STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515047	A. Building B. Wing	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worthington Healthcare Center	2675 36th Street Parkersburg, WV 26104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 31520 Based on observation, resident interview and staff interview; the facility failed to make reasonable accommodations for each resident's needs. Residents #56, #79, #2, #46, and #85; were unable to reach the cord for the overbed light. Additionally, Resident #46's wheelchair was unable to fit through the bathroom door; which interfered in her ability to use the toilet. These observation were random opportunities of discovery. Resident identifiers: #56, #79, #2, #46 and #85. Facility census: 97. Findings included: a) Resident #56 Observation on 09/09/19 at 1:30 pm, found the residents cord to the overbed light's cord was short and Resident #56 was unable to reach the cord to turn on and off the overbed light if needed and/or want the light on or off. b) Resident #79 Observation on 09/09/19 at 3:30 pm, found the residents cord to the overbed light's cord was short and Resident #79 was unable to reach the cord to turn on and off the overbed light if needed and/or want the light on or off. He was observed ambulating in the room; but still not able to reach the cord. c) Resident #2 Observation and interview on, 09/09/19 at 3:30 pm, found the residents cord to the overbed light's cord was short and Resident #2 was unable to reach the cord to turn on and off the overbed light if needed and/or want the light on or off. When asked if he could reach the over the bed light cord, he said, no. d) Resident #46 Observation and interview, on 09/09/19 at 4:15 pm, found the residents was unable to reach her cord to the overbed light due to it being too short and Resident #46 also voiced to me she could not use the toilet in her bathroom due to her wheelchair was too wide to go through the door. She further expressed she had to use the bedside commode and would really like to use the toilet in her room. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nursing Home Administrator (NHA), on 09/12/19 at 10:15 am, informed her Residents #56, #79, #2, and #46 was unable to reach the cords to the over the bed lights and additionally, Resident #46's wheelchair was too big to fit through the bathroom door and she would like to use the toilet in her bathroom. No further information provided. Director of Nursing (DON) also informed of the findings. 30153 . e) Resident #85 During the initial tour of the facility, on 09/09/12 at 2:52 PM, observed Resident #85 had two (2) clear trash bags tied together which were attached to the overbed light pull. When Resident #85 was asked what the trash bags were for she stated that is so I can turn on my overbed light. An interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DoN) on 09/12/19 at 8:26 AM both confirmed this was not an appropriate pull cord for the overbed light.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 33947 Based on medical record review and staff interview, the facility failed to properly record a resident's advanced directives in the medical record regarding specifying the length of a trial period of intravenous fluids (IVFs). This was true for one (1) of one (1) sampled residents reviewed for the care area of advanced directives. This practice had the potential to affect a limited number of residents. Resident identifier: #41. Facility census: 97. Findings included: a) Resident #41 A review of Resident (R#41)'s medical record, on 09/09/19 at 4:11 PM, revealed the Physician Order for Scope of Treatment (POST) form indicated Resident #41 did not want to receive Cardiopulmonary Resuscitation in the event she would need it. Resident #41 POST indicates the resident is a 'Do Not Resuscitate (DNR)'. Review of the R#41's POST revealed the trial period for IV (Intravenous) fluids was not designated in section C. Section C read, IV fluids for trial period no longer than ___. Section C was left blank and did not instruct for how long the trial period should last. On 09/11/19 at 10:51 AM an interview with the Director of Nursing (DON) revealed the DON confirmed R#41's POST should have been filled out in its entirety. The DON agreed Section C of R#41's POST should have designated how long the trial period for IV fluids should last.

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F 0580 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 situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31520 Based on medical record review, staff interview, and family interview; the facility failed to notify the resident representative and/or the physician when changes in their condition occurred. This was true for one (1) of one (1) resident reviewed for the care area of notification of change and a random opportunity for discovery. Resident #46'sphysician was not notified when blood sugar was greater than 500 as directed by the physician-ordered parameters. Resident #2's physician and registered dietician was not notified timely of weight loss. Resident #41's family was not notified concerning a fall and additionally, Resident #41's physician was not notified of the resident's abnormal blood pressures. Resident identifiers: #46, #2 and #41. Facility census: 97. Findings include: a) Resident #46 Review of Resident #46's medical record found she was readmitted on [DATE] after having an abdominal hysterectomy. Review of the physician orders found an order dated 06/27/19; which read: Fasting sugar at 5:30 am and blood sugar at 4:30 pm on Mondays and Thursdays. No sliding scale coverage. Notify the physician if blood sugar is less than 40 or greater than 500. Review of June and July 2019's Medication Administration Record (MAR), found on 07//18/19 at 4:30 pm, blood sugar was 513. Nurse's notes reviewed and no indication the nurse notified the physician as directed by the physician-ordered parameters. Interview with the Director of Nursing (DON) on 09/12/19 at 11:15 am; review of Resident #46's medical records confirmed the physician was not notified on 07/18/19. b) Resident #2 Review of Resident #2's medical records found the electronic weights found the following: --01/01/19- weight 110.6 pounds (lbs.) --02/01/19- weight 112.4 lbs. --03/05/19- weight 109.8 lbs. --04/05/19- weight 105.8 lbs. --05/09/19- weight 101.4 lbs. --06/07/19- weight 98.6 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--07/15/19- weight 99.9 lbs. --08/09/19- weight at 12:05 am 98 lbs.