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	03/22/2023

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on medical record review and staff interview, the facility failed to ensure Advance Directive paperwork was part of the resident's medical record. This was true for one (2) of 19 residents reviewed in the Long-Term Care Survey process. Resident identifier: #31 and #72. Facility census: 93. Findings included: a) Resident #31 A medical record review, completed on 03/20/23 at 3:07 PM, indicated that Resident #31 was admitted to the facility on [DATE]. It also identified the following details: -A Physician Determination of Capacity was on file and indicated Resident #31 lacked capacity to make her own medical decisions. -A WV Physician Orders for Scope of Treatment (POST) form was on file and indicated Resident #31's legal representative had signed the form. -There was a copy of a Power of Attorney (POA) scanned into the electronic record. There was also a copy of the POA on the resident's paper chart at the nurses station. However, the POA specifically stated, This power of attorney does not authorize the agent to make health-care decisions for you. During an interview on 03/21/23 at 12:40 PM, LPN #100 confirmed the current POA document on file did not authorize the agent to make health-care decisions. Additionally, the Director of Social Services acknowledged, during an interview on 03/21/23 at 12:45 PM, the facility did not have the correct paperwork on file to prove who was the appropriate medical decision maker for resident. b) Resident #72 A medical record review, completed on 03/20/23 at 2:39 PM, indicated that Resident #72 was admitted to the facility on [DATE]. It also identified the following details: (continued on next page)

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.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A Physician Determination of Capacity was on file and indicated Resident #72 lacked capacity to make her own medical decisions. -A WV Physician Orders for Scope of Treatment (POST) form was on file and indicated Resident #72's Health Care Surrogate (HCS) had signed the form. -There was no copy of the HCS paperwork scanned into the electronic record. There was also no copy of the HCS paperwork on the resident's paper chart at the nurses station. During an interview on 03/21/23 at 11:57 PM, LPN #100 confirmed the HCS paperwork was not scanned into the electronic medical record nor was it part of Resident's paper chart at the nurse's station. The Director of Social Services also confirmed, during an interview on 03/21/23 at 12:08 PM, the facility did not have a copy of the HCS paperwork. The Director of Social Services stated she would contact the resident's family member and/or the admitting hospital and obtain it.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 43340 Based on observation, record review, and staff interview, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition. This was a random opportunity for discovery. Resident Identifier #33. Facility census: 93. Findings included: a) Resident #33 A record review, completed on 03/21/23 at 11:24 AM, found the following: -There was a Grievance/Concern Form on file that was dated 01/18/23. Description of concern read: Resident states she cannot see well enough to feed herself meals and that she doesn't get enough to eat because of this. States she would like to have assistance with meals. -The Annual Minimum Data Set (MDS), with an assessment reference date of 02/09/23, read Eating: One person physical assist. On 03/21/23 at 2:20 PM, visible from hallway outside of Resident #33's room, it was evident the noon meal was still at her bedside and Resident #33 had 1/2 of a dropped, uneaten grilled cheese sandwich resting on her chest. Once by the bedside, it was evident Resident #33 had accidentally knocked a bowl of brussels sprouts over onto her lap. Both the bowl and four (4) individual brussels sprouts were resting in the resident's lap. The brussels sprouts had rolled out of the bowl and were randomly on her lap. Resident #33's meal tray ticket indicated she was a DD [Dependent Diner]. At 2:30 PM, CNA #78 verified it was well after the noon meal and Resident #33 had accidentally dropped and/or spilled 1/2 her meal. CNA #78 agreed 1/2 of the grilled cheese sandwich resting on resident's chest was readily visible to anyone walking by and was a dignity concern. CNA #78 verified the lunch meal was still in the room at 2:30 PM and it appeared no staff member had offered assistance with eating on this date. During an interview on 03/22/23 at 11:50 AM, [NAME] #44 reported resident is to be considered a dependent diner and staff would know they need to feed her because her meal tray ticket indicates she is a DD [dependent diner]. Review of the Eating Task documentation in Resident's Electronic Medical record, completed on 03/22/23 at 12:00 PM, included documentation from the past 14 days and revealed the following dates which Certified Nurse Aide (CNA) staff had documented resident had been Independent - No help or staff oversight at any time: -03/09/23 -03/12/23 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-03/14/23 -03/18/23 -03/20/23 -03/21/23 During an interview on 03/22/23 at 1:40 PM, CNA #50 reported, She [Resident #33] is a dependent diner which means she needs to be fed by staff. On 03/22/23 at 1:50 PM, the Director of Nursing acknowledged the facility did not have the appropriate documentation to indicate Resident #33 was consistently receiving the necessary services to maintain good nutrition.

