

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

PRINTED: 02/09/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2000
NAME OF PROVIDER OR SUPPLIER SENECA TRAIL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 MAPLEWOOD AVENUE Lewisburg, WV 24901		
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F 000 SS=C	<p>INITIAL COMMENTS</p> <p>483.13(c) Requirement STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined that the facility failed to develop written policies for screening potential employees for a history of abuse or neglect. This has the potential to affect all residents. Facility census 91.</p> <p>a) Facility policies and procedures were reviewed on 8/23/00. It was noted that there was no policy and procedure which addressed the screening of potential employees for a history of abuse or neglect.</p> <p>On that same date, one member of the administrative staff confirmed that the facility did not have a written policy and procedure for screening potential employees.</p>	F 000			
F 281 SS=A	<p>483.20(k)(3)(i) RESIDENT ASSESSMENT</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, record review, and staff interview, it was determined that the facility failed to assure that nursing staff implemented facility policy and procedure to date and initial multiple</p>	F 281			

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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F 323 SS=D	<p>use vials upon initial use for two (2) of two (2) vials in use. Facility census 91.</p> <p>Findings include:</p> <p>a) The emergency medication box located on the second floor was reviewed on 8/23/00.</p> <p>The box contained a multiple use vial of Vistaril for injection and another of Thorazine. Both had been opened and used. Neither were dated or initialed to identify when or by whom the medications were first used.</p> <p>When interviewed, the nurse confirmed that the facility required nursing staff to date and initial multiple dose vials upon initial use. She also confirmed that the two (2) vials in question had not been dated or initialed.</p> <p>Review of the facility policy and procedure revealed that nursing staff were required to date and initial multiple dose vials upon initial use.</p> <p>The accepted professional standard of clinical practice is to date and initial multiple dose vials upon initial use so as to avoid administering a contaminated drug.</p> <p>483.25(h)(1) QUALITY OF CARE</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>Based on observation and staff interview, it was determined that the facility failed to assure that the resident environment remains as free of</p>	F 323	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.		

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F 364 SS=F	<p>accident hazards as possible during one (1) random observation. Facility census 91.</p> <p>Findings include:</p> <p>a) The nurse was observed as she performed a treatment on 8/22/00. During the treatment, the nurse was in the resident's room behind a privacy curtain with the door to the room closed.</p> <p>The treatment cart remained in the hall throughout the treatment, unlocked and unsupervised.</p> <p>Other residents were in the hallway during the procedure, and could have accessed the treatment cart at any time. The cart contained various ointments and topical medications, as well as scissors, other sharp instruments, and plastic trash bags. A cognitively impaired resident could have inflicted harm upon himself or others with some of the items or could have ingested some of the topicals.</p> <p>During an interview, the nurse confirmed that the treatment cart was left unlocked and unsupervised.</p> <p>483.35(d)(1)&(2) DIETARY SERVICES</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observations and staff interviews, it was determined that each resident was not provided with food that was at the proper</p>	F 364	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.		

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	<p>temperature at the time it left the kitchen nor at the point of service to the resident. Additionally, the food was not always served in a manner that maintained its nutritive value and appearance. This has the potential to affect all residents who consume food by oral means as food for all residents are prepared and served from this central location.</p> <p>Findings include:</p> <p>a) Prior to serving the last resident on the first floor at dinner, the temperatures of the food was taken and found to not be at professionally accepted temperatures. On 8/22, the trays were delivered to the first floor at 5:15 p.m. The last tray was taken from the cart to be served at 6:45 p.m. This resulted in a one and one-half (1 1/2) hour time span from the time the trays arrived until they were all served. The temperatures were taken and found to be: tomato soup 96 F, pureed tomatoes 67 F, pureed cheese sandwich 70 F, and pureed fruit 71 F. The acceptable ranges for hot food at the time of service to the resident is 120 F or above and for cold food, 50 F or below.</p> <p>b) During observations of the evening meal service in the kitchen on 8/22 it was found that pureed cheese sandwiches were not at the professionally acceptable temperature of 41 F or below. The temperature was taken at 4:50 p.m. and revealed that the sandwiches were 47 F.</p> <p>c) At this same meal, a resident's tray card indicated that they did not like crust on bread. The appearance of the sandwich was affected due to staff manually taking the bread for the cheese sandwich and pulling the crust off. The edges of the bread were left jagged and</p>			

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F 444 SS=E	<p>indentations from the staff member's fingers were seen on the bread. The staff took cheese and put it on this bread and placed it in a baggie, then on the resident's tray.</p> <p>d) The evening menu indicated that the cheese sandwiches should have been grilled, not plain. All the plain sandwiches were served in sandwich baggies and then on the residents' trays. This did not make the trays look attractive.</p> <p>e) During observations of the dietary department, raw, peeled, cup-up potatoes were observed soaking in water in a large pan that was sitting in the sink. The staff indicated that these potatoes were to be used the next day and would be placed in the refrigerator prior to closing the kitchen for the evening. Later, the potatoes were observed in the refrigerator soaking in water. This practice does not conserve the nutritive value of the potatoes.</p> <p>All the above issues were discussed with the dietary staff on 8/23/00 at mid-morning. RH</p> <p>483.65(b)(3) INFECTION CONTROL</p> <p>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.</p> <p>Based on observation and staff interview, it was determined that the facility failed to implement appropriate handwashing according to accepted professional practice. Five (5) staff members did not employ handwashing as indicated by standards of practice.</p>	F 444	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.		

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F 368 SS=C	<p>Findings include:</p> <p>a) A nurse was observed as she performed a treatment on 8/22/00. The nurse failed to wash her hands after the treatment was completed.</p> <p>The nurse confirmed during an interview, that she forgot to wash her hands.</p> <p>b) On 8/22/00, three (3) staff members were observed as they served dinner trays immediately after handling the trash cans. The three (3) staff members did not wash their hand after handling the trash cans and before serving the trays.</p> <p>On 8/23/00, a fourth staff member was observed during lunch. She served trays immediately after she handled the trash can without washing her hands.</p> <p>483.35(f)(1)-(3) DIETARY SERVICES</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p>	F 368	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.		

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	<p>Based on observations and interviews, it was determined that each resident is not offered a snack at bedtime daily. This practice has the potential to affect all residents who can consume snacks by oral means.</p> <p>Findings include:</p> <p>a) While conducting individual resident interviews, it was discovered that all residents are not offered snacks at bedtime as required. They stated that you can get a snack if you ask for it, but they are not routinely offered.</p> <p>b) On 8/23/00, beginning at 7:50 p.m., the distribution of snacks was observed. At 8:15 p.m., the first floor staff began to pass the snacks that had been sent on a tray from dietary. There were some peanut butter sandwiches and drinks on the tray labeled with specific resident's names. Those snacks were based on what was approved according to their dietary regimen or what was known as a specific snack request by the individual.</p> <p>A resident who had commented, during an interview, "Once in a blue moon they might bring me a peanut butter sandwich". As the snack pass was going on, a staff member went into this resident's room to deliver a snack to the roommate. The staff member offered the roommate her snack, but did not ask the other resident if she would like something. When prompted by the surveyor, the staff member asked the other resident if she would like something as a snack and the resident said she would take some ice cream.</p> <p>c) Interview with the staff on the second floor</p>				

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	revealed that it could not be verified that all the residents were offered a snack every evening. A staff member stated that snacks are not usually passed until 9:00 or 9:30 p.m. and that residents could ask for something if they got hungry a little later. RH			