- {greater than 10% change in weight over 180 day (s); Comparison weight 02/01/19. 112.4 lbs.; which is a 12.8% or a loss of 14.4 lbs.} --08/09/19- weight at 3:18 pm 97 lbs. {greater than 10% change in weight over 180 day (s); Comparison weight 02/01/19. 112.4 lbs.; which is a 13.7% or a loss of 15.4 lbs.} --09/03/19- weight 95.2 lbs. {greater than 10% change in weight over 180 day (s); Comparison weight 03/05/19. 109.8 lbs.; which is a 13.3% or a loss of 14.6 lbs.} Review of Resident #2's nurses note found the physician and registered dietician was notified of the weight loss on 08/19/19. Interview with the DON on 09/12/19 at 11:30 am, after review of the medical records, she confirmed the physician and registered dietician was not notified of the weight loss noted on 08/09/19; until ten (10) days later on 08/19/19 at 12:54 pm. She agreed this was not timely notification of the resident weight loss. 33947 c) Resident (R#41) 1. Failed to notify Medical Power of Attorney (MPOA) of a fall. A family interview, on 09/09/19 at 12:21 PM, revealed the resident's Medical Power of Attorney (MPOA) was not always notified when the resident has had a fall. The MPOA said that she was told by the resident's roommate her mother had fallen several months ago. The MPOA stated, No one at the facility told her only the roommate, none of the staff. On 09/10/19 at 01:26 PM reviewed of the incident log revealed R#41had fallen several times, including 05/12/19. Review of records revealed a nurse was summoned to the resident's room by the daughter of the roommate's visitor, on 05/12/19 to help R#41 because she had fallen. The record showed the physician was notified of the fall, however there was no documentation showing that the MPOA was notified. 2. Facility failed to notify the physician of a change in R#41's blood pressure reading Review of records, on 09/10/19 at 4:02 PM, revealed a progress note dated 09/04/19 stating the MPOA was in and expressed concerns of her mother being sleepy. R#41's blood sugars and blood pressure (BP) was checked. Blood sugars was 155 and blood pressure was high at 178/106. The physician was notified, and new orders were given Check BP BID FOR 2 WEEKS R/T ELEVATED BP (check blood pressure two times a day for two weeks related to elevated blood pressure) Review of the blood pressures being monitored, on 09/11/19 01:00 PM, revealed a reading taken on 09/10/2019 at 8:20 AM of -10.0% change from baseline value at a reading of 145/68. There was no documentation or evidence the physician was notified of this change. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/11/19 at 01:30 PM an interview with the Director of Nursing (DoN) confirmed there was no evidence the physician was notified of the blood pressure reading taken on 09/10/2019 at 8:20 AM of -10.0% change from baseline. The DoN stated her expectation of the nursing staff would be for the nurses to notify the physician of the change in blood pressure on 09/10/2019 and for the nurses to clarify the order to include specific parameters.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 33947 Based on observation and staff interview the facility failed to ensure personal privacy during incontinence care. This was true for one (1) of one (1) sampled residents reviewed for the care area of incontinence. This practice had the potential to affect a limited number of residents. Resident identifier: #81. Facility census: 97. Findings included: Review of Resident (R#81)'s recent thirty (30) day minimum data set (MDS) with an assessment reference date (ARD) 08/24/19 revealed the resident's Brief Interview for Mental Status (BIMS) with a score of three (03) indicating resident is cognitively severely impaired. The resident is dependent for bathing and needs extensive assistance with all other activities of daily living. Resident #81 is frequently incontinent of bladder and bowel. Some pertinent diagnoses include dementia, heart failure, hypertension, and chronic kidney disease, stage 4. Observations of Nurse Aid (NA#118) providing incontinence care for R#81 on 09/12/19 at 08:59 AM, revealed NA#118 failed to maintain R#81 personal privacy. NA#118 forgot to place a plastic bag to dispose of used soiled supplies within the area the NA was working. When NA#118 went to get the plastic bag she opened the privacy curtain and forgot to close the curtain back. The resident was fully exposed if anyone should have open the resident's room door while she was being cleaned and her brief was being changed. NA#118 confirmed she compromised the resident's privacy while providing incontinence care when she forgot to pull the privacy curtain back to block the view from the doorway.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31520 Based on record review and staff interview, the facility failed to ensure the Minimum Data Sets (MDS)accurately reflected the resident's status. This was true for four (5) of twenty-three (23) sampled resident's MDSs reviewed during the Long-Term Survey Process (LTCSP). Resident #56's MDS was inaccurate in the area of falls in the facility. Resident #39's MDS was in the area of pressure ulcers. Resident #60's was inaccurate in area of nutritional/weight loss status. Residents #22's MDS was inaccurate in area of medication. Resident's identifiers: #56, #39, #60, and #22. Facility census: 97. Findings included: a) Resident #56 Review of Resident #56's significant change MDS with Assessment reference date (ARD) of 07/17/19, found under section J related to falls. The MDS question is J1800- Has the resident had any falls since admission/readmission or the prior assessment (quarterly MDS with ARD of 04/18/19), whichever is more recent? Answer on MDS with ARD of 07/17/19 was, No. Review of the resident falls found Resident #56 had fell on [DATE] at 6:30 pm. Interview with Employee #109, Registered Nurse (RN) MDS coordinator, on 09/11/19 at 2:10 pm, confirmed the MDS with ARD of 07/17/19 was inaccurate in area of falls. She immediately corrected and resubmitted the corrected MDS. b) Resident #39 Review of Resident #39's 30 day MDS with Assessment reference date (ARD) of 07/11/19, found under section M related to pressure ulcers. The MDS question is M0100- Check all that apply: a) resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, b) formal assessment instrument/tool (e.g. Braden, [NAME], or other), c) clinical assessment, z) none of above. Checked was c. only. Further review of section M pressure ulcers, found resident had a stage 2 pressure ulcer and was present on admission. Interview with Employee #109, Registered Nurse (RN) MDS coordinator, on 09/11/19 at 3:10 pm, confirmed the MDS with ARD of 07/11/19 was inaccurate in area of pressure ulcers. She immediately corrected and resubmitted the corrected MDS with M100- a, b, and c were all checked. 