The resident states understanding. This incident of alleged abuse/neglect was never entered on a Complaint/Grievance form and was never reported to the appropriate agencies.  f) Residents in room [ROOM NUMBER] on 06/19/17   1. A review of grievance/concern book found an incident, in which, occurred between RN #124 and Employee NA #54 on 06/19/17 at 9:30 PM.   Review of the statements found:  --Statement by Employee #124, RN read, On 06/19/17 at around 9:30 pm I went to find who had Resident #117 to do a skin assessment. The NAs stated that NA #54 had Resident #117. I went into room [ROOM NUMBER]and pecked on the door, when I entered the room I said, Good I need to do (Resident #118's skin assessment and you have her undressed. NA #54 said, Why  you want to look at her ass. I asked him what he meant by that and he said, I don't have time for this. I told him I needed him to help me turn Resident #117 on her side for a skin assessment that I had already did everything but her buttock and back. NA #54 stated, I have more patients to do and you treat NAs and nurses like were dirt under her feet. I told him that wasn't true and I hadn't even talked to him before, that I was told to get help turning the patients and he kept saying you never asked. I asked again for help and he refused. I told him I was going to write him up for insubordination and he stated, I am getting a union representative. As I came down the hall I stated, I hate it when people are smart asses.  Statement by Employee #54, NA read: I was on west wing and was in room [ROOM NUMBER] assisting the residents in getting ready for bed, when RN #124 came into the room and told me that I was to come to room [ROOM NUMBER]. I asked her to give me a minute, she then told me that she needed me to do it now. I told her she needed to give me a minute. I asked her if she  needed to look at their butt. She then told me I was getting wrote up for insubordination. I never refused to help. I told  her to give me a minute. Then she yelled at me and called me a smartass. She stated she was the RN and that meant I would do as I am told and not question her. She pulled her name badge at my face and said that is what this means.   1. This allegation of abuse and neglect was not reported till after this Surveyor's inquiry of situation. It was reported on 06/08/18 (a year after the occurrence).   g) Resident #58   1. A review of the Complaint/Grievance book found a concern by Resident #58. This allegation was reported to Employee #125, SW on 01/23/18.   Concern: Resident reports that she doesn't know how to take the Employee #43, NA on evening shift. NA sometimes. She takes good care of me but she likes to joke and sometimes doesn't know how to take her. She makes me anxious.  Interventions: NA #43 received a written warning. The resident no longer has the NA as her caregiver.   1. No further statements could be located. This allegation of abuse/neglect was not reported until after this Surveyors inquiry. Reported on 06/05/18 to the required agencies.   h) Resident #4  1) A review of the complaint/grievance book found a concern by Resident #4. This allegation was reported to SW #6 on 06/01/18.  Concerns noted by Resident #4's family read: Still not getting coffee at all meals. Staff were mocking the resident Help at the west wing nurses' station. One NA would not give the NA caring for Resident #4 the proper size of diapers. Wednesday, pm shift. The resident was lying angled in her bed. She couldn't get to her tray to eat. She had a bowl of peaches in her  bed with her. She needs pulled up to the tray to eat her meals. Residents name is not over her bed it is a different residents' name. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0609  **Level of harm -** Actual harm  **Residents Affected -** Some  F 0610  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 11)  Interventions: Coffee is being served at all meals. Diaper issue is resolved. Resident will eat in day lounge (sitting upward).  2) No further statements could be located. This allegation of abuse/neglect was not reported until after this Surveyors inquiry. Reported on 06/05/18 to the required agencies.  i) Complaint made by the Ombudsman   1. A review of the complaint/grievance book found a concern by the Ombudsman. This allegation was reported to SW #6 on 05/15/18.   Concern: I had more complaints of staff being rude to residents. One employee (NA) was huffing and puffing and complaining because they were short staffed and everyone was acting crazy. After the visitor reported this a resident spoke up and  reported a nurse who is mean and hateful and this nurse had to shut up and quit talking so much. The NA said that is her personality. There is one employee that is hateful as the devil; when one resident asked for a drink and another asked if there was church tonight; she yelled and was hateful to both residents. Please address this issue with your staff.   1. This surveyor was provided a copy of an in-service for Ethical behavior and Unethical behavior conducted on 05/16/18 by the Administrator. 2. No further statements could be located. This allegation of abuse/neglect was not reported until after this Surveyors inquiry. Reported on 06/06/18 to the required agencies. 3. Resident #114    1. Review of Resident #114's medical records found the resident was admitted on [DATE].   Care Plan initiated; Resident is a 53yr. old female-Diagnosis: [REDACTED]. Staff supervises meals, assists as needed. She is noted to take food from other resident's trays. Easily agitated. Diet Regular NAS with lidded cups for safety. Weight 102#  --below IBW range (123#-149#) She feeds herself meals--often uses her fingers to eat --likes sweets and snack foods. No teeth or dentures.   * 1. Progress notes found the following incident/altercations involving resident-to-resident:   --10/18/2017 at 08:28 - Resident noted to be up walking around day lounge throwing food on the floor and taking food from other resident's trays.  --10/19/2017 at 18:00 - Resident up and ambulating in day lounge throwing her shoes across room pushing furniture against resident's wheelchairs. staff sits down with resident to assist with meal resident then gets up and proceeds to remove food from her brother's tray. when attempting to redirect resident begins hitting self in head and slamming fists on wall,  offered activities, fluids and snacks with staff to monitor for safety.  --11/6/2017 at 18:00 - Another resident was calling out to resident and calling her names. Resident became agitated and grabbed other resident's hair and pulled hard. Residents were separated by staff. Vital signs unable to be obtained due to resident was agitated.  --11/9/2017 at 21:46 - Late Entry: Note: resident has been noted to be up wandering in other resident's rooms, taking food and drinks off resident's dinner trays this shift requiring redirection numerous times.  --11/27/2017 at 07:59 - Resident up ambulating in day lounge removing food from other resident's trays requiring redirection numerous times. resident becomes agitated and begins hitting self in head. attempts to take resident to room for  self-soothing.  --12/7/2017 at 13:20 - Resident in day lounge at this time alert and nonverbal skin clean dry warm to touch resident noted to hit her head on the walls and glass numerous times this shift , staff makes attempts to redirect this resident , with no positive results noted , this resident noted to be grabbing other residents chairs in the day lounge and halls x 4 this  shift staff attempts to redirect this resident to the day lounge resident placed in chair at which time resident proceeds to kick and hit staff numerous times along with attempting to hit her head on tables and chairs in the day lounge , staff remains with resident at this time.  --12/7/2017 at 17:40 - Resident continues to be aggressive to staff along with continues to hit her head on the walls and windows, with each attempt to redirect (TRUNCATED)  **Respond appropriately to all alleged violations.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record, Incident/Accident reports, Complaints/Grievances and Reportable reports, staff interview, and resident interview, the facility failed to ensure each allegation of abuse and/or neglect were thoroughly investigated to prevent further potential abuse, neglect and mistreatment. This deficient practice caused actual harm for Residents #89, #99, #26 and #5. This deficient practice had the potential to affect more than an isolated number. Resident identifiers: #89, #99, #26, #11, #71, #5, #44, #58, #4, #212, #114. Facility census: 107.  Findings included:   * + 1. Resident #89  1. Review of Resident #89's medical records found an annual Minimum Data Set (MDS) with an Assessment reference date (ARD) of 11/07/18. This MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 for   severe cognitive impairment. Resident # 89's [DIAGNOSES REDACTED]. Severe confusion was noted with poor safety awareness with a history of falls. Resident #89 required the physical assistance of one person with bathing/showering. Resident #89  was noted as always continent of bowel and bladder functions. Requiring only supervision with most Activities of Daily living except bathing and personal hygiene.   1. A review of the Incident/Accident reports found on 02/01/18 at 10:20 AM found an incident occurred in the shower room. The incident description was as follows: Called to shower room per staff. Resident sitting in floor in shower room.   Resident noted to have a complaint of pain in left wrist. Left wrist noted to be swollen at this time. Resident has no other complaints of pain. No redness or bruising noted at this time. Resident was unable to give description states, My wrist is really hurting me. Resident noted to be holding left wrist at this time. Resident was transferred to nearby hospital and was diagnosed with [REDACTED].  A review of statements by the two (2) nurse aides (NA) present in the shower room found:  --Statement by Employee #56, NA read: I was showering (Resident #89's name) with another staff member in the shower room. As I turned to get a piece of clothing the resident got up and tried to walk by herself and lost her footing and fall the  other staff member (Employee #43, NA) tried to catch her but wasn't quick enough then got (Employee #32, licensed practical nurse (LPN) name.  --Statement by Employee #43, NA read: I was assisting another staff member in showering resident (Resident #89). As the other staff member turned to get a piece of the resident's clothing. Resident got up unassisted. She lost her footing. I  tried to catch her but I was too late.   1. Review of the significant change MDS with an ARD of 05/09/18 found the resident has had a decline in her activities of daily living (ADL) and has more episodes of incontinence. Resident remains alert to person only and continues to have poor safety awareness secondary to impaired cognitive status.   This indicates following the incident on 02/01/18 resulting in a fractured left wrist, Resident #89 has experienced a decline in her ADL status and incontinence status.   1. On 02/02/18 at 11:00 AM an in-service was provided on Proper showering techniques the following was included, Maintain a face-to-face contact when possible, stay with resident during the entire process . do not leave residents alone while   bathing or showering .   1. This incident was not reported as potential neglect until 06/12/18 (after surveyor intervention). The Social Worker (SW)   and the Director of Nursing (DON) agreed the NAs were neglectful by stepping away from the resident, whom has poor safety awareness due to impaired short term and long term memory.  This indicates actual harm for Resident #89 due to leaving the resident unsupervised and out of reach while in the shower resulting in a fall acquired fracture and pain.  No evidence was found or provided to support the facility conducted a thorough investigation or put interventions in place to protect the resident.  b) Resident #99  1) Review of the reportable allegation of abuse found a report for Resident #99, dated 05/23/18 at 1:34 AM, this report read Resident told reporter (Employee #6, Social Worker (SW) that she was trying to get out the door to smoke. She tried to get a lighter out of the alleged perpetrator's pocket. While trying to get the resident back into the building, it was alleged | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0610  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 12)  that (Employee #59, licensed practical nurse (LPN) grabbed Resident #99's right hand and squeezed her fingers hard causing pain. Resident #99 stated, It hurt real bad. I thought she had broken it.  Review of statements found:  --Statement by the alleged perpetrator, Employee #59, LPN read: On 05/23/18 at 11:34 AM, Resident #99 was trying to exit through the back door, as I was trying to redirect the resident. The resident was moving wheelchair back into facility the resident grabbed the door frame. I slid my hand under her wrist to guide it backwards. The resident started putting her  hand in my pockets, when I asked her not to. At which time resident became agitated and stated, She was going out and we couldn't stop her. then she turned her wheelchair and propelled her self-down the hallway muttering and cursing.  --Statement by the nurse whom examined the resident, Employee #23, RN read: This nurse was on East wing, approached by SW and asked to assess (Resident #99's) hand. Resident sitting in her room in her wheelchair at bedside with remote in hand.  This nurse asked her if something occurred, she stated, Yes, I don't remember if it was yesterday or today. I was going outside to smoke. I opened the door, I know all the codes. Somebody grabbed my chair, it jerked me backwards. I couldn't go forward or backwards. I saw the girl's lighter in her pocket and I grabbed it. She grabbed my hand and squeezed it real  hard. It hurt bad. I thought she broke it. I continued to assess the resident's right hand, this is the hand that was squeezed .   1. This allegation was submitted to Adult Protective Service (APS) on 05/24/18 only. Was not faxed to all of the other required agencies until 05/30/18. Only statements obtained was the perpetrator, Employee #59, LPN and Resident #99. Employee #23, registered nurse (RN) provided a statement with her assessment of Resident 99's injuries (she did not observe the incident). 2. Interview with Resident #99, on 06/05/18 at 9:15 AM, she stated, The staff punishes me with not letting me smoke with the other residents due to I feed the cats my leftover food and cat food that I have bought. They say all kinds of stuff to me,   they mock me and they take the food I have for the cats and throws it in the trash can in front of me and says, Ha,Ha. They  grab my wheelchair and prevent me from moving and jerks my chair backwards at times. Employee #59 squeezed my hand/fingers one time so hard I thought she broke it. The resident appeared distraught and upset as she recalled these incidents.  No evidence was found or provided to support the facility conducted a thorough investigation or put interventions in place to protect the resident.  This deficient practice has caused Resident #99 actual psychosocial and physical harm which caused mental anguish, pain, intimidation, punishment, and humiliation.  c) Resident #11   1. Review of Complaint/Concern log found a complaint for Resident #11 dated 03/14/18 and made by the resident's family. The concern stated, (DON's name) received a call from (Name of resident's family) on 03/14/18. Also, another family member was also on the call. The family stated, I want to report abuse. Nurse Aide (NA) #46, is pulling out resident's hair. The   family member stated, I have reported this to Employee #23, RN and nothing is been done. The family goes on to say they do not want NA #46 taking care of her as they feel mistreatment by NA #46 is a retaliation due to some criminal activity by residents and NA #46's family.  A review of the statements found:  --Statement by Director of Nursing (DON) #18, NA #7 and Registered Nurse (RN) dated at 2:00 PM on 03/14/18, statement read: Employee #23, NA #7 and myself (DON) went to the residents room. I asked her if she was happy here and she stated, No, I want to go to Williamson. I asked her if everyone is good to her and she stated, They take my stuff. I asked her if anyone  has done anything mean to her and she stated, No. I asked her if anyone had smacked her or hit her she stated, No. I asked  her if NA #7, RN #23 or myself (DON) had ever pulled her hair and she stated, No. She denied anyone being mean to her and stated they take care of her.  --Statement by Employee #46, NA, the alleged perpetrator read: I was putting the resident (Resident #11) to bed after the last smoke break. The resident became combative and I asked the nurse (No name mentioned) to assist me with the resident.  She continued hitting and scratching me. We got her in bed and I was removing her jewelry and the necklace pulled her hair. I told her, I was sorry and she said, She was fine and told me to put her stuff on the table.   1. This alleged allegation of abuse/neglect was not reported till 06/15/18 after this Surveyor's inquiry.   No evidence was found or provided to support the facility conducted a thorough investigation or put interventions in place to protect the resident.  d) Resident #71   1. A review of the Complaint log found a complaint dated 03/28/18. This complaint was from Resident #71 and was made to the DON. This complaint read: (Resident's name) made a complaint that the staff got her up at 4 am to take a shower. 2. No statements or investigation could be found. After this surveyors intervention it was determined by the staff this was an allegation of neglect/abuse. This was submitted on 06/05/18 to the proper agencies.   No evidence was found or provided to support the facility conducted a thorough investigation or put interventions in place to protect the resident.  e) Resident #44  Review of the grievance/concern forms for the last year found three (3) concern/allegations:  1) Allegation #1: On 06/08/17, Resident #44 reported that Licensed Practical Nurse (LPN) #36 did not give her medication to her. The resident reported this to RN #123, who informed the DON. Social Worker (SW) #124 and DON spoke with the resident separately concerning her allegation. Resident denies the allegation of abuse, neglect or anyone treating her in a mean  manner. She stated she does not like her nurse because she crushes her medicine. On 06/22/17, resident is no longer receiving medication crushed.  Review of the statements found:  Statement by Employee #36, LPN, made on 06/01/17 at approximately 1700 (5pm): (Employee #123, RN's name) approached nurse's station and stated, who is (Resident #116's name) nurse? Myself as well as another LPN were sitting at desk when RN #123  states, she needs Tylenol, I explained to RN #123 that this resident did not have a current RX (prescription) for Tylenol.  RN #123 states, well you need to give her some Tylenol again I explained, we can call the doctor and ask but most generally she doesn't give Tylenol for a temperature of 99 degrees. Rn #123 states, well I said to give it to her. I explained that I  could not give a medication without an order from the physician and again I explained I would contact the physician regarding residents request. I attempted to explain the parameters for Tylenol toxicity due to the resident currently had  an order for [REDACTED]. At this time, RN #123 states well you are well within your limits and what could Tylenol hurt? This writer attempted to let Rn #123 know of resident's drug seeking behaviors but that again one of us would contact the physician and let her know the residents request.  Statement by Employee #16, LPN on 06/01/17 at 17:40 (5:40 pm): A resident went up to (Employee #123's name) and told her she had a temperature of 99 degrees. The RN came out and told the nurse to give her two (2) Tylenol. Staff attempted to explain  to the RN we could not give medication without a physician's orders [REDACTED].#116 two (2) Tylenol. Resident stated she had a temperature of 99 degrees. Staff again attempted that we could not give it. This nurse took RN into the office and attempted to give some of the resident's history with being told I was just an LPN and that she had been a nurse for [AGE] years. Rn became loud to the point that it was almost a scream cutting this nurse off.  Statement by Employee #36, LPN on 06/06/17 at approximately 15:10 (3:10 pm) While sitting at nurse's station attempting to complete paperwork to send a resident to hospital. RN #123 is noted to approach the nurse's station and state, I need drugs this writer informed her that I would be with her in just a minute as I was on the telephone attempting to transfer a  resident to the hospital. RN #123 states, I wasn't speaking to you, I was speaking to Employee #57, nurse assistant (NA). This writer explained if you are referring to Resident #214's antibiotic then I am his nurse and Employee #57, NA cannot help you. Then Rn #123 stated, I apparently, I didn't make myself clear I was speaking to Employee #57, NA. Again, this writer explained I was the resident's nurse and would get the medication for her in a minute that I am in the process of sending someone to the hospital. RN #123 stated, Obviously, you don't seem to understand that I am not speaking to you. At this time, this writer went into the med room and got the said antibiotic and handed it to the RN #123. RN #123 walks off.  Statement by Employee #36, LPN on 06/08/17 at approximately 18:45 (6:45 pm) Front door alarm sounds and this writer proceeds up to the front to check for safety and reset the alarm. I proceeded out to the parking lot to be sure that no residents  were in the parking lot unattended. For further safety, this writer walked around building to be sure the parking lot and surrounding areas were clear. This writer then proceeded to the west wing to check with nursing staff to be sure all | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0610  **Level of harm -** Actual harm  **Residents Affected -** Some | (continued... from page 13) residents were accounted for.  Upon entering front hall of the east wing (Employee #123, RN name) was noted to be standing at the nurses station with the Medication Administration Report (MAR) for the A section opened. This writer enters the nurses station to begin charting on the computer when Employee #123, RN states, You did not give (Resident #44' name) her meds today. At this time this writer states, yes I did. Employee #123, RN then states, Well, I don't think you did. She told me you didn't. I explained to the  RN that the resident has hoarding behaviors, refusal of medications and false accusations. The RN then states, Well if she says you didn't give the medication, as far as I concerned you didn't. RN proceeds to state, There are no initials in the  box (referring to the MAR). Then asked, Is 0900 9am or pm. At this time, I stated 0900 is 9am and I have been checking my MAR to be sure all of my finger sticks and etc. has been documented. RN then states, Well, apparently you did not learn anything in nursing school, you are to sign medication out when you give them, therefore, as far as I am concerned you did not give her medication and that is abuse. At no time did the RN allow me to see which area of MAR that she was referring  to and nor did she know the resident had been found with a [MEDICATION NAME] (pain medication) in her bra. While attempting to explain this resident's behavior the RN became loud and she pointed her finger in this writers face and saying, Where  were you when I was looking for you. I explained I was assessing the situation with the door alarm going off and being sure there was no elopement, while she sat in the office not responding.  She (RN) continued to point finger in this writer's face. This writer states, please get your finger out of my face. RN states, you need to get in the office to continue this conversation. This writer informed the RN , I will not go to a  private area to hold a conversation with you alone. You are pointing your finger in my face and approached me here in front of my peers and other residents. So, I will not go to a private area with you if you want to speak to me I will do it in  front of the DON only. At this time, the RN looks to her right where several staff as well as residents in the hallway. The RN then states, (Employee #57, NA name) go to the office. At this time this writer explained that the NA was a union representative but as a union employee I did not wish to have her present to speak with the RN without the DON in the building due to her aggressive tone with me. RN states, Well, we will see about this I am calling the DON. At no time during this shift did this RN look at any other MAR located on the east wing or any other resident's MAR regarding medications or administration. But the RN stated, Well she is my family and I will take care of this.  Statement by Employee #125, SW read, On 06/09/17, I spoke with resident, (Resident #44's Name), regarding allegations a nurse made that the resident was not getting her medications. (Resident #44's name) came to my office in private and I asked her if any nurse failed to give her medications to her. The resident stated, No, I get my medication but she makes me take them crushed and I don't like that. I then looked in the resident's chart to verify that the resident had an  physician's orders [REDACTED]. There was a fact an order stating that the resident was to receive crushed meds. I explained this to the resident and she stated her understanding.  Statement by Employee #60. LPN read, On 06/11/17, I worked the A hallway on the west wing and (Employee #39, LPN name) worked B hallway. She came to me with a [MEDICATION NAME] (pain medication) in a cup and asked me to waste it with her.  She  stated she had popped it out in error when pulling a residents medicine, Medication was wasted. We counted at the end of shift and a [MEDICATION NAME](pain med) was signed out by Employee #39 for 06/11/17 at 9 pm and count was correct. This allegation of abuse/neglect was never reported to the required state agencies.   1. Allegation #2: Resident #44 reported an allegation of neglect on 06/12/17 to RN #123. RN #123 reported teh allgeation to   the Nursing Home Administrator and DON. The allegation made by the resident was not given her medication by LPN #123. LPN #123 went to the resident's room to confront the resident by reportedly saying, Since you told on me now your medication  will be crushed and I will give them to you in the hallway.  Employee #124, social worker (SW) talked with resident regarding the allegations and resident denies the allegation. The resident continues to deny any issues with staff being mean to her. She continues to be upset about her medications being crushed.  A review of the statements found:  --Statement by Employee #44, RN, made on 06/12/17 at 5:35 p.m.: While doing skin assessments, patient in room [ROOM NUMBER]-  (Resident #112, Name) called me into her room. She asked me if I was a nurse and I told her yes. Resident stated she did not receive her 9 pm meds last night. I asked her did she know what med, she stated little blue pill (pain pill-  [MEDICATION NAME]). I told her I would check the MAR (Medication Administration Record), it may have been not available. I checked the MAR and the medication ([MEDICATION NAME]) had been signed out with the initials of (Employee #39, LPN). I went  back into Resident #112's room with Employee #125, Graduate Nurse (GN). What month is it? she stated, June. I asked the year, she stated, (YEAR). I asked her who was the President, she said, Trump. I asked her if she was mistaken, she said,  No, I check my pills, my pain pill is the little blue pill and it wasn't there. And I asked the nurse (Employee #39) about it and she told she didn't have it and that they would give it at 12:00 a.m. She went on to tell me several nurses about it and nobody came to see her.  --Statement by Employee #49, NA read: On (MONTH) 12, (YEAR) (time ineligible) I was putting (Name of Resident #76) in bed. The wife of Resident #76 was in the room. Employee #124, RN came in the room to do an assessment on the resident. The RN #124 started talking to the resident's wife about an incident that happened on east hallway. She told the wife it involved  Resident #44 and Employee #36, LPN. She said she was in the bathroom and heard everything between Resident #44 and LPN #36.  She told the wife she had took it to the Administrator and the DON. She told the wife she had screen shot all the nurses whom had been notified. She said they were that the facility was trying to get rid of her and that she reported it to the  state. On (MONTH) 20, (YEAR) the wife of Resident #76 was told by RN #124 this morning she had received her letter from the state and they were investigated.  --Statement by Employee #41, NA, written on 06/12/17 read: I witnessed a resident come up to the RN and asked about her medicine, The RN came up to the nurse's station and asked where the nurse was at. The RN started looking through the medicine book and when the LPN came back to the nurse's station the RN asked the LPN about the resident's medicine and the  MAR book. The RN was telling the LPN she must have not learned anything or she would have signed the book when she gave the resident meds. RN points at LPN and asked her to come to the office. LPN asked the RN to stop pointing her finger in her  face. The RN said I'm not pointing in your face.  --Statement by Employee #125, SW, written on 06/12/17 read: On 06/12/17, SW spoke with (Resident #44's name), regarding allegations the LPN #36 had not gave her medications and that she came into her room and stated, Since you told on me now your meds will be crushed and I will give it to you in the hall. Resident #44 denies that this was said and also says,  Nobody has been mean to me here but I don't like that nurse (LPN #36) because she crushes my meds.  --Statement by Employee #127, NA written on 06/12/17 read; I witnessed Resident #44 go into the DON's office and told RN #124 she had not had any of her medicine all day. The RN looked at the MAR and the book had holes in it where the LPN had  not signed the MAR. The LPN assured the RN she had gave the meds but had not signed the MAR. The RN's and the LPN's voices kept getting louder.  This allegation of abuse/neglect was never reported to the required agencies.   1. Allegation #3: A review of the concern/grievance log found a statement on 06/20/17 at approximately 9:00 AM, NA #58 entered Resident #44's room to find her roommate some clothes, this resident had her roommates pants on. I came out and got my nurse (LPN #36) to assist me. The housekeeper and I was standing in the closet doorway and Resident #44 exited the bathroom holding the clothes. The resident threw the pants and hit LPN #36 in the side of head and then openly smacked her across the face knocking her glasses off. I attempted to get the resident away from the nurse and calm her down. The   resident started yelling at the nurse stating, I am going to have your job [\*\*\*] . I dare you to hit me queer.  --Statement by Employee #36, LPN dated 06/20/17 at 9:15 am read: Upon entering Resident #44's room I found the resident had her roommates pants on. This writer, NA and Housekeeper were standing in the doorway of this resident's room when she exited the bathroom striking this nurse in left side of face multiple times screaming, (RN #124) and I are going to have  your job [\*\*\*] . I dare you to hit me I'm calling RN #124 and she will beat your face in. This writer exited the room and notified the supervisor of this resident's behaviors and notified the physician with new orders to administer [MEDICATION NAME] 20 milligrams (mg) intramuscularly (IM) now for agitation. Power of attorney (POA) notified and made aware of residents room change from east to west wing.  --Statement by Employee #125, SW read: On 06/20/17, I talked with Resident #44, to discuss her recent behaviors against LPN #36. I asked (Resident #44) why she hit LPN#36 and the resident stated the nurse was discrimating against her. I then asked her why she felt LPN #36 was discriminating against her and she stated, She crushes my medicine and RN #124 told me it was | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0610  **Level of harm -** Actual harm  **Residents Affected -** Some  F 0641  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 14)  discrimation. I then asked the resident why she called the LPN #36 a queer. She at first denied calling her a queer but later she said, RN #124 told me that she was married to a girl so what would you call her. I told the resident that she could not act that way toward a staff member regardless of her personal opinion. The resident states understanding. This incident of alleged abuse/neglect was never entered on a Complaint/Grievance form and was never reported to the appropriate agencies.  No evidence was found or provided to support the facility conducted a thorough investigation or put interventions in place to protect the resident.  f) Residents in room [ROOM NUMBER] on 06/19/17   1. A review of grievance/concern book found an incident, in which, occurred between RN #124 and Employee NA #54 on 06/19/17 at 9:30 PM.   Review of the statements found:  --Statement by Employee #124, RN read, On 06/19/17 at around 9:30 pm I went to find who had Resident #117 to do a skin assessment. The NAs stated that NA #54 had Resident #117. I went into room [ROOM NUMBER]and pecked on the door, when I entered the room I said, Good I need to do (Resident #118's skin assessment and you have her undressed. NA #54 said, Why  you want to look at her ass. I asked him what he meant by that and he said, I don't have time for this. I told him I needed him to help me turn Resident #117 on her side for a skin assessment that I had already did everything but her buttock and back. NA #54 stated, I have more patients to do and you treat NAs and nurses like were dirt under her feet. I told him that wasn't true and I hadn't even talked to him before, that I was told to get help turning the patients and he kept saying you never asked. I asked again for help and he refused. I told him I was going to write him up for insubordination and he stated, I am getting a union representative. As I came down the hall I stated, I hate it when people are smart asses.  Statement by Employee #54, NA read: I was on west wing and was in room [ROOM NUMBER] assisting the residents in getting ready for bed, when RN #124 came into the room and told me that I was to come to room [ROOM NUMBER]. I asked her to give me a minute, she then told me that she needed me to do it now. I told her she needed to give me a minute. I asked her if she  needed to look at their butt. She then told me I was getting wrote up for insubordination. I never refused to help. I told  her to give me a minute. Then she yelled at me and called me a smartass. She stated she was the RN and that meant I would do as I am told and not question her. She pulled her name badge at my face and said that is what this means.   1. This allegation of abuse and neglect was not reported till after this Surveyor's inquiry of situation. It was reported on 06/08/18 (a year after the occurrence).   No evidence was found or provided to support the facility conducted a thorough investigation or put interventions in place to protect the resident.  g) Resident #58   1. A review of the Complaint/Grievance book found a concern by Resident #58. This allegation was reported to Employee #125, SW on 01/23/18.   Concern: Resident reports that she doesn't know how to take the Employee #43, NA on evening shift. NA sometimes. She takes good care of me but she likes to joke and sometimes doesn't know how to take her. She makes me anxious.  Interventions: NA #43 received a written warning. The resident no longer has the NA as her caregiver.   1. No further statements could be located. This allegation of abuse/neglect was not reported until after this Surveyors inquiry. Reported on 06/05/18 to the required agencies.   No evidence was found or provided to support the facility conducted a thorough investigation or put interventions in place to protect the resident.  h) Resident #4   1. A review of the complaint/grievance book found a concern by Resident #4. This allegation was reported to SW #6 on 06/01/18.   Concerns noted by Resident #4's family read: Still not getting coffee at all meals. Staff were mocking the resident Help at the west wing nurses' station. One NA would not give the NA caring for Resident #4 the proper size of diapers. Wednesday, pm shift. The resident was lying angled in her bed. She couldn't get to her tray to eat. She had a bowl of peaches in her  bed with her. She needs pulled up to the tray to eat her meals. Residents name is not over her bed it is a different residents' name.  Interventions: Coffee is being served at all meals. Diaper issue is resolved. Resident will eat in day lounge (sitting upward).   1. No further statements could be located. This allegation of abuse/neglect was not reported until after this Surveyors inquiry. Reported on 06/05/18 to the required agencies.   i) Complaint made by the Ombudsman   1. A review of the complaint/grievance book found a concern by the Ombudsman. This allegation was reported to SW #6 on 05/15/18.   Concern: I had more complaints of staff being rude to residents. One employee (NA) was huffing and puffing and complaining because they were short staffed and everyone was acting crazy. After the visitor reported this a resident spoke up and  reported a nurse who is mean and hateful and this nurse had to shut up and quit talking so much. The NA said that is her personality. There is one employee that is hateful as the devil; when one resident asked for a drink and another asked if there was church tonight; she yelled and was hateful to both residents. Please address this issue with your staff.   1. This surveyor was provided a copy of an in-service for Ethical behavior and Unethical behavior conducted on 05/16/18 by the Administrator. 2. No further statements could be located. This allegation of abuse/neglect was not reported until after this Surveyors inquiry. Reported on 06/06/18 to the required agencies.   No evidence was found or provided to support the facility conducted a thorough investigation or put interventions in place to protect the resident.   1. Resident #114    1. Review of Resident #114's medical records found the resident was admitted on [DATE].   Care Plan initiated; Resident is a 53yr. old female-Diagnosis: [REDACTED]. Staff supervises meals, assists as needed. She is noted to take food from other resident's trays. Easily agitated. Diet Regular NAS with lidded cups for safety. Weight 102#  --below IBW range (123#-149#) She feeds herself meals--often uses her fingers to eat --likes sweets and snack foods. No teeth or dentures.   * 1. Progress notes found the following incident/altercations involving resident-to-resident:   --10/18/2017 at 08:28 - Resident noted to be up walking around day lounge throwing food on the floor and taking food from other resident's trays.  --10/19/2017 at 18:00 - Resident up and ambulating in day lounge throwing her shoes across room pushing furniture against resident's wheelchairs. staff sits down with resident to assist with meal resident then gets up and proceeds to remove food from her brother's tray. when attempting to redirect resident begins hitting self in head and slamming fists on wall,  offered activities, fluids and snacks with staff to monitor for safety.  --11/6/2017 at 18:00 - Another resident was calling out to resident and calling her names. Resident became agitated and grabbed other resident's hair and pulled hard. Residents were separated by staff. Vital signs unable to be obtained due to resident was agitated.  --11/9/2017 at 21:46 - Late Entry: Note: resident has been noted to be u (TRUNCATED)  **Ensure each resident receives an accurate assessment.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and staff interview, the facility failed to ensure they completed an accurate minimum data set (MDS) assessment for one (1) of resident reviewed Resident #90's MDS assessment was not accurate in the area of restraints. This failed practice had the potential to affect a limited number of residents. Resident identifier: #90.  Facility census: 107. Finindgs included:   * + 1. Resident #90   The medical record review for Resident #90 revealed an MDS assessment dated [DATE] which indicated the resident had a limb restraint used less than daily. Observations of the resident on 06/05/18 at 11:09 AM revealed the resident did not have a | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0641  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few F 0656  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 15)  limb restraint. During an interview with MDS Coordinator #18 on 06/05/18 at 11:20 AM she confirmed the resident did not have a limb restraint and this was an error on the MDS assessment.  **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, staff review, resident interview and medical record review, the facility failed to develop and/or implement a person-centered comprehensive care plan for four (4) of twenty-eight (28) residents whose care plans were reviewed during the long term care survey process.  Resident #19 did not receive a lidded cup for his coffee, as directed by the care plan. Resident #57's care plan was not implemented for skin breakdown. Resident #37's care plan was not implemented for pressure ulcer prevention. Resident #58 did not have a care plan developed to address dental needs. Resident identifiers: #19, #57, #37. #58. Facility census: 107.  Findings included:   1. Resident #19   Observation of the morning meal on 06/11/18 at 7:15 a.m., found the resident was seated in the dining room. Activity employees were serving beverages to the residents in the dining room, prior to the meal service. Employee #93 a activities employee, served the resident a cup of coffee. The resident attempted to drink the coffee from the cup, spilling the cup of coffee on his leg.  At 8:08 a.m. on 06/05/18, Employee #95, a restorative nursing assistant, verified the resident did not have and was not using his special, sippy cup, as he should have been, when he spilled his coffee.  Review of the physician's orders [REDACTED].  Review of the current plan of care found the following focus/problem:  The resident has, nutritional problem or potential nutritional problem related to weight loss while in hospital .at times will not allow staff to assist with feeding him. Restorative dining program-supplements and appetite stimulant added.  The goal associated with the problem: The resident will maintain adequate nutritional status as evidenced by maintaining weight within ideal body range-no signs or symptoms of malnutrition and consuming at least 75% of at least 2 meals daily through next review.  Interventions included: Provide and serve diet as ordered. Regular no added salt/no concentrated sweets-weighted utensils and lidded cup for drinks. The intervention was updated on 10/03/17.  The director of nursing (DON) was interviewed at 10:50 a.m. on 06/11/18. The DON said the nursing assistant/activities employee should have looked in the system, looked at the care plan and should have known to serve liquids in a cup with a lid.   1. Resident #37   Observation of the resident at 8:30 a.m. on 06/05/18 found the resident was in bed eating breakfast. The resident was not wearing heel protectors.  At 1:55 p.m. on 06/05/18, the resident again did not have heel protectors on while in bed.  At 2:10 p.m. observation with Employee #22, a licensed practical nurse (LPN), confirmed the resident was not wearing heel protectors. E #22 said she would get a pair of heel protectors for the resident. E#22 was unable to find the heel protector  in the resident's room. E #22 said the resident frequently removes the heel protectors.  At 8:25 a.m. on 06/12/18, observation of the resident with nursing assistant #68 confirmed the resident in bed without her heel protectors. The heel protectors were aligned side by side at the foot of the bed.  Review of the care plan found the following focus/problem: The resident has potential for pressure ulcer development related to incontinence, Dementia, Decreased mobility status [REDACTED].  The goal associated with the problem: The resident will have intact skin, free of redness, blisters or discoloration through review date.  Interventions included: Heel Protectors on while in bed, the intervention was dated 06/23/14.  Review of the medical record found the last minimum data set (MDS) a 30 day medicare MDS with an assessment reference date (ARD) of 04/03/18. The MDS coded the resident as requiring extensive assistance of one staff person for bed mobility.  Transfers required extensive assistance of 2 staff members. The resident did not ambulate.  It would be unlikely the resident could have removed the heel protectors from her room. The care plan did not indicate the resident removed the heel protectors.  At 8:57 a.m. on 06/12/18, the above information was discussed with the director of nursing (DON) who had no further information to present.   1. Resident #57   At 4:28 p.m. on 06/05/18, the resident said he thought he had a pressure ulcer on his right heel and one on his coccyx. Observation of the residents right heel with the director of nursing (DON) at 9:17 a.m. on 06/07/18, found what appeared to be an unstageable pressure ulcer to the resident's right heel. The DON said the area could not be pressure because it was not open.  At 9:50 a.m. on 06/07/18, the nurse surveyor observed the resident's heel with the DON and also felt the area to the right heel was an unstageable pressure area.  The DON provided a copy of weekly skin audits, starting on 02/26/18. Further Skin audit were dated: 03/02/18, 03/09/18, 03/16/18, 03/23/18, 03/30/18, 04/07/18, 04/14/18, 05/19/18, 04/25/18, 04/30/18, 05/05/18, 05/10/18, 05/10/18, 05/16/18,  05/22/18, 05/28/18, and 06/03/18. All of the audits noted the resident has no skin breakdown.  On 06/07/18 the physician examined the resident and documented the following: Today I was requested to see resident due to area on his right heel and skin issues on his buttocks and coccyx area. Today his is alert and verbal. Resident skin assessment done. I requested resident to position. He is noted to put pressure on his heels and is also noted to pull self  up in bed causing shearing. He lays on part of his left side and on the left side of his bed. I have tried to instruct resident to turn from side to side and position self and also I have showed him how to position self without causing shearing and pressure. Resident has a odd sense of humor.  The assessment concluded: Unstageable pressure tissue injury on right heel and shearing on buttocks from position self. Medications and orders reviewed. Heel pads have been in use. I will change this to moon boots. He has ossur rebound knee brace to left knee as needed. He does not use brace. Right heel has been receiving skin prep. I am going to use [MEDICATION NAME] every day. (Name of resident) has been instructed on positioning self which I have demonstrated to him. He is encouraged to turn and position every 2 hours  Review of the current care pan found the following focus/problem: The resident has potential for impaired skin integrity or pressure ulcer development related to decreased mobility, weakness, incontinence of bowel, does not like to get out of bed. Has diabetes mellitus but is non-compliant, 11/03/17 area to right heel Achilles area 05/22/18 treated with [MEDICATION NAME] for yeast.  The goal associated with the problem: The resident will have intact skin, free of redness, blisters or discoloration through review date.  Interventions included: Notify nurse/doctor of any new areas of skin breakdown. Redness, blisters, bruises, discoloration noted during bath or daily care.  At 11:00 a.m. on 06/11/18, the DON confirmed the facility was unaware of any pressure areas/skin breakdown regarding the resident until surveyor intervention on 06/07/18 at 9:17 a.m.   1. Resident #58   During an interview on 06/05/18 at 07:24 AM, Resident #58 stated she had a bottom loose tooth that she would like to have pulled. She stated the loose tooth affects her ability to eat certain foods. She was noted to have a missing bottom tooth  and possible decay of other bottom teeth. Resident #58 stated she had no upper teeth and she wore upper dentures.  Resident #58's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/23/18 stated the resident had obvious or likely cavities or broken natural teeth.  Review of Resident #58's comprehensive care plan revealed the resident did not have a care plan focus related to dental | | | |