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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 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. 31518 Based on observation, record review and staff interview the facility failed to provide care/treatment and services in accordance with professional standards of practice. The facility failed to assess Resident #350 after a fall. The pharmacist and physician declined to complete the required Food and Drug Act (FDA) paper work to be able to continue to prescribe and administer Clozapine in a safe manner for Resident #395. Physician orders were not followed for house supplements for Resident #88. These findings are true for one of four reviewed for falls, one of six reviewed for psychotropic medications and one of two reviewed for food preferences. Resident identifiers: 350, 395, 88. Facility census: 93. Findings include: a) Resident (R) 350 Review of the medical record on 3/21/23 revealed a note by the nurse practitioner on 05/13/22 at 9:46 PM stating R#350 had a fall earlier at 2:00 PM which was not reported. The nurses notes lack any information related to this fall until a hematoma was identified by a nurse aide at 9:30 PM on 05/13/23. On 03/22/23 at 10:30 AM, Licensed Practical Nurse (LPN) #76 stated she was the nurse on duty the day R#350 fell . LPN #76 reported she was told the resident sat on the floor. LPN #76 acknowledged a resident sitting on the floor is considered a fall. LPN #76 agreed the medical record lacks any information related to the resident being assessed for injury until the hematoma was found on the next shift. b) Resident (R) #395 Because of the risk of severe neutropenia and infection, the FDA requires prescribers and pharmacists to complete a a Risk Evaluation and Mitigation Strategy to manage the risk of severe neutropenia associated with Clozapine treatment. Review of the medical record on 03/22/23, revealed R #395 was admitted to the facility in December 2021. Her diagnoses included dementia with behaviors, paranoid schizophrenia, mood affective disorder, depression, anxiety, seizures and developmental delay. Her admission medications included Clozapine (Clozaril) and antipsychotic used to treat schizophrenia. On 06/13/22, the attending physician began decreasing the Clozapine over a six week period. The Behavior note dated 06/13/22 states: Clarification order reviewed regarding changing CLozaril to a different medication. New order noted to reduce Clozaril to 150 milligrams (mg) for two weeks then 100 mg for two weeks, then 50 mg for two weeks then discontinue. Add Quetiapine (an antipsychotic) 25 mg twice a day for two weeks and increase 25 mg every two weeks to a 100 mg twice a day. Monitor the resident's response to medication changes. On 06/25/22, the attending physician was notified of R#395's behaviors including cursing and false accusations while weaning the Clozaril. The physician declined to increase the Clozaril back to 200 mg a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/27/22, there was a request made to sent the resident to a behavioral health facility. On 07/15/22 the resident was following staff and making false health complaints. On 07/24/22, another request to a behavioral health facility was faxed stating the physician saw R#395 and requested she be sent to a behavioral health unit immediately as paranoid schizophrenia and behaviors have worsened her condition. R#395 was transferred and admitted to an acute care center on 08/03/22. The acute care center's initial psychiatric consult dated 08/04/22, notes she was transferred for a decline in mentation over the past two weeks after she was completely taken off Clozapine on 07/19/22 due to the medical teams decision that Clozapine is to difficult to manage. Resident became loud, refused all intake and cares. The hospital's progress note dated 08/07/22, states the most likely cause to the resident's metabolic encephalopathy is due to a change in her antipsychotic medications. The medical director at (name of this facility) stopped her Clozapine because this takes a registry. There is a lot of paperwork involved. Psychiatry agreed to put her back on the registry and restart the Clozapine. During an interview on 03/22/23 at 2:13 PM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) presented an undated portion of an email from the pharmacist with directions on how to wean the Clozaril. The ADON reported the Clozaril was no longer available from the pharmacy the facility used. When asked about getting the medication from another pharmacy she stated We only get our drugs from one pharmacy. The DON did not comment when shown the note from the acute care center stating the resident's change in condition was most likely due to the change in her antipsychotic medications and the medical director of the facility's decline to complete the paper work to continue to prescribe the Clozaril. 