30153 c) Resident #22 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the medical record for Resident #22 during the survey, revealed Resident #22 Minimum Data Set (MDS) with Assessment Reference Dates (ARDs) of 05/23/19, 05/30/19, 6/18/19, 06/25/19, 07/09/19 and 08/01/19 Section N coded as having received insulin. Resident #22 was ordered Victoza (hormone to help body secrete own insulin) and not insulin. The MDS Coordinator confirmed, on 09/11/10 at 11:44 AM, that the Victoza was coded as insulin which made Section Nof the MDS inaccurate. The MDS Coordinator stated that Section N would be corrected immediately. 40835 d) Resident #60 - Nutritional Status On 09/11/19 at 9:52 AM Resident #60's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/23/19 was reviewed. Resident #60's weight in section K, the nutritional section of the MDS, was coded as 150 pounds. Per MDS section K instructions, weight should be based on the most recent measurement in the last 30 days. A review of Resident #60's weight measurements during the survey found no weight measurement within 30 days of the ARD of 07/23/19. On 09/11/19 at 10:27 AM Resident Assessment Coordinator Registered Nurse (RAC RN) #109 stated that Resident #60's 06/07/19 weight of 149.6 pounds had been used to code section K. When asked why a weight over 30 days old was used to code the MDS, RAC RN #109 stated she needed to read the resident assessment instrument (RAI) manual before responding. On 09/11/19 at 10:42 AM RAC RN agreed that the wrong weight was used to code Resident #60's section K. On 09/11/19 at 2:59 PM the above information was discussed with the facility's Administrator. No further information was provided prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33947 Based on observation, record review, and staff interview, the facility failed to revise the comprehensive care plan for 5 out of 23 sample residents reviewed in the annual long-term care survey process (LTCSP). This practice had the potential to affect more than a limited number of residents. Resident identifiers: #35, #39, #41, #60 and #82. Facility census: 97. Findings included: a) Resident #41 Resident (R#41)'s care plan was not revised to include restorative nursing services. An interview with R#41's Medical Power of Attorney (MPOA), on 09/09/19 at 12:12 PM, revealed concerns about the resident spending too much time in a wheelchair and not being walked by staff. The MPOA states she visits frequently almost daily and rarely sees her mother being walked by staff. The MPOA said she was told there is no restorative program, but they said they were going to start it up again soon. On 09/11/19 at 03:02 PM, an interview with Nurse Aid (NA#105) assigned to R#41 revealed NA#105 did not walk R#41 because the resident has had falls recently and NA#105 said she is afraid to walk R#41 for fear she would fall. NA#105 also stated the resident would need a walker and she did not have one in her room. An interview with Registered Nurse (RN#109), on 09/11/19 at 03:56 PM, revealed the resident was currently on restorative nursing services for ambulation. RN#109 was responsible for the restorative nursing program and stated the resident was on the 'Walk to Dine' program. RN#109 explained the NAs on the floor are responsible for the resident's 'Walk to Dine' program. RN#109 said the NAs would walk the resident to lunch and dinner 6 days a week using a front wheel walker which typically is kept in the resident's room. RN#109 stated the resident was discharged from physical therapy on 05/17/19 and then was ordered restorative services at that time. On 09/12/19 at 11:51 AM, an interview with Nurse Aid (NA#19), revealed NA#19 occasionally walks R#41. NA#19 stated, I walk her with a gait belt. We walk her if we have time, and that is not every day. When asked if the resident was on any restorative nursing programs, NA#19 said she was not aware of her being on any programs. Observations on 09/12/19 at 11:54 AM revealed R#41 sitting in her wheelchair at a dining room table with her daughter waiting on lunch. Her daughter/MPOA stated I bring her to the dining room in her wheelchair almost every day for lunch no one has ever told me about a walk to dine program and none of the NAs has ever came to her room to get her to walk her to lunch. An interview with the resident assessment coordinator RN#103 responsible for developing and revising care plans, on 09/12/19 at 12:11 PM, confirmed restorative services were ordered for R#41. RN#103 stated the care plan should have been revised to include restorative and was not. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R#41's quarterly care plan meeting was not held as required. An interview with R#41's Medical Power of Attorney (MPOA), on 09/09/19 at 12:04 PM, revealed the MPOA is not always invited to all of R#41's care plan meetings. The MPOA stated it has been longer than 3 months since she attended a care plan meeting for her mother. Review of records, on 09/10/19 at 03:14 PM, revealed the Resident's (R#41) Initial Care Plan conference was held on Tuesday 11/20/18 at 2:15 PM with resident's daughter in attendance. Records showed a quarterly care plan conference was also held on 2/26/19. On 09/11/19 at 10:00 AM, an interview with social worker (SW#79) revealed she tracked residents scheduled care plan meetings and calendars in a notebook. SW#79 explained how she uses her notebook as her system of tracking and ensuring care plan meetings occur quarterly as required. SW#79 stated she keeps up with care plan meetings that are to be held and hand writes changes on her scheduling sheets in her notebook. When asked to see when R#41's care plan meetings had been scheduled, SW#79 looked through her notebook twice and could not find R#41 in her notebook other than 11/20/18 and 2/26/19. Review of a social work note dated 03/01/19, revealed a quarterly care plan conference was held on 2/26/19. SW#79 stated the next date for a meeting must have been in another book and she would look and get back to this surveyor. SW#79 informed this surveyor, on 09/11/19 at 02:55 PM, that a quarterly care plan meeting for R#41 was missed. SW#79 said they did not have one as they should have, but they will make it up. 31520 30153 c) Resident #35 A review of the care plan and physician orders for Resident #35 on 09/12/19 at 10:57 AM found a physician order date 9/21/19 weight Resident weekly due to heart failure/kidney failure dx. The care plan stated Monitor/document/report to MD PRN (as needed) the following s/sx (signs/symptoms): Edema; weight gain of over 2 lbs a day; . dated 11/09/17. The Assistant Director of Nursing (ADON) confirmed the care plan had not been revised/updated to reflect current physician orders. 