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Previous Versions Obsolete

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0656 | (continued... from page 16) status.  During an interview on 06/11/18 at 12:21 PM, the MDS Coordinator Registered Nurse (RN) verified Resident #58's comprehensive care plan did not have a care plan focus related to dental status. She stated the comprehensive care plan should have a  focus related to dental status. The MDS Coordinator RN stated she would revise Resident #58's comprehensive care plan to include a focus related to dental status.  **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and staff interview, the facility to failed to revise the comprehensive care plan in the area of bowel and bladder elimination for one of 28 residents reviewed. This failed practice had the potential to affect a limited number of residents. Resident identifier: #17. Facility census: 107.  Findings included:  a) Resident #17  Review of Resident #17's physician orders [REDACTED].  Review of Resident #17's comprehensive care plan contained the focus, The resident has alteration in b/b (bowel and bladder) functions r/t (related to) .Returned from hospital 3/13/18 with Foley cath for retention. Comprehensive care plan interventions/tasks included the following interventions:  --#16 fr (French) with 10 cc balloon drainage d/t (due to) retention.  --#16 fr with 10 cc balloon to bedside drainage d/t retention. Change prn (as needed).  During an interview on 06/11/18 at 02:44 PM, the Minimum Data Set (MDS) Coordinator Registered Nurse (RN) was informed Resident #17's comprehensive care plan contained a focus and interventions related to the resident's Foley catheter, which  had been removed on 04/21/18. The MDS Coordinator RN stated she would revise Resident #17's comprehensive care plan.  **Provide appropriate treatment and care according to orders, resident’s preferences and goals.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, staff interview and record review, the facility failed to ensure two (2) of twenty-eight (28)  residents reviewed received care and services in accordance with professional standards of care. Resident #19 had increased [MEDICAL CONDITION] and significant weight gain which was not evaluated. The facility failed to identify a non-pressure skin condition for Resident #74. Resident identifier: #19 and #74. Facility census: 107.  Findings included:   1. Resident #19   Observation of the resident at 9:58 a.m. on 06/05/18, found his feet appeared to be very swollen from excess fluid, especially the right foot. The resident was wearing gripper socks. The top of the socks extended approximated two inches above the ankle. The socks were stretched tight against the residents feet and ankles with excess puffiness of the skin around the band at the top of the sock and around the ankles.  Further review of the medical record on 06/07/18, found the resident weighted 169.2 pounds on 05/05/18. On 06/02/18, the residents weight was 191 pounds.  An interview with the dietary manager (DM) at 8:18 a.m. on 06/07/18, found the increased weight of 21.8 pounds in 28 days was not addressed. She said the facility should have addressed the weight gain. She then said the doctor probably address  it but she could find no evidence to support her statement. The DM then said some of the weight gain was probably fluid because the resident's weight fluctuates and he receives a diuretic. The DM said the resident had previously lost weight so the facility had placed the resident in restorative dining and had added a weight stimulating medication and extra supplements.  On 04/13/18, the physician examined the resident and noted he had 2 plus [MEDICAL CONDITION] to his bilateral lower extremities. There was no evidence in the medical record to support the resident had been evaluated by the physician since 04/13/18.  At 9:45 a.m. on 06/07/18, the resident was observed with the Director of Nursing (DON). The resident was seated in his room, in a wheelchair. The resident was wearing purple gripper socks. When the DON removed the sock to the right foot, many indentations were present in the residents skin from the [MEDICAL CONDITION]. The resident had an indentation around his entire lower leg where the top of the sock had been against the skin. Indentations were found in the area around the  residents ankle where the sock was against the folds of the skin due to the [MEDICAL CONDITION]. The DON removed the socks. After the observation of the resident, the physician examined the resident and noted the resident had a 3 plus [MEDICAL CONDITION] to the bilateral lower extremities. The physician ordered a BNP, BMP and chest x-ray to be obtained immediately. (Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BPN that is made by your  heart and blood vessels. BNP levels are higher than normal when you have heart failure. The basic metabolic panel (BMP) is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and  potassium, and how well the kidneys are working.)  At 6:59 p.m. on 06/07/18, a nurses note indicated the physician was noted of the results of the laboratory values. The residents [MEDICATION NAME] was increased from 20 mg's daily to 40 mg's daily for a [DIAGNOSES REDACTED]. The residents glucose and BUN were high. The BNP was high-178. (Reference range is 0-100.) The chest x-ray results, The heart is normal in size, lungs are clear, no plural effusion, no acute fracture, no pneumothorax. The conclusion was no  acute disease.  At 8:45 a.m. on 06/12/18, the DON said the physician told her the resident was actually doing better than before, he had  gained weight. She confirmed the physician had increased the resident's [MEDICATION NAME] to address the access fluid. The physician did not document in her visit notes of 06/07/18, the resident had improved.  .   1. Resident #74   On 06/07/18 at 11:36 AM, the dressing change to Resident #74's right ankle pressure ulcer was observed. The pressure ulcer dressing change was performed by Licensed Practical Nurse (LPN) #38 with assistance from LPN #16. Following the procedure, the surveyor requested the pressure ulcer prevention boot on Resident #74's left foot be removed for inspection of her left  ankle. Upon removal of the pressure ulcer prevention boot by LPN #38, a purplish-reddish area was noted on the bottom of the resident's left heel. A previous review of Resident #74's medical records had not revealed information regarding a skin condition on the resident's left heel. LPN #38 and LPN #16 stated they were not aware of a current skin condition on Resident #74's left heel.  The Director of Nursing (DoN) was called into the room to assess the skin condition on Resident #74's left foot. She stated the pressure ulcer prevention boot was removed every day for foot care, but she did not know why the skin condition had not been previously identified.  Resident #74's attending physician was asked by the DoN to assess the skin condition on Resident #74's left heel. The physician asked when the condition had been identified and was told it had been identified today. The physician stated she did not believe the condition was a pressure ulcer due to the location on the bottom of the heel.  The DoN and the physician stated non-pressure skin conditions should have weekly assessments performed. The physician stated she would order a new treatment for [REDACTED].  A nursing progress note written at 6/7/2018 on 10:45 AM stated, Resident noted to have area 4cm L (long) x 3.9cm W (wide), superficial, purplish in color on bottom of left heel. (Attending physician) in house at time and assessed area, determined  to be blood blister, no soft boggy skin noted, new orders written: clean left heel with nss (normal saline solution), pat dry, apply spray [MEDICATION NAME] q (every) day until resolved.  The physician's progress note written 06/07/18 stated, Staff report that resident has a discoloration on her left foot which | | | |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Some |
| F 0657 |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Few |
| F 0684 |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Few |