45174 c) Resident #88 During the initial interview on 03/20/23 at 2:08 PM, Resident # 88 stated I have no appetite, I was supposed to start getting a milkshake with my meals and I have not gotten it. During a record review on 03/20/23 at 3:00 PM, Resident #88's medical record revealed a physician order dated 03/10/23 House Supplement two times a day for house shake 118 ml kitchen to provide. 12:00 and 5:00 PM During an lunch meal observation on 03/21/23 at 12:43 PM, Resident # 88's lunch meal tray did not have a house supplement. Nurse Aide (NA) #119 verified there was no house supplement on the lunch meal tray. A lunch meal tray ticket did not reveal a house supplement/shake was provided with the meal. NA #119 stated when the supplements are on the meal tickets they are listed below the drinks and there is nothing there. I did not know that he was to supposed to get one. During an interview on 03/21/23 at 1:17 PM, Culinary Director (CD) stated I did not receive any diet order for Resident # 88 to receive a house supplement at meals. The CD revealed a list of orders she has received and Resident #88 house supplement were not present. During the interview on 03/21/23 at 1:31 PM, Director Of Nursing acknowledge the facility failed to follow physician orders to provide Resident # 88 with house supplement two (2) times a day.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45173 Based on observation, record review, staff interview and resident interview, the facility failed to ensure respiratory care was provided according to professional standards of practice. These were random opportunities for discovery. Resident Identifiers: #6 and #49. Facility Census: 93. Findings Included: a) Resident #6 On 03/20/23 at 1:10 PM, a continuous positive airway pressure (CPAP) mask was observed hanging from the night stand for Resident #6. The CPAP mask was not stored in a respiratory bag which decreases the risk of infections. On 03/20/23 at 1:12 PM, Licensed Practical Nurse (LPN) #37 confirmed the CPAP mask was not stored in a respiratory bag. LPN #37 stated, let me go get a respiratory bag. On 03/20/23 at 3:00 PM, the Directory of Nursing (DON) was notified and confirmed the CPAP mask should be stored in a respiratory bag. b) Resident #49 On 03/20/23 at 1:05 PM, a nebulizer mask was observed hanging by the bed rail. The nebulizer mask was not stored in a respiratory bag which decreases the risk of infections. On 03/20/23 at 1:07 PM, LPN #37 confirmed the nebulizer mask was not stored in a respiratory bag. LPN #37 stated, I'll go get a respiratory bag. On 03/20/23 at 3:00 PM, the DON was notified and confirmed the nebulizer mask should be stored in a respiratory bag. No further information was obtained during the long-term survey process.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 43340 Based on resident interviews during resident council, and staff interview, the facility failed to ensure a substantial/nourishing snack was provided between the evening meal and breakfast. This had the ability to affect all residents who did not have a dietary order to receive an evening snack or the cognitive and/or physical ability to make their way to the nurse's station to request something to eat from the nourishment room. Facility Census: 93. Findings included: a) Resident Council Meeting During the resident council meeting with Surveyor on 03/21/22 at 1:00 PM, three (3) out of five (5) residents in attendance stated the facility did not offer an evening snack to residents. They went on to say they felt the majority of facility residents would enjoy a bedtime snack. One (1) resident stated, They used to do that, but they don't do it anymore. Another resident explained if he was hungry before bedtime, he independently made his way to the nurse's station and asked for something. When asked if all residents in the facility knew how to acquire something from the nourishment room at the nurses station, resident council members were not sure everyone understood. One resident in attendance stated that not everyone would feel comfortable requesting a snack or may not even remember if it was an option. b) Record Review A brief medical record review, completed on 03/21/22 at 8:05 PM, revealed all three residents who reported the facility did not offer an evening snack were cognitively intact. Additionally, review of the Eating Nights documentation in each resident's electronic medical record, which included documentation from the past 14 days, revealed the following dates which Certified Nurse Aide (CNA) staff had documented Activity did not occur: -03/09/23 -03/11/23 -03/12/23 -03/13/23 -03/15/23 -03/16/23 -03/17/23 (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-03/18/23 -03/19/23 -03/20/23 -03/21/23 -03/22/23 c) Administrative Interview The aforementioned details were reviewed with the Director of Nursing on 03/22/23 at 1:15 PM. No additional information was provided prior to Surveyor exit on 03/22/23 at 4:00 PM.