40835 d) Resident #39's Nutrition Care Plan On 09/10/19 at 12:18 PM Resident #39 was observed eating lunch. She appeared thin and frail upon observation. A review of Resident #39's weight records during the survey found that she had lost 29.8 pounds since her admission to the facility on [DATE]. Per weight records, on 06/14/19 Resident #39 weighed 100 pounds and on 08/09/19 she weighed 70.2 pounds. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/11/19 at 11:30 AM Regional Director of Clinical Operations (RDCO) #64 provided a hospital speech evaluation dated 05/24/19. Per the evaluation, Resident #39 weighed 80 pounds at the time of the assessment. RDCO #64 agreed that Resident #39 had lost weight, but also stated she believed Resident #39's admission weight to be inaccurate. A review of Resident #39's nutrition care plan during the survey found the following focus, last revised on 06/14/19: [Resident's Name] has potential nutritional problem r/t (related to) Severe Protein Calorie Malnutrition, Failure to Thrive, multiple vitamin deficiencies. The goal associated with the focus was last revised on 06/28/19 and stated: [Resident's Name] will maintain adequate nutritional status as evidenced by maintaining weight within 5% (percent) of baseline, no s/sx (signs/symptoms) of malnutrition, and consuming at least 76-100% of all meals daily through review date. On 09/11/19 at 12:29 PM Culinary Director (CD) #123 was interviewed regarding Resident #39's care plan. CD #123 agreed that, due to her weight loss since admission, Resident #39 had an actual nutritional problem rather than a potential nutritional problem and Resident #39's goal for no significant weight loss was no longer appropriate. CD #123 added that the facility's Registered Dietitian (RD) would update the care plan to reflect Resident #39's weight change. The above information was discussed with the facility's Administrator on 09/11/19 at 2:59 PM. No further information was provided prior to exit. e) Resident #60's Nutrition Care Plan On 09/10/19 at 12:21 PM Resident #60 was observed eating lunch. Resident #60 appeared thin and frail during the observation. A review of Resident #60's weight records during the survey found that Resident #60 had experienced a significant weight loss of 18 percent of his body weight in three (3) months. On 05/08/19 Resident #60 weighed 156.2# and on 08/09/19 he weighed 128.4 pounds. A review of Resident #60's nutrition care plan during the survey found the following focus, last revised on 07/05/19: [Resident's Name] has a potential nutritional problem r/t (related to) nursing home placement, HX (history) of CVA (cerebrovascular accident). The goal associated with the focus, last revised on 08/02/19, stated: [Resident's Name] will maintain adequate nutritional status as evidenced by maintaining weight within 5% (percent) of baseline, no s/sx (signs/symptoms) of malnutrition, and consuming at least 76-100% of all meals daily through review date. On 09/11/19 at 12:29 PM Culinary Director (CD) #123 was interviewed regarding Resident #60's care plan. CD #123 agreed that, due to his significant weight loss, Resident #60 had an actual nutritional problem rather than a potential nutritional problem and Resident #60's goal for no significant weight loss had not been revised to reflect Resident #60's significant weight loss over three (3) months. CD #123 added that the facility's Registered Dietitian (RD) would update the care plan to reflect Resident #60's weight change. The above information was discussed with the facility's Administrator on 09/11/19 at 2:59 PM. No further information was provided prior to exit. f) Resident #82's Care Conference (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/19 at 8:14 AM Resident #82 stated that she wanted to attend her care conferences but could not because they were scheduled for days and times during which she was receiving dialysis treatments. Resident #82 stated that on her dialysis days she was out of the facility from approximately 11:00 AM to 5:00 PM. A review of Resident #82's physician's orders during the survey found that Resident #82 received dialysis treatments each Monday, Wednesday, and Friday. The order was dated 04/20/19. Record review during the survey found a Social Services Note dated 06/13/19 stating, Resident's care plan conference is scheduled for 6/19/19 at 2:00 pm. Resident was notified in person on 6/13/19. 06/19/19 was a Wednesday, meaning that Resident #82 was scheduled to receive a dialysis treatment that day. During the survey, a review of Resident #60's Plan of Care Note dated 06/20/19 and care conference signature sheet dated 06/19/19 confirmed that Resident #60 had not attended her care conference on 06/19/19. On 09/10/19 at 3:06 PM Social Worker (SW) #79 agreed that Resident #82's care conference had been scheduled for a dialysis day when Resident #82 could not attend. The above information was discussed with the facility's Administrator on 09/10/19 at 3:53 PM. She stated she would speak to SW #79 about it. 42100