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Previous Versions Obsolete

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0684  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few F 0686  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0689  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 17)  staff has asked me to evaluate. The assessment was a blood blister on the bottom of left foot.  **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, resident interview, staff interview, and record review, the facility failed to ensure one (1) of three  (3) residents reviewed for the care area of pressure ulcers received care consistent with professional standards of practice. The facility was unaware the resident had an unstageable pressure area to the right heel until surveyor intervention. Resident identifier #57. Facility census: 107.  Findings included:  a) Resident #57  At 4:28 p.m. on 06/05/18, the resident said he thought he had a pressure ulcer on his right heel and one on his coccyx. The resident was observed wearing a padded boot to both his left and right feet.  Review of the resident's most recent minimum data set (MDS), with an assessment reference date (ARD) of 04/23/18 noted the resident did not have any pressure ulcers but had been assessed to be at risk for developing pressure ulcers.  Review of the current care plan found the resident only had the potential for impaired skin integrity of pressure ulcer development.  The medical record did not indicate the resident had any indication of terminally illness or end of life conditions. He had no weight loss or any indication of malnutrition.  The resident had capacity to make medical decisions and had a score of 14 out of 15 on his brief interview for mental status (BIMS) on 04/23/18. A score of 14 indicates the resident is cognitively intact.  Observation of the residents right heel with the director of nursing (DON) at 9:17 a.m. on 06/07/18, found what appeared to be an unstageable pressure ulcer to the resident's right heel. The DON said the area could not be pressure because it was not open.  At 9:50 a.m. on 06/07/18, a nurse surveyor observed the resident's heel with the DON and three (3) licensed nurses. Licensed Practical Nurse, (LPN) #27 picked up the resident's foot and began tapping on the right heel with her index and middle finger. The resident said, Ouch, that hurts, on two occasions. The surveyor asked, It that really necessary? LPN #27  lowered the resident's heel to the bed. The nurse surveyor concluded the resident had an unstageable pressure ulcer to the right heel.  Review of the medical record found a physician's orders [REDACTED].  A second order written on 01/12/18, to wash bilateral buttocks with warm, soapy water, rinse and dry well, apply [MEDICATION NAME]. [MEDICATION NAME] every shift and as needed due to redness and denuding.  The treatments on the treatment administration record (TAR) had been initialed by nursing staff as being provided as directed.  At 10:30 a.m. on 06/07/18, the licensed practical nurse (LPN) #36 was asked if she knew anything about the condition of the resident's right heel. She said the resident gets a treatment. When asked if she was aware of the pressure area, she  replied, I just do the treatment.  The DON provided a copy of weekly skin audits, on 06/07/18 at 11:30 a.m. The weekly skin audits began on 02/26/18. Further Skin audit were dated: 03/02/18, 03/09/18, 03/16/18, 03/23/18, 03/30/18, 04/07/18, 04/14/18, 05/19/18, 04/25/18, 04/30/18, 05/05/18, 05/10/18, 05/10/18, 05/16/18, 05/22/18, 05/28/18, and 06/03/18. All of the audits noted the resident has no skin breakdown. The DON said the resident's physician was coming in to examine the resident.  On 06/11/18 at 10:53 a.m. the DON was asked for a copy of the physician's examination and was asked for any other documentation regarding the resident's coccyx and right heel. The following information was provided:  --On 06/07/18 the physician examined the resident and documented the following: Today I was requested to see resident due to area on his right heel and skin issues on his buttocks and coccyx area. Today his is alert and verbal. Resident skin  assessment done. I requested resident to position. He is noted to put pressure on his heels and is also noted to pull self up in bed causing shearing. He lays on part of his left side and on the left side of his bed. I have tried to instruct resident to turn from side to side and position self and also I have showed him how to position self without causing shearing and pressure. Resident has a odd sense of humor.  --The assessment documented: Unstageable pressure tissue injury on right heel and shearing on buttocks from position self. Medications and orders reviewed. Heel pads have been in use. I will change this to moon boots. He has ossur rebound knee brace to left knee as needed. He does not use brace. Right heel has been receiving skin prep. I am going to use [MEDICATION NAME] every day. (Name of resident) has been instructed on positioning self which I have demonstrated to him. He is encouraged to turn and position every 2 hours  A skin/Wound note dated 06/07/18 at 2:30 p.m. revealed an unstageable pressure ulcer to the right heel. 2.8 centimeters by  2.5 centimeters. The depth was undetermined. The description: yellow scabbed like area.  Review of the current care plan found the following focus/problem: The resident has potential for impaired skin integrity or pressure ulcer development related to decreased mobility, weakness, incontinence of bowel, does not like to get out of bed. Has diabetes mellitus but is non-compliant, 11/03/17 area to right heel Achilles area 05/22/18 treated with [MEDICATION NAME] for yeast.  The goal associated with the problem: The resident will have intact skin, free of redness, blisters or discoloration through review date.  Interventions included: Notify nurse/doctor of any new areas of skin breakdown. Redness, blisters, bruises, discoloration noted during bath or daily care.  At 11:00 a.m. on 06/11/18, the DON confirmed the facility was unaware of any pressure areas regarding the resident until surveyor intervention on 06/07/18 at 9:17 a.m.  **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, record review, and staff interview, the facility failed to ensure the resident's environment was as free from accidents as possible for one (1) of three (3) residents reviewed for the care area of accidents during the long term care survey. Staff failed to follow the physician's orders [REDACTED].#19. The resident spilled his coffee resulting in a burn to the resident's thigh. Resident identifier: #19. Facility census: 107.  Findings included:  a) Resident #19  Observation of the morning meal on 06/11/18 at 7:15 a.m., found the resident was seated in the dining room. Activity employees were serving beverages to the residents in the dining room, prior to the meal service. Employee #93 a activities employee, also a certified nursing assistant, served the resident a cup of coffee. The resident attempted to drink the  coffee from the cup, spilling the cup of coffee on his leg.  At 8:08 a.m. on 06/05/18, Employee #95, a restorative nursing assistant, verified the resident did not have and was not using his special, sippy cup, as he should have been, when he spilled his coffee.  Further review of the medical record found a physician's orders [REDACTED]. The resident's [DIAGNOSES REDACTED].  A nurses note, dated 06/05/18 at 7:30 a.m. found, Resident was brought to the floor at this time from the dining room. Per staff report resident requested a cup of coffee and activities staff gave him a cup. The cup of coffee didn't have a lid.  Resident spilled the coffee on his outer left thigh. Resident was immediately brought to his room and body audit revealed a reddened area to his left outer thigh. Area was cleaned with NSS (normal saline solution), and patted dry. Resident was cleaned and changed. Resident was assisted back to the dining room for breakfast. Resident denies nor exhibits signs of  pain. New orders rec. (received) from (name of physician) to apply [MEDICATION NAME] cream q (every) 6 hours PRN (as needed). Obtain PT/INR. r/p (responsible party) informed.  Review of the current plan of care found the following focus/problem: The resident has, nutritional problem or potential | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0689  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0726  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 18)  nutritional problem related to weight loss while in hospital .at times will not allow staff to assist with feeding him. Restorative dining program-supplements and appetite stimulant added.  The goal associated with the problem: The resident will maintain adequate nutritional status as evidenced by maintaining weight within ideal body range-no signs or symptoms of malnutrition and consuming at least 75% of at least 2 meals daily through next review.  Interventions included: Provide and serve diet as ordered. Regular no added salt/no concentrated sweets-weighted utensils and lidded cup for drinks. The intervention was updated on 10/03/17.  The facility reported the incident to adult protective services, the nursing home program, and the nurse aide registry on 06/05/18 starting at 10:38 a.m.  The immediate fax reporting noted the brief description of the allegation as, The alleged perpetrator gave (name of resident) a cup of coffee without knowledge of him having an order for [REDACTED].  The director of nursing (DON) was interviewed at 10:50 a.m. on 06/11/18. The DON said the nursing assistant should have looked in the system, looked at the care plan and should have known to serve liquids in a cup with a lid.  **Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review, incident/accident reports review, complaint/grievance report review, immediate reports review, staff interview, resident interview and review of the facility's abuse policy. The facility failed to ensure competent nursing staff to ensure abuse and neglect allegation reporting, identifying pressure ulcers, identifying  non-pressure related skin conditions, proper medication storage and labeling, and proper laundry sterilization. This practice had the potential to affect all residents in the facility. Facility census: 107  Findings included:   1. Free from Abuse/Neglect and Reporting/Investigating Abuse/Neglect    1. Resident #89   Review of Resident #89's medical records found an annual Minimum Data Set (MDS) with an Assessment reference date (ARD) of 11/07/18. This MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 for  severe cognitive impairment. Resident # 89's [DIAGNOSES REDACTED]. Severe confusion was noted with poor safety awareness with a history of falls. Resident #89 required the physical assistance of one person with bathing/showering. Resident #89  was noted as always continent of bowel and bladder functions. Requiring only supervision with most Activities of Daily living except bathing and personal hygiene.  A review of the Incident/Accident reports found on 02/01/18 at 10:20 AM found an incident occurred in the shower room. The incident description was as follows: Called to shower room per staff. Resident sitting in floor in shower room. Resident  noted to have a complaint of pain in left wrist. Left wrist noted to be swollen at this time. Resident has no other complaints of pain. No redness or bruising noted at this time. Resident was unable to give description states, My wrist is really hurting me. Resident noted to be holding left wrist at this time. Resident was transferred to nearby hospital and was diagnosed with [REDACTED].  A review of statements by the two (2) nurse aides (NA) present in the shower room found:  --Statement by Employee #56, NA read: I was showering (Resident #89's name) with another staff member in the shower room. As I turned to get a piece of clothing the resident got up and tried to walk by herself and lost her footing and fall the  other staff member (Employee #43, NA) tried to catch her but wasn't quick enough then got (Employee #32, licensed practical nurse (LPN) name.  --Statement by Employee #43, NA read: I was assisting another staff member in showering resident (Resident #89). As the other staff member turned to get a piece of the resident's clothing. Resident got up unassisted. She lost her footing. I  tried to catch her but I was too late.  Review of the significant change MDS with an ARD of 05/09/18 found the resident has had a decline in her activities of daily living (ADL) and has more episodes of incontinence. Resident remains alert to person only and continues to have poor safety awareness secondary to impaired cognitive status.  This indicates following the incident on 02/01/18 resulting in a fractured left wrist, Resident #89 has experienced a decline in her ADL status and incontinence status.  On 02/02/18 at 11:00 AM an in-service was provided on Proper showering techniques the following was included, Maintain a face-to-face contact when possible, stay with resident during the entire process . do not leave residents alone while  bathing or showering .  This indicates actual harm for Resident #89 due to leaving the resident unsupervised and out of reach while in the shower resulting in a fall acquired fracture and pain.   * 1. Resident #99   Review of the reportable allegation of abuse found a report for Resident #99, dated 05/23/18 at 1:34 AM, this report read Resident told reporter (Employee #6, Social Worker (SW) that she was trying to get out the door to smoke. She tried to get a lighter out of the alleged perpetrator's pocket. While trying to get the resident back into the building, it was alleged  that (Employee #59, licensed practical nurse (LPN) grabbed Resident #99's right hand and squeezed her fingers hard causing pain. Resident #99 stated, It hurt real bad. I thought she had broken it.  Review of statements found:  --Statement by the alleged perpetrator, Employee #59, LPN read: On 05/23/18 at 11:34 AM, Resident #99 was trying to exit through the back door, as I was trying to redirect the resident. The resident was moving wheelchair back into facility the resident grabbed the door frame. I slid my hand under her wrist to guide it backwards. The resident started putting her  hand in my pockets, when I asked her not to. At which time resident became agitated and stated, She was going out and we couldn't stop her. then she turned her wheelchair and propelled her self-down the hallway muttering and cursing.  --Statement by the nurse whom examined the resident, Employee #23, RN read: This nurse was on East wing, approached by SW and asked to assess (Resident #99's) hand. Resident sitting in her room in her wheelchair at bedside with remote in hand.  This nurse asked her if something occurred, she stated, Yes, I don't remember if it was yesterday or today. I was going outside to smoke. I opened the door, I know all the codes. Somebody grabbed my chair, it jerked me backwards. I couldn't go forward or backwards. I saw the girl's lighter in her pocket and I grabbed it. She grabbed my hand and squeezed it real  hard. It hurt bad. I thought she broke it. I continued to assess the resident's right hand, this is the hand that was squeezed .  Only statements obtained was the perpetrator, Employee #59, LPN and Resident #99. Employee #23, registered nurse (RN) provided a statement with her assessment of Resident 99's injuries (she did not observe the incident).  Interview with Resident #99, on 06/05/18 at 9:15 AM, she stated, The staff punishes me with not letting me smoke with the other residents due to I feed the cats my leftover food and cat food that I have bought. They say all kinds of stuff to me, they mock me and they take the food I have for the cats and throws it in the trash can in front of me and says, Ha,Ha. They  grab my wheelchair and prevent me from moving and jerks my chair backwards at times. Employee #59 squeezed my hand/fingers one time so hard I thought she broke it. The resident appeared distraught and upset as she recalled these incidents.  This deficient practice has caused Resident #99 actual psychosocial and physical harm which caused mental anguish, pain, intimidation, punishment, and humiliation.   * 1. Resident #11   Review of Complaint/Concern log found a complaint for Resident #11 dated 03/14/18 and made by the resident's family. The concern stated, (DON's name) received a call from (Name of resident's family) on 03/14/18. Also, another family member was also on the call. The family stated, I want to report abuse. Nurse Aide (NA) #46, is pulling out resident's hair. The  family member stated, I have reported this to Employee #23, RN and nothing is been done. The family goes on to say they do not want NA #46 taking care of her as they feel mistreatment by NA #46 is a retaliation due to some criminal activity by residents and NA #46's family.  A review of the statements found: | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0726  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 19)  --Statement by Director of Nursing (DON) #18, NA #7 and Registered Nurse (RN) dated at 2:00 PM on 03/14/18, statement read: Employee #23, NA #7 and myself (DON) went to the residents room. I asked her if she was happy here and she stated, No, I want to go to Williamson. I asked her if everyone is good to her and she stated, They take my stuff. I asked her if anyone  has done anything mean to her and she stated, No. I asked her if anyone had smacked her or hit her she stated, No. I asked  her if NA #7, RN #23 or myself (DON) had ever pulled her hair and she stated, No. She denied anyone being mean to her and stated they take care of her.  --Statement by Employee #46, NA, the alleged perpetrator read: I was putting the resident (Resident #11) to bed after the last smoke break. The resident became combative and I asked the nurse (No name mentioned) to assist me with the resident.  She continued hitting and scratching me. We got her in bed and I was removing her jewelry and the necklace pulled her hair. I told her, I was sorry and she said, She was fine and told me to put her stuff on the table.   1. Resident #71   A review of the Complaint log found a complaint dated 03/28/18. This complaint was from Resident #71 and was made to the DON. This complaint read: (Resident's name) made a complaint that the staff got her up at 4 am to take a shower.  No statements or investigation could be found. After this surveyors intervention it was determined by the staff this was an allegation of neglect/abuse.   1. Resident #44   Review of the grievance/concern forms for the last year found three (3) concern/allegations:  Allegation #1: On 06/08/17, Resident #44 reported that Licensed Practical Nurse (LPN) #36 did not give her medication to  her. The resident reported this to RN #123, who informed the DON. Social Worker (SW) #124 and DON spoke with the resident separately concerning her allegation. Resident denies the allegation of abuse, neglect or anyone treating her in a mean  manner. She stated she does not like her nurse because she crushes her medicine. On 06/22/17, resident is no longer receiving medication crushed.  Review of the statements found:  Statement by Employee #36, LPN, made on 06/01/17 at approximately 1700 (5pm): (Employee #123, RN's name) approached nurse's station and stated, who is (Resident #116's name) nurse? Myself as well as another LPN were sitting at desk when RN #123  states, she needs Tylenol, I explained to RN #123 that this resident did not have a current RX (prescription) for Tylenol.  RN #123 states, well you need to give her some Tylenol again I explained, we can call the doctor and ask but most generally she doesn't give Tylenol for a temperature of 99 degrees. Rn #123 states, well I said to give it to her. I explained that I  could not give a medication without an order from the physician and again I explained I would contact the physician regarding residents request. I attempted to explain the parameters for Tylenol toxicity due to the resident currently had  an order for [REDACTED]. At this time, RN #123 states well you are well within your limits and what could Tylenol hurt? This writer attempted to let Rn #123 know of resident's drug seeking behaviors but that again one of us would contact the physician and let her know the residents request.  Statement by Employee #16, LPN on 06/01/17 at 17:40 (5:40 pm): A resident went up to (Employee #123's name) and told her she had a temperature of 99 degrees. The RN came out and told the nurse to give her two (2) Tylenol. Staff attempted to explain  to the RN we could not give medication without a physician's orders [REDACTED].#116 two (2) Tylenol. Resident stated she had a temperature of 99 degrees. Staff again attempted that we could not give it. This nurse took RN into the office and attempted to give some of the resident's history with being told I was just an LPN and that she had been a nurse for [AGE] years. Rn became loud to the point that it was almost a scream cutting this nurse off.  Statement by Employee #36, LPN on 06/06/17 at approximately 15:10 (3:10 pm) While sitting at nurse's station attempting to complete paperwork to send a resident to hospital. RN #123 is noted to approach the nurse's station and state, I need drugs this writer informed her that I would be with her in just a minute as I was on the telephone attempting to transfer a  resident to the hospital. RN #123 states, I wasn't speaking to you, I was speaking to Employee #57, nurse assistant (NA). This writer explained if you are referring to Resident #214's antibiotic then I am his nurse and Employee #57, NA cannot help you. Then Rn #123 stated, I apparently, I didn't make myself clear I was speaking to Employee #57, NA. Again, this writer explained I was the resident's nurse and would get the medication for her in a minute that I am in the process of sending someone to the hospital. RN #123 stated, Obviously, you don't seem to understand that I am not speaking to you. At this time, this writer went into the med room and got the said antibiotic and handed it to the RN #123. RN #123 walks off.  Statement by Employee #36, LPN on 06/08/17 at approximately 18:45 (6:45 pm) Front door alarm sounds and this writer proceeds up to the front to check for safety and reset the alarm. I proceeded out to the parking lot to be sure that no residents  were in the parking lot unattended. For further safety, this writer walked around building to be sure the parking lot and surrounding areas were clear. This writer then proceeded to the west wing to check with nursing staff to be sure all residents were accounted for.  Upon entering front hall of the east wing (Employee #123, RN name) was noted to be standing at the nurses station with the Medication Administration Report (MAR) for the A section opened. This writer enters the nurses station to begin charting on the computer when Employee #123, RN states, You did not give (Resident #44' name) her meds today. At this time this writer states, yes I did. Employee #123, RN then states, Well, I don't think you did. She told me you didn't. I explained to the  RN that the resident has hoarding behaviors, refusal of medications and false accusations. The RN then states, Well if she says you didn't give the medication, as far as I concerned you didn't. RN proceeds to state, There are no initials in the  box (referring to the MAR). Then asked, Is 0900 9am or pm. At this time, I stated 0900 is 9am and I have been checking my MAR to be sure all of my finger sticks and etc. has been documented. RN then states, Well, apparently you did not learn anything in nursing school, you are to sign medication out when you give them, therefore, as far as I am concerned you did not give her medication and that is abuse. At no time did the RN allow me to see which area of MAR that she was referring  to and nor did she know the resident had been found with a [MEDICATION NAME] (pain medication) in her bra. While attempting to explain this resident's behavior the RN became loud and she pointed her finger in this writers face and saying, Where  were you when I was looking for you. I explained I was assessing the situation with the door alarm going off and being sure there was no elopement, while she sat in the office not responding.  She (RN) continued to point finger in this writer's face. This writer states, please get your finger out of my face. RN states, you need to get in the office to continue this conversation. This writer informed the RN , I will not go to a  private area to hold a conversation with you alone. You are pointing your finger in my face and approached me here in front of my peers and other residents. So, I will not go to a private area with you if you want to speak to me I will do it in  front of the DON only. At this time, the RN looks to her right where several staff as well as residents in the hallway. The RN then states, (Employee #57, NA name) go to the office. At this time this writer explained that the NA was a union representative but as a union employee I did not wish to have her present to speak with the RN without the DON in the building due to her aggressive tone with me. RN states, Well, we will see about this I am calling the DON. At no time during this shift did this RN look at any other MAR located on the east wing or any other resident's MAR regarding medications or administration. But the RN stated, Well she is my family and I will take care of this.  Statement by Employee #125, SW read, On 06/09/17, I spoke with resident, (Resident #44's Name), regarding allegations a nurse made that the resident was not getting her medications. (Resident #44's name) came to my office in private and I asked her if any nurse failed to give her medications to her. The resident stated, No, I get my medication but she makes me take them crushed and I don't like that. I then looked in the resident's chart to verify that the resident had an  physician's orders [REDACTED]. There was a fact an order stating that the resident was to receive crushed meds. I explained this to the resident and she stated her understanding.  Statement by Employee #60. LPN read, On 06/11/17, I worked the A hallway on the west wing and (Employee #39, LPN name) worked B hallway. She came to me with a [MEDICATION NAME] (pain medication) in a cup and asked me to waste it with her.  She  stated she had popped it out in error when pulling a residents medicine, Medication was wasted. We counted at the end of shift and a [MEDICATION NAME](pain med) was signed out by Employee #39 for 06/11/17 at 9 pm and count was correct. Allegation #2: Resident #44 reported an allegation of neglect on 06/12/17 to RN #123. RN #123 reported teh allgeation to the  Nursing Home Administrator and DON. The allegation made by the resident was not given her medication by LPN #123. LPN #123 went to the resident's room to confront the resident by reportedly saying, Since you told on me now your medication will be  crushed and I will give them to you in the hallway.  Employee #124, social worker (SW) talked with resident regarding the allegations and resident denies the allegation. The resident continues to deny any issues with staff being mean to her. She continues to be upset about her medications being | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0726  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 20) crushed.  A review of the statements found:  --Statement by Employee #44, RN, made on 06/12/17 at 5:35 p.m.: While doing skin assessments, patient in room [ROOM NUMBER]-  (Resident #112, Name) called me into her room. She asked me if I was a nurse and I told her yes. Resident stated she did not receive her 9 pm meds last night. I asked her did she know what med, she stated little blue pill (pain pill-  [MEDICATION NAME]). I told her I would check the MAR (Medication Administration Record), it may have been not available. I checked the MAR and the medication ([MEDICATION NAME]) had been signed out with the initials of (Employee #39, LPN). I went  back into Resident #112's room with Employee #125, Graduate Nurse (GN). What month is it? she stated, June. I asked the year, she stated, (YEAR). I asked her who was the President, she said, Trump. I asked her if she was mistaken, she said,  No, I check my pills, my pain pill is the little blue pill and it wasn't there. And I asked the nurse (Employee #39) about it and she told she didn't have it and that they would give it at 12:00 a.m. She went on to tell me several nurses about it and nobody came to see her.  --Statement by Employee #49, NA read: On (MONTH) 12, (YEAR) (time ineligible) I was putting (Name of Resident #76) in bed. The wife of Resident #76 was in the room. Employee #124, RN came in the room to do an assessment on the resident. The RN #124 started talking to the resident's wife about an incident that happened on east hallway. She told the wife it involved  Resident #44 and Employee #36, LPN. She said she was in the bathroom and heard everything between Resident #44 and LPN #36.  She told the wife she had took it to the Administrator and the DON. She told the wife she had screen shot all the nurses whom had been notified. She said they were that the facility was trying to get rid of her and that she reported it to the  state. On (MONTH) 20, (YEAR) the wife of Resident #76 was told by RN #124 this morning she had received her letter from the state and they were investigated.  --Statement by Employee #41, NA, written on 06/12/17 read: I witnessed a resident come up to the RN and asked about her medicine, The RN came up to the nurse's station and asked where the nurse was at. The RN started looking through the medicine book and when the LPN came back to the nurse's station the RN asked the LPN about the resident's medicine and the  MAR book. The RN was telling the LPN she must have not learned anything or she would have signed the book when she gave the resident meds. RN points at LPN and asked her to come to the office. LPN asked the RN to stop pointing her finger in her  face. The RN said I'm not pointing in your face.  --Statement by Employee #125, SW, written on 06/12/17 read: On 06/12/17, SW spoke with (Resident #44's name), regarding allegations the LPN #36 had not gave her medications and that she came into her room and stated, Since you told on me now your meds will be crushed and I will give it to you in the hall. Resident #44 denies that this was said and also says,  Nobody has been mean to me here but I don't like that nurse (LPN #36) because she crushes my meds.  --Statement by Employee #127, NA written on 06/12/17 read; I witnessed Resident #44 go into the DON's office and told RN #124 she had not had any of her medicine all day. The RN looked at the MAR and the book had holes in it where the LPN had  not signed the MAR. The LPN assured the RN she had gave the meds but had not signed the MAR. The RN's and the LPN's voices kept getting louder.  Allegation #3: A review of the concern/grievance log found a statement on 06/20/17 at approximately 9:00 AM, NA #58 entered Resident #44's room to find her roommate some clothes, this resident had her roommates pants on. I came out and got my  nurse (LPN #36) to assist me. The housekeeper and I was standing in the closet doorway and Resident #44 exited the bathroom holding the clothes. The resident threw the pants and hit LPN #36 in the side of head and then openly smacked her across  the face knocking her glasses off. I attempted to get the resident away from the nurse and calm her down. The resident started yelling at the nurse stating, I am going to have your job [\*\*\*] . I dare you to hit me queer.  --Statement by Employee #36, LPN dated 06/20/17 at 9:15 am read: Upon entering Resident #44's room I found the resident had her roommates pants on. This writer, NA and Housekeeper were standing in the doorway of this resident's room when she exited the bathroom striking this nurse in left side of face multiple times screaming, (RN #124) and I are going to have  your job [\*\*\*] . I dare you to hit me I'm calling RN #124 and she will beat your face in. This writer exited the room and notified the supervisor of this resident's behaviors and notified the physician with new orders to administer [MEDICATION NAME] 20 milligrams (mg) intramuscularly (IM) now for agitation. Power of attorney (POA) notified and made aware of residents room change from east to west wing.  --Statement by Employee #125, SW read: On 06/20/17, I talked with Resident #44, to discuss her recent behaviors against LPN #36. I asked (Resident #44) why she hit LPN#36 and the resident stated the nurse was discrimating against her. I then asked her why she felt LPN #36 was discriminating against her and she stated, She crushes my medicine and RN #124 told me it was discrimation. I then asked the resident why she called the LPN #36 a queer. She at first denied calling her a queer but  later she said, RN #124 told me that she was married to a girl so what would you call her. I told the resident that she could not act that way toward a staff member regardless of her personal opinion. The resident states understanding.   1. Residents in room [ROOM NUMBER] on 06/19/17   A review of grievance/concern book found an incident, in which, occurred between RN #124 and Employee NA #54 on 06/19/17 at 9:30 PM.  Review of the statements found:  --Statement by Employee #124, RN read, On 06/19/17 at around 9:30 pm I went to find who had Resident #117 to do a skin assessment. The NAs stated that NA #54 had Resident #117. I went into room [ROOM NUMBER]and pecked on the door, when I entered the room I said, Good I need to do (Resident #118's skin assessment and you have her undressed. NA #54 said, Why  you want to look at her ass. I asked him what he meant by that and he said, I don't have time for this. I told him I needed him to help me turn Resident #117 on her side for a skin assessment that I had already did everything but her buttock and back. NA #54 stated, I have more patients to do and you treat NAs and nurses like were dirt under her feet. I told him that wasn't true and I hadn't even talked to him before, that I was told to get help turning the patients and he kept saying you never asked. I asked again for help and he refused. I told him I was going to write him up for insubordination and he stated, I am getting a union representative. As I came down the hall I stated, I hate it when people are smart asses.  Statement by Employee #54, NA read: I was on west wing and was in room [ROOM NUMBER] assisting the residents in getting ready for bed, when RN #124 came into the room and told me that I was to come to room [ROOM NUMBER]. I asked her to give me a minute, she then told me that she needed me to do it now. I told her she needed to give me a minute. I asked her if she  needed to look at their butt. She then told me I was getting wrote up for insubordination. I never refused to help. I told  her to give me a minute. Then she yelled at me and called me a smartass. She stated she was the RN and that meant I would do as I am told and not question her. She pulled her name badge at my face and said that is what this means.   1. Resident #58   A review of the Complaint/Grievance book found a concern by Resident #58. This allegation was reported to Employee #125, SW on 01/23/18.  Concern: Resident reports that she doesn't know how to take the Employee #43, NA on evening shift. NA sometimes. She takes good care of me but she likes to joke and sometimes doesn't know how to take her. She makes me anxious. Interventions: NA #43 received a written warning. The resident no longer has the NA as her caregiver.  No further statements, investigation or intervention could be located.   1. Resident #4   A review of the complaint/grievance book found a concern by Resident #4. This allegation was reported to SW #6 on 06/01/18.  Concerns noted by Resident #4's family read: Still not getting coffee at all meals. Staff were mocking the resident Help at the west wing nurses' station. One NA would not give the NA caring for Resident #4 the proper size of diapers. Wednesday, pm shift. The resident was lying angled in her bed. She couldn't get to her tray to eat. She had a bowl of peaches in her  bed with her. She needs pulled up to the tray to eat her meals. Residents name is not over her bed it is a different residents' name.  Interventions: Coffee is being served at all meals. Diaper issue is resolved. Resident will eat in day lounge (sitting upward).  No further statements could be located.   1. Complaint made by the Ombudsman   A review of the complaint/grievance book found a concern by the Ombudsman. This allegation was reported to SW #6 on 05/15/18. Concern: I had more complaints of staff being rude to residents. One employee (NA) was huffing and puffing and complaining because they were short staffed and everyone was acting crazy. After the visitor reported this a resident spoke up and | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0726  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0761  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0791  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 21)  reported a nurse who is mean and hateful and this nurse had to shut up and quit talking so much. The NA said that is her personality. There is one employee that is hateful as the devil; when one resident asked for a drink and another asked if there was church tonight; she yelled and was hateful to both residents. Please address this issue with your staff.  This surveyor was provided a copy of an in-service for Ethical behavior and Unethical behavior conducted on 05/16/18 by the Administrator.  No further statements could be located.  10) Resident #114  Review of Resident #114's medical records found the resident was admitted on [DATE].  Care Plan initiated; Resident is a 53yr. old female-Diagnosis: [REDACTED]. Staff supervises meals, assists as needed. She is noted to take food from other resident's trays. Easily agitated. Diet Regular NAS with lidded cups for safety. Weight 102#  --below IBW range (123#-149#) She feeds herself meals--often uses her fingers to eat --likes sweets and snack foods. No teeth or dentures.  Progress notes found the following incident/altercations involving resident-to-resident:  --10/18/2017 at 08:28 - Resident noted to be up walking around day lounge throwing food on the floor and taking food from other resident's trays.  --10/19/2017 at 18:00 - Resident up and ambulating in day lounge throwing her shoes across room pushing furniture against resident's wheelchairs. staff sits down with resident to assist with meal resident then gets up and proceeds to remove food from her brother's tray. when attempting to redirect resident begins hitting self in head and slamming fists on wall,  offered activities, fluids and snacks with staff to monitor for safety.  --11/6/2017 at 18:00 - Another resident was calling out to resident and calling her names. Resident became agitated and grabbed other resident's hair and pulled hard. Residents were separated by staff. Vital signs unable to be obtained due to resident was agitated.  --11/9/2017 at 21:46 - Late Entry: Note: resident has been noted to be up wandering in other resident's rooms, taking food and drinks off resident's dinner trays this shift requiring redirection numerous times.  --11/27/2017 at 07:59 - Resident up ambulating in day lounge removing food from other resident's trays requiring redirection numerous times. resident becomes agitated and begins hitting self in head. attempts to take resident to room for  self-soothing.  --12/7/2017 at 13:20 - Resident in day lounge at this time alert and nonverbal skin clean dry warm to touch resident noted to hit her head on the walls and glass numerous times this shift , staff makes attempts to redirect this resident , with no positive results noted , this resident noted to be grabbing other residents chairs in the day lounge and halls x 4 this  shift staff attempts to redirect this resident to the day lounge resident placed in chair at which time resident proceeds to kick and hit staff numerous times along with attempting to hit her head on tables and chairs in the day lounge , staff remains with resident at this time.  --12/7/2017 at 17:40 - Resident continues to be aggressive to staff along with continues to hit her head on the walls and windows, with each attempt to redirect this resident from getting upset and pushing another resident's wheelchair.  --12/12/2017 at 09:35- Resident is noted to be standing at the nurse's station grabbing other resident w/c as they pass x 1 this shift along with getting notably agitated x 1 at nurse station then enters the day lounge door and began to push and shake another residents merri walker resident assisted to room via staff now to self-soothing.  --2/14/2018 at 15:21 - Resident was agitated and shoving tray tables and tables in dining area. when this nurse enters dining area to calm her down another resident stated that you smashed my hand remover other resident near nurse's station for further evaluations.  --2/27/2018 at 10:30 - RNA states that Resident was in DL and ran over and grabbed another female resident by the hair and got ahold of her left breast. No injuries were noted to either resident. The residents were separated.  --3/16/2018 at 16:40 - Nurse called to day lounge this resident grabbed another resident by arm and struck him on his chest. staff separated residents and redirected this resident verbally and assisted to sit on couch to watch the television. vital  signs refused now.  --3/26/2018 at 15:56 - Reported via staff that resident has been noted to get in bed with roommate now, resident removed from roommate's bed. Will continue to monitor resident  --3/26/2018 at 16:30 - Resident has been noted to run up and grab another resident's mobile device now. Re (TRUNCATED)  **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation and staff interview, the facility failed to store and properly label medications in accordance with standard practice. This had the potential to effect the potency and effectiveness of the medication. This was true for  eight out of 14 insulin (a medication used to control the blood sugar levels for people diagnosed with [REDACTED]. Resident identifiers: #21, #79, #14, #61, #69, #90 and #99. Facility census 107.  Findings included:   1. East Wing   During a review of medication cart on 06/06/18 at 8:44 AM, with Licensed Practical Nurse #63, revealed eight (8) of 14 vials of insulin without dates to indicate the initial date the medication was opened. Listed below are the Residents and the medication:  --Resident # 21, [MEDICATION NAME] and [MEDICATION NAME];  --Resident # 14, [MEDICATION NAME] and [MEDICATION NAME] R;  --Resident # 61, [MEDICATION NAME];  --Resident # 99, [MEDICATION NAME] and [MEDICATION NAME]; and  --Resident # 79 [MEDICATION NAME].  During an interview on 06/06/18 at 9:00 AM, DON was informed of findings. She had no comment.   1. West hall medication cart   During the facility task medication administration on 06/06/18 at 8:29 AM, observation revealed two (2) of nine (9) insulin bottles in the west hall medication cart were not dated when they were opened. These insulin bottles were [MEDICATION  NAME]for Resident #90 and Resident #69. Licensed Practical Nurse (LPN) #121 and LPN #28 confirmed the two (2) insulin vials had not been dated when opened. They agreed the insulin vials should have been dated when they were opened so the vial  discard date could be determined.  **Provide or obtain dental services for each resident.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on resident interview, medical record review and staff interview, the facility failed to provide dental services for three (3) of seven (7) residents reviewed for the care area of dental. The facility failed to replace missing dentures for Resident #17, failed to have a loose tooth evaluated for Resident #58, and failed to schedule teeth cleaning for Resident #44. Resident identifiers: #17, #58, #44. Facility census: 107.  Findings included:  a) Resident #17  During an interview on 06/05/18 at 06:59 AM, Resident #17 stated while in the facility she used to have upper dentures but they have been missing. The resident stated she had reported her upper dentures were missing but nothing had been done to replace them. Resident #17 was unable to state how long her upper dentures were missing or to whom she had reported the loss. She stated she was unable to eat some of the food she was given due to the lack of upper dentures.  The monthly nursing summary dated 04/16/18 stated Resident #17 was edentulous with upper dentures.  During an interview on 06/11/18 at 02:45 PM, the Minimum Data Set (MDS) Coordinator confirmed Resident #17 had upper dentures. She stated she was not aware the resident no longer had her dentures. She stated she would attempt to locate the | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0791  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0812  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0842  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0865  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 22)  upper dentures. She stated Resident #17's upper dentures would be replaced if they were unable to be located.  During an interview on 06/11/18 at 04:23 PM, the Registered Nursing Assistant (RNA) and Activities Coordinator, who is responsible for lost items, stated she was not aware Resident #17's upper dentures were missing. The Director of Quality Assurance Social Worker was also present during this conversation.  During an interview on 06/12/18 at 03:37 PM, the MDS Coordinator stated Resident #17's upper dentures could not be located.  She stated the resident said she would like an appointment for replacement dentures be made, but the resident was not sure she would attend the appointment. The resident declined an alteration in the consistency of her meals to make it easier to chew.  A Nursing Progress note was written on 6/12/2018 at 07:11 and stated as follows: Spoke with resident this am regarding diet and misplaced top denture. Resident stated that she has some difficulty chewing food but declined to have food cut or chopped. Stated that she wanted it left the way it was. New order to schedule Apt (appointment) / Consult with (outside physician) for denture replacement.   1. Resident #58   During an interview on 06/05/18 at 07:24 AM, Resident #58 stated she had a bottom loose tooth that she would like to have pulled. She stated the loose tooth affects her ability to eat certain foods. She was noted to have a missing bottom tooth,  and possible decay of other bottom teeth. Resident #58 stated she had no upper teeth and she wore upper dentures.  On 06/11/18 at 12:21 PM, the Minimum Data Set (MDS) Coordinator Registered Nurse (RN) accompanied the surveyor into Resident #58's room. In response to Resident #58's question about whether she was having any dental problems, the resident stated  she had a loose tooth. She showed the MDS Coordinator RN that she was able to wiggle back and forth the bottom tooth. The MDS Coordinator RN asked Resident #58 if she would like to have the loose tooth evaluated for possible extraction. The resident replied she would like to have all her remaining bottom teeth removed. The MDS Coordinator RN stated she would make a dental appointment for Resident #58.   1. Resident #44   During an observation on 06/05/18 at 8:58 AM, Resident #44's bottom teeth had visible heavy plaque.  During an interview on 06/05/18 at 9:20 AM, DON stated she does not know the last time the resident had a dentist appointment.  During an interview on 06/05/18 at 4:24 PM, DON came in room to show dental appointment was made for this resident today for 06/06/18.  A review of medical records revealed that during the dentist appointment on 06/06/18 this resident was given [MEDICATION NAME] 300 mg (this is an antibiotic) for abscessed teeth.  **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**  Based on observations and staff interview, the facility failed to ensure food was prepared in a sanitary environment as evidenced by unclean kitchen and pantry floors. This practice had the potential to affect more than a limited number of residents. Facility Census: 107  Findings included:  On 06/05/18 at 06:03 AM observations revealed the kitchen and pantry floors had loose debris scattered throughout. The debris consisted of various small to medium size pieces of paper and dirt. The floors appeared to need to be swept and mopped.  An interview, with Dietary Cook #107, revealed the cook comes in at 5:00 am each morning. Dietary Cook #107 agreed the floor needed to be cleaner than what they presently were. Dietary Cook #107 stated the floors are not usually like this when she comes in to work. Dietary Cook #107 agreed the floors appeared to need to be swept and mopped.  Observations on 06/11/18 at 11:40 AM, revealed kitchen and pantry floors dirty with small amount of loose debris and dried paint splatters. A very large puddle of water, from water dripping from the steam table, was observed on the floor under and beside the steam table. Under the steam table was a glob of yellowish greasy looking substance that the water dripping from the steam table had eroded out the center of the glob. After surveyor pointed out the large puddle of water on the  floor and the glob of yellowish greasy looking substance, the staff stated they had placed too much water in the steam table and it over flowed. Staff mopped up the water and decided the yellowish greasy looking substance was butter used in the rice. Also found as they were mopping up the kitchen floor, were pieces of bread that had earlier fallen and been left on the floor.  **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**  Based on medical record review and staff interview, the facility failed to ensure complete and accurate medical records for one of 28 residents reviewed. The nutritional evaluation was incorrect in the area of oral status for Resident #17.  Resident identifier: #17. Facility census: 107. Findings included:  a) Resident #17  A monthly nursing summary was completed for Resident #17 on 04/16/18. The Oral Hygiene section stated Resident #17 was edentulous with upper dentures.  A nutritional evaluation was completed for Resident #17 on 5/18/18. The Oral Status section stated Resident #17 had her own teeth.  During an interview on 06/11/18 at 2:45 PM, the Minimum Data Set (MDS) Coordinator confirmed Resident #17 had upper dentures.  During an interview on 06/11/18 at 03:41 PM, the Director of Nursing (DoN) was informed Resident #17's nutritional evaluation completed on 05/18/18 was incorrect in the area of oral status and dentures. The DoN had no further information regarding the matter.  **Have a plan that describes the process for conducting QAPI and QAA activities.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, resident interview, staff interview, facility policy and record review, the facility's quality  assurance and performance improvement program (QAPI) / quality assessment and assurance (QAA) committee failed to identify, analyze, develop, monitor and implement corrective action for quality deficiencies for which they were aware of or show  have been aware of to improve the lives of the residents. Deficient practices were identified in the care areas of: Freedom from abuse, neglect and exploitation, quality of care, nursing services, and infection control. These practices had the potential to affect all residents at the facility. Facility census: 107.  Findings included:   1. Free from Abuse/Neglect and Reporting/Investigating Abuse/Neglect    1. Resident #89   Review of Resident #89's medical records found an annual Minimum Data Set (MDS) with an Assessment reference date (ARD) of 11/07/18. This MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 for  severe cognitive impairment. Resident # 89's [DIAGNOSES REDACTED]. Severe confusion was noted with poor safety awareness with a history of falls. Resident #89 required the physical assistance of one person with bathing/showering. Resident #89  was noted as always continent of bowel and bladder functions. Requiring only supervision with most Activities of Daily living except bathing and personal hygiene.  A review of the Incident/Accident reports found on 02/01/18 at 10:20 AM found an incident occurred in the shower room. The | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0865  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 23)  incident description was as follows: Called to shower room per staff. Resident sitting in floor in shower room. Resident noted to have a complaint of pain in left wrist. Left wrist noted to be swollen at this time. Resident has no other complaints of pain. No redness or bruising noted at this time. Resident was unable to give description states, My wrist is really hurting me. Resident noted to be holding left wrist at this time. Resident was transferred to nearby hospital and was diagnosed with [REDACTED].  A review of statements by the two (2) nurse aides (NA) present in the shower room found:  --Statement by Employee #56, NA read: I was showering (Resident #89's name) with another staff member in the shower room. As I turned to get a piece of clothing the resident got up and tried to walk by herself and lost her footing and fall the  other staff member (Employee #43, NA) tried to catch her but wasn't quick enough then got (Employee #32, licensed practical nurse (LPN) name.  --Statement by Employee #43, NA read: I was assisting another staff member in showering resident (Resident #89). As the other staff member turned to get a piece of the resident's clothing. Resident got up unassisted. She lost her footing. I  tried to catch her but I was too late.  Review of the significant change MDS with an ARD of 05/09/18 found the resident has had a decline in her activities of daily living (ADL) and has more episodes of incontinence. Resident remains alert to person only and continues to have poor safety awareness secondary to impaired cognitive status.  This indicates following the incident on 02/01/18 resulting in a fractured left wrist, Resident #89 has experienced a decline in her ADL status and incontinence status.  On 02/02/18 at 11:00 AM an in-service was provided on Proper showering techniques the following was included, Maintain a face-to-face contact when possible, stay with resident during the entire process . do not leave residents alone while  bathing or showering .  This indicates actual harm for Resident #89 due to leaving the resident unsupervised and out of reach while in the shower resulting in a fall acquired fracture and pain.   1. Resident #99   Review of the reportable allegation of abuse found a report for Resident #99, dated 05/23/18 at 1:34 AM, this report read Resident told reporter (Employee #6, Social Worker (SW) that she was trying to get out the door to smoke. She tried to get a lighter out of the alleged perpetrator's pocket. While trying to get the resident back into the building, it was alleged  that (Employee #59, licensed practical nurse (LPN) grabbed Resident #99's right hand and squeezed her fingers hard causing pain. Resident #99 stated, It hurt real bad. I thought she had broken it.  Review of statements found:  --Statement by the alleged perpetrator, Employee #59, LPN read: On 05/23/18 at 11:34 AM, Resident #99 was trying to exit through the back door, as I was trying to redirect the resident. The resident was moving wheelchair back into facility the resident grabbed the door frame. I slid my hand under her wrist to guide it backwards. The resident started putting her  hand in my pockets, when I asked her not to. At which time resident became agitated and stated, She was going out and we couldn't stop her. then she turned her wheelchair and propelled her self-down the hallway muttering and cursing.  --Statement by the nurse whom examined the resident, Employee #23, RN read: This nurse was on East wing, approached by SW and asked to assess (Resident #99's) hand. Resident sitting in her room in her wheelchair at bedside with remote in hand.  This nurse asked her if something occurred, she stated, Yes, I don't remember if it was yesterday or today. I was going outside to smoke. I opened the door, I know all the codes. Somebody grabbed my chair, it jerked me backwards. I couldn't go forward or backwards. I saw the girl's lighter in her pocket and I grabbed it. She grabbed my hand and squeezed it real  hard. It hurt bad. I thought she broke it. I continued to assess the resident's right hand, this is the hand that was squeezed .  Only statements obtained was the perpetrator, Employee #59, LPN and Resident #99. Employee #23, registered nurse (RN) provided a statement with her assessment of Resident 99's injuries (she did not observe the incident).  Interview with Resident #99, on 06/05/18 at 9:15 AM, she stated, The staff punishes me with not letting me smoke with the other residents due to I feed the cats my leftover food and cat food that I have bought. They say all kinds of stuff to me, they mock me and they take the food I have for the cats and throws it in the trash can in front of me and says, Ha,Ha. They  grab my wheelchair and prevent me from moving and jerks my chair backwards at times. Employee #59 squeezed my hand/fingers one time so hard I thought she broke it. The resident appeared distraught and upset as she recalled these incidents.  This deficient practice has caused Resident #99 actual psychosocial and physical harm which caused mental anguish, pain, intimidation, punishment, and humiliation.   1. Resident #11   Review of Complaint/Concern log found a complaint for Resident #11 dated 03/14/18 and made by the resident's family. The concern stated, (DON's name) received a call from (Name of resident's family) on 03/14/18. Also, another family member was also on the call. The family stated, I want to report abuse. Nurse Aide (NA) #46, is pulling out resident's hair. The  family member stated, I have reported this to Employee #23, RN and nothing is been done. The family goes on to say they do not want NA #46 taking care of her as they feel mistreatment by NA #46 is a retaliation due to some criminal activity by residents and NA #46's family.  A review of the statements found:  --Statement by Director of Nursing (DON) #18, NA #7 and Registered Nurse (RN) dated at 2:00 PM on 03/14/18, statement read: Employee #23, NA #7 and myself (DON) went to the residents room. I asked her if she was happy here and she stated, No, I want to go to Williamson. I asked her if everyone is good to her and she stated, They take my stuff. I asked her if anyone  has done anything mean to her and she stated, No. I asked her if anyone had smacked her or hit her she stated, No. I asked  her if NA #7, RN #23 or myself (DON) had ever pulled her hair and she stated, No. She denied anyone being mean to her and stated they take care of her.  --Statement by Employee #46, NA, the alleged perpetrator read: I was putting the resident (Resident #11) to bed after the last smoke break. The resident became combative and I asked the nurse (No name mentioned) to assist me with the resident.  She continued hitting and scratching me. We got her in bed and I was removing her jewelry and the necklace pulled her hair. I told her, I was sorry and she said, She was fine and told me to put her stuff on the table.   1. Resident #71   A review of the Complaint log found a complaint dated 03/28/18. This complaint was from Resident #71 and was made to the DON. This complaint read: (Resident's name) made a complaint that the staff got her up at 4 am to take a shower.  No statements or investigation could be found. After this surveyors intervention it was determined by the staff this was an allegation of neglect/abuse.   1. Resident #44   Review of the grievance/concern forms for the last year found three (3) concern/allegations:  Allegation #1: On 06/08/17, Resident #44 reported that Licensed Practical Nurse (LPN) #36 did not give her medication to  her. The resident reported this to RN #123, who informed the DON. Social Worker (SW) #124 and DON spoke with the resident separately concerning her allegation. Resident denies the allegation of abuse, neglect or anyone treating her in a mean  manner. She stated she does not like her nurse because she crushes her medicine. On 06/22/17, resident is no longer receiving medication crushed.  Review of the statements found:  Statement by Employee #36, LPN, made on 06/01/17 at approximately 1700 (5pm): (Employee #123, RN's name) approached nurse's station and stated, who is (Resident #116's name) nurse? Myself as well as another LPN were sitting at desk when RN #123  states, she needs Tylenol, I explained to RN #123 that this resident did not have a current RX (prescription) for Tylenol.  RN #123 states, well you need to give her some Tylenol again I explained, we can call the doctor and ask but most generally she doesn't give Tylenol for a temperature of 99 degrees. Rn #123 states, well I said to give it to her. I explained that I  could not give a medication without an order from the physician and again I explained I would contact the physician regarding residents request. I attempted to explain the parameters for Tylenol toxicity due to the resident currently had  an order for [REDACTED]. At this time, RN #123 states well you are well within your limits and what could Tylenol hurt? This writer attempted to let Rn #123 know of resident's drug seeking behaviors but that again one of us would contact the physician and let her know the residents request.  Statement by Employee #16, LPN on 06/01/17 at 17:40 (5:40 pm): A resident went up to (Employee #123's name) and told her she | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
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| F 0865  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 24)  had a temperature of 99 degrees. The RN came out and told the nurse to give her two (2) Tylenol. Staff attempted to explain to the RN we could not give medication without a physician's orders [REDACTED].#116 two (2) Tylenol. Resident stated she had a temperature of 99 degrees. Staff again attempted that we could not give it. This nurse took RN into the office and attempted to give some of the resident's history with being told I was just an LPN and that she had been a nurse for [AGE] years. Rn became loud to the point that it was almost a scream cutting this nurse off.  Statement by Employee #36, LPN on 06/06/17 at approximately 15:10 (3:10 pm) While sitting at nurse's station attempting to complete paperwork to send a resident to hospital. RN #123 is noted to approach the nurse's station and state, I need drugs this writer informed her that I would be with her in just a minute as I was on the telephone attempting to transfer a  resident to the hospital. RN #123 states, I wasn't speaking to you, I was speaking to Employee #57, nurse assistant (NA). This writer explained if you are referring to Resident #214's antibiotic then I am his nurse and Employee #57, NA cannot help you. Then Rn #123 stated, I apparently, I didn't make myself clear I was speaking to Employee #57, NA. Again, this writer explained I was the resident's nurse and would get the medication for her in a minute that I am in the process of sending someone to the hospital. RN #123 stated, Obviously, you don't seem to understand that I am not speaking to you. At this time, this writer went into the med room and got the said antibiotic and handed it to the RN #123. RN #123 walks off.  Statement by Employee #36, LPN on 06/08/17 at approximately 18:45 (6:45 pm) Front door alarm sounds and this writer proceeds up to the front to check for safety and reset the alarm. I proceeded out to the parking lot to be sure that no residents  were in the parking lot unattended. For further safety, this writer walked around building to be sure the parking lot and surrounding areas were clear. This writer then proceeded to the west wing to check with nursing staff to be sure all residents were accounted for.  Upon entering front hall of the east wing (Employee #123, RN name) was noted to be standing at the nurses station with the Medication Administration Report (MAR) for the A section opened. This writer enters the nurses station to begin charting on the computer when Employee #123, RN states, You did not give (Resident #44' name) her meds today. At this time this writer states, yes I did. Employee #123, RN then states, Well, I don't think you did. She told me you didn't. I explained to the  RN that the resident has hoarding behaviors, refusal of medications and false accusations. The RN then states, Well if she says you didn't give the medication, as far as I concerned you didn't. RN proceeds to state, There are no initials in the  box (referring to the MAR). Then asked, Is 0900 9am or pm. At this time, I stated 0900 is 9am and I have been checking my MAR to be sure all of my finger sticks and etc. has been documented. RN then states, Well, apparently you did not learn anything in nursing school, you are to sign medication out when you give them, therefore, as far as I am concerned you did not give her medication and that is abuse. At no time did the RN allow me to see which area of MAR that she was referring  to and nor did she know the resident had been found with a [MEDICATION NAME] (pain medication) in her bra. While attempting to explain this resident's behavior the RN became loud and she pointed her finger in this writers face and saying, Where  were you when I was looking for you. I explained I was assessing the situation with the door alarm going off and being sure there was no elopement, while she sat in the office not responding.  She (RN) continued to point finger in this writer's face. This writer states, please get your finger out of my face. RN states, you need to get in the office to continue this conversation. This writer informed the RN , I will not go to a  private area to hold a conversation with you alone. You are pointing your finger in my face and approached me here in front of my peers and other residents. So, I will not go to a private area with you if you want to speak to me I will do it in  front of the DON only. At this time, the RN looks to her right where several staff as well as residents in the hallway. The RN then states, (Employee #57, NA name) go to the office. At this time this writer explained that the NA was a union representative but as a union employee I did not wish to have her present to speak with the RN without the DON in the building due to her aggressive tone with me. RN states, Well, we will see about this I am calling the DON. At no time during this shift did this RN look at any other MAR located on the east wing or any other resident's MAR regarding medications or administration. But the RN stated, Well she is my family and I will take care of this.  Statement by Employee #125, SW read, On 06/09/17, I spoke with resident, (Resident #44's Name), regarding allegations a nurse made that the resident was not getting her medications. (Resident #44's name) came to my office in private and I asked her if any nurse failed to give her medications to her. The resident stated, No, I get my medication but she makes me take them crushed and I don't like that. I then looked in the resident's chart to verify that the resident had an  physician's orders [REDACTED]. There was a fact an order stating that the resident was to receive crushed meds. I explained this to the resident and she stated her understanding.  Statement by Employee #60. LPN read, On 06/11/17, I worked the A hallway on the west wing and (Employee #39, LPN name) worked B hallway. She came to me with a [MEDICATION NAME] (pain medication) in a cup and asked me to waste it with her.  She  stated she had popped it out in error when pulling a residents medicine, Medication was wasted. We counted at the end of shift and a [MEDICATION NAME](pain med) was signed out by Employee #39 for 06/11/17 at 9 pm and count was correct. Allegation #2: Resident #44 reported an allegation of neglect on 06/12/17 to RN #123. RN #123 reported teh allgeation to the  Nursing Home Administrator and DON. The allegation made by the resident was not given her medication by LPN #123. LPN #123 went to the resident's room to confront the resident by reportedly saying, Since you told on me now your medication will be  crushed and I will give them to you in the hallway.  Employee #124, social worker (SW) talked with resident regarding the allegations and resident denies the allegation. The resident continues to deny any issues with staff being mean to her. She continues to be upset about her medications being crushed.  A review of the statements found:  --Statement by Employee #44, RN, made on 06/12/17 at 5:35 p.m.: While doing skin assessments, patient in room [ROOM NUMBER]-  (Resident #112, Name) called me into her room. She asked me if I was a nurse and I told her yes. Resident stated she did not receive her 9 pm meds last night. I asked her did she know what med, she stated little blue pill (pain pill-  [MEDICATION NAME]). I told her I would check the MAR (Medication Administration Record), it may have been not available. I checked the MAR and the medication ([MEDICATION NAME]) had been signed out with the initials of (Employee #39, LPN). I went  back into Resident #112's room with Employee #125, Graduate Nurse (GN). What month is it? she stated, June. I asked the year, she stated, (YEAR). I asked her who was the President, she said, Trump. I asked her if she was mistaken, she said,  No, I check my pills, my pain pill is the little blue pill and it wasn't there. And I asked the nurse (Employee #39) about it and she told she didn't have it and that they would give it at 12:00 a.m. She went on to tell me several nurses about it and nobody came to see her.  --Statement by Employee #49, NA read: On (MONTH) 12, (YEAR) (time ineligible) I was putting (Name of Resident #76) in bed. The wife of Resident #76 was in the room. Employee #124, RN came in the room to do an assessment on the resident. The RN #124 started talking to the resident's wife about an incident that happened on east hallway. She told the wife it involved  Resident #44 and Employee #36, LPN. She said she was in the bathroom and heard everything between Resident #44 and LPN #36.  She told the wife she had took it to the Administrator and the DON. She told the wife she had screen shot all the nurses whom had been notified. She said they were that the facility was trying to get rid of her and that she reported it to the  state. On (MONTH) 20, (YEAR) the wife of Resident #76 was told by RN #124 this morning she had received her letter from the state and they were investigated.  --Statement by Employee #41, NA, written on 06/12/17 read: I witnessed a resident come up to the RN and asked about her medicine, The RN came up to the nurse's station and asked where the nurse was at. The RN started looking through the medicine book and when the LPN came back to the nurse's station the RN asked the LPN about the resident's medicine and the  MAR book. The RN was telling the LPN she must have not learned anything or she would have signed the book when she gave the resident meds. RN points at LPN and asked her to come to the office. LPN asked the RN to stop pointing her finger in her  face. The RN said I'm not pointing in your face.  --Statement by Employee #125, SW, written on 06/12/17 read: On 06/12/17, SW spoke with (Resident #44's name), regarding allegations the LPN #36 had not gave her medications and that she came into her room and stated, Since you told on me now your meds will be crushed and I will give it to you in the hall. Resident #44 denies that this was said and also says,  Nobody has been mean to me here but I don't like that nurse (LPN #36) because she crushes my meds.  --Statement by Employee #127, NA written on 06/12/17 read; I witnessed Resident #44 go into the DON's office and told RN #124 she had not had any of her medicine all day. The RN looked at the MAR and the book had holes in it where the LPN had  not signed the MAR. The LPN assured the RN she had gave the meds but had not signed the MAR. The RN's and the LPN's voices kept getting louder. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0865  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 25)  Allegation #3: A review of the concern/grievance log found a statement on 06/20/17 at approximately 9:00 AM, NA #58 entered Resident #44's room to find her roommate some clothes, this resident had her roommates pants on. I came out and got my  nurse (LPN #36) to assist me. The housekeeper and I was standing in the closet doorway and Resident #44 exited the bathroom holding the clothes. The resident threw the pants and hit LPN #36 in the side of head and then openly smacked her across  the face knocking her glasses off. I attempted to get the resident away from the nurse and calm her down. The resident started yelling at the nurse stating, I am going to have your job [\*\*\*] . I dare you to hit me queer.  --Statement by Employee #36, LPN dated 06/20/17 at 9:15 am read: Upon entering Resident #44's room I found the resident had her roommates pants on. This writer, NA and Housekeeper were standing in the doorway of this resident's room when she exited the bathroom striking this nurse in left side of face multiple times screaming, (RN #124) and I are going to have  your job [\*\*\*] . I dare you to hit me I'm calling RN #124 and she will beat your face in. This writer exited the room and notified the supervisor of this resident's behaviors and notified the physician with new orders to administer [MEDICATION NAME] 20 milligrams (mg) intramuscularly (IM) now for agitation. Power of attorney (POA) notified and made aware of residents room change from east to west wing.  --Statement by Employee #125, SW read: On 06/20/17, I talked with Resident #44, to discuss her recent behaviors against LPN #36. I asked (Resident #44) why she hit LPN#36 and the resident stated the nurse was discrimating against her. I then asked her why she felt LPN #36 was discriminating against her and she stated, She crushes my medicine and RN #124 told me it was discrimation. I then asked the resident why she called the LPN #36 a queer. She at first denied calling her a queer but  later she said, RN #124 told me that she was married to a girl so what would you call her. I told the resident that she could not act that way toward a staff member regardless of her personal opinion. The resident states understanding.   1. Residents in room [ROOM NUMBER] on 06/19/17   A review of grievance/concern book found an incident, in which, occurred between RN #124 and Employee NA #54 on 06/19/17 at 9:30 PM.  Review of the statements found:  --Statement by Employee #124, RN read, On 06/19/17 at around 9:30 pm I went to find who had Resident #117 to do a skin assessment. The NAs stated that NA #54 had Resident #117. I went into room [ROOM NUMBER]and pecked on the door, when I entered the room I said, Good I need to do (Resident #118's skin assessment and you have her undressed. NA #54 said, Why  you want to look at her ass. I asked him what he meant by that and he said, I don't have time for this. I told him I needed him to help me turn Resident #117 on her side for a skin assessment that I had already did everything but her buttock and back. NA #54 stated, I have more patients to do and you treat NAs and nurses like were dirt under her feet. I told him that wasn't true and I hadn't even talked to him before, that I was told to get help turning the patients and he kept saying you never asked. I asked again for help and he refused. I told him I was going to write him up for insubordination and he stated, I am getting a union representative. As I came down the hall I stated, I hate it when people are smart asses.  Statement by Employee #54, NA read: I was on west wing and was in room [ROOM NUMBER] assisting the residents in getting ready for bed, when RN #124 came into the room and told me that I was to come to room [ROOM NUMBER]. I asked her to give me a minute, she then told me that she needed me to do it now. I told her she needed to give me a minute. I asked her if she  needed to look at their butt. She then told me I was getting wrote up for insubordination. I never refused to help. I told  her to give me a minute. Then she yelled at me and called me a smartass. She stated she was the RN and that meant I would do as I am told and not question her. She pulled her name badge at my face and said that is what this means.   1. Resident #58   A review of the Complaint/Grievance book found a concern by Resident #58. This allegation was reported to Employee #125, SW on 01/23/18.  Concern: Resident reports that she doesn't know how to take the Employee #43, NA on evening shift. NA sometimes. She takes good care of me but she likes to joke and sometimes doesn't know how to take her. She makes me anxious. Interventions: NA #43 received a written warning. The resident no longer has the NA as her caregiver.  No further statements, investigation or intervention could be located.   1. Resident #4   A review of the complaint/grievance book found a concern by Resident #4. This allegation was reported to SW #6 on 06/01/18.  Concerns noted by Resident #4's family read: Still not getting coffee at all meals. Staff were mocking the resident Help at the west wing nurses' station. One NA would not give the NA caring for Resident #4 the proper size of diapers. Wednesday, pm shift. The resident was lying angled in her bed. She couldn't get to her tray to eat. She had a bowl of peaches in her  bed with her. She needs pulled up to the tray to eat her meals. Residents name is not over her bed it is a different residents' name.  Interventions: Coffee is being served at all meals. Diaper issue is resolved. Resident will eat in day lounge (sitting upward).  No further statements could be located.   1. Complaint made by the Ombudsman   A review of the complaint/grievance book found a concern by the Ombudsman. This allegation was reported to SW #6 on 05/15/18. Concern: I had more complaints of staff being rude to residents. One employee (NA) was huffing and puffing and complaining because they were short staffed and everyone was acting crazy. After the visitor reported this a resident spoke up and  reported a nurse who is mean and hateful and this nurse had to shut up and quit talking so much. The NA said that is her personality. There is one employee that is hateful as the devil; when one resident asked for a drink and another asked if there was church tonight; she yelled and was hateful to both residents. Please address this issue with your staff.  This surveyor was provided a copy of an in-service for Ethical behavior and Unethical behavior conducted on 05/16/18 by the Administrator.  No further statements could be located.   1. Resident #114   Review of Resident #114's medical records found the resident was admitted on [DATE].  Care Plan initiated; Resident is a 53yr. old female-Diagnosis: [REDACTED]. Staff supervises meals, assists as needed. She is noted to take food from other resident's trays. Easily agitated. Diet Regular NAS with lidded cups for safety. Weight 102#  --below IBW range (123#-149#) She feeds herself meals--often uses her fingers to eat --likes sweets and snack foods. No teeth or dentures.  Progress notes found the following incident/altercations involving resident-to-resident:  --10/18/2017 at 08:28 - Resident noted to be up walking around day lounge throwing food on the floor and taking food from other resident's trays.  --10/19/2017 at 18:00 - Resident up and ambulating in day lounge throwing her shoes across room pushing furniture against resident's wheelchairs. staff sits down with resident to assist with meal resident then gets up and proceeds to remove food from her brother's tray. when attempting to redirect resident begins hitting self in head and slamming fists on wall,  offered activities, fluids and snacks with staff to monitor for safety.  --11/6/2017 at 18:00 - Another resident was calling out to resident and calling her names. Resident became agitated and grabbed other resident's hair and pulled hard. Residents were separated by staff. Vital signs unable to be obtained due to resident was agitated.  --11/9/2017 at 21:46 - Late Entry: Note: resident has been noted to be up wandering in other resident's rooms, taking food and drinks off resident's dinner trays this shift requiring redirection numerous times.  --11/27/2017 at 07:59 - Resident up ambulating in day lounge removing food from other resident's trays requiring redirection numerous times. resident becomes agitated and begins hitting self in head. attempts to take resident to room for  self-soothing.  --12/7/2017 at 13:20 - Resident in day lounge at this time alert and nonverbal skin clean dry warm to touch resident noted to hit her head on the walls and glass numerous times this shift , staff makes attempts to redirect this resident , with no positive results noted , this resident noted to be grabbing other residents chairs in the day lounge and halls x 4 this  shift staff attempts to redirect this resident to the day lounge resident placed in chair at which time resident proceeds to kick and hit staff numerous times along with attempting to hit her head on tables and chairs in the day lounge , staff remains with resident at this time.  --12/7/2017 at 17:40 - Resident continues to be aggressive to staff along with continues to hit her head on the walls and | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/12/2018** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0865  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0880  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 26)  windows, with each attempt to redirect this resident from getting upset and pushing another resident's wheelchair.  --12/12/2017 at 09:35- Resident is noted to be standing at the nurse's station grabbing other resident w/c as they pass x 1 this shift along with getting notably agitated x 1 at nurse station then enters the day lounge door and began to push and shake another residents merri walker resident assisted to room via staff now to self-soothing.  --2/14/2018 at 15:21 - Resident was agitated and shoving tray tables and tables in dining area. when this nurse enters dining area to calm her down another resident stated that you smashed my hand remover other resident near nurse's station for further evaluations.  --2/27/2018 at 10:30 - RNA states that Resident was in DL and ran over and grabbed another female resident by the hair and got ahold of her left breast. No injuries were noted to either resident. The residents were separated.  --3/16/2018 at 16:40 - Nurse called to day lounge this resident grabbed another resident by arm and struck him on his chest. staff separated residents and redirected this resident verbally and assisted to sit on couch to watch the television. vital  signs refused now.  --3/26/2018 at 15:56 - Reported via staff that resident has been noted to get in bed with roommate now, resident removed from roommate's bed. Will continue to monitor resident  **Provide and implement an infection prevention and control program.**  Based on observation and staff interview, the facility failed to maintain an infection prevention and control program to prevent the development and transmission of communicable disease and infection to the extent possible. This was revealed during an observation the facility failed to follow guidelines for using the washing machine according to manufacturer's instructions for sanitation of the laundry for all residents and failure to remove soiled gloves after giving peri care for Resident # 79. This failed practice had the potential to affect all the residents of the facility. Facility census 107.  Findings included:   1. Laundry Room   During an observation and interview on 06/12/18 at 2:02 PM, with Housekeeping Supervisor (HS) #1 and Maintenance Supervisor (MS) #8 agreed they do not have a washing machine that sanitizes the laundry for the residents and the laundry detergent  used is not what is recommended to be used for disinfecting the laundry properly. MS#8 stated he was aware of the problem and has the correct chemicals but had not had them installed to be used yet. The type of detergent being used presently was Sun laundry detergant (purchased at a local store), 5 gallon buckets of laundry destainer and laundry detergent with surfactant. HS#1 stated the laundry chemicals would have been changed over already but the person that was going to do it got sick and had to have surgery.   1. Resident #79   During an observation on 06/07/18 at 9:30 AM, Nurse Aide (NA) #77 and #50 in the room of Resident #79, to do peri care. After providing the care NA #77 did not remove her soiled gloves before using the bed controls. Both NA #77 and #50 agreed that she should have removed her gloves before touching items in the room.  During an interview with the Director of Nursing (DON) on 06/07/18 at 1:30 PM, to inform her about NA # 77. She said she would have someone clean the room. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0156  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0159  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0160  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | **Give each resident a notice of rights, rules, services and charges. Tell each resident who can get Medicaid benefits about 1) which items and services Medicaid covers and which the resident must pay for.**  Based on staff interview and review of the facility's notices of Medicare provider non-coverage forms, the facility failed to notify the beneficiary or responsible party of the decision to terminate covered Medicare services no later than 2 days before the proposed end of the services. This was true for three (3) of three (3) residents reviewed for the care area of liability notices and beneficiary appeal during Stage 2 of the Quality Indicator Survey (QIS). Resident identifiers: #3, #35, and #44. Facility census: 113.  Findings include:   1. Resident #3   A form entitled Medicare Determination of Non coverage on Continued Stay, noted the resident's last day of Medicare services was 01/14/17. The form contained no information to verify when the responsible party was notified of the decision to terminate Medicare services.   1. Resident #35   On 03/10/17, the resident's responsible party signed a form entitled Medicare Determination of Non coverage on Continued Stay. The resident's last day of Medicare coverage was 03/04/17.   1. Resident #44   On 01/10/17, the resident's responsible party signed a form entitled Medicare Determination of Non coverage on Continued Stay. The resident's last day of Medicare coverage was 01/10/17.   1. At 3:27 p.m. on 04/05/17, Business Office Manager (BOM) #13 confirmed she did not have verification the responsible parties of Residents #3, #35, and #44 had at least a 2 day notice before the proposed end of Medicare services. BOM #13 said she did mail the notices to the responsible parties in advance, but she had no verification as to when the responsible parties actually received the notice. BOM #13 said she was unaware if the resident or responsible party was unable to receive the notice, the facility representative could contact the legal representative and inform him/her by telephone. The date of telephone contact was considered the date the notice was given as long as it was not disputed by the beneficiary. The facility must also follow up the telephone contact with written notice.   **Properly hold, secure and manage each resident's personal money which is deposited with the nursing home.**  Based on staff interview, family interview, and review of resident personal funds account balances, the facility failed to ensure residents who had a personal funds account at the facility had access to petty cash after business office hours. This practice had the potential to affect more than an isolated number of residents. In addition, the facility failed to ensure a quarterly statement of the balance of Resident #15's personal funds account was provided in writing to the resident's representative within 30 days after the end of the quarter. Resident identifier: #15. This was identified during a random opportunity for discovery. Resident identifier: #15. Facility census: 113.  Findings include:   1. Personal funds   At 2:23 p.m. on 04/10/17, Business Office Manager (BOM) #13 verified the facility did not have a means to provide any petty cash to residents with personal funds accounts when the business office was closed, which included evenings and weekends. BOM #13 said residents could only get personal funds monies Monday through Friday during the daytime hours.   1. Resident #15   During Stage 1 of the Quality Indicator Survey, at 9:28 a.m. on 04/04/17, the resident's responsible party (the resident's daughter) said she had never received any statements regarding Resident #15's personal funds account. The daughter said she received the resident's monthly check and wrote a personal check to the facility for the resident's monthly room and board.  She also deposited money in the resident's account for, Things like a haircut at the beauty shop. She stated she did not know the exact amount in her mother's account.  At 1:06 p.m. on 04/05/17, BOM #13 confirmed she did not mail a quarterly statement to the resident's daughter. She said she gave a copy of the quarterly statement to the resident. The BOM said she did not think she could send a statement to the daughter because the daughter did not have a durable power of attorney. BOM #13 did confirm the daughter paid the resident's monthly bill at the facility and deposited money in the resident's personal funds account.  Review of the resident's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 01/06/17 found the resident scored a 3 on her Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. A score of 3 indicated the resident would not be capable of understanding a personal funds account statement.  These findings were discussed with the administrator at 8:12 a.m. on 04/11/17. As of the close of the survey on 04/11/17 at 2:45 p.m., the administrator had provided no further information.  **Follow policies and procedures to convey the resident's personal funds to the appropriate party responsible after the resident's death.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview, the facility failed to ensure five (5) of seven (7) residents reviewed for the care area of personal funds during Stage 2 of the Quality Indicator Survey (QIS), had his/her personal funds conveyed within 30 days of death to the individual or probate jurisdiction administering the resident's estate. This practice had the potential to affect more than an isolated number of residents. Resident identifiers: #136, #39, #73, #95, and #110. Facility census: 113.  Findings include:  a) Resident #136 | | | |