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43340 45173 Based on record review and staff interview, the facility failed to maintain accurate and complete medical records for the Physician Orders for Scope of Treatment (POST) form for Resident #92 and Resident #39, a capacity form for Resident #92 and documentation of supplements for Resident #88. This is true for three (3) of 25 medical records reviewed during the long-term survey process. Resident Identifiers: #92, #39 and #88. Facility Census: 93. Findings Included: a1.) Resident #92 On 03/22/23 at 8:01 AM, a record review was completed for Resident #92. The review found the POST form was incomplete. The preparer's signature was not dated upon completion of the form. On 03/22/23 at 8:20 AM, the Director of Nursing (DON) was notified and confirmed the POST form was incomplete. No further information was obtained during the long-term survey process. a-2) Resident #92 On 03/22/23 at 8:01 AM, a record review was completed for Resident #92. The review found the capacity form was incomplete. The capacity form did not list the duration, nature or causes of the incapacity finding. On 03/22/23 the DON was notified and confirmed the capacity form was incomplete. No further information was obtained during the long-term survey process. b) Resident #39 A brief record review, completed on 03/21/23 at 8:44 AM, identified the following details: -Resident #39 had a 2021 Physician Orders for Scope of Treatment (POST) form on file which was dated 10/20/22. -Resident #39 began to receive hospice services on 02/2/23. -A care plan conference was held on 03/14/23. The POST form was not updated at that time to reflect Resident #39 was receiving Hospice services or the name and contact number of the Hospice agency. The 2021 POST Form Guidance instructs, this form should be reviewed whenever the patient: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Is transferred from one level of care to another -Has a substantial change in health status During an interview on 03/21/23 at 12:52 PM, the Director of Social Services reported it was an error that the POST form was not updated during the last care plan conference on 03/14/22. 45174 c) Resident #88 During the initial interview on 03/20/23 at 2:08 PM Resident # 88 stated I have no appetite, I was supposed to start getting a milkshake with my meals and I have not gotten it. During a record review on 03/20/23 at 3:00 PM, Resident #88's medical record revealed a physician order dated 03/10/23, for a House Supplement two times a day for house shake 118 ml kitchen to provide. 12:00 and 5:00 PM During an lunch meal observation on 03/21/23 at 12:43 PM Resident # 88's lunch meal tray did not have a house supplement. Nurse Aide (NA) #119 verified there was no house supplement on the lunch meal tray. A lunch meal tray ticket did not reveal a house supplement/shake was provided with the meal. NA #119 stated when the supplements are on the meal tickets they are listed below the drinks and there is nothing there. I did not know that he was supposed to get one. During a record review on 03/21/23 at 01:03 PM Resident #88 medical record revealed the Medication Administration Record with a physician order, house supplement two times a day for house shake 118 ml kitchen to provide Start Date 03/10/23 5:00 PM. The dates and precentages documented are as follows: -03/10/23 5:00 PM - 90% -03/11/23 12:00 PM - 100% -03/11/23 5:00 PM - 118% -03/12/23 12:00 PM - 100% -03/12/23 5:00 PM - 118% -03/13/23 12:00 PM - 240% -03/13/23 5:00 PM - 120% -03/14/23 12:00 PM - 118% -03/14/23 5:00 PM - 90% -03/15/23 12:00 PM - 100% (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-03/15/23 5:00 PM -100% -03/16/23 12:00 PM -237% -03/16/23 5:00 PM -120% -03/17/23 12:00 PM - 90% -03/17/23 5:00 PM - 90% -03/18/23 12:00 PM -118% -03/18/23 5:00 PM - 90% -03/19/23 12:00 PM -118% -03/19/23 5:00 PM - 0% -03/20/23 12:00 PM - 118% -03/20/23 5:00 PM - 90% During an interview on 03/21/23 at 1:09 PM, the Licensed Practical Nurse(LPN) #40 stated the house supplements are 120 ml. We get the amount the resident consumed off the NA task documentation and then we enter it into the MAR. During an interview on 03/21/23 at 1:17 PM, the Culinary Director (CD) stated I did not receive any diet order for Resident # 88 to receive a house supplement at meals. The CD revealed a list of orders she has received and Resident #88 house supplements were not present. During an interview on 03/21/23 at 1:31 PM, the Director of Nursing (DON) stated the LPN's document the amount of house supplement the resident consumes in the MAR. During the interview on 03/21/23 at 1:31 PM, the DON acknowledged the LPN's were documenting amount consuming of a house supplement Resident # 88 was not receiving.