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31520 Based on medical record review, staff interview, observation and family interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This was true for three (3) of twenty-three (23) residents reviewed. For Resident #56 the facility failed to follow up on resident's right hand and arm weakness. Resident #46 failed to provide her with incisional care after surgery and failed to follow physician orders for antibiotics. Resident #41the facility failed to follow physician orders for restorative program. Resident identifiers: #56, #46, and #41. Facility census: 97. Findings include: a) Resident #56 Medical record review for Resident #56, found a progress note written on 07/26/19 at 2:00 am which read: Reported from evening shift that resident's mother reported resident changes. Assessed patient and noted right hand and arm weakness. No other deficits noted at this time. Fax sent to doctor. No further notes found in reference of the resident's right hand and arm weakness. On 09/12/19 at 11: am. the Director of Nursing (DON) was asked about whether physician had responded to the fax from 07/26/19, concerning Resident #56's right arm and hand weakness. At 09/12/19 at 11:45 am, I was provided a fax concerning Resident #56's right arm and hand weakness. This fax was returned to the facility on [DATE] at 4:33 am with instructions from the physician to do neurological checks every shift for seventy-two (72) hours. DON confirmed at this time this was not completed as doctor requested. No further information provided. b) Resident #46 b.1.) Review of Resident #46's medical record, found on 01/31/19 the resident was readmitted after having an abdominal hysterectomy. Discharge instructions were to shower daily and provide wound care while in the shower with cleansing the area with warm soapy water. Use white, unscented soap like Dove or Dial. Pat the wound dry. Keep the wound clean, dry, and exposed to air. Review of readmission orders found and order that read: Shower daily and provide wound care while in the shower with cleansing the area with warm soapy water. Use white, unscented soap like Dove or Dial. Pat the wound dry. Keep the wound clean, dry, and exposed to air. Review of Resident #46's shower record for February 2019 found Resident #46 received a shower on 02/07/19 and was documented two (2) times on 02/11/19 and 02/21/19. No further documentation could be found. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/11/19 at 2:05 pm, the DON was asked if Resident #46 had received incisional care as directed in the discharge summary on 01/31/19. She confirmed there was not documentation the resident was offered and/or received the wound care as directed on the discharge summary. b 2.) On 02/15/19, Resident #46 had a follow-up appointment with the surgeon and was sent to the emergency room (ER) at local hospital from the doctor's appointment prior to returning to the facility. On 02/15/19, Resident #46 had a new order for Augmentin 875-125 milligrams (mg) by mouth twice daily for treatment of urinary burning and frequency; possible urinary tract infection (UTI) for seven (7) days. To be started on 02/15/19 at 5:00 pm and to end on 02/22/19 at 9:00 am. Review of the Medication Administration Record for February 2019 found Resident #46, received six (6) of the fourteen (14) doses ordered. No information could be located to determine why Resident #46 received the Augmentin as ordered. On 09/12/19 at 11:45 am, Resident #46's medical records were reviewed with the DON and she confirmed the resident only received six (6) of the fourteen (14) doses prescribed. She also confirmed the reason the resident did not receive her antibiotic could be located. b. 3.) Resident #46 was ordered on 05/07/19 for Rocephin one 1 gram (gm) intramuscularly (IM) at 10:00 pm for five (5) days for the treatment of a UTI. Review of the MAR for May 2019, found the resident only received four (4) doses of the five (5) doses ordered. Review of the May 2019 MAR with the DON on 09/11/19 at 11:45 am, she confirmed the resident only received four (4) doses of the five (5) doses as prescribed. 33947 c) Resident #41 The facility failed to follow physician's orders for Resident (R#41)'s restorative program An interview with R#41's Medical Power of Attorney (MPOA), on 09/09/19 at 12:12 PM, revealed concerns about the resident spending too much time in a wheelchair and not being walked by staff. The MPOA states she visits frequently almost daily and rarely sees her mother being walked by staff. The MPOA said she was told there is no restorative program, but they said they were going to start it up again soon. On 09/11/19 at 03:02 PM, an interview with Nurse Aid (NA#105) assigned to R#41 revealed NA#105 did not walk R#41 because the resident has had falls recently and NA#105 said she is afraid to walk R#41 for fear she would fall. NA#105 also stated the resident would need a walker and she did not have one in her room. Observation of resident's room revealed no walker currently in the resident's room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Registered Nurse (RN#109), on 09/11/19 at 03:56 PM, revealed the resident was currently on restorative nursing services for ambulation. RN#109 was responsible for the restorative nursing program and stated the resident was on the 'Walk to Dine' program. RN#109 explained the NAs on the floor are responsible for the resident's 'Walk to Dine' program. RN#109 said the NAs would walk the resident to lunch and dinner 6 days a week using a front wheel walker which typically is kept in the resident's room. RN#109 stated the resident was discharged from physical therapy on 05/17/19 and then was ordered restorative services at that time. On 09/12/19 at 11:51 AM, an interview with Nurse Aid (NA#19), revealed NA#19 occasionally walks R#41. NA#19 stated, I walk her with a gait belt. We walk her if we have time, and that is not every day. When asked if the resident was on any restorative nursing programs, NA#19 said she was not aware of her being on any programs. Observations on 09/12/19 at 11:54 AM revealed R#41 sitting in her wheelchair at a dining room table with her daughter waiting on lunch. Her daughter/MPOA stated I bring her to the dining room in her wheelchair almost every day for lunch no one has ever told me about a walk to dine program and none of the NAs has ever came to her room to get her to walk her to lunch. An interview with the resident assessment coordinator RN#103 responsible for developing and revising care plans, on 09/12/19 at 12:11 PM, confirmed restorative services were ordered for R#41. RN#103 stated the care plan should have been revised to include restorative and was not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30153 Based on observation, staff interviews and resident interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible. Resident #3 was observed having a cigarette and lighter on his person. This practice was true for one (1) of two (2) residents who smoked. Resident identifier: #3. Facility census: 97. Findings included: a) Resident #3 Observed Resident #3 in the designated resident smoking area, on 09/10/19 at 11:32 AM, remove a cigarette and lighter from his person and begin smoking. Resident #3 put the lighter in his pocket. A review of the facility smoking policy and procedure during the survey found under Procedure 8. Facility staff will: a. Secure smoking materials in a locked area when not in use by the resident/patient for both independent and supervised smokers. 