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.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0160  **Level of harm -** Minimal | (continued... from page 1)  Medical record review found Resident #136 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $17.00. | | | |
| harm or potential for actual | b) Resident #39 | | | |
| harm  **Residents Affected -** Some | Medical record review found Resident #39 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $189.19.  c) Resident #73  Medical record review found Resident #73 expired on [DATE]. On [DATE], the resident's trust account contained a balance of | | | |
|  | $877.26. | | | |
|  | d) Resident #95 | | | |
|  | Medical record review found Resident #95 expired on [DATE]. On [DATE], the resident's trust account contained a balance of | | | |
|  | $942.43. | | | |
|  | e) Resident #110 | | | |
|  | Medical record review found Resident #110 expired on [DATE]. On [DATE], the resident's trust account contained a balance of | | | |
|  | $70.10. | | | |
|  | f) At 2:49 p.m. on [DATE], Business Office Manager (BOM) #13 confirmed the personal funds of Residents #136, #39, #73, #95, | | | |
|  | and #110 were not conveyed to the individual or probate jurisdiction administering the residents' estates within 30 days of | | | |
|  | the resident's death. | | | |
| F 0164 | **Keep each resident's personal and medical records private and confidential.** | | | |
| **Level of harm -** Minimal | Based on observation and staff interview, the facility failed to maintain personal privacy for a resident receiving an | | | |
| harm or potential for actual | enteral feeding. This affected one (1) resident observed at random during the survey while her enteral feeding was | | | |
| harm  **Residents Affected -** Few | infusing. Resident identifier: #17. Facility census: 113. Findings include:  a) Resident #17  An observation on 04/04/17 at 8:32 a.m. noted Resident #17 self-propelling her wheelchair in the hallway near her room. Her | | | |
|  | enteral feeding, attached to a pole, was infusing. The exposed feeding bottle identified the type of nutrition infusing, | | | |
|  | the resident's name and room number, the infusion rate, the time it was started, and the time it was due to be stopped. | | | |
|  | Licensed Practical Nurse (LPN) #24 was also in the hall. When interviewed on 04/04/17 at 8:35 a.m., she said the enteral | | | |
|  | feedings were not covered. | | | |
|  | A second observation on 04/05/17 at 10:30 a.m., again found Resident #17 up in the hall with the personal information on her | | | |
|  | enteral feeding exposed. | | | |
|  | During an interview with LPN #17 on 04/05/17 at 10:35 a.m., said they did not typically cover feeding tube bottles when a | | | |
|  | resident was out of his or her room. | | | |
|  | When discussed with the director of nursing on 04/10/17 at 12:47 p.m., she had no comment. | | | |
| F 0170 | **Send and promptly deliver unopened mail to residents.** | | | |
| **Level of harm -** Potential | Based on staff interview and resident interview, the facility failed to ensure residents received mail delivery on | | | |
| for minimal harm  **Residents Affected -** Many | Saturdays. This practice had the potential to affect all residents at the facility. Resident identifier: #121. Facility census: 113.  Findings include:  a) Resident #121 | | | |
|  | At 3:00 p.m. on 04/03/17, when asked about mail delivery on Saturdays, Resident #121 (the resident council president) said | | | |
|  | she did not believe residents received mail on Saturdays. She said the activities staff delivered the mail to the residents. | | | |
|  | Activity Director (AD) #98, when interviewed at 6:40 a.m. on 04/06/17, said there was no mail delivery on Saturdays. | | | |
|  | At 04/06/17 at 7:15 a.m., the administrator confirmed there was mail delivery from the post office in the neighborhood on | | | |
|  | Saturdays. | | | |
|  | At 8:11 a.m. on 04/11/17, the administrator said he arranged for the mail carrier to deliver the mail to the facility on | | | |
|  | Saturdays. I guess he (the mail man) didn't come before because he knew there was nobody in the office on Saturdays. | | | |
| F 0225  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.**  Based on record review and staff interview, the facility failed to report immediately (within the first 24 hours) an incident of resident-to-resident abuse requiring physician intervention to the required State agencies. This was true for one (1) of eight (8) reportable incidents reviewed during Stage 2 of the Quality Indicator Survey (QIS). The incident involved Residents #61 and #88. Resident Identifiers: #61 and #88. Facility Census: 113. | | | |
|  | Findings Include: | | | |
|  | a) A review of the facility's reportable incidents for the previous 12 months at 6:41 a.m. on 04/06/17 found an immediate | | | |
|  | fax reporting of an allegation to the Office of Health Facility Licensure and Certification (OHFLAC) Nursing Home Program | | | |
|  | completed by the Social Services Director on 03/17/17. Handwritten under the section titled, Allegation Information was, | | | |
|  | (typed as written) Date of incident: 03/12/17. Time of Incident 7:52 p.m. Location of Incident: Facility Hallway. Brief | | | |
|  | Description of the Incident: Alleged victim (Resident #61) got into a fight with another female resident (Resident #88) | | | |
|  | resulting in a 1X1 incision to right palm of hand. | | | |
|  | Under the section titled, Immediate actions taken to protect residents it noted the physician was contacted and (typed as | | | |
|  | written), Treatment applied to residents hand after staff separated the two residents. | | | |
|  | An interview with the Social Service Director at 2:56 p.m. on 04/06/17, confirmed the facility did not report the incident | | | |
|  | between Resident #88 and Resident #61 to the appropriate State agencies within 24 hours. She stated, Sometimes I don't know | | | |
|  | about them. Then when (name of the Director of Nursing) sees them she will tell me, and I will report it. She agreed the | | | |
|  | facility did not report this allegation within the required timeframe. | | | |
| F 0226  **Level of harm -** Minimal | **Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* | | | |
| harm or potential for actual | Based on record review, policy review, and staff interview, the facility failed to develop an abuse policy that included all | | | |
| harm  **Residents Affected -** Many | required training. The policy did not address training related to dementia management and resident abuse prevention. In addition, the facility did not implement its policy as it pertained to training of new employees and the immediate reporting of all allegations of resident-to-resident abuse involving physician intervention. These practices had the potential to affect all residents residing in the facility. Facility Census: 113. | | | |
|  | Findings include: | | | |
|  | a) Policy Development | | | |
|  | Review of the facility's policy titled, Abuse and Neglect Policy at 10:00 a.m. on 04/05/17 found the following related to | | | |
|  | training of employees (typed at written): | | | |
|  | 2. The facility shall in-service all staff on orientation and at regular intervals regarding | | | |
|  | a. Policies and procedure relating to abuse, neglect, exploitation, or mistreating residents | | | |
|  | b. Appropriate intervention to deal with aggressive or catastrophic reaction of residents | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0226  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0241  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 2)   1. How to report allegations of abuse, neglect, exploitation, or mistreating residents 2. What constitutes abuse, neglect, exploitation, or mistreating residents 3. How to recognize s/s (signs and symptoms) of burnout.   Review of the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities revision 168, with a revision date of 03/08/17 found the following,  F226 \*\*  (Rev. 168, Issued: 03-08-17, Effective: 03-08-17, Implementation: 03-08-17)  483.12(b) The facility must develop and implement written policies and procedures that .  (3) Include training as required at paragraph §483.95 .  §483.95(c) Abuse, neglect, and exploitation.  In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-  §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.  §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property  §483.95(c)(3) Dementia management and resident abuse prevention.  During an interview with the Director of Nursing (DON), Social Services Director (SSD), and the Nursing Home Administrator (NHA) at 1:40 p.m. on 04/05/17, the DON confirmed the facility's Abuse and Neglect Policy did not contain training on Dementia management and resident abuse prevention. She stated, That was overlooked and will be corrected immediately.  2. Implementation of Policy.   1. Training of Employees   Review of the facility's policy titled, Abuse and Neglect Policy with an implementation date of 11/28/16, at 10:00 a.m. on 04/05/17, found the following related to training of employees (typed at written):   1. The facility shall in-service all staff on orientation and at regular intervals regarding    1. Policies and procedure relating to abuse, neglect, exploitation, or mistreating residents   A review of Quality Assurance Aide (QA) #63's personnel file found pages two (2) and three (3) of an abuse neglect policy which was different than the policy provided to the surveyor by the facility.  An interview with Nurse Aide Supervisor (NAS) #41 at 10:34 a.m. on 04/05/17 confirmed she does the orientation training for all new employees. When asked if the policy contained in QA #63's personnel file was the Abuse and Neglect Policy provided during her orientation training, she stated, That is the policy I give them to read as part of their orientation. When  asked why she was giving the new employees the old Abuse and Neglect policy she said she overlooked replacing it in the new employee packets when the new one was implemented at the end of (MONTH) (YEAR). An additional interview with the NAS #41 on  04/10/17 confirmed that all new employees hired since 12/01/16 were provided the wrong abuse and neglect policy during their in-service training.  A review of the employee list found the following employees, hired on or after 12/01/16, were provided training on the wrong Abuse and Neglect Policy:  -- Licensed Practical Nurse (LPN) #54 - hired 01/15/17.  -- Nurse Aide (NA) #39 - hired 12/16/16.  -- NA #90 - hired 01/06/17.  -- NA #73 - hired 01/06/17.  -- NA #72 - hired 01/19/17.  -- QA #63 - hired 03/01/17.  -- QA #57 - hired 02/07/17.  -- QA #56 - hired 03/10/17.  -- QA #55 - hired 03/14/17.  2. Immediate Reporting  Review of the facility's policy titled, Abuse and Neglect Policy at 10:00 a.m. on 04/05/17 found the following related to reporting of abuse and/or neglect (typed as written):  Anyone who witnesses an incident of abuse, neglect, exploitation, misappropriation of property, or mistreating residents is to tell the abuser to stop immediately, get the resident to safety and report the incidence to the grievance officer .  c. All cases of abuse and neglect should be reported within one working day to the Department of Health and Human Services and to one or more of the following:   1. APS (Adult Protective Services) 2. Office of Advocacy for Incidents involving persons who have mental [MEDICAL CONDITION] 3. The Long Term Care Ombudsman Program for incidents involving elderly persons 4. Disability Rights Center for incidents involving persons who have mental illness   A review of the facility's reportable incidents for the previous 12 months at 6:41 a.m. on 04/06/17 found an immediate fax reporting of an allegation to the nursing home program completed by the Social Services Director on 03/17/17. The following was handwritten under the section titled, Allegation Information (typed as written): Date of incident: 03/12/17. Time of Incident 7:52 p.m. Location of Incident: Facility Hallway. Brief Description of the Incident: Alleged victim (Resident #61) got into a fight with another female resident (Resident #88) resulting in a 1X1 incision to right palm of hand.  Under the section titled, Immediate actions taken to protect residents it noted the physician was contacted and (typed as written), Treatment applied to residents hand after staff separated the two residents.  An interview with the Social Service Director at 2:56 p.m. on 04/06/17, confirmed the facility did not report the incident between Resident #88 and Resident #61 to the appropriate State agencies within 24 hours. She stated, Sometimes I don't know about them. Then when (name of the Director of Nursing) sees them she will tell me, and I will report it. She agreed this allegation was not reported in the appropriate timeframe.  **Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.**  Based on observation and staff interview, the facility failed to provide a dignified dining experience to multiple residents in the facility's main dining room and to Residents #132 and #32 who were dining in their room during the noon meal.  Additionally, the facility failed to provide dignity to Resident #17 in regards to her clothing. The dining experience in  the main dining room affected more than an isolated number of residents. The other concerns were identified through random opportunities for discovery. Resident Identifier: #132, #32, and #17.  Findings include:   1. Main Dining Room   Observations of the noon meal began in the main dining room at 12:10 p.m. on 04/03/17. There were 32 residents in the dining room seated at nine (9) tables. More than one resident sat at each of the nine (9) tables.  The meal service began at 12:42 p.m. with four (4) staff members serving the residents' meals. Each of the four (4) staff members took a meal from the meal cart and served residents sitting at four (4) different tables. The staff then returned to the meal cart and served four (4) more meals all to residents sitting at four (4) different tables. The staff had served one (1) resident at each of eight (8) tables prior to serving any tablemates of the residents who received their meals first.  An interview with an activities employee at 12:56 p.m. on 04/03/17, confirmed that not all residents seated at the same table received their meals at the same time. She stated, We usually serve the entire table at the same time, but the residents are not sitting where they usually sit so it was all messed up.   1. Residents #132 and #32   Observation of the noon meal on 04/03/17, found Resident #132 received his tray at 12:38 p.m. on 04/03/17. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0241  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0253  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0272  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 3)  Staff continued to serve other residents residing in other rooms.  At 12:52 p.m. on 04/03/17, Nurse Aide (NA) #80 delivered the noon meal to Resident #32, the roommate of Resident #132. NA #80 said Resident #32 did not receive a tray at the same time as his roommate because, He usually eats in the dining room, but he isn't feeling very well so he stayed in his room. His tray did not come out on the cart.  c) Resident #17  During an observation of Resident #17 on 04/05/17 at 10:30 a.m., Resident #17 was dressed in a wide necked green shirt. The shirt was hanging off center, exposing her bare left shoulder.  Further observation of Resident #17 on 04/05/17 at 1:15 p.m. again found her in the hallway, this time near the dining room, with her wide-necked shirt exposing her bare left shoulder.  When informed of the observations, Social Worker #12 stated that would be a dignity issue if a resident did not normally dress in this fashion and did not choose to dress that way on her own.  Record review on 04/05/17 at 4:00 p.m., found the annual comprehensive minimum data set (MDS) assessment identified Resident #17 as requiring the extensive assist of one (1) staff member for dressing.  When discussed with the director of nursing on 04/10/17 at 12:47 p.m., she had no additional comment.  **Provide housekeeping and maintenance services.**  Based on observation and staff interview, the facility failed to ensure the residents' environment was sanitary, orderly,  and comfortable. Cove molding was not affixed to the walls, veneer on nightstands was chipped and missing, the frame around a resident's window was cracked, the paint on the wall was chipped, and resident heating and air conditioning units were  dirty. This was true for seven (7) of thirty-four (34) rooms observed during Stage 1 of the Quality Indicator Survey. These practices had the potential to affect more than an isolated number of residents. Facility census: 113.  Findings include:  a) A tour with the maintenance coordinator (MC) at 1:45 p.m. on 04/10/17, found the following environmental issues:   1. Room 101   Observation found the cove molding to the left of the sink area was not affixed to the wall, leaving rough, hard plastic edges protruding outward from the wall.   1. Room 110   The veneer on the nightstand was chipped and missing.   1. Room 119   The bathroom wall paint was chipped in front of the toilet and to the right side of the toilet.   1. Room 122   The grill of the heating and air conditioning unit had a buildup of dust and debris. The plastic casing around the window had a rough hole about the size of a fifty-cent piece. The cove molding to the left of the sink area was not affixed to the wall, leaving rough, hard plastic edges protruding outward from the wall.   1. Room 124   The grill of the heating and air conditioning unit had a build of dust and debris. The nightstand had chipped and missing veneer, exposing the chipboard.   1. Room 125   The grill of the heating and air conditioning unit had a buildup of dust and debris. The nightstand had chipped and missing veneer, exposing rough chipboard.   1. Room 406   The nightstand had chipped and missing veneer, exposing rough chipboard.  **Conduct initial and periodic assessments of each resident's functional capacity.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and staff interview, the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessments accurately reflected each residents' status. Resident #121's MDS was inaccurate in regards to behaviors (rejection of care). For Residents #109, #142, and #102, the MDSs were inaccurate in the area of prognosis (life expectancy  of six months or less). For Resident #90, the Care Area Assessments (CAA) for behavior and [MEDICAL CONDITION] medication use did not identify dates and locations of information used to complete the additional assessments. This was true for five  (5) of twenty-three (23) residents reviewed for accuracy of comprehensive assessments during Stage 2 of the Quality Indicator Survey (QIS). Resident identifiers: #121, #109, #142, #102, and #90. Facility Census: 113.  Findings include:   1. Resident #121   Medical record review found the resident's annual MDS with an assessment reference date (ARD) of [DATE] identified the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.  Further review found the MDS indicated the resident exhibited the behavior of rejection of care that occurred four (4) to six (6) days of the seven (7) day look back period, but not on a daily basis. It also indicated this was a worsening of behavior.  Interview with Resident #121 on [DATE] at 10:15 a.m., found the resident did not choose to take her nebulizer treatment due to it made her nervous and made her heart race. She said she had repeatedly informed the nurses and physician she did not need it as often as it was ordered.  An interview on [DATE] at 11:00 a.m. with MDS Coordinator #4, found the MDS with an ARD of [DATE] was inaccurate regarding behaviors for Resident #121. She further confirmed Resident #121 had capacity and made her own medical decisions.   1. Resident #109   Resident #109 was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident's physician had documented the resident's prognosis indicating the resident's life expectancy was 6 months or less. This resident had been receiving hospice care at  home [MEDICAL CONDITION]. The resident experienced multiple falls at home and the family was unable to care for her and chose nursing home placement for comfort care only and for end of life care. According to the medical record, the resident expired at the facility on [DATE].  The admission MDS with an ARD of [DATE] did not indicate the resident had a condition or terminal illness which would result in a life expectancy of less than six (6) months.  In an interview on [DATE] at 11:00 a.m., MDS Coordinator #4 verified the MDS with an ARD date of [DATE] was inaccurate. She confirmed the resident had a terminal illness that might result in a life expectancy of less than six (6) months. She  further verified the resident/family had declined hospice.   1. Resident #142   Resident #142 was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident's physician had documented the resident's prognosis indicating the resident's life expectancy was 6 months or less. The resident/family chose nursing home placement  for comfort care only and for end of life care. According to the medical record, the resident expired at the facility on [DATE].  The admission MDS with an ARD of [DATE] did not indicate the resident had a condition or terminal illness which would result in a life expectancy of less than six (6) months.  In an interview on [DATE] at 12:00 p.m., MDS coordinator #4 verified the MDS with an ARD of [DATE] was inaccurate. She confirmed the resident had a terminal illness that might result in a life expectancy of less than six (6) months. She  further verified the resident/family had declined hospice.   1. Resident #102   Resident #102 was admitted on [DATE] with diagnoses, which included malignant neoplasm (cancer) of the breast with metastasis and [MEDICAL CONDITIONS]. The resident's physician had documented the resident's prognosis indicating the resident's life expectancy was 6 months or less. This resident had been receiving hospice care at home for two weeks prior to admission to the facility. The family was unable to care for her and chose nursing home placement for comfort care and end of life care.  The admission MDS with an ARD of [DATE] did not indicate the resident had a condition or terminal illness which would result | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0272  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0279  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0280  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 4)  in a life expectancy of less than six (6) months.  On [DATE] at 3:00 p.m., MDS Coordinator #4 verified the MDS with an ARD of [DATE] was inaccurate. She confirmed the resident had a terminal illness/disease that might result in a life expectancy of less than six (6) months. She further verified the  resident/family had declined hospice.  e) Resident #90  Record review on [DATE], found the last comprehensive minimum data set (MDS) assessment with an assessment reference date (ARD) of [DATE] for Resident #90 was incomplete. Specifically, the assessor failed to identify the date and location of the information used to complete additional assessment of the triggered care area assessments (CAAs) for behavioral symptoms  and [MEDICAL CONDITION] drug use.  When discussed with MDS Coordinator #4 and MDS Licensed Practical Nurse (LPN) #30 at 3:54 p.m. on [DATE], both employees stated they were not aware the location of information used to complete CAAs was a required piece for the triggered care  areas requiring additional assessment.  **Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, resident interview, staff interview, and record review, the facility failed to develop a comprehensive care plan which included the visual needs for one (1) of three (3) resident's reviewed for the care area of vision during Stage 2 of the Quality Indicator Survey (QIS). Resident identifier: #126. Facility census: 113.  Findings include:  a) Resident #126  Record review on 04/04/17 at 2:54 p.m., found the resident's last admission to the facility was on 01/10/17.  The resident's admission minimum data set (MDS) with an assessment reference date (ARD) of 01/17/17 coded the resident as having impaired vision and no corrective lenses.  Review of the care area assessment (CAA) for vision, found the facility would not care plan the resident's visual problems because, Resident states that she has had one cataract removed for left eye and 2 off of right eye. States it was at (name of hospital) 4 or 5 years ago. She was able to see large print but not small print. No glasses in use. No s/s (signs or  symptoms) infection noted. No referrals or appointments at this time. The CAA noted the resident had diabetic retinopathy and decreased visual acuity.  Review of the current care plan found the problem:  The resident is at risk for falls r/t (related to) [MEDICAL CONDITION], weakness, fx (fracture) RUE (right upper extremity) pain med use. Falls at home and fell at home before Christmas resulting in Fx. (R) shoulder. Fall 1/17/17, assist resident  with toileting needs as needed, Fall 3/28/17. Remind resident to watch where she is going when ambulating. Fall 3/28/17 up with out shoes.  A fall risk assessment, dated 03/28/17, the response to question #6 of the assessment noted the resident's vision was  .inadequate-impaired vision in adequate light with glasses on.  At 3:14 p.m. on 04/04/17, when asked about her vision, the resident said she had never worn glasses. She said she had an appointment (resident stated name of local doctor) to determine if she needed glasses after her cataract removal. She missed the appointment because she was in the hospital. She said, If I had a way to go I would go to the eye doctor now. The resident said she could not see her television, which was about 5 feet in front of her. She said, Everything looks black when I watch television. Sometimes everything just looks black, I think I need my eyes looked at. The resident said she had not had any eye exams since her cataract surgery about 5 years ago.  The resident was deemed to have capacity to make medical decisions on 01/06/17. The resident was cognitively intact with a score of 14 on her Brief Interview for Mental Status (BIMS) on the admission MDS with an ARD of 01/17/17.  During an interview at 3:27 p.m. on 04/04/17, the director of nursing (DON) said the resident told her she had glasses when she was at home, but after her surgery, she did not need glasses anymore. The DON said she did not document this interview in the resident's medical record. The DON confirmed the resident had not had any exams since her admission to the facility to determine the extent of her visual problems and she did not have any glasses at this time; therefore, the fall risk assessment dated [DATE], was incorrect. The DON contacted the doctor's office identified by the resident during her interview at 3:14 p.m. on 04/04/17, with whom she had an appointment. The physician's office stated the resident did have an appointment in (MONTH) of 2010 to have an eye exam, but she did not keep the appointment.  Licensed Practical Nurse (LPN) #30, identified as an MDS coordinator, when interviewed at 3:41 p.m. on 04/04/17, said the resident did not want any glasses or any treatment, but she did not record this interview in the resident's medical record.  When asked about the resident's care plan for falls which directed, .remind the resident to watch where she is going ., the LPN said that had nothing to do with the resident's eyesight, that was just written because she falls over her own feet.  At 4:03 p.m. on 04/04/17 the Registered Nurse (RN) MDS coordinator said she scheduled an eye exam for the resident.  **Allow the resident the right to participate in the planning or revision of the resident's care plan.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview, the facility failed to revise the care plans for two (2) of twenty-three (23) residents whose care plans were reviewed during Stage 2 of the Quality Indicator Survey (QIS) when the residents experienced a change in condition. The facility did not revise Residents #134's and #118's care plans when the residents experienced a decline in activity attendance due to an overall decline. Resident identifiers: #134 and #118. Facility census: 113.  Findings include:   1. Resident #134   The QIS triggered a review of activities for Resident #134 when the resident was not observed attending and/or participating in any activities during Stage 1 of the survey.  On 04/10/17 at 11:10 a.m., review of the resident's current care plan, revised on 03/03/17, found a problem statement dated 11/02/16 of, Resident with decreased mobility related to little to no interest in doing anything, tired with little energy.  The goal associated with the problem dated 11/02/16 was, The resident will be off the unit to activity one (1) to two (2) times a week through review date. The interventions associated with this goal, all dated 11/02/16, included, Will encourage him to attend exercise for strengthening, will invite family to socials, events, parties, to assist with resident attending  for socialization, and will visit to explain the importance of attending and participating in the life of the facility.  This was the only care plan referencing the resident's activities. The care plan was not revised when the resident's ability  to attend activities declined secondary to [MEDICAL CONDITION] that had metastasized to the bone as reflected on the MDS with an ARD of 02/22/17.  At 1:32 p.m. on 04/10/17, the Director of Nursing (DON) confirmed the resident's care plan was not revised concerning activities. She further stated it had been several weeks since the resident had been out for an activity.   1. Resident #118   Observations of the resident during Stage 1 of the Quality Indicator Survey (QIS) found she was always in bed. The resident was not observed attending any activities.  Review of the resident's current care plan at 8:27 a.m. on 04/05/17 found the problem statement of, Little interest or pleasure in doing anything d/t (due to) health status rarely understood.  The goal associated with this problem was, Resident will be out of room daily for different surroundings through next review. Approaches included:  Will provide verbal and tactile stimuli and look for different responses. Will visit and provide sensory awareness | | | |

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Previous Versions Obsolete

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0280 | (continued... from page 5)  Have staff to assist out of room to different surroundings such as day lounge, passive activities, church and sing-a-long. At 6:22 a.m. on 04/06/17, during an interview, Activity Director (AD) #98 stated her staff were doing in room activities with the resident, such as reality orientation, sensory activities, etc. She said the resident rarely came out for  activities. She said, I was going to change the care plan, I think maybe it is time for a review.  Review of the participation logs for (MONTH) through (MONTH) (YEAR) found the resident had only been out of her room one (1) day in January, no days in February, four (4) days in March, and no days in April.  AD #98 said her care plan goal should be revised as the resident was not attending out of room activities daily due to her health status.  **Provide care by qualified persons according to each resident's written plan of care.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on staff interview and record review, the facility failed to implement the care plan in regards to behavior monitoring  for a resident receiving [MEDICAL CONDITION] medications. This failed practice affected one (1) of twenty-three (23) sample residents whose care plans were reviewed. Behavior monitoring was not implemented for a target behavior for the entire  month of (MONTH) (YEAR) and for (MONTH) (YEAR) until brought to the facility's attention on 04/0617. Because this lack of monitoring spanned thirty-seven (37) days, across all shifts, a pattern of deficient practice was found. Resident  identifier: #90. Facility census: 113. Findings include:  a) Resident #90  Record review on 04/05/17 and 04/06/17 found Resident #90 had [DIAGNOSES REDACTED]. She also had unspecified [MEDICAL CONDITION] not due to a substance or known physiological condition (09/10/13), for which she received [MEDICATION NAME] 125  mg by mouth every morning and 150 mg by mouth at bedtime.  Her current care plan, initiated 09/13/13 had a focus related her anxiety disorder of, Gets restless and yells often. Her goal was to show decreased episodes of s/sx (signs and symptoms) of anxiety through the next review date. Interventions  included Give anti-anxiety medications ordered by physician. [MEDICATION NAME] ([MEDICATION NAME]) 0.5 mg q 12 hrs (every  12 hours). Monitor/document side effects and effectiveness. Also, (typed as written) Observe and report to nurse/MD (doctor) occurrence of for target behavior symptoms (such as increased restlessness, c/o (complaints of) nervousness.) and document per facility protocol.  The behavior monthly flow sheets for (MONTH) through (MONTH) (YEAR) identified three (3) behaviors for monitoring - afraid/panic, continuous screaming/yelling, and jittery or nervousness. For the month of (MONTH) (YEAR), all three behaviors were listed for monitoring each shift by the nurse, however, the behavior of jittery or nervousness had not been  monitored the entire month. On the (MONTH) (YEAR) behavior monthly flow sheet, the behavior of jittery or nervousness was not included on the behavior monthly flow sheet at all. When discussed with the director of nursing 04/06/17 at 12:19 p.m.,  she said the resident had some improvements in behaviors. When asked how the facility determined when to stop monitoring behaviors, she stated, I guess it's up to the discretion of the nurses.  On 04/06/17 at 1:00 p.m., nurse manager, Licensed Practical Nurse (LPN) #33 said the [MEDICATION NAME] was ordered for anxiety, the care plan said to monitor for behaviors, and it just wasn't done.  **Provide necessary care and services to maintain the highest well being of each resident**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review, staff interview, and physician interviews, the facility failed to ensure Resident #53 received [MEDICATION NAME], an anticoagulant (blood thinner) upon return from a stay at an acute care hospital. After initiating [MEDICATION NAME] therapy, the facility failed to ensure prompt notification of the resident's physician of the results of ordered [MEDICATION NAME]/International Ratio (PT/INR) laboratory (lab) tests. Additionally, on two (2) separate occasions, the physician gave orders to increase Resident #53's [MEDICATION NAME], but the facility failed to administer the increased dose until the next day despite the fact it was available in the emergency medication box.  These significant medication errors placed Resident #53 at an immediate risk for serious harm and/or death, resulting in a determination of immediate jeopardy.  Additionally, the discharge summary from the hospital included an appointment was scheduled with a cardiologist for 04/04/17. The resident, who had a recent [MEDICAL CONDITION] infarction, did not attend due to the facility's failure to arrange for transportation to and from the appointment.  The Nursing Home Administrator (NHA) and the Director of Nursing (NHA) were notified of the immediate jeopardy at 3:05 p.m. on 04/06/16.  The facility provided a plan of correction (P[NAME]) to the State agency at 4:13 p.m. on 04/06/17, which the State agency reviewed and accepted at 4:17 p.m. on 04/06/17. The State agency representatives onsite ascertained implementation of the P[NAME] and abated the immediacy at 4:50 p.m. on 04/06/17.  This immediate jeopardy began on 03/21/17, when the facility failed to initiate [MEDICATION NAME] therapy. From 03/21/17, forward the facility continued to make errors in following resident's plan of care.  After removal of the immediacy, deficient practices remained for Residents #76 and #79. The scope and severity was decreased from a K to D for the deficient practices that were no a part of the immediate jeopardy.  For Resident #76, a scheduled appointment with the wound care center was not kept and Resident # 79 had non-pressure related wounds for which the facility failed to attempt to determine the cause of her wounds.  These issues were found for three (3) of twenty-three (23) sampled residents. Resident identifiers: #53, #76, and #79. Facility census: 113.  Findings include:  a) Resident #53   1. A review of Resident #53's medical record at 12:00 p.m. on 04/05/17, found the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The discharge instructions included, but not limited to:   -- [MEDICATION NAME] ([MEDICATION NAME]) two (2) milligrams (mg) by mouth daily at bedtime for treatment of [REDACTED].  -- A scheduled appointment with a Cardiologist on 04/04/17 at 10:20 a.m. for follow-up treatment of [REDACTED]. (Address and phone number included)  -- The facility was to call for an appointment with a neurologist within six (6) weeks from date of discharge. (Address and phone number included)  Review of Resident #53's Medication Administration Record [REDACTED]. The medication was started after the attending physician visited and ordered [MEDICATION NAME] 2 mg and a PT/INR on 03/23/17.  During an interview at 11:15 a.m. on 04/06/17, when asked about the resident not receiving [MEDICATION NAME] after her readmission, the resident's attending physician stated she would not have discontinued the resident's [MEDICATION NAME] unless she had hematuria or some other bleeding condition. (The medical contained no evidence Resident #53 had these conditions). The physician further stated she did not recall if they told her the resident was started on [MEDICATION NAME] while in the hospital. She stated, I don't remember what they found I would have to look at her record.  The facility did not obtain the PT/INR ordered on [DATE] until 03/27/17.  The results of the PT/INR obtained at 5:00 a.m. on 03/27/17, were available for review by the facility by 1:00 p.m. on 03/27/17. Facility staff did not review or print the results of this PT/INR until 03/28/17. On 03/28/17, the facility reported the PT/INR result of 1.21 to the physician by telephone, at which time the physician increased the dose of  [MEDICATION NAME] to 3 mg. However, the facility did not increase Resident #53's [MEDICATION NAME] dose until the evening  of 03/29/17, despite the fact it was available in the emergency medication box.  The facility obtained the repeat PT/INR 04/03/17 as ordered, but did not notify the physician of the PT/INR results obtained on 04/03/17, until 04/04/17 of the result of 1.39 (low). The physician then gave orders to increase the resident's [MEDICATION NAME] to 4 mg. She did not get the first dose of this increased dosage until 04/05/17, despite the fact it was available in the emergency medication box.  An interview with the Director of Nursing (DON) on 04/06/17 at 11:25 a.m., found the facility had an emergency medication  box that contained [MEDICATION NAME]. She confirmed Resident #53 did not receive the [MEDICATION NAME] as ordered.   1. The facility failed to arrange transportation for Resident #53 to and from her appointment with the cardiologist | | | |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Few |
| F 0282 |
| **Level of harm -** Minimal harm or potential for actual harm |
| **Residents Affected -** Some |
| F 0309 |
| **Level of harm -** Immediate jeopardy |
| **Residents Affected -** Some |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0309  **Level of harm -** Immediate jeopardy  **Residents Affected -** Some | (continued... from page 6)  scheduled for 10:20 a.m. on 04/04/17. Therefore, the resident was not seen by the cardiologist after her recent [MEDICAL CONDITION] as directed by the discharge summary due to the facility's failure to make arrangements.  An interview with the DON on 04/06/17 at 10:30 a.m., found the facility followed the hospital discharge summary when a resident was admitted /readmitted to the facility unless the attending physician specified differently. When the attending physician wished to provide a different medication and/or treatment, it was documented in the nurses' notes. She verified the physician wished to follow the orders as directed by the discharge summary.   1. These failures by the facility placed Resident #53 at an immediate risk for serious harm and/or death. This has resulted in a determination of immediate jeopardy.   The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the immediate jeopardy at 1:30 p.m. on 04/06/16.  The facility provided a plan of correction (P[NAME]) to the State agency at 4:13 p.m. on 04/06/17, which the State agency reviewed and accepted at 4:17 p.m. on 04/06/17. The State agency representatives onsite, verified implementation of the P[NAME] and abated the immediacy at 4:50 p.m. on 04/06/17.  This immediate jeopardy began on 03/21/17, when the facility first began to fail to provide appropriate medications and treatments as outlined in the discharge summary from an acute care hospital for treatment of [REDACTED]. From 03/21/17, forward the facility continued to make errors in following the identified resident's plan of care.  After removal of the immediate jeopardy, deficient practices. not a part of the immediate jeopardy remained for Residents #76 and #79. The scope and severity was decreased from a K to D   1. The Facility's Plan of Correction contained:   On 04/06/17 Medical Director and Director of Nursing implemented the following plan:  -- The DON and LPN immediately evaluated the resident number 53. Vital signs were B/P (blood pressure) 108/58, SPO2 (oxygen saturation) 97% on 2L O2 (2 liters of oxygen), RR 20 (respiratory rate), Temp 98.6 (temperature), and Pulse 87. The  resident assessment revealed resident without s/s of distress. No bleeding or new bruising noted to skin. Old ecchymosis areas in various shades were noted on her arm, abdomen, and around her right knee. The DON notified the physician of the resident condition and re-notified the physician of a PT/INR that was not obtained on 3/23/17 as ordered following a med error/lab error from a readmission on 3/21/17. The DON also re-reported the PT/INR values for the labs collected on 3/27/17 and 4/3/17 and the subsequent orders given by the physician. The physician was notified of a missed cardiology appointment scheduled for 4-4-17 and discussed previous discharge orders that required the resident to be re-evaluated within 6 weeks.  Staff re-scheduled an appointment for the earliest available appointment on (MONTH) 28th (YEAR), which falls within the 6 week time period. The physician requested the resident be sent to the emergency room for further evaluation. During the emergency room evaluation, the physician will request a complete cardiac work up. Nursing staff present were immediately in-serviced and all other nurses will be in-serviced prior to their next scheduled shift by the DON or designee on  [MEDICATION NAME] therapy, collecting labs, reporting lab findings, reporting [MEDICATION NAME] levels promptly, starting medications within a reasonable time following order, utilization of \the ER box if medications are needed, ordering labs,  making follow up appointments, and transcribing admission and readmission orders [REDACTED]  -- The DON and nursing staff will review the medical records for all other resident's receiving [MEDICATION NAME]. All residents receiving [MEDICATION NAME] will be assessed by nursing staff and documentation will be provided in the medical record. All residents receiving [MEDICATION NAME] will be ordered a stat PT/INR to ensure therapeutic levels. Once the levels are received they will be reported promptly to the physician for orders as indicated. The DON and nursing staff will review the medical records of all admissions and re-admissions for (MONTH) of (YEAR) to ensure all admission/re-admission orders [REDACTED]. If the in house physician does not agree with an order, documentation and rationale for order not being completed will be documented in the medical record.  -- Because this had the potential to effect all residents receiving [MEDICATION NAME], nursing staff present were immediately in-serviced and all other nurses will be in-serviced prior to their next scheduled shift by the DON or designee  on [MEDICATION NAME] therapy, collecting labs, reporting lab findings, reporting [MEDICATION NAME] levels promptly, starting medications within a reasonable time following order, utilization of the ER box if medications are needed,  ordering labs, making follow up appointments, and transcribing admission and readmission orders [REDACTED]. PT/INR levels will be recorded on a monitoring log for each resident on [MEDICATION NAME] and will be promptly reported for the physician. A re-admission/admission monitor will be instituted to ensure that all orders are properly transcribed into the  facility system and ordered as directed by the physician. A [MEDICATION NAME] therapy monitoring for will be instituted and to ensure [MEDICATION NAME] levels are obtained as prescribed, results are called to the physician in a timely manner, and medications are started in a timely manner.  -- The interdisciplinary team will review the aforementioned monitoring forms at the weekly team meeting for quality improvement x 8 weeks or until the committee determines satisfactory resolution has been achieved to ensure compliance.  -- All nurses will be in-serviced prior to working their next shift. All resident charts will be reviewed by 4-14-17.  c) After removal of the immediate jeopardy, deficient practices remained for Residents #76 and #79 at a scope and severity of D  1. Resident #76  Review of Resident #76s medical record on 04/10/17 at 9:45 a.m., revealed the resident had a Stage 4 pressure ulcer on right foot Symes amputation (an amputation through the ankle joint) site which occurred following an attempt to wear a prosthesis. An outside wound clinic treated and monitored the pressure ulcer.  Review of consultation reports found an outside wound clinic saw and treated Resident #76' pressure ulcer on 03/13/17. This consult specified recommended treatments and a return appointment in three (3) weeks. The facility physician ordered an appointment for the resident to go to the wound clinic on 04/03/17. There was no evidence found in the resident's medical record to indicate the resident went to the wound clinic on the specified date, and if not, why the resident missed the appointment.  An interview with the DON on 04/10/17 at 12:30 p.m., found the staff did not know why the appointment with the wound care clinic had been missed. She further confirmed the appointment had been rescheduled.  c) Resident #79  At 8:06 a.m. on 04/04/17, observation of the resident found he had numerous areas of discoloration to both forearms and a band-aid on his right elbow. The areas were various shades of red and purple.  Review of a monthly summary, dated 03/03/07, found the resident had no skin issues.  Further review of the medical record found a nurse's note, dated 04/04/17, New orders received and noted to cleanse open ecchymotic area to right elbow with NNS (normal saline solution), Pat dry, apply [MEDICATION NAME] and cover with band aid daily and PRN (as needed), Left message for  A second nurse's note, dated 04/03/17, New orders received and noted to discontinue tx (treatment) to right and left forearm areas resolved.  At 1:42 p.m. on 04/05/17, Licensed Practical Nurse (LPN) #31, when asked if she had any information regarding the reddened areas on the resident's forearms and the skin tear, said she did not have an incident report for the skin tear. She said  the reddened areas on the resident's forearms were ecchymotic areas due to the use of [MEDICATION NAME] (an anti-platelet).  At 1:53 p.m. on 04/05/17, LPN #22 said the area to his elbow was just a scab the resident had picked at. The areas come and go where he just constantly picks, he is on [MEDICATION NAME]. Review of the current care plan found the use of [MEDICATION  NAME] and the ecchymotic areas identified by the staff were not currently care planned. She stated, I did not care plan the use of [MEDICATION NAME].  On 04/03/17 at 9:27 a.m., Registered Nurse (RN) #38, the quality assurance coordinator, was asked if the facility had any information regarding the reddened areas to the resident's forearms and the recent skin tear to the resident's elbow. She had no additional information to offer.  At 11:05 a.m. on 04/11/17, RN #4 said she had ordered elbow protectors, after surveyor intervention, for the resident because he hits his arms on things.  On 04/11/17, at 11:06 a.m., the director of nursing (DON) said she would have expected staff to do an incident report to attempt to determine how the skin tear could have occurred. The DON was unable to provide any evidence to explain what had caused, or may have caused, the discolorations. Prior to the surveyor asking about the resident's skin condition, there was  no documentation regarding the areas observed on the resident's forearms and the recent skin tear to the right elbow other | | | |