9. a. Smoking materials will be maintained by the facility staff and provided to the resident/patient on request. c. Smoking materials will be returned to the facility staff upon completion of smoking. An interview with Licensed Practical Nurse (LPN) #32 on 09/ 12/19 at 8:05 AM found that no smoking materials were locked up in the medication room for Resident #3. An interview conducted on 09/12/19 at 8:07 AM with Resident #3 found this resident stated that he had no cigarettes or lighter in his room. On 09/12 at 11:58 AM the Nursing Home Administrator (NHA) stated that she had interviewed Resident #3 and he had cigarettes and a lighter in his room. The NHA stated that the cigarettes and lighter were removed from Resident #3 room and reeducated the resident as to the policy and procedure regarding smoking materials.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31520 40835 Based on observation, record review, staff interview, and policy review the facility failed to fully address the nutritional status of its residents when the facility's clinical team and Registered Dietitian failed to address weight change timely. This deficient practice was found for 2 out of 5 residents reviewed for the care area of nutrition. Resident identifiers: #60 and #39. Facility census: 97. Findings included: a) Resident #60 On 09/10/19 at 12:21 PM Resident #60 was observed eating lunch. Resident #60 appeared thin and frail during the observation. A review of Resident #60's weight records during the survey found that Resident #60 had experienced a significant weight loss of 18 percent of his body weight in three (3) months. On 05/08/19 Resident #60 weighed 156.2# and on 08/09/19 he weighed 128.4 pounds. During the survey, a review of the facility's weight policy, last reviewed on 05/29/19, found that, Weight loss concerns will be discussed at the weekly clinical meetings. However, no weekly clinical meeting notes were found for Resident #60. During the survey, all documentation regarding Resident #60's nutritional status was requested from administration. On 09/11/19 at 11:52 AM Regional Director of Clinical Operations (RDCO) #64 stated that there was no documentation and that the facility's Registered Dietitian (RD) had not addressed Resident #60's nutritional status since his weight change. b) Resident #39 On 09/10/19 at 12:18 PM Resident #39 was observed eating lunch. She appeared thin and frail upon observation. A review of Resident #39's weight records during the survey found that she had lost 29.8 pounds since her admission to the facility on [DATE]. Per weight records, on 06/14/19 Resident #39 weighed 100 pounds and on 08/09/19 she weighed 70.2 pounds. During the survey, a review of the facility's weight policy, last reviewed on 05/29/19, found that, Weight loss concerns will be discussed at the weekly clinical meetings. However, no weekly clinical meeting notes were found for Resident #39. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the survey, all documentation regarding Resident #39's nutritional status was requested from administration. On 09/11/19 at 11:52 AM Regional Director of Clinical Operations (RDCO) #64 stated that there was no documentation and that the facility's Registered Dietitian (RD) had not addressed Resident #39's nutritional status since her weight change.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 40835 Based on record review and staff interview, the facility failed to document the clinical rationale for not following pharmacy recommendations to discontinue a medication determined to be contraindicated for Resident #82. This deficient practice affected one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifier: #82. Facility census: 97. Findings included: a) Resident #82 Resident #82 was selected by the Long-Term Care Survey Process (LTCSP) system for a review for unnecessary medications. A review of Resident #82's physician's orders during the survey found that Resident #82 received dialysis treatments three (3) times weekly. On 09/11/19 at 8:10 AM Resident #82's pharmacy consultation reports from May 2019 were received and reviewed. Per the reports, the facility's Pharmacist recommended on 04/24/19 that the facility's Attending Physician discontinue Resident #82's Duloxetine HCl (hydrochloride), a medication used to treat depression and anxiety, as Duloxetine HCl was contraindicated in residents receiving dialysis. The Attending Physician signed the report and provided written agreement with the recommendation on 05/02/19. Additionally, the Pharmacist's report stated, If this therapy is to continue, it is recommended that a) The prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensures ongoing monitoring for adverse effects. A review of Resident #82's medication administration record (MAR) from May 2019 through September 2019 found that Resident #82's Duloxetine HCl had been received continuously since 05/10/19, despite the Pharmacist's recommendation to the contrary. On 09/11/19 at 1:09 PM the facility's Director of Nursing (DoN) provided information regarding Resident #82's Duloxetine HCl indicating that the medication had been discontinued on 05/02/19 and restarted on 05/09/19 because the discontinuation failed. Documentation regarding the failure was requested from the DoN. On 09/11/19 at 1:27 PM Regional Director of Clinical Operations (RDCO) #64 stated that Resident #82 requested to restart the Duloxetine HCl. Documentation regarding the risks versus the benefits for restarting the medication was requested from RDCO #64 at that time. During a phone interview on 09/11/19 at 1:40 PM in the presence of RDCO #64, the Attending Physician acknowledged that he did not document the clinical rationale for restarting the Duloxetine HCl in Resident #82's medical record. No further information was provided prior to exit.