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Previous Versions Obsolete

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0309  **Level of harm -** Immediate jeopardy  **Residents Affected -** Some F 0313  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0325  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 7)  than the 04/05/17 order for treatment for [REDACTED].  **Make sure that residents receive proper treatment and assistive devices to maintain their vision and hearing.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on resident interview, staff interview, observation, and record review, the facility failed to follow up with vision care for two (2) of three (3) residents reviewed for the care area of vision after admission to the facility. Resident identifiers: #126 and #66. Facility census: 113.  Findings include:   1. Resident #126   Record review on 04/04/17 at 2:54 p.m., found the resident's last admission to the facility was on 01/10/17.  The resident's admission minimum data set (MDS) with an assessment reference date (ARD) of 01/17/17 identified the resident had impaired vision and no corrective lenses.  Review of the care area assessment (CAA) for vision, found the facility would not care plan the resident's visual problems because, Resident states that she has had one cataract removed for left eye and 2 off of right eye. States it was at (name of hospital) 4 or 5 years ago. She was able to see large print but not small print. No glasses in use. No s/s (signs or  symptoms) infection noted. No referrals or appointments at this time. The CAA noted the resident had diabetic retinopathy and decreased visual acuity.  Review of the resident's current care plan found the problem statement, The resident is at risk for falls r/t (related to) [MEDICAL CONDITION], weakness, fx (fracture) RUE (right upper extremity) pain med use . Falls at home and fell at home before Christmas resulting in fx. (R) shoulder. Fall 1/17/17, assist resident with toileting needs as needed, Fall 3/28/17.  Remind resident to watch where she is going when ambulating. Fall 3/28/17 up with out shoes.  A fall risk assessment, dated 03/28/17, (question #6) noted the resident's vision was inadequate-impaired vision in adequate light with glasses on.  At 3:14 p.m. on 04/04/17, when asked about her vision, she said she had never worn glasses. She said she had an appointment (resident stated name of local doctor) to determine if she needed glasses after her cataract removal. She missed the appointment because she was in the hospital. She said, If I had a way to go I would go to the eye doctor now. The resident said she could not see her television, which was about 5 feet in front of her. She said, Everything looks black when I  watch television. Sometimes everything just looks black, I think I need my eyes looked at. The resident said she had not had any eye exams since her cataract surgery about 5 years ago.  The resident was deemed to have capacity to make medical decisions on 01/06/17. The resident was cognitively intact with a score of 14 on her brief interview for mental status (BIMS) on the admission MDS with an ARD of 01/17/17.  The director of nursing (DON), when interviewed at 3:27 p.m. on 04/04/17, said the resident told her she had glasses when she was at home but after her surgery, she did not need glasses anymore. The DON said she did not document this interview in the resident's medical record. The DON confirmed the resident had not had any exams since her admission to the facility to determine the cause of her visual problems and she did not have any glasses at that time; therefore, the fall risk assessment, dated 03/28/17, was incorrect. The DON contacted the doctor identified by the resident during her interview at  3:14 p.m. on 04/04/17. The physician's office stated the resident did have an appointment in (MONTH) of 2010 to have an eye exam but she did not keep the appointment.  Licensed Practical Nurse (LPN) #30, identified as an MDS coordinator, when interviewed at 3:41 p.m. on 04/04/17, said the resident did not want any glasses or any treatment, but she did not record this interview in the resident's medical record.  When asked about the resident's care plan for falls that directed, .remind the resident to watch where she is going ., she said that had nothing to do with the resident's eyesight, That was just written because she falls over her own feet.  At 4:03 p.m. on 04/04/17, Registered Nurse (RN), MDS Coordinator #4 said she scheduled an eye exam for the resident.   1. Resident #66   Resident #66 was chosen for review for the care area of vision because her most recent Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/20/17 indicated her vision was impaired and she had no corrective lenses.  A review of Resident #66's medical record at 8:09 a.m. on 04/11/17 found an admission MDS with an ARD of 11/22/16. Review of this MDS found a Care Area Assessment (CAA) worksheet related to Resident #66's impaired vision completed by Licensed Practical Nurse (LPN) #30. Under the heading, Care Plan Considerations LPN #30 wrote, Resident states that she has no  glasses and could not see small print. Can see large print but states she has [MEDICAL CONDITION] and [MEDICAL CONDITION].  Seen (name of Resident #66's eye doctor) for years. No s/s (signs or symptoms) of infection noted. No referrals at this time. Will not CP (care plan) at this time.  Review of Resident #66's physician orders [REDACTED].#66 was on this medication upon her admission to the facility and remained on the medication at the time of this review.  Further review of the record found no evidence Resident #33 was ever sent for a consultation with an eye doctor despite her [DIAGNOSES REDACTED].  An interview with the Director of Nursing at 10:30 a.m. on 04/11/17 confirmed that Resident #66 had not seen an eye doctor since her admission to the facility in (MONTH) (YEAR).  An interview with LPN #30 at 10:39 a.m. on 04/11/17 confirmed she had completed Resident #66's admission MDS and had completed her vision CAA worksheet. She indicated that her statement about no referrals at that time should have been a little clearer. She said the resident and her responsible party wanted to hold off on any vision consults at the time of  her admission due to her recent hospital stay and they wanted her to have time to get stronger. LPN #30 agreed they should follow up with the resident and her responsible party upon her return from the hospital and see if they would like any consults for her vision.  **Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, staff interview, and record review, the facility failed to ensure one (1) of three (3) residents reviewed for the care area of nutrition maintained acceptable parameters of nutritional status. The facility failed to recognize, evaluate, and address a weight loss for Resident #154. Resident identifier: #154. Facility census: 113. Findings include:  a) Resident #154  Record review found the resident, admitted to the facility on [DATE], was not on a planned weight loss program, and did not have a chronic disease that might result in a life expectancy of less than six (6) months. The resident was not receiving a nutritional supplement and had a physician's orders [REDACTED]. The resident had a body mass index (BMI) of less than 22, resulting in the investigation of the care area of nutrition. The resident's height was 67 inches and her current weight  was 123.2 pounds, resulting in a BMI of 19.3.  Review of the medical record found the only assessment completed by the registered dietitian (RD) was dated 04/04/17. The assessment noted the resident's ideal body weight should be between 153 pounds to 185 pounds. The RD noted the resident ate independently, had no current chewing or swallowing problems, and had an unplanned/undesired weight loss.  The nutritional summary noted this [AGE] year-old female, admitted with a [DIAGNOSES REDACTED]. Her weight was 123 pounds,  she had weight loss prior to admission, and was below her ideal body weight. She was able to feed herself meals after trays set-up. Staff were to encourage her at meals and offer substitutes for foods not eaten. The summary identified the resident said she did not have an appetite.  Review of the documentation of the resident's daily meal percentages found the resident had refused 19 meals from 03/15/17 to 04/04/17. The resident's daily consumption of meals varied from 25% to 50%.  Review of the weight summary, located in the computerized medical record, found the following weights recorded for the | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0325  **Level of harm -** Minimal | (continued... from page 8) resident:  03/15/17 122.6 pounds (#) | | | |
| harm or potential for actual | 03/20/17 123.2 # | | | |
| harm  **Residents Affected -** Few | 03/27/17 122.6 #  04/04/17 122.6 #  Review of the current care plan found a problem identified as, The resident has, nutritional problem or potential  nutritional problem r/t (related to) poor appetite-weight loss prior to admission 123# (IBW range 153-185#) Severe protein | | | |
|  | malnutrition. | | | |
|  | The goal associated with this problem was, the resident will increase nutritional status as evidenced by increasing weight | | | |
|  | 5% toward IBW range no s/s (signs or symptoms) of malnutrition, and consuming at least 75% of at least 2 meals daily. | | | |
|  | Approaches included: | | | |
|  | Invite resident to activities, | | | |
|  | Monitor record report to MD (doctor) PRN (as needed) s/sx (signs or symptoms) of malnutrition, | | | |
|  | Obtain and monitor lab/diagnostic work as ordered, | | | |
|  | Provide and serve diet as ordered, | | | |
|  | Staff to encourage resident to feed self and consume 3/4 of meals Staff to assist as needed to complete meal. | | | |
|  | At 12:23 p.m. on 04/05/17, Director of Rehabilitation Services #123 said the resident was being seen by the speech therapist | | | |
|  | for sound production and language, not swallowing, chewing or any issues related to eating. | | | |
|  | At 1:10 p.m. on 04/05/17, the resident was observed eating her lunch. Nurse Aide (NA) #83 said the resident would only eat | | | |
|  | 25% of her meal. | | | |
|  | At 2:07 p.m. on 04/05/17, Register Nurse (RN) Unit Manager #2 was asked if she could re-weigh the resident. Three (3) NAs | | | |
|  | (#87, #80, and #83) assisted RN #2 with weighing the resident. The resident's weight was 114.8. The previous day, 04/04/17, | | | |
|  | the resident's weight was recorded as 122.6 pounds - a weight loss of 7.8 pounds. RN #2 said she put in the weight of 122.6 | | | |
|  | pounds in the computer on 04/04/17, but the weight was not actually obtained on that date. That was just the date the | | | |
|  | weight was entered into the computer. | | | |
|  | At 2:25 p.m. on 04/05/17, during an interview, Dietary Supervisor (DS) #40 said, We were going to wait to see if she picked | | | |
|  | up any weight before adding any interventions. When the weights were discussed with the DS, she said she thought the | | | |
|  | 04/04/17 weight of 122.6 pounds was obtained on 04/04/17. I did not know she had lost weight. She was advised of the | | | |
|  | observation of the percentage of meal consumption, which was poor, and of the surveyor's request for staff to re-weigh the | | | |
|  | resident. The meal consumption percentages did not support that the resident would currently weigh the same as she weighed | | | |
|  | on admission. | | | |
|  | After surveyor intervention, a nurse's progress note, dated 04/05/17 at 3:21 p.m., noted, Resident's weight today 114.8 #, | | | |
|  | weight loss noted. (Name of physician) made aware. Orders received to start [MEDICATION NAME] 15 milligrams by mouth at | | | |
|  | bedtime for depression/weight loss, mighty shakes, 3 times a day. Obtain CBC (complete blood count), CMP (comprehensive | | | |
|  | metabolic panel), folate level, vitamin B-12, [MEDICAL CONDITION] panel, and urinalysis. | | | |
|  | At 8:20 a.m. on 04/11/17, the director of nursing (DON) and the administrator were advised of the findings regarding | | | |
|  | Resident #154. The DON said she would expect the date recorded in the medical record to be the date the resident was | | | |
|  | actually weighed. | | | |
| F 0333  **Level of harm -** Immediate | **Make sure that residents are safe from serious medication errors.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review, staff interview, and physician interviews, the facility failed to ensure Resident #53 received | | | |
| jeopardy  **Residents Affected -** Some | [MEDICATION NAME], an anticoagulant (blood thinner) upon return from a stay at an acute care hospital. After initiating [MEDICATION NAME] therapy, the facility failed to ensure prompt notification of the resident's physician of the results of ordered [MEDICATION NAME]/International Ratio (PT/INR) laboratory (lab) tests. Additionally, on two (2) separate occasions, the physician gave orders to increase Resident #53's [MEDICATION NAME], but the facility failed to administer the increased | | | |
|  | dose until the next day despite the fact it was available in the emergency medication box. | | | |
|  | These significant medication errors placed Resident #53 at an immediate risk for serious harm and/or death, resulting in a | | | |
|  | determination of immediate jeopardy. | | | |
|  | The Nursing Home Administrator (NHA) and the Director of Nursing (NHA) were notified of the immediate jeopardy at 3:05 p.m. | | | |
|  | on 04/06/16. | | | |
|  | The facility provided a plan of correction (P[NAME]) to the State agency at 4:13 p.m. on 04/06/17, which the State agency | | | |
|  | reviewed and accepted at 4:17 p.m. on 04/06/17. The State agency representatives onsite ascertained implementation of the | | | |
|  | P[NAME] and abated the immediacy at 4:50 p.m. on 04/06/17. | | | |
|  | After removal of the immediate jeopardy, no deficient practice for this requirement remained. | | | |
|  | Resident identifier: #53. Facility Census: 113 | | | |
|  | Findings include: | | | |
|  | a) Resident #53 | | | |
|  | Resident #53 was readmitted from an acute care facility on 03/21/17 at 9:00 a.m. Review of the resident's medical record | | | |
|  | found the hospital discharge summary noted [DIAGNOSES REDACTED]. An echocardiogram completed during her hospitalization | | | |
|  | showed an ejection fraction of 40-45%, apical hypokinesis (abnormally decreased muscle function) and left ventricular | | | |
|  | apical thrombus (clot). Her target INR (international ratio) was 3.0. The discharge summary included an instruction for the | | | |
|  | resident to receive [MEDICATION NAME] 2 mg by mouth every evening. | | | |
|  | Review of Resident #53's Medication Administration Record [REDACTED]. The medication was started after the attending | | | |
|  | physician visited and ordered [MEDICATION NAME] 2 mg and a PT/INR on 03/23/17. | | | |
|  | During an interview at 11:15 a.m. on 04/06/17, when asked about the resident not receiving [MEDICATION NAME] after her | | | |
|  | readmission, the resident's attending physician stated she would not have discontinued the resident's [MEDICATION NAME] | | | |
|  | unless she had hematuria or some other bleeding condition. (The medical contained no evidence Resident #53 had these | | | |
|  | conditions). | | | |
|  | The facility did not obtain the PT/INR ordered on [DATE] until 03/27/17. | | | |
|  | Facility staff reviewed, printed, and notified the physician of the results of this PT/INR on 03/28/17. The physician | | | |
|  | ordered the dose of [MEDICATION NAME] increased to 3 mg. However, the facility did not increase Resident #53's | | | |
|  | [MEDICATION | | | |
|  | NAME] dose until the evening of 03/29/17, despite the fact it was available in the emergency medication box. | | | |
|  | The facility did not notify the physician of the PT/INR results obtained on 04/03/17, until 04/04/17 of the result of 1.39 | | | |
|  | (low). The physician then gave orders to increase the resident's [MEDICATION NAME] to 4 mg. She did not get the first dose | | | |
|  | of this increased dosage until 04/05/17, despite the fact it was available in the emergency medication box. | | | |
|  | An interview with the DON on 04/06/17 at 11:25 a.m., found the facility has an emergency medication box that contains | | | |
|  | [MEDICATION NAME]. She confirmed Resident #53 did not receive the [MEDICATION NAME] as ordered. | | | |
|  | These significant medication errors placed Resident #53 at an immediate risk for serious harm and/or death, resulting in a | | | |
|  | determination of immediate jeopardy. | | | |
|  | The Nursing Home Administrator (NHA) and the Director of Nursing (NHA) were notified of the immediate jeopardy at 3:05 p.m. | | | |
|  | on 04/06/16. | | | |
|  | The facility provided a plan of correction (P[NAME]) to the State agency at 4:13 p.m. on 04/06/17, which the State agency | | | |
|  | reviewed and accepted at 4:17 p.m. on 04/06/17. The State agency representatives onsite ascertained implementation of the | | | |
|  | P[NAME] and abated the immediacy at 4:50 p.m. on 04/06/17. | | | |
|  | After removal of the immediate jeopardy, no deficient practice for this requirement remained. | | | |
|  | b) The Facility's Plan of Correction: | | | |
|  | On 04/06/17 Medical Director and Director of Nursing (DON) implemented the following plan: | | | |
|  | -- The DON and LPN immediately evaluated the resident number 53. Vital signs were B/P 108/58, SPO2 97% on 2L O2, RR 20, | | | |
|  | Temp | | | |
|  | 98.6, and Pulse 87. The resident assessment revealed resident without s/s of distress. No bleeding or new bruising noted to | | | |
|  | skin. Old ecchymosis areas in various shades were noted on her arm, abdomen, and around her right knee. The DON notified | | | |
|  | the physician of the resident condition and re-notified the physician of a PT/INR that was not obtained on 3/23/17 as | | | |
|  | ordered following a med error/lab error from a readmission on 3/21/17. The DON also re-reported the PT/INR values for the | | | |

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| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0333  **Level of harm -** Immediate | (continued... from page 9)  labs collected on 3/27/17 and 4/3/17 and the subsequent orders given by the physician. The DON reported to the physician  the dates and times which ordered [MEDICATION NAME] therapy was instituted. The physician requested the resident be sent to | | | |
| jeopardy  **Residents Affected -** Some | the emergency room for further evaluation. During the emergency room evaluation. Nursing staff present were immediately in-serviced and all other nurses will be in-serviced prior to their next scheduled shift by the DON or designee on [MEDICATION NAME] therapy, collecting labs and reporting lab findings, starting medications within a reasonable time following order, and utilization of the ER box if medications are needed. | | | |
|  | -- The DON and nursing staff will review the medical records for all other resident's receiving [MEDICATION NAME]. All | | | |
|  | residents receiving [MEDICATION NAME] will be assessed by nursing staff and documentation will be provided in the medical | | | |
|  | record. All residents receiving [MEDICATION NAME] will be ordered a stat PT/INR to ensure therapeutic levels. Once the | | | |
|  | levels are received they will be reported promptly to the physician for orders as indicated and any medication changes will | | | |
|  | be addressed promptly. | | | |
|  | -- Because this had the potential to effect all residents receiving [MEDICATION NAME], nursing staff present were | | | |
|  | immediately in-serviced and all other nurses will be in-serviced prior to their next scheduled shift by the DON or designee | | | |
|  | on [MEDICATION NAME] therapy, collecting labs and reporting lab findings, starting medications within a reasonable time | | | |
|  | following order, and utilization of the ER box if medications are needed. The facility also ordered a finger stick PT/INR | | | |
|  | monitor to perform in house monitoring of levels to avoid a delay in care. PT/INR levels will be recorded on a monitoring | | | |
|  | log for each resident on [MEDICATION NAME] and will be promptly reported for the physician and medications will be started | | | |
|  | promptly following orders received. The ER Box will be utilized as needed to provide timely medication. A [MEDICATION NAME] | | | |
|  | review monitor will be utilized to ensure that as results are obtained and orders are given, medications are started in a | | | |
|  | timely manner. | | | |
|  | -- The interdisciplinary team will review the aforementioned monitoring forms at the weekly team meeting for quality | | | |
|  | improvement x 8 weeks or until the committee determines satisfactory resolution has been achieved to ensure compliance. | | | |
|  | -- All nurses will be in-serviced prior to working their next shift. All resident charts will be reviewed by 4-14-17. | | | |
| F 0356 | **Post nurse staffing information/data on a daily basis.** | | | |
| **Level of harm -** Potential | Based on observation and staff interview, the facility failed to ensure the nurse staff posting reflected staffing numbers | | | |
| for minimal harm  **Residents Affected -** Many | for nigh shift. This practice had the potential to affect all residents and/or family members/visitors wishing to see how many staff were working. Facility Census: 113.  Findings include:  a) Upon entrance to the facility at 6:00 a.m. on 04/06/17, observation found the nurse staff posting form dated 04/05/17 | | | |
|  | contained spaces for staffing numbers for all three (3) shifts. | | | |
|  | 1. Day shift 6:30 a.m. to 2:30 p.m., 7:00 a.m. to 3:00 p.m., 9:00 a.m. to 5:00 p.m., and 10:30 a.m. to 6:30 p.m. | | | |
|  | 2. Evening Shift 2:30 p.m. to 10:30 p.m., 3:00 p.m. to 11:00 p.m., 3:00 p.m. to 3:00 a.m., 7:00 p.m. to 7:00 .a.m. | | | |
|  | 3. Night Shift: 10:30 p.m. to 6:30 a.m., 11:00 p.m. to 7:00 a.m., and 3:00 a.m. to 3:00 p.m. | | | |
|  | The day shift and evening shift staffing numbers were completed, but the night shift numbers were not filled in. | | | |
|  | An interview with Nurse Aide Supervisor (NAS) #41 confirmed the nurse staff posting was not completed for night shift. She | | | |
|  | stated, I take care of updating it before I leave in the evenings and I forgot to update it yesterday evening. | | | |
| F 0371 | **Store, cook, and serve food in a safe and clean way** | | | |
| **Level of harm -** Minimal | Based on observation and staff interview, and record review, the facility failed to ensure food was stored in a safe and | | | |
| harm or potential for actual | sanitary manner to prevent the spread of foodborne illnesses. Multiple containers of juice in the dry storage area were | | | |
| harm  **Residents Affected -** Many | expired. An open container of three-bean salad with an open date of 03/22/17 was in the walk-in refrigerator. The dietary manager confirmed the salad should have been discarded after seven (7) days. These findings had the potential to affect all residents residing in the facility that received food from the kitchen. Facility Census: 113.  Findings include: | | | |
|  | a) Initial tour of the facility's kitchen | | | |
|  | An initial tour of the kitchen, accompanied by the Dietary Manager, began at 11:00 a.m. on 04/03/16. | | | |
|  | 1. In the walk-in cooler there was an open container of three-bean salad. The opened date on the container was 03/22/17. The | | | |
|  | dietary manager, when asked how long this was good for, stated, It should have been discarded after seven (7) days. | | | |
|  | 2. The tour of the dry storage area found the following: | | | |
|  | -- Nine (9) 46 ounce containers of prune juice with a manufacturer's stamped use by date of 10/01/15. | | | |
|  | -- Four (4) 46 ounce containers of prune juice with a manufacturer's stamped use by date of 07/07/16. | | | |
|  | -- One (1) 46 ounce container of light cranberry juice with a manufacturer's stamped use by date of 10/26/16. | | | |
|  | -- Twenty Four (24) 46 ounce containers of light cranberry juice with a manufacturer's stamped use by date of 02/02/17. | | | |
|  | -- One (1) 46 ounce container of light cranberry juice with a manufacturer's stamped use by date of 02/03/17. | | | |
|  | The dietary manager indicated that the juices must have come from the distributor already expired because she had not had | | | |
|  | them that long. She confirmed all of the identified juices were expired. She instructed her staff to dump them and keep the | | | |
|  | lids so she could call the distributor and get credit since they were expired when sent. | | | |
| F 0460 | **Provide bedrooms that don't allow residents to see each other when privacy is needed.** | | | |
| **Level of harm -** Minimal | Based on observation and staff interview, the facility failed to ensure bedside privacy curtains in seventeen (17) of | | | |
| harm or potential for actual | thirty-four (34) rooms observed during Stage 1 of the Quality Indicator Survey (QIS) provided full visual privacy for the | | | |
| harm  **Residents Affected -** Some | residents. This had the potential to affect more than an isolated number of residents. Facility census: 113. Findings include:  a) A tour of the facility with Maintenance Coordinator (MC) #14 at 1:45 p.m. on 04/10/17, found the outer and middle privacy curtains around the beds were not wide enough to ensure full visual privacy. | | | |
|  | 1. Affected rooms on the 100 hall were: | | | |
|  | - 101, | | | |
|  | - 119, | | | |
|  | - 110, | | | |
|  | - 113, | | | |
|  | - 121, | | | |
|  | - 122, | | | |
|  | - 124, | | | |
|  | - 126, | | | |
|  | - 130, and | | | |
|  | - 131. | | | |
|  | 2. Affected rooms on the 200 hall were: | | | |
|  | - 202, | | | |
|  | - 205, | | | |
|  | - 220, and | | | |
|  | - 222. | | | |
|  | 3. The affected room on the 300 hall was: | | | |
|  | - 305 | | | |
|  | 4. The affected rooms on the 400 hall were: | | | |
|  | - 401 and | | | |
|  | - 406. | | | |
|  | MC #14 confirmed the findings and said the facility was planning to purchase new privacy curtains for the resident rooms. | | | |

F 0490 **Be administered in an acceptable way that maintains the well-being of each resident .**

**Level of harm -** Minimal harm or potential for actual harm

**Residents Affected -** Many

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| 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 0490  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 10)  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, record review, and resident interviews, the facility was not administered in an efficient, effective manner. Deficiencies related to resident rights, administration, and quality of care were found to be out of compliance during the current Quality Indicator Survey (QIS). The issues identified were results of systemic breakdowns in the manner in which the facility staff administered care and services to its residents. These issues had been ongoing for multiple months giving facility administration ample time to identify and correct the deficient practices prior to their QIS survey which began on [DATE]. These practices had the potential to affect all residents. Facility census: 113.  Findings include:  a) Staff interview, family interview, and review of resident personal funds account balances, found the facility failed to ensure residents who had a personal funds account at the facility had access to petty cash after business office hours. In addition, the facility failed to ensure a quarterly statement of the balance of Resident #15's personal funds account was provided in writing to the resident's representative within 30 days after the end of the quarter.   1. Personal funds   At 2:23 p.m. on [DATE], Business Office Manager (BOM) #13 verified the facility did not have a means to provide any petty cash to residents with personal funds accounts when the business office was closed, which included evenings and weekends. BOM #13 said residents could only get personal funds monies Monday through Friday during the daytime hours.   1. Resident #15   During Stage 1 of the Quality Indicator Survey, at 9:28 a.m. on [DATE], the resident's responsible party (the resident's daughter) said she had never received any statements regarding Resident #15's personal funds account. The daughter said she received the resident's monthly check and wrote a personal check to the facility for the resident's monthly room and board.  She also deposited money in the resident's account for, Things like a haircut at the beauty shop. She stated she did not know the exact amount in her mother's account.  At 1:06 p.m. on [DATE], BOM #13 confirmed she did not mail a quarterly statement to the resident's daughter. She said she gave a copy of the quarterly statement to the resident. The BOM said she did not think she could send a statement to the daughter because the daughter did not have a durable power of attorney. BOM #13 did confirm the daughter paid the resident's monthly bill at the facility and deposited money in the resident's personal funds account.  Review of the resident's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of [DATE] found the resident scored a 3 on her Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. A score of 3 indicated the resident would not be capable of understanding a personal funds account statement.  These findings were discussed with the administrator at 8:12 a.m. on [DATE]. As of the close of the survey on [DATE] at 2:45 p.m., the administrator had provided no further information.  b) Record review and staff interview, revealed the facility failed to ensure five (5) of seven (7) residents reviewed for  the care area of personal funds during Stage 2 of the Quality Indicator Survey (QIS), had his/her personal funds conveyed within 30 days of death to the individual or probate jurisdiction administering the resident's estate. Resident  identifiers: #136, #39, #73, #95, and #110.   1. Resident #136   Medical record review found Resident #136 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $17.00.   1. Resident #39   Medical record review found Resident #39 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $189.19.   1. Resident #73   Medical record review found Resident #73 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $877.26.   1. Resident #95   Medical record review found Resident #95 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $942.43.   1. Resident #110   Medical record review found Resident #110 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $70.10.   1. At 2:49 p.m. on [DATE], Business Office Manager (BOM) #13 confirmed the personal funds of Residents #136, #39, #73, #95, and #110 were not conveyed to the individual or probate jurisdiction administering the residents' estates within 30 days of   the resident's death.  c) Staff interview and resident interview, found the facility failed to ensure residents received mail delivery on Saturdays. This practice had the potential to affect all residents at the facility. Resident identifier: #121.   1. Resident #121   At 3:00 p.m. on [DATE], when asked about mail delivery on Saturdays, Resident #121 (the resident council president) said she did not believe residents received mail on Saturdays. She said the activities staff delivered the mail to the residents.   1. Activity Director (AD) #98, when interviewed at 6:40 a.m. on [DATE], said there was no mail delivery on Saturdays. At [DATE] at 7:15 a.m., the administrator confirmed there was mail delivery from the post office in the neighborhood on Saturdays.   At 8:11 a.m. on [DATE], the administrator said he arranged for the mail carrier to deliver the mail to the facility on Saturdays. I guess he (the mail man) didn't come before because he knew there was nobody in the office on Saturdays.  d) Record review, staff interview, and physician interviews, found the facility failed to ensure Resident #53 received the necessary care and services to attain or maintain the highest practicable level of physical well-being, consistent with the resident's comprehensive assessment and plan of care. The facility failed to ensure Resident #53 received the anticoagulant [MEDICATION NAME] upon return from a stay at an acute care hospital. After initiating [MEDICATION NAME] therapy, the facility failed to ensure prompt notification of the resident's physician of the results of ordered [MEDICATION NAME]/International Ratio (PT/INR) laboratory (lab) tests. Additionally, the facility failed to ensure the resident kept  follow-up appointments.  These failures placed Resident #53 at an immediate risk for serious harm and/or death. These findings resulted in a determination of immediate jeopardy.  The Nursing Home Administrator (NHA) and the Director of Nursing (NHA) were notified of the immediate jeopardy at 1:30 p.m. on [DATE].  The facility provided a plan of correction (P[NAME]) to the State agency at 4:13 p.m. on [DATE], which the State agency reviewed and accepted at 4:17 p.m. on [DATE]. The State agency then observed for the implementation of the P[NAME] and abated the immediacy at 4:50 p.m. on [DATE].  This immediate jeopardy began on [DATE], when the facility first began to fail to provide appropriate medications and treatments as outlined in the discharge summary from an acute care hospital for treatment of [REDACTED]. From [DATE], forward the facility continued to make multiple errors in following the identified resident's plan of care.  1. A review of Resident #53's medical record at 12:00 p.m. on [DATE], found the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The discharge instructions included, but not limited to:  -- [MEDICATION NAME] ([MEDICATION NAME]) two (2) milligrams (mg) by mouth daily at bedtime for treatment of [REDACTED].  -- A scheduled appointment with a Cardiologist on [DATE] at 10:20 a.m. for follow-up treatment of [REDACTED]. (Address and phone number included)  -- The facility was to call for an appointment with a neurologist within six (6) weeks from date of discharge. (Address and phone number included)  Review of Resident #53's Medication Administration Record [REDACTED]. The medication was started after the attending physician visited and ordered [MEDICATION NAME] 2 mg and a PT/INR on [DATE].  During an interview at 11:15 a.m. on [DATE], when asked about the resident not receiving [MEDICATION NAME] after her readmission, the resident's attending physician stated she would not have discontinued the resident's [MEDICATION NAME] unless she had hematuria or some other bleeding condition. (The medical contained no evidence Resident #53 had these conditions). The physician further stated she did not recall if they told her the resident was started on [MEDICATION NAME] | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0490  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0502  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 11)  while in the hospital. She stated, I don't remember what they found I would have to look at her record. The facility did not obtain the PT/INR ordered on [DATE] until [DATE].  The results of the PT/INR obtained at 5:00 a.m. on [DATE], were available for review by the facility by 1:00 p.m. on [DATE]. Facility staff did not review or print the results of this PT/INR until [DATE]. On [DATE], the facility reported the PT/INR result of 1.21 to the physician by telephone, at which time the physician increased the dose of [MEDICATION NAME] to 3 mg.  However, the facility did not increase Resident #53's [MEDICATION NAME] dose until the evening of [DATE], despite the fact it was available in the emergency medication box.  The facility obtained the repeat PT/INR [DATE] as ordered, but did not notify the physician of the PT/INR results obtained  on [DATE], until [DATE] of the result of 1.39 (low). The physician then gave orders to increase the resident's [MEDICATION NAME] to 4 mg. She did not get the first dose of this increased dosage until [DATE], despite the fact it was available in  the emergency medication box.  An interview with the Director of Nursing (DON) on [DATE] at 11:25 a.m., found the facility had an emergency medication box that contained [MEDICATION NAME]. She confirmed Resident #53 did not receive the [MEDICATION NAME] as ordered.  The facility failed to arrange transportation for Resident #53 to and from her appointment with the cardiologist scheduled  for 10:20 a.m. on [DATE]. Therefore, the resident was not seen by the cardiologist after her recent [MEDICAL CONDITION] as directed by the discharge summary due to the facility's failure to make arrangements.  An interview with the DON on [DATE] at 10:30 a.m., found the facility followed the hospital discharge summary when a resident was admitted /readmitted to the facility unless the attending physician specified differently. When the attending physician wished to provide a different medication and/or treatment, it was documented in the nurses' notes. She verified the physician wished to follow the orders as directed by the discharge summary.  These failures by the facility placed Resident #53 at an immediate risk for serious harm and/or death. This has resulted in a determination of immediate jeopardy.  The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the immediate jeopardy at 1:30 p.m. on [DATE].  The facility provided a plan of correction (P[NAME]) to the State agency at 4:13 p.m. on [DATE], which the State agency reviewed and accepted at 4:17 p.m. on [DATE]. The State agency representatives onsite, verified implementation of the P[NAME] and abated the immediacy at 4:50 p.m. on [DATE].  This immediate jeopardy began on [DATE], when the facility first began to fail to provide appropriate medications and treatments as outlined in the discharge summary from an acute care hospital for treatment of [REDACTED]. From [DATE], forward the facility continued to make errors in following the identified resident's plan of care.  2. After removal of the immediate jeopardy, deficient practices remained for Residents #76 and #79 at a scope and severity of D   1. Resident #76   Review of Resident #76s medical record on [DATE] at 9:45 a.m., revealed the resident had a Stage 4 pressure ulcer on right foot Symes amputation (an amputation through the ankle joint) site which occurred following an attempt to wear a prosthesis. An outside wound clinic treated and monitored the pressure ulcer.  Review of consultation reports found an outside wound clinic saw and treated Resident #76' pressure ulcer on [DATE]. This consult specified recommended treatments and a return appointment in three (3) weeks. The facility physician ordered an appointment for the resident to go to the wound clinic on [DATE]. There was no evidence found in the resident's medical record to indicate the resident went to the wound clinic on the specified date, and if not, why the resident missed the appointment.  An interview with the DON on [DATE] at 12:30 p.m., found the staff did not know why the appointment with the wound care clinic had been missed. She further confirmed the appointment had been rescheduled.   1. Resident #79   At 8:06 a.m. on [DATE], observation of the resident found he had numerous areas of discoloration to both forearms and a band-aid on his right elbow. The areas were various shades of red and purple.  Review of a monthly summary dated [DATE], found the resident had no skin issues.  A nursing entry dated [DATE] noted, New orders received and noted to discontinue tx (treatment) to right and left forearm areas resolved.  Further review of the medical record found another nurse's entry dated [DATE] that noted, New orders received and noted to cleanse open ecchymotic area to right elbow with NNS (normal saline solution), Pat dry, apply [MEDICATION NAME] and cover with band aid daily and PRN (as needed), Left message for  At 1:42 p.m. on [DATE], Licensed Practical Nurse (LPN) #31, when asked if she had any information regarding the reddened areas on the resident's forearms and the skin tear, she said she did not have an incident report for the skin tear. She  said the reddened areas on the forearms were ecchymotic areas due to the use of [MEDICATION NAME]. She verified these areas were not on the resident's current care plan.  At 1:53 p.m. on [DATE], Licensed Practical Nurse, (LPN) # 22 said the area to his elbow was just a scab the resident had picked at. The areas come and go where he just constantly picks, he is on [MEDICATION NAME]. Review of the resident's current care plan found the use of [MEDICATION NAME] and the ecchymotic areas identified by the staff were not currently care planned. She stated, I did not care plan the use of [MEDICATION NAME].  On [DATE] at 9:27 a.m., Registered Nurse (RN)/Quality Assurance Coordinator #38, when asked if the facility had any information regarding the reddened areas to the resident's forearms and the recent skin tear to the resident's elbow, she had no additional information to provide.  At 11:05 a.m. on [DATE], Registered Nurse (RN) #4 said she had ordered elbow protectors for the resident because he hit his arms on things. This was after the surveyor began asking questions about the resident's skin condition.  On [DATE], at 11:06 a.m., the director of nursing (DON) said she would have expected staff to do an incident report to attempt to determine how the incident could have occurred. The DON was unable to provide any evidence, before surveyor intervention, the facility had documented the areas to the forearms and had addressed the recent skin tear to the right elbow, other than the order for the treatment dated [DATE].  e) The DON said the facility's Quality Assessment and Assurance committee had been tracking resident appointments and the timeliness of obtaining laboratory values once ordered by the physician. There were some problems in the past but she though these issues had been taken care of.  **Give or get quality lab services/tests in a timely manner to meet the needs of residents.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview the facility failed to obtain all physician ordered laboratory (lab) services to meet the needs of each resident and obtained a lab study for one resident without an order. The facility obtained a lab  study for Resident #48 without a physician's orders [REDACTED].#102, #53, #68, #54, and #81. This was true for six (6) of twenty-three (23) residents reviewed during Stage 2 of the Quality Indicator Survey (QIS). Resident identifiers: #102, #53, #68, #54, #81, and #48. Facility census: 113.  Findings include:   1. Resident #102   A review of Resident #102's medical record on 04/05/17 at 11:34 a.m., found a physician's orders [REDACTED]. These labs were not obtained until 02/22/17.  On 04/05/17 at 11:48 a.m., the Director of Nursing (DON) indicated the BMP, PT/INR, TSH, CBC, BNP, and Lipid and Liver function panel to be obtained on next lab day (02/20/17) were not obtained until 02/22/17.   1. Resident #53   A review of Resident #53's medical record on 04/05/17 at 12:34 p.m., found a physician's orders [REDACTED]. The PT/INR was not obtained until 03/28/17.  On 04/05/17 at 1:08 p.m., the DON indicated the PT/INR ordered for 03/23/17 was not obtained until 03/28/17.   1. Resident #68   Review of Resident #68's medical records on 04/06/17 at 9:00 a.m., found an order for [REDACTED].  Interview with the DON, on 04/06/17 at 9:35 a.m., found the PT/INRs ordered for 03/13/17 and 03/20/17 were not obtained as | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0502  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0505  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0514  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 12)  ordered and the results could not be provided.   1. Resident #54   Resident #54's medical records reviewed at 10:45 a.m. on 04/06/17, found an order for [REDACTED].  Interview with the DON on 04/06/17 at 11:35 a.m., found the BMP and PT/INR ordered for (MONTH) (YEAR) and (MONTH) (YEAR)  were not obtained as ordered and results could not be provided.   1. Resident #81   Resident #81's medical records on 04/06/17 at 1:30 p.m., found an order for [REDACTED].  Interview with the DON on 04/06/17 at 1:55 p.m., found the CMP, CBC and lactic acid ordered for 03/06/17 were not obtained as ordered and results could not be provided.   1. Resident #48   Medical record review on 04/06/17 at 3:00 p.m., found for Resident #48 had a PT/INR obtained on 03/31/17 without a  physician's orders [REDACTED].>On 04/06/17 at 3:45 p.m., the DON confirmed Resident #48 had a PT/INR completed without a physician's orders [REDACTED].>  **Quickly tell the resident's doctor the results of lab tests.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on record review and staff interview, the facility failed to notify the attending physician promptly of [MEDICATION NAME] Time/International Ratio (PT/INR) laboratory (lab) results for Residents #102, #53, #68, #54, #81, and #48 used to regulate the dosage of [MEDICATION NAME]. This was true for six (6) of twenty-three (23) residents reviewed during Stage 2 of the Quality Indicator Survey (QIS). Resident identifiers: #102, #53, #68, #54, #81, and #48. Facility census: 113.  Findings include:   1. Resident #102   Medical record review for Resident #102 found the result of a PT/INR done on 02/22/17 was an INR of 1.36 - Low (L). The facility did not notify the physician until 02/23/17 and the [MEDICATION NAME] dose was increased.  Another PT/INR result obtained on 03/28/17 was 2.62 and the facility did not notify the physician until 03/29/17.  (Note: [MEDICATION NAME], an anticoagulant, requires titration to a specific blood level. The dosage varies from individual to individual. [MEDICATION NAME] has a Narrow Therapeutic Index (NTI) meaning the therapeutic dose is very close to the toxic dose. The dosage varies from individual to individual and even a single individual may require frequent dosage adjustments. The usual therapeutic range for a PT/INR for most conditions is 2.0 - 3.0.)   1. Resident #53   Medical record review found a PT/INR done on 03/27/17 with result of 1.21 (L). The facility did not notify the physician until 03/28/17 and the [MEDICATION NAME] dose was increased.  Additionally, review of the resident's medical record found no evidence the facility notified the physician the PT/INR obtained on 04/03/17 was 1.39 (L).   1. Resident #68   Review of Resident #68's medical records found the resident had the following PT/INRs:  -- Obtained on 03/06/17 - results 2.1 - Physician notified 03/07/17  -- Obtained on 03/08/17 - results 2.8 - Physician notified 03/09/17  -- Obtained on 03/17/17 - results 1.99 - Physician notified 03/21/17  -- Obtained on 03/20/17 - results 2.28 - Physician notified 03/21/17   1. Resident #54   Review of Resident #54's medical record found the resident had the following PT/INRs:  -- Obtained on 01/05/17 - results .97 (L) - Physician notified 01/06/17 - [MEDICATION NAME] dose increased.  -- Obtained on 01/20/17 - results 1.06 (L) - Physician notified 01/23/17 - [MEDICATION NAME] dose increased.  -- Obtained on 01/31/17 - results 2.55 - Physician notified 02/01/17  -- Obtained on 02/02/17 - results 2.41 - Physician notified 02/03/17  -- Obtained on 02/13/17 - results 3.32 High (H) - Physician notified 02/14/17  -- Obtained on 02/16/17 - results 3.28 (H) - Physician notified 02/17/17 - [MEDICATION NAME] dose decreased.  -- Obtained on 02/28/17 - results 1.28 (L) - Physician notified 03/01/17 - [MEDICATION NAME] dose increased  -- Obtained on 03/14/17 - results 3.58 (H) - Physician notified 03/15/17   1. Resident #81   Medical record review for Resident #81, found a PT/INR done on 03/14/17 with result of INR 1.33 (L). The facility did not notify the physician until 03/15/17.  A PT/INR obtained on 03/17/17 with a result of 1.42 (L), but the facility did not notify the physician until 03/21/17.   1. Resident #48   Medical record review found a PT/INR done on 03/20/17 had a result of 3.38 (H). The facility did not notify the physician until 03/21/17, who decreased the dose of [MEDICATION NAME].  A PT/INR obtained on 03/31/17 had a result of 2.25. The facility notified the physician on 04/04/17.   1. An interview with the Director of Nursing (DON) on 04/06/17 at 4:30 p.m., found the nurses were to notify the physician of the PT/INR results on the day the lab was obtained due to the resident's [MEDICATION NAME] dosage was regulated according to the PT/INR results. She confirmed the nurses did not notify the physician promptly of the PT/INR lab results for Residents #102, #53, #68, #54, #81, and #48.   **Keep accurate, complete and organized clinical records on each resident that meet professional standards**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, staff interview, resident interview, and record review, the facility failed to maintain medical records on each resident that were complete, accurate, and systematically organized. This failed practice affected six (6) of twenty-three (23) sample residents reviewed during Stage 2 of the Quality Indicator Survey (QIS). Nursing monthly summaries were inaccurate in regards to urinary incontinence for two (2) residents (#59 and #66) and in regards to dental  assessment twice for one (1) resident (#132). Physician orders [REDACTED].#11). The physician documentation on a pharmacy recommendation was inaccurate in regards to gradual dose reduction (GDR) for one (1) resident (#15). The care plan was inaccurately dated when revised for one (1) resident (#79). In addition, the facility did not maintain the influenza (flu)  and pneumonia vaccination consents in the residents' medical records, which had the potential to affect all residents in the facility. Resident identifiers: #59, #132, #66, #11, #15, and #79. Facility census: 113.  Findings include:   1. Resident #59   A record review on 04/10/17 at 1:24 p.m. with the assistance of Minimum Data Set (MDS) Coordinator #4, found Resident #59 assessed as always incontinent of bladder on her quarterly MDS with an assessment reference date (ARD) of 02/01/17. She was also incontinent for every voiding episode on nurse aide documentation from 03/01/17 to 03/31/17. Her monthly summary, effective 03/03/17, identified her in Section I as C. Continent of bladder.  When discussed with nurse manager Licensed Practical Nurse (LPN) #33 on 04/10/17 at 1:41 p.m., she agreed the monthly summary dated 03/03/17 was inaccurate and that Resident #59 was always incontinent of bladder.   1. Resident #132   During an observation and interview on 04/04/17 at 3:23 p.m., the resident said he had his natural teeth, although they had been in poor repair for over a year. Observation found his teeth in various states of decay, with some natural teeth remaining intact.  Record review on 04/11/17 found his monthly summaries effective 01/18/17 and 02/16/17 documented he had dentures under section L Oral Hygiene.  When discussed with the nurse manager, LPN #33, on 04/11/17 at 10:19 a.m., she agreed the monthly summaries were both inaccurate.   1. Resident #66 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
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| F 0514  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0520  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 13)  A review of Resident #66's medical record at 11:30 a.m. on 04/10/17 found two (2) monthly summary notes dated 02/24/17 and 03/24/17, each completed by a Licensed Nurse. Each monthly summary indicated Resident #66 was always continent of her bowel and bladder. Review of the nurse aide flow sheets for the months of 02/2017 and 03/2017 found Resident #66 was always incontinent of her bowel and bladder.  During an interview with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #33 at 2:34 p.m. on 04/10/17, LPN #33 confirmed that based on the nurse aide flow sheets that Resident #66 was always incontinent. She agreed the monthly summaries dated 02/24/17 and 03/24/17 did not accurately reflect the resident's continence status.   1. Resident #11   Record review at 9:36 a.m. on 04/05/17, found a physician's orders [REDACTED].  At 11:20 a.m. on 04/05/17, Restorative Nurse Aide (RNA) #107 verified the resident was receiving restorative nursing services daily. She said she ambulated the resident, but did not apply the brace to the resident's right hand. RNA #107 said the nurse aides (NA) applied the hand brace. She said the resident was to wear the hand brace all day until he went to bed.  Licensed Practical Nurse (LPN) #30 said the resident was to wear the right hand brace for 3 hours on and off during waking hours. A total of 3 hours on for the day and this could be during any part of the day. LPN #30 said the order for RNA did not refer to the restorative nurse aide, but to the registered nurse aide. They just changed the classification of a  nursing assistant to registered NA, instead of a certified NA.  At 11:44 a.m. on 04/05/17, the resident's NA, NA #83, said the resident was to wear the right hand brace for 2 hours and then remove it for 2 hours.  LPN #31 said the resident only needed the brace for a total of 3 hours a day at 11:50 a.m. on 04/05/17.  Registered Nurse (RN) MDS Coordinator #4 confirmed the order was confusing. She said she would clarify the order with the therapy department.   1. Resident #15   Review of the care area for unnecessary medications found the pharmacist had recommended a gradual dose reduction (GDR) of [MEDICATION NAME] and [MEDICATION NAME] on 02/15/17.  The pharmacy form provided two (2) responses for the physician to use to answer the recommendation. The physician chose recommendation #2, which was The resident's target symptoms returned or worsened after the most recent GDR The physician documented, Stable at this time on current dose. This is lowest effective dose. I do not want to decrease or change.  At 12:43 p.m. on 04/10/17, the director of nursing was asked to provide verification of a failed GDR.  At 8:40 a.m. on 04/11/17, the DON provided evidence the resident had two (2) dose reductions in the past year. She was unable to find evidence of a failed GDR. The resident's medication had not been increased since the dose reductions. She stated the physician checked the incorrect box on the pharmacy form. She said the physician meant to check recommendation #1, Continued use is in accordance with current standard of practice and a GDR attempt at this time is likely to impair the individuals function or cause psychiatric instability by exacerbating an underlying condition or psychiatric disorders   1. Resident #79   At 8:06 a.m. on 04/04/17, observation of the resident found he had numerous areas of discoloration to both forearms and a band-aid on his right elbow. The areas were various shades of red and purple.  Review of a monthly summary dated 03/03/07, found the resident had no skin issues.  A nursing entry dated 04/03/17 noted, New orders received and noted to discontinue tx (treatment) to right and left forearm areas resolved.  Further review of the medical record found another nurse's entry dated 04/04/17 that noted, New orders received and noted to cleanse open ecchymotic area to right elbow with NNS (normal saline solution), Pat dry, apply [MEDICATION NAME] and cover with band aid daily and PRN (as needed), Left message for  At 1:42 p.m. on 04/05/17, Licensed Practical Nurse (LPN) #31, when asked if she had any information regarding the reddened areas on the resident's forearms and the skin tear, she said she did not have an incident report for the skin tear. She  said the reddened areas on the forearms were ecchymotic areas due to the use of [MEDICATION NAME]. She verified these areas were not on the resident's current care plan.  At 1:53 p.m. on 04/05/17, Licensed Practical Nurse, (LPN) # 22 said the area to his elbow was just a scab the resident had picked at. The areas come and go where he just constantly picks, he is on [MEDICATION NAME]. Review of the resident's current care plan found the use of [MEDICATION NAME] and the ecchymotic areas identified by the staff were not currently care planned. She stated, I did not care plan the use of [MEDICATION NAME].  On 04/03/17 at 9:27 a.m., Registered Nurse (RN)/Quality Assurance Coordinator #38, when asked if the facility had any information regarding the reddened areas to the resident's forearms and the recent skin tear to the resident's elbow, she had no additional information to provide.  At 11:05 a.m. on 04/11/17, Registered Nurse (RN) #4 said she had ordered elbow protectors for the resident because he hit his arms on things. This was after the surveyor began asking questions about the resident's skin condition.  On 04/11/17, at 11:06 a.m., the director of nursing (DON) said she would have expected staff to do an incident report to attempt to determine how the incident could have occurred. The DON was unable to provide any evidence, before surveyor intervention, the facility had documented the areas to the forearms and had addressed the recent skin tear to the right elbow, other than the order for the treatment dated 04/05/17.  The copy of the resident's current care plan provided on 04/04/17 included a problem of:  The resident has potential for pressure ulcer development r/t (related to) decreased mobility, poor PO (by mouth) intake, developing stage II to coccyx on 06/22/16, returned to facility from (initials of hospital) on 06/26/16 with Stage III ulcer to coccyx, slough present to wound bed, dark red Peri-wound. Reopened skin tear right elbow 07/14/16. Stage III resolved on 08/04/16.  A copy of a care plan provided on 04/11/17, included a problem dated 07/24/17, The resident has potential for pressure ulcer development r/t (related to) decreased mobility, poor PO intake, developing stage II to coccyx on 06/22/16, returned to facility from (initials of hospital) on 06/26/16 with Stage III ulcer to coccyx, slough present to wound bed, dark red  Peri-wound. Reopened skin tear right elbow 07/14/16. Stage III resolved on 08/04/16. Is on [MEDICATION NAME] and is noted to scratch himself, and pick at skin at times causing open areas. Open ecchymotic area to (R) right elbow. Open ecchymotic  area to (l) left elbow. Hits elbows on walls.  At 11:15 a.m. on 04/11/17, the DON said the date of 07/24/17 was just a mistake on the care plan. The care plan was updated after surveyor intervention, not on 07/24/17. She said the problem should have had the date entered when the care plan was updated.   1. Influenza and Pneumonia Consent Forms   Medical record review of Stage 2 residents during the Quality Indicator Survey (QIS) and review of the electronic and paper records of discharged residents during the Infection Control review, found no influenza and/or pneumonia consents within each residents' medical record.  An interview on 04/11/17 at 10:10 a.m. with Medical Records (MR) Staff #45, found the medical records department did not receive the vaccination consent forms to scan and/or place in the medical records of each resident. The Infection Control (IC) nurse maintained all of the pneumonia and/or Influenza vaccination consents and the consents had never been placed in each residents' medical record.  On 04/11/17 at 11:05 a.m., interview with the Director of Nursing (DON) and the IC nurse found the consents for pneumonia and influenza were not placed in each resident's medical record. The IC nurse stated she kept them in her office. The DON and IC nurse further verified the consents should be in each residents' medical. They said the medical records staff would put the consents in residents' medical records immediately.  **Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  . | | | |