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 31520 Based on medical record review, observation, resident interview and staff interview, the facility failed to assist Resident #46 to obtain needed dental appointments for extraction of two (2) decayed and broken teeth. This was a random opportunity for discovery. Resident identifier: #46. Facility census: 79. Findings include: a) Resident #46 Observation and interview, on 09/09/19 at 4:15 pm, found the residents had few of her own teeth, which was decayed and broken .Resident #46 also voiced the dentist had seen her in the facility and had recommended to have two (2) of her teeth extracted. She could not recall the date of the exam but the staff had told her she would have to pay for it before they would make the appointment and she had told them she could not afford to have the teeth extracted. Review of Resident #46's medical records found on 02//22/19 the dentist had recommended she have two (2) teeth (#3 and #19 teeth) extracted. Tooth #19 was decayed and #3 tooth was broken at the gum level per the dentist consultation on 02/22/19. Nurse's notes for Resident #46 found a note written on 04/09/19 at 2:40 pm by Employee #132. registered nurse (RN) which read: (Dentist's name) made recommendations during last visit to have some teeth extracted. Spoke with the Business Office Manager (BOM) and since the resident has Medicaid insurance the procedure will have to be paid up front. Resident states She does not have the means to do this at this time. On 09/12/19 at 11:45 am, an interview with the Director of Nursing (DON), confirmed the facility had not assisted the resident in receiving needed dental care. She confirmed an appointment would be made as soon as possible.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40835 Based on observation and staff interview, the facility failed to maintain their main kitchen and resident nourishment rooms in a safe and sanitary manner when they failed to properly label and date foods and condiments and ensure the ice machine was clean. This deficient practice was found during a random opportunity for discovery and had the potential to affect more than an isolated number of residents. Facility census: 97 Findings included: a) Kitchen On 09/09/19 at 11:37 AM an initial tour of the facility's kitchen began with Regional Director of Clinical Operations (RDCO) #64 and Culinary Director (CD) #123. On 09/09/19 at 11:40 AM an open-to-air plastic bag containing corn bread was found in the reach-in freezer. RDCO #64 and CD #123 agreed that the cornbread needed to be discarded since it had been left open. On 09/09/19 at 11:46 AM residue was noted around the opening of the ice maker in the main kitchen. The residue was brown and rubbed off the ice maker with ease. At the time of the finding RDCO #64 confirmed the ice maker needed to be cleaned. On 09/09/19 at 11:50 AM, 27 pre-poured containers of what appeared to be maple syrup were found on a tray in the dry storage room with no label or date. At 11:51 AM two (2) 22-quart containers labeled flour and two (2) 22-quart containers labeled bread crumbs were found to have no date on them, though the containers held what appeared to be flour and bread crumbs. At 11:52 AM CD #123 confirmed the 27 syrup containers and four (4) 22-quart containers did not have dates. CD #123 then removed the syrup containers from the dry storage room and stated she would ensure the 22-quart containers were labeled. On 09/09/19 at 1:00 PM RDCO #64 was informed of the above findings. No further information was provided prior to exit. b) [NAME] Nourishment Room On 09/09/29 at 12:03 PM in the [NAME] nourishment room, a bottle of Gatorade in the refrigerator was found to have no date on it. CD #123 discarded the bottle upon discovery. On 09/09/19 at 1:00 PM RDCO #64 was informed of the above findings. No further information was provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 33947 Based on record review, CDC's (Centers for Disease Control and Prevention) Guidelines for infection control in Long term care facilities, and staff interview; the facility failed to maintain an effective infection control program. This is evident by the failure to maintain and complete infection control surveillance records in their entirety. This practice had the potential to affect more than a isolated number of residents. Facility census: 97. Findings included: a) Infection control program According to the CDC, surveillance is defined as the ongoing systematic collection, analysis, interpretation, and dissemination of data. A facility's infection prevention and control (IPC) program should use surveillance to identify infections and monitor performance of practices to reduce infection risks among residents, staff and visitors. Surveillance includes monitoring epidemiological significant organisms, such as multi-drug resident organisms (for example, MRSA, VRE, and CRE) or C. difficile among residents in the facility. The detailed data collection and analysis helps track and identify trends and opportunities for prevention. Review of the facility's infection surveillance, tracking and trending records kept in an infection control notebook, on 09/10/19 at 08:40 AM, revealed incomplete tracking information on the Infection Control Log. Review of the Infection Control Log showed the information to be documented included: Resident name; room number; admitted ; onset date; in house acquired (yes or no); site; infection related diagnosis; culture (yes or no); date of culture or chest X-ray; organism; antibiotic; isolated (yes or no); re-culture date; and date resolved. Review of the Infection Control Log, for August 2019 East, revealed twenty-one (21) entries concerning residents. Three (3) entries did not document whether cultures were done with a yes or a no concerning one (1) wound and two (2) urinary tract infections. Out of the twenty-one (21) entries, only two (2) entries had the name of the organism. Only five (5) entries out of twenty-one (21) entries designated no for isolated, the rest were all blank and did not designate either yes or no as was the option. All twenty-one (21) entries did not have re-culture date or date resolved documented, they were left blank. Review of the Infection Control Log, for August 2019 West, revealed twelve (12) entries concerning residents. Six (6) entries did not document whether cultures were done with a yes or a no. Out of the six (6) that did document a yes or a no whether cultures were done, only one (1) was marked yes but no date when the culture was done was recorded. Only one (1) organism was named. Only three (3) entries out of twelve (12) entries designated no for isolated, the rest were all blank. All twelve (12) entries did not have re-culture date or date resolved documented, they were left blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515047	A. Building B. Wing	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worthington Healthcare Center	2675 36th Street Parkersburg, WV 26104

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 - Some	Review of the Infection Control Log, for July 2019 East, revealed twelve (12) entries concerning residents. Six (6) entries did not document whether cultures were done with a yes or a no. Out of the twelve (12) entries, only one (1) entry had the name of the organism. All twelve (12) entries did not have re-culture date or date resolved documented, they were left blank. Review of the Infection Control Log, for July 2019 West, revealed eleven (11) entries concerning residents. Nine (9) entries did not document whether cultures were done with a yes or a no. Out of the eleven (11) entries, only two (2) entries had the name of the organism. All eleven (11) entries did not have re-culture date or date resolved documented, they were left blank. Interview with Registered Nurse (RN#113) responsible for the facility's Infection control program, on 09/12/19 at 10:56 AM, revealed that several different staff had been responsible for the position of overseeing the Infection control program during the past year. RN#113 stated not everyone did what they were supposed to do with surveillance and tracking. RN#113 stated she had recently started doing the infection control program and was aware key information was missing in the surveillance and tracking documentation. RN#113 confirmed some key information was not tracked, such as the name of an organism, or whether a culture was or was not done, or when it was resolved. RN#113 verified the infection control log was to be filled out in its entirety and it had not been. RN#113 agreed it was important to know what the organisms were when monitoring and tracking trends, and to document all pertinent information asked for on the infection control log.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33947 Based on record review, policy review, review of Centers for Disease Control (CDC) recommendations, review of the State Operation Manual Appendix P, and staff interview; the facility failed to determine and offer to residents or resident's representatives the opportunity for the resident to receive the pneumococcal vaccine in accordance with accepted guidelines (pneumococcal polysaccharide vaccine (PPSV23) and/or pneumococcal conjugate vaccine (PCV13)). This was true for 2 of 5 residents reviewed for the care area of immunizations. This practice had the potential to affect more than a limited number of residents. Resident identifiers: Residents #81 and #37. Facility census: 97. Findings included: a) Resident (R#81) Review of Resident (R#81) records, on 09/12/19 at 12:17 PM, revealed an informed consent for Pneumococcal Polysaccharide vaccine (PPSV23) dated 11/14/16. The informed consent referenced and provided education concerning only PPSV23, with information on the vaccine name/route, indications, primary schedule, and contraindications. Review of R#81's medical records revealed no evidence or indication information concerning the PCV13 pneumococcal vaccine was ever provided nor was there any evidence PCV13 was ever offered to the resident or resident representative. The informed consent dated 11/14/16 showed the resident's representative refused PPSV23 for the resident. The record showed no reason was documented for the refusal. The facility had no record of pneumococcal vaccine history for R#81. This resident is over the age of 65. b) Resident (R#37) Review of Resident (R#37) records revealed an informed consent for Pneumococcal Polysaccharide vaccine (PPSV23) dated 05/08/13. The informed consent referenced and provided education concerning only PPSV23, with information on the vaccine name/route, indications, primary schedule, and contraindications. Review of R#37's medical records revealed no information on the PCV13 pneumococcal vaccine was ever provided nor was there any evidence PCV13 was ever offered to the resident or resident representative. The informed consent showed the resident's representative refused PPSV23 for the resident. The record showed no reason was documented for the refusal. The facility had no record of pneumococcal vaccine history for R#37. R#37 is over the age of 65. d) CDC / ACIP Recommendations The Advisory Committee on Immunization Practices (ACIP) currently recommends that a dose of PCV13 be followed by a dose of PPSV23 in all adults aged greater or equal to [AGE] years who have not previously received pneumococcal vaccine and in persons aged greater or equal to 2 years who are at high risk for pneumococcal disease because of underlying medical conditions . The recommended intervals between PCV13 and PPSV23 given in series differ by age and risk group and the order in which the two vaccines are given. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e) A review of the policy and procedure IC-1019-00 dated 10/01/17, notes Residents who refuse the vaccination may receive the vaccinations at a later date if they reconsider. and the pneumonia vaccine are considered part of the routine vaccine schedule for those over the age of 65 but both should not be given at same time. If the resident desires to receive both, PCV 13 should be administered first with PPSV23 to follow in 11 months. f) Review of the facility's current consent/declination for Pneumonia vaccine, Form#1117-01, revised 03/01/17 revealed under the Consent section, I/resident representative have received education including but not limited to the following, prior to receiving pneumonia vaccination: provider decision for PCV13 or PPSV23 based on CDC guidelines and past history of pneumonia vaccinations, if any . g) Interview with Registered Nurse (RN#113) currently responsible for the facility's Infection control program, on 09/12/19 at 10:56 AM, revealed after review of R#81 and R#37 medical records, RN#113 verified that there was no evidence in R#81 and R#37's medical records indicating education or information about PCV13 was provided. Also, there was no evidence the PCV13 vaccine was ever offered as an option to the residents or their representatives. There was no evidence of any kind of follow up after the initial refusal of PPSV23 by R#81 and R#37's representatives or after the revision of the facility's consent forms for Pneumonia vaccine.