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| F 0520  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 14)  Based on observation, resident interview, record review, and staff interview, the facility's Quality Assurance and Assessment (QA&A) Committed failed to identify and correct quality deficiencies, of which the facility was aware of or should have been aware. Deficiencies related to resident rights, administration, and quality of care, were found to be out of compliance during the current Quality Indicator Survey (QIS). These issues identified were results of systemic breakdowns in the manner in which the facility staff administered care and services to their residents. The issues had been ongoing for multiple months giving the facility time to identify and correct the quality deficiency prior to their QIS survey, which began on [DATE].  In the care area of resident rights:  The facility failed to ensure resident's personal funds were available after the close of the business office.  The facility failed to convey personal funds to the individual or probate jurisdiction administering the resident's estate within 30 days of the resident's death.  The facility failed to ensure mail delivery of mail to residents.  The facility failed to ensure residents were treated with dignity during dining. In the care area of administration:  The facility failed to obtain laboratory (lab) studies timely and according to physician's orders [REDACTED]. The facility failed to notify the physician of lab results promptly.  In the care area of quality of care:  The facility failed to ensure resident's kept appointments at outside providers as ordered by the physician.  Review of the attendance sign in sheets of the Quality Assurance and Assessment (QA&A) Committee and staff interview, the facility failed to ensure the medical director attended the facility's quarterly meetings.  These practices had the potential to affect all residents. Facility census: 113. Findings include:  a) Availability of Funds  Staff interview, family interview, and review of resident personal funds account balances, revealed the facility failed to ensure residents who had a personal funds account at the facility had access to petty cash after business office hours. In addition, the facility failed to ensure a quarterly statement of the balance of Resident #15's personal funds account was provided in writing to the resident's representative within 30 days after the end of the quarter.   1. Personal funds   At 2:23 p.m. on [DATE], Business Office Manager (BOM) #13 verified the facility did not have a means to provide any petty cash to residents with personal funds accounts when the business office was closed, which included evenings and weekends. BOM #13 said residents could only get personal funds monies Monday through Friday during the daytime hours.   1. Resident #15   During Stage 1 of the Quality Indicator Survey, at 9:28 a.m. on [DATE], the resident's responsible party (the resident's daughter) said she had never received any statements regarding Resident #15's personal funds account. The daughter said she received the resident's monthly check and wrote a personal check to the facility for the resident's monthly room and board.  She also deposited money in the resident's account for, Things like a haircut at the beauty shop. She stated she did not know the exact amount in her mother's account.  At 1:06 p.m. on [DATE], BOM #13 confirmed she did not mail a quarterly statement to the resident's daughter. She said she gave a copy of the quarterly statement to the resident. The BOM said she did not think she could send a statement to the daughter because the daughter did not have a durable power of attorney. BOM #13 did confirm the daughter paid the resident's monthly bill at the facility and deposited money in the resident's personal funds account.  Review of the resident's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of [DATE] found the resident scored a 3 on her Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. A score of 3 indicated the resident would not be capable of understanding a personal funds account statement.  These findings were discussed with the administrator at 8:12 a.m. on [DATE]. As of the close of the survey on [DATE] at 2:45 p.m., the administrator had provided no further information.  b) Conveyance of personal monies within 30 days of death  Record review and staff interview, found the facility failed to ensure five (5) of seven (7) residents reviewed for the care area of personal funds during Stage 2 of the Quality Indicator Survey (QIS), had his/her personal funds conveyed within 30 days of death to the individual or probate jurisdiction administering the resident's estate. Resident identifiers: #136,  #39, #73, #95, and #110.   1. Resident #136   Medical record review found Resident #136 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $17.00.   1. Resident #39   Medical record review found Resident #39 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $189.19.   1. Resident #73   Medical record review found Resident #73 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $877.26.   1. Resident #95   Medical record review found Resident #95 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $942.43.   1. Resident #110   Medical record review found Resident #110 expired on [DATE]. On [DATE], the resident's trust account contained a balance of  $70.10.   1. At 2:49 p.m. on [DATE], Business Office Manager (BOM) #13 confirmed the personal funds of Residents #136, #39, #73, #95, and #110 were not conveyed to the individual or probate jurisdiction administering the residents' estates within 30 days of   the resident's death.  c) Mail delivery  Staff interview and resident interview, found the facility failed to ensure residents received mail delivery on Saturdays. This practice had the potential to affect all residents at the facility. Resident identifier: #121.   1. Resident #121   At 3:00 p.m. on [DATE], when asked about mail delivery on Saturdays, Resident #121 (the resident council president) said she did not believe residents received mail on Saturdays. She said the activities staff delivered the mail to the residents.   1. Activity Director (AD) #98, when interviewed at 6:40 a.m. on [DATE], said there was no mail delivery on Saturdays. At [DATE] at 7:15 a.m., the administrator confirmed there was mail delivery from the post office in the neighborhood on Saturdays.   At 8:11 a.m. on [DATE], the administrator said he arranged for the mail carrier to deliver the mail to the facility on Saturdays. I guess he (the mail man) didn't come before because he knew there was nobody in the office on Saturdays.  d) Timeliness of laboratory services keeping resident appointments.  Review of Resident #53's Medication Administration Record [REDACTED]. The medication was started after the attending physician visited and ordered [MEDICATION NAME] 2 mg and a PT/INR on [DATE].  During an interview at 11:15 a.m. on [DATE], when asked about the resident not receiving [MEDICATION NAME] after her readmission, the resident's attending physician stated she would not have discontinued the resident's [MEDICATION NAME] unless she had hematuria or some other bleeding condition. (The medical contained no evidence Resident #53 had these conditions). The physician further stated she did not recall if they told her the resident was started on [MEDICATION NAME] while in the hospital. She stated, I don't remember what they found I would have to look at her record.  The facility did not obtain the PT/INR ordered on [DATE] until [DATE].  The results of the PT/INR obtained at 5:00 a.m. on [DATE], were available for review by the facility by 1:00 p.m. on [DATE]. Facility staff did not review or print the results of this PT/INR until [DATE]. On [DATE], the facility reported the PT/INR result of 1.21 to the physician by telephone, at which time the physician increased the dose of [MEDICATION NAME] to 3 mg.  However, the facility did not increase Resident #53's [MEDICATION NAME] dose until the evening of [DATE], despite the fact | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **04/11/2017** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0520  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 15)  it was available in the emergency medication box.  The facility obtained the repeat PT/INR [DATE] as ordered, but did not notify the physician of the PT/INR results obtained  on [DATE], until [DATE] of the result of 1.39 (low). The physician then gave orders to increase the resident's [MEDICATION NAME] to 4 mg. She did not get the first dose of this increased dosage until [DATE], despite the fact it was available in  the emergency medication box.  An interview with the Director of Nursing (DON) on [DATE] at 11:25 a.m., found the facility had an emergency medication box that contained [MEDICATION NAME]. She confirmed Resident #53 did not receive the [MEDICATION NAME] as ordered.  e) Resident's outside appointments  1. The hospital discharge summary on [DATE] included the date and time the resident had an appointment with a Cardiologist.  The facility failed to arrange transportation for Resident #53 to and from her appointment with the cardiologist scheduled  for 10:20 a.m. on [DATE]. Therefore, the resident was not seen by the cardiologist after her recent [MEDICAL CONDITION] as directed by the discharge summary due to the facility's failure to make arrangements.  An interview with the DON on [DATE] at 10:30 a.m., found the facility followed the hospital discharge summary when a resident was admitted /readmitted to the facility unless the attending physician specified differently. When the attending physician wished to provide a different medication and/or treatment, it was documented in the nurses' notes. She verified the physician wished to follow the orders as directed by the discharge summary.  2 Resident #76  Review of Resident #76s medical record on [DATE] at 9:45 a.m., revealed the resident had a Stage 4 pressure ulcer on right foot Symes amputation (an amputation through the ankle joint) site which occurred following an attempt to wear a prosthesis. An outside wound clinic treated and monitored the pressure ulcer.  Review of consultation reports found an outside wound clinic saw and treated Resident #76' pressure ulcer on [DATE]. This consult specified recommended treatments and a return appointment in three (3) weeks. The facility physician ordered an appointment for the resident to go to the wound clinic on [DATE]. There was no evidence found in the resident's medical record to indicate the resident went to the wound clinic on the specified date, and if not, why the resident missed the appointment.  An interview with the DON on [DATE] at 12:30 p.m., found the staff did not know why the appointment with the wound care clinic had been missed. She further confirmed the appointment had been rescheduled.  3. Resident #79  At 8:06 a.m. on [DATE], observation of the resident found he had numerous areas of discoloration to both forearms and a band-aid on his right elbow. The areas were various shades of red and purple.  Review of a monthly summary, dated [DATE], found the resident had no skin issues.  Further review of the medical record found a nurse's note, dated [DATE], New orders received and noted to cleanse open ecchymotic area to right elbow with NNS (normal saline solution), Pat dry, apply [MEDICATION NAME] and cover with band aid daily and PRN (as needed), Left message for  A second nurse's note, dated [DATE], New orders received and noted to discontinue tx (treatment) to right and left forearm areas resolved.  At 1:42 p.m. on [DATE], Licensed Practical Nurse (LPN) #31, when asked if she had any information regarding the reddened areas on the resident's forearms and the skin tear, said she did not have an incident report for the skin tear. She said  the reddened areas on the resident's forearms were ecchymotic areas due to the use of [MEDICATION NAME] (an anti-platelet). At 1:53 p.m. on [DATE], LPN #22 said the area to his elbow was just a scab the resident had picked at. The areas come and go where he just constantly picks, he is on [MEDICATION NAME]. Review of the current care plan found the use of [MEDICATION NAME] and the ecchymotic areas identified by the staff were not currently care planned. She stated, I did not care plan the  use of [MEDICATION NAME].  On [DATE] at 9:27 a.m., Registered Nurse (RN) #38, the quality assurance coordinator, was asked if the facility had any information regarding the reddened areas to the resident's forearms and the recent skin tear to the resident's elbow. She had no additional information to offer.  At 11:05 a.m. on [DATE], RN #4 said she had ordered elbow protectors, after surveyor intervention, for the resident because he hits his arms on things.  On [DATE], at 11:06 a.m., the director of nursing (DON) said she would have expected staff to do an incident report to  attempt to determine how the skin tear could have occurred. The DON was unable to provide any evidence to explain what had caused, or may have caused, the discolorations. Prior to the surveyor asking about the resident's skin condition, there was  no documentation regarding the areas observed on the resident's forearms and the recent skin tear to the right elbow other than the [DATE] order for treatment for [REDACTED].  f) Observation and staff interview revealed the facility failed to provide a dignified dining experience to multiple residents in the facility's main dining room and to Residents #132 and #32 who were dining in their room during the noon meal. Resident Identifiers: #132, #32, and #17.   1. Main Dining Room   Observations of the noon meal began in the main dining room at 12:10 p.m. on [DATE]. There were 32 residents in the dining room seated at nine (9) tables. More than one resident sat at each of the nine (9) tables.  The meal service began at 12:42 p.m. with four (4) staff members serving the residents' meals. Each of the four (4) staff members took a meal from the meal cart and served residents sitting at four (4) different tables. The staff then returned to the meal cart and served four (4) more meals all to residents sitting at four (4) different tables. The staff had served one (1) resident at each of eight (8) tables prior to serving any tablemates of the residents who received their meals first.  An interview with an activities employee at 12:56 p.m. on [DATE], confirmed that not all residents seated at the same table received their meals at the same time. She stated, We usually serve the entire table at the same time, but the residents  are not sitting where they usually sit so it was all messed up.   1. Residents #132 and #32   Observation of the noon meal on [DATE], found Resident #132 received his tray at 12:38 p.m. on [DATE]. Staff continued to serve other residents residing in other rooms.  At 12:52 p.m. on [DATE], Nurse Aide (NA) #80 delivered the noon meal to Resident #32, the roommate of Resident #132. NA #80 said Resident #32 did not receive a tray at the same time as his roommate because, He usually eats in the dining room, but he isn't feeling very well so he stayed in his room. His tray did not come out on the cart.  g) Staff interviews:  The director of nursing (DON) and the administrator were interviewed at 8:45 a.m. on [DATE].  The administrator confirmed a physician had not attended any QA&A meetings since January, (YEAR). He said, We relay the information discovered at the meetings to our medical director.  The administrator said he knew mail was delivered on Saturdays because he lives in the neighborhood and receives his own mail on Saturdays. He just never thought about ensuring residents received their mail also.  He stated the controller at the home office had been supposed to set up something with the State's unclaimed properties to allow the facility to be able to send unclaimed personal funds if no beneficiary comes forward to claim the resident's monies within 30 days of their death. He said the business office manager had been on the controller for about 3 months to get this process taken care of.  He also said at one time, petty cash was available after hours in the activity department but this practice was stopped. The DON made the following comments:  Staff are aware to serve all resident's seated together at a table before serving out residents at other tables. The DON was reminded the facility had been cited for this practice during the previous year's survey.  The facility's Quality Assessment and Assurance committee had been tracking resident appointments and the timeliness of obtaining laboratory values once ordered by the physician. There were some problems in the past but she though these issues had been taken care of. I don't know what went wrong. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **01/28/2016** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0157  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0241  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0253  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | **Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, staff interview, medical record review, and policy review, the facility failed to notify the physician and responsible party for one (1) of twenty-four (24) Stage 2 residents when there was an injury to Resident #55's leg that could potentially require physician intervention. The facility also did not notify Resident #55's responsible party when the resident began to receive new medication and treatments, and/or changes due to the resident's refusal of treatment.  Resident identifier: #55. Facility census: 108. Findings include:  a) Resident #55  A Stage 1 observation, on 01/25/16 at 4:10 p.m., revealed a two by two (2 x 2) brown colored dressing on Resident #55's left anterior shin, dated 01/23 and initialed. Upon inquiry as to whether the wound beneath the dressing may be a skin tear or laceration, Licensed Practical Nurse #46 (LPN) reviewed the medical record and related she did not see an order for [REDACTED].  Review of physician's orders [REDACTED]. (This was two (2) days after the date on the dressing.) No evidence was present to indicate the facility notified the responsible party.  An interview, on 01/27/16 at 8:24 a.m., with LPN #154, revealed when an incident/accident occurred, the resident was evaluated; the physician was notified, and new orders received and put in the medical record. The responsible party was notified of the incident and new orders.  LPN #49, LPN #56, and the director of nursing (DON), reviewed the medical record during an interview on 01/27/16 at 10:25 a.m., and confirmed no information was present to indicate the physician had been notified at the time of the injury, or  the responsible party had been notified of the wound.  Review of the incident and accident policy, on 01/27/16 at 11:32 a.m., noted medical attention included examining the resident, notifying the physician, notify the victim's responsible party/family and document the notification of the physician/responsible party/family in the medical record.  Additionally, further review of the medical record, on 01/28/16 at 2:00 p.m., revealed no evidence the responsible party had been notified of the following physician's orders [REDACTED].>-- 01/28/16: [MEDICATION NAME] tablets  -- 01/26/16: [MEDICATION NAME] tablet 40 milligrams (mg) orally three times a day for [MEDICAL CONDITIONS]  -- 01/26/16: late entry for 01/23/16 treatment order to cleanse open area to left shin with normal saline solution (NSS), apply [MEDICATION NAME] every other day (qod) and as needed (prn)  -- 01/26/16: treatment to clean open area to left shin with NSS, apply [MEDICATION NAME] with zinc, cover with [MEDICATION NAME] and wrap with cling every day (QD) and prn  -- 12/20/16: a progress note indicated a resident to resident altercation in which Resident #55 acquired a pink area on her chin  -- 11/06/15: the physician discontinued the resident's TED hose related to refusal  -- 10/28/15: Fluid restrictions were discontinued due to the resident was nonadherent.  The assistant director of nursing (ADON #39) reviewed the medical record on 01/28/16 at 2:45 p.m., and confirmed no evidence was present to indicate the responsible party had been notified of the physician's orders [REDACTED].  **Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.**  Based on observation and staff interview, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her  individuality. On 01/26/16, residents were not served at the same time during the breakfast meal. Resident identifiers: #66 and #8. Facility census: 108.  Findings include:   1. Resident #66   Observations of the breakfast meal, on 01/26/16, found Resident #129 received her breakfast at 7:45 a.m. in her room. She had consumed her meal by 8:00 a.m. Resident #66 was in the room in her bed, and she did not receive her breakfast meal.   1. Resident #8   Observation on 01/26/16 at 7:50 a.m., revealed Resident #85 was in her room in her bed consuming her breakfast. Resident #8 was in her bed, and she was not served her meal. Resident #8 was not assisted with eating her meal until 01/26/16 at 8:08 a.m.   1. On 01/26/16 at 8:05 a.m., the director of nursing (DON) was walking down the two-hundred (200) hall. When asked how staff passed out the residents' meal trays on the floor, she stated, The staff members are to pass out the trays and assist the   residents with their meals in the room at the same time. She then looked into the rooms where Resident #129 and Resident #66, and Resident #85 and #8 shared a room and agreed the residents were not served at the same time. The director of  nursing (DON) instructed a nurse aide (NA) to go and get Resident #66's meal. NA #101 went and obtained Resident #66's meal at 8:10 a.m. and then assisted the resident with her meal.  **Provide housekeeping and maintenance services.**  Based on observations and staff interview, the facility failed to provide maintenance and housekeeping services necessary to maintain a comfortable and sanitary interior for eleven (11) of thirty-five (35) rooms observed during Stage 1 of the  Quality Indicator Survey (QIS). Room 101 had wallpaper separating from the wall. Rooms 105, 107, 108, 111, 124, 129, 202, 203, 204, and 205 had unpainted areas and brown stains on the walls. Room 111 had damage to a closet door. This had the potential to affect more than an isolated number of residents. Room numbers: 101, 105, 107, 108, 111, 124, 129, 202, 203,  204, and 205. Facility census: 108. Findings include:  a) Walls | | | |

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.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **01/28/2016** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0253  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0278  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0279  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0280  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  -- Observation of Room 101, on 01/26/16 at 3:17 p.m., had wallpaper separating on the wall and brown stains on the bathroom walls.  -- Observation of Room 105, on 01/26/16 at 10:58 a.m., had cove base separating from the wall.  -- Observation of Room 107, on 01/26/16 at 11:28 a.m., had an unpainted area above the paper towel holder.  -- Observation of Room 108, on 01/26/16 at 10:55 a.m., had puncture areas in the walls.  -- Observation of Room 111, on 01/26/16 at 10:15 a.m., had puncture holes and an unpainted area above the paper towel holder.  -- Observation of Room 124, on 01/26/16 at 12:57 p.m., had paint scraped off the corner guard.  -- Observation of Room 129, on 01/26/16 at 12:54 p.m., had a missing corner guard.  -- Observation of Room 202, on 01/25/16 at 2:34 p.m., had an unpainted area above the paper towel holder and peeling paint.  -- Observation of Room 203, on 01/25/16 at 2:52 p.m., had an unpainted area above the paper towel holder.  -- Observation of Room 204, on 01/26/16 at 7:42 a.m., had an unpainted area above the paper towel holder and brown stains on the bathroom walls.  -- Observation of Room 205, on 01/26/16 at 7:49 a.m., had an unpainted area above the paper towel holder.  **Make sure each resident receives an accurate assessment by a qualified health professional.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and staff interview, the individual completing and certifying the accuracy of a resident's Minimum Data Set (MDS) assessment failed to identify an active [DIAGNOSES REDACTED]. This was found for one (1) of twenty-four (24) residents reviewed in Stage 2 of the Quality Indicator Survey (QIS). Resident identifier: #129. Facility census: 108.  Findings include:  a) Resident #129 A review of Resident #129's physician orders [REDACTED].  On 01/28/16 at 1:22 p.m., a review of Resident #129's quarterly MDS with an ARD of 12/16/15, revealed Section I - Active Diagnoses, Item I - [MEDICAL CONDITION] other than [MEDICAL CONDITION], indicated Resident #129 did not have a [DIAGNOSES  REDACTED].  In an interview on 01/28/16 at 2:00 p.m., MDS Coordinator #41 agreed that Section I Item I5950 - Psychiatric/Mood Disorder of the quarterly MDS, with the ARD of 12/16/15, was inaccurately assessed, because Resident #129 did have a [DIAGNOSES REDACTED].  **Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, staff interview, and medical record review, the facility failed to develop a comprehensive care plan for two (2) of twenty-four (24) Stage 2 residents reviewed. The facility did not develop a comprehensive care plan for Resident #55's leg wound, or for Resident #103, who received anticoagulant therapy. Resident identifiers: #55 and #103. Facility census: 108.  Findings include:   1. Resident #55   A Stage 1 observation on 01/25/16 at 4:10 p.m., revealed a two by two (2 x 2) brown colored dressing on Resident #55's left anterior shin, dated 01/23 and initialed. Upon inquiry as to whether the wound beneath the dressing might be a skin tear or laceration, Licensed Practical Nurse (LPN) #46 reviewed the medical record and related she did not see an order for [REDACTED].  LPN #50 and the ADON#39 immediately went to the resident's room and evaluated the wound. Removal of the dressing revealed a pear shaped wound, with the narrow area at twelve o'clock (A wound is described in clock time, with head to toe body  alignment). The wound bed was wet and had a macerated appearance. The peri-wound area was dark pink and extended beyond the borders of the 2 x 2 dressing.  Review of physician's orders [REDACTED].  Further review of the medical record, on 01/28/16 at 8:00 a.m., revealed another treatment order, dated 01/26/16 as a late entry for 01/23/16. The order noted a treatment to clean the open area on Resident #55's left lower leg with NSS (normal saline solution), apply a [MEDICATION NAME] dressing, and change every other day.  On 01/28/16 at 8:30 a.m., review of the care plan found no evidence the open wound had been addressed in the care plan. After review of the resident's care plan with the director of nursing (DON), the DON confirmed the wound was not addressed to identify objectives and interventions for wound care.   1. Resident #103   A review of the clinical record of Resident #103, on 01/28/16 at 11:50 a.m., revealed an admission date of [DATE] with the following relevant Diagnosis: [REDACTED].  A review of Resident #103's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/06/15, Item I8000 - additional active diagnoses, revealed the resident had [MEDICAL CONDITION] and long term (current) use of anticoagulants. Under Section N - Medications, Item N0410 - identified the resident received an anticoagulant seven  (7) days during the last seven (7) days.  A review of Resident #103's physician's orders [REDACTED]. The Xarelto was ordered on [DATE].  A review of Resident #103's medical record on 01/28/15 at 12:00 p.m., found Resident #103 did not have a comprehensive care plan related to taking an anticoagulant medication. (Anticoagulant use can predispose a resident to increased bleeding, bruising more easily, etc.)  On 01/28/16 at 12:18 p.m., during a review of Resident #103's care plan with Assistant Director of Nursing #39, she agreed there was no care plan related to Resident #103 taking an anticoagulant.  **Allow the resident the right to participate in the planning or revision of the resident's care plan.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, record review, and staff interviews, the facility failed to revise the care plan for one (1) of three  (3) residents reviewed for pressure ulcers during Stage 2 of the Quality Indicator Survey (QIS). A resident's care plan was not revised after his skin status changed. Resident identifier: #60. Facility Census: 108.  Findings include:  a) Resident #60  Review of Resident #60's care plan, on 01/27/16 at 11:20 a.m., found a care plan related to pressure ulcer development. The care plan had a treatment intervention for the right hand third (3) digit, right lateral leg, a Stage 2 pressure ulcer to  the right inner leg, an unstageable pressure ulcer to left metatarsal head, and right lower leg. A review of the physician's orders [REDACTED]. This treatment was started on 01/12/16.  On 01/27/16 at 8:00 a.m., Licensed Practical Nurse (LPN) #48, assisting LPN #56, performed care skin care to Resident #60's hand. The LPNs confirmed the resident did not have any other skin problems. The nurses assessed the resident's skin at that time, and revealed the resident did not have the skin problems as identified on the resident's care plan for pressure  ulcers (i.e., right lateral leg, a Stage 2 pressure ulcer to the right inner leg, an unstageable pressure ulcer to left metatarsal head, and right lower leg).  Interview with the assistant director of nursing (ADON) on 01/27/16 at 11:45 a.m., revealed the only treatment the resident was receiving was to the third (3) digit of the right hand. She stated, The other treatments need to be resolved. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **01/28/2016** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0280  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few F 0309  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0332  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0428  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 2)  On 01/27/16 at 11:59 a.m., the assistant director of nursing (ADON) printed off the dates the wounds had healed. The report revealed the treatment was discontinued on the right lateral leg wound on 11/25/15, right inner leg wound on 10/01/15, the unstageable pressure ulcer to the left metatarsal head on 11/13/15, and the right lower leg on 10/01/15. The ADON stated she would revise the care plan as soon as she could.  **Provide necessary care and services to maintain the highest well being of each resident**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, staff interview, medical record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one (1) of twenty-four (24) Stage 2 residents. The facility  did not adequately assess and monitor Resident #55's leg wound. Resident identifier: #55. Facility census: 108. Findings include:  a) Resident #55  A Stage 1 observation on 01/25/16 at 4:10 p.m., revealed a two by two (2 x 2) brown colored dressing on Resident #55's left anterior shin dated 01/23 and initialed. Upon inquiry as to whether the wound beneath the dressing might be a skin tear or laceration, Licensed Practical Nurse #46 (LPN) reviewed the medical record and related she did not see an order for [REDACTED].  LPN #50 and the ADON#39, immediately went to the resident's room and evaluated the wound. The dressing had a circular white discoloration beneath the dressing (which occurred when the dressing absorbed drainage). Removal of the dressing revealed a pear shaped wound, with the narrow area at twelve o'clock. (A wound is described in clock time, with head to toe body  alignment.) The wound bed was wet and had a macerated appearance. The peri-wound area was dark pink and extended beyond the borders of the 2 x 2 dressing.  Review of physician's orders [REDACTED].  In an interview on 01/27/16 at 8:24 a.m., LPN #154 revealed when the incident/accident occurred, the resident was evaluated, the physician was notified and new orders were received and put in the medical record. The responsible party was notified  of the incident and new orders.  Review of the minimum data set (MDS) with an assessment reference date (ARD) of 01/11/15 revealed the resident was cognitively impaired and unable to relate what had happened to her leg. Section M indicated no ulcers were present at that time, and the resident received no applications of non-surgical dressings.  LPN #49, LPN #56, and the director of nursing (DON), reviewed the medical record during an interview on 01/27/16 at 10:25  a.m They confirmed no information was present to indicate the physician had been notified at the time of the injury, or that the responsible party was notified of the wound.  ADON #39 reviewed the medical record on 01/28/16 at 2:45 p.m., and confirmed no evidence was present to indicate the wound had been monitored after the treatment was initiated on 01/23/16, until discussed with the facility on 01/25/16, or to  indicate the physician had been notified of the wound when identified on 01/23/16.  **Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, medical record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent (5%). The facility had two (2) errors out of thirty (30) administration opportunities for a total error rate of 6.6%. A medication was omitted and a wrong medication was administered to a resident during medication pass. Resident identifier: #125. Facility census: 108.  Findings include:   1. Resident #125   During a medication administration pass observation on 01/27/16 at 8:48 a.m., Licensed Practical Nurse #60 (LPN) entered the room of Resident #125. Prior to administering the [MEDICATION NAME] nebulizer treatment (a [MEDICATION NAME][MEDICATION  NAME] containing [MEDICATION NAME] and [MEDICATION NAME]).  Review of physician's orders [REDACTED]. No evidence of an order for [REDACTED].  Medication in the medication cart included [MEDICATION NAME] (used to control and prevent symptoms such as wheezing and shortness of breath caused by ongoing lung disease) and [MEDICATION NAME] nebulization treatments. No evidence of [MEDICATION NAME] sulfate was present when reviewed with LPN #60, on 01/27/16 immediately following the medical record review. The nurse confirmed the facility had administered [MEDICATION NAME] solution since 01/23/16, and the resident had received twenty (20) doses of the [MEDICATION NAME] medication.   1. Additionally, the medication record review indicated the resident had an order for [REDACTED].   Further review of the Medication Administration Record [REDACTED]. The nurse related she had not offered the medication because the resident frequently refused [MEDICATION NAME]. However, upon review of the MAR, LPN #60 confirmed no evidence  was present to indicate the resident had refused the medication during the previous twenty-six (26) days.   1. The General Dose Preparation and Medication Administration policy noted the facility, . should verify that the medication name and dose are correct . Prior to medication administration, the facility staff should verify each time a medication is administered that it is the correct drug, at the correct dose, the correct route, at the correct rate, at the correct time,   for the correct resident. Facility staff should confirm that the MAR indicated [REDACTED]  **At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and staff interview, the registered pharmacist (RPh) failed to identify irregularities during the monthly drug regimen reviews. The medical records for two (2) residents did not contain laboratory (lab) reports for medications that required monitoring to ensure no changes were necessary in the dosage of the drug. A Valproic Acid level  was not completed for Resident #63 and a hemoglobin A1c was not done for Resident #103. Resident identifiers: #63 and #103. Facility census: 108  Findings include:   1. Resident #63   On 01/27/16 at 1:30 p.m., review of the resident's medical record found an order for [REDACTED].  A review of drug regimen reviews found the registered pharmacist (RPh) did not identify an irregularity regarding Valproic Acid level not being done as ordered.  This was discussed with the director of nursing on 01/28/16 at 12:50 p.m. and it was determined these lab test had not been completed. The drug regimen reviews from (MONTH) through the current month did not show the RPh had identified this irregularity.   1. Resident #103   A review of Resident #103's physician's orders [REDACTED]. The physician's orders [REDACTED]. (This is a lab test that shows the average level of blood sugar (glucose) over the previous three (3) months. It shows how well the diabetes is being  controlled).  Review of Resident #103's lab results on 01/28/16 at 11:00 a.m., found no lab result for the hemoglobin A1c which was due in (MONTH) (YEAR).  The pharmacist's monthly consultation report for 01/07/16 did not identify and report to the facility that a hemoglobin A1c was not obtained for Resident #103 in (MONTH) (YEAR).  In an interview on 01/28/16 12:56 p.m., the assistant director of nursing (ADON) stated, I have been unable to find the hemoglobin A1c for December.  On 01/28/16 at 2:50 p.m., ADON #39 verified the pharmacist did not identify and report to the facility that the hemoglobin A1c was not obtained in (MONTH) (YEAR) for Resident #103. | | | |

F 0502 **Give or get quality lab services/tests in a timely manner to meet the needs of residents.**

**Level of harm -** Minimal harm or potential for actual harm

**Residents Affected -** Few

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:4/25/2019 FORM APPROVED OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **515140** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **01/28/2016** |
| NAME OF PROVIDER OF SUPPLIER  **TRINITY HEALTH CARE OF LOGAN** | | | STREET ADDRESS, CITY, STATE, ZIP  **1000 WEST PARK AVENUE LOGAN, WV 25601** | |
| 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 0502  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0514  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 3)  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and staff interview, the facility failed to obtain laboratory services to meet the needs of its residents. Two (2) of five (5) residents reviewed for unnecessary medications did not have laboratory (lab) tests  completed as ordered by their physician. Resident #63 had an order for [REDACTED].#63 and #103. Facility census: 108. Findings include:   1. Resident #63   A review of the resident's medical record on 01/26/16 at 3:00 p.m., found the resident had a [DIAGNOSES REDACTED]. This was discussed with Director of Nursing #38 on 01/28/16 at 12:50 p.m. She was unable to locate the lab results in the medical record, and said she would attempt to locate the results. She returned at 1:50 p.m. on 01/28/16 and stated she was unable to find the lab test results.   1. Resident #103   A review of Resident #103's physician's orders [REDACTED]. The resident was to have a lab test, hemoglobin A1C (hbA1c) collected every three (3) months. (This test shows the average level of blood sugar (glucose) over the previous three (3) months, indicating how well the diabetes is being controlled.)  Review of Resident #103's lab results on 01/28/16 at 11:00 a.m., found no result for the HbA1c which was due in (MONTH) (YEAR).  In an interview on 01/28/16 12:56 p.m., the assistant director of nursing (ADON) stated, I have been unable to find the hbA1c for December.  **Keep accurate, complete and organized clinical records on each resident that meet professional standards**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, staff interview, medical record review, and policy review, the facility failed to maintain clinical records which were complete and accurately documented in accordance with accepted professional standards and practices. This was found for two (2) of twenty-four (24) residents reviewed during Stage 2 of the Quality Indicator Survey (QIS). The medical record did not contain a complete and accurate record of Resident #55's left lower leg skin impairment or Resident #125's diagnoses. Resident identifiers: #55 and #125. Facility census: 108.  Findings include:  a) Resident #55  A Stage 1 observation on 01/25/16 at 4:10 p.m., revealed a two by two (2 x 2) brown colored dressing on Resident #55's left anterior shin, dated 01/23/16 and initialed. Upon inquiry as to whether the wound beneath the dressing was a skin tear or laceration, Licensed Practical Nurse #46 (LPN) reviewed the medical record and related she did not see an order for [REDACTED].  LPN #50 and Assistant Director of Nursing (ADON) #39 immediately went to the resident's room and evaluated the wound. The dressing had a circular white discoloration beneath the dressing. Removal of the dressing revealed a pear shaped wound,  with the narrow area at twelve o'clock. (A wound is described in clock time, with head to toe body alignment.) The wound  bed was wet and had a macerated appearance. The peri-wound area was dark pink and extended beyond the borders of the 2 x 2 dressing.  Review of physician's orders [REDACTED].  In an interview on 01/27/16 at 8:24 a.m., LPN #154 revealed when and incident/accident occurred, the resident was evaluated, the physician was notified and new orders received and put in the medical record. The responsible party was notified of the incident and new orders.  LPN #49, LPN #56, and the director of nursing (DON), reviewed the medical record during an interview on 01/27/16 at 10:25  a.m. They confirmed no information was present to indicate the physician or responsible party had been notified at the time of the injury. Additionally, no wound assessments were present to indicate the wound status when identified on 01/23/16. Additionally, the medical record did not contain a physician's orders [REDACTED].  Review of the incident and accident policy, on 01/27/16 at 11:32 a.m., found it included all . Medical attention included examining the resident, notifying the physician, notify the victim's responsible party/family and document the notification of the physician/responsible party/family in the medical record.  ADON #39 reviewed the medical record on 01/28/16 at 2:45 p.m., and confirmed no information related to the left lower leg wound was entered on 01/23/16, 01/24/16, or 01/25/16 until discussed with licensed nursing staff on 01/25/16.  b) Resident #125  Review of Resident #125's physician's orders [REDACTED]. He was started on [MEDICATION NAME] one (1) milligram (mg) at bedtime (HS) for atypical [MEDICAL CONDITION] on 09/02/15. On 09/03/15, he was ordered to receive [MEDICATION NAME] half  (0.5) mg by mouth in the morning for atypical [MEDICAL CONDITION].  A review of Resident #125's [DIAGNOSES REDACTED]. The resident had no [DIAGNOSES REDACTED]. The physician progress notes [REDACTED].  In an interview on 01/28/16 at 2:30 p.m., Minimum Data Set Coordinator (MDSC) #41 stated, The resident's record is inaccurate due to having a [DIAGNOSES REDACTED]. MDSC #41 confirmed the resident was receiving the [MEDICATION NAME] for  Atypical [MEDICAL CONDITION]. | | | |

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(Tags:  Trial Attorney, nursing home lawyer, nursing home attorney, overmedication, medication error, pressure sores, bed sores, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, private equity firms, nursing home chains, statistics on nursing home abuse, hip fracture, west Virginia abuse attorney, nursing home neglect and abuse,