

WV DHHR, Office of Health Facility Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>506145</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WYNGATE OF WEIRTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 WYNGATE DRIVE Weirton, WV 26062</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 108	<p>64CSR14-5.2.b. The Licensee</p> <p>The licensee shall protect the physical and mental well-being of residents. (Class II)</p> <p><b>DEFICIENT PRACTICE and FINDINGS:</b></p> <p>Based on review, interview and observation on December 7, 2009, the administrator has failed to ensure the physical well-being of a resident is maintained.</p> <p>1. During interview on December 7, 2009, the administrator stated Resident #51 received burns on December 1, 2009, at approximately 8:35 a.m., when she apparently rolled out of her bed onto the base board heater in her room. The administrator stated Resident #51 is confused and did not use her call bell or call out for help. She had returned from a hospital admission on November 30, 2009 and staff were conducting more frequent monitoring. After conducting an investigation, the administrator determined Resident #51 had been in contact with the heater for approximately thirty-five (35) minutes.</p> <p>2. During observation, Resident #51 was observed to have burns covering the anterior and lateral aspects of her left thigh approximately twelve (12) inches in length. This was one (1) extensive burn which wrapped around her thigh. A circular burn, approximately six (6) inches is observed to her left lateral abdomen and a burn, in an oval shape, and approximately six (6) inches in length is noted to the area just below her left knee and extending to her left lateral calf.</p> <p>3. Record review revealed Resident #51 has a</p>	E 108	<p>Directed Plan of Correction:</p> <p>The administrator will take steps to ensure base board heaters in all residents rooms and throughout the facility are incapable of burning an individual if they should inadvertently come in contact with them.</p> <p>Date of Completion:</p> <p>January 30, 2010</p>	

Office of Health Facility Licensure and Certification  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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E 004	<p>diagnosis of moderate dementia. On December 2, 2009 the physician ordered Dilaudid 2 mg., one (1) hour prior to dressing changes with Silvadene, 4x4s and kling to secure the dressing.</p> <p>4. During interview, staff stated the base board heaters do become very hot, and an individual could be burned by inadvertently touching the heaters.</p> <p>Complaint Investigation</p> <p>#WV00005383 December 7, 2009 Census: 54</p> <p>Surveyors: Jane Cost, RN HFNS II Louise Hall, RN HFNS II December 14, 2009 Census 54</p> <p>Surveyors: Jason T. Lintner</p>	E 004	<p>Directed Plan of Correction:</p> <p>The administrator will take steps to ensure base board heaters in all residents rooms and throughout the facility are incapable of burning an individual if they should inadvertently come in contact with them.</p> <p>Date of Completion:</p> <p>January 30, 2010</p>	
E 252	<p>64CSR14-11.1.b. Physical Facilities</p> <p>The licensee shall provide maintenance and housekeeping to the interior and exterior of the residence that maintains a safe, sanitary, and accident free living environment. (CLASS I)</p> <p>DEFICIENT PRACTICE and FINDINGS:</p>	E 252	<p>December 14, 2009</p> <p>Directed Plan of Correction:</p> <p>1. The surface temperatures of the heating units in the residents' rooms is considered an immediate and serious threat both to the risk of bodily injury and the risk of fire. An immediate solution must be devised to eliminate this risk. The heating units must be either covered or blocked in a safe manor so that they</p>	

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	<p>Based observations made on December 14, 2009, the administrator failed to maintain a safe and accident free living environment.</p> <ol style="list-style-type: none"> <li>The temperature measured on the surface of the base board heating unit in Resident #51's room ranged from approximately one hundred thirty-five degrees Fahrenheit (135 F) to two hundred thirty-three degrees Fahrenheit (233 F). This unit was open to touch and created the risk of bodily injury and possibly fire.</li> <li>Additionally, the surface temperature on the wall directly above Resident #51's heating unit measured approximately one hundred sixty-four degrees Fahrenheit (164 F), creating the potential for fire.</li> <li>The surface of the window sill above Resident #51's heating unit appeared to be bubbling or peeling due to the heat.</li> <li>Some of the residents' beds located within close proximity on the same hallway of Resident #51's room posed an extreme risk of burning to residents due to the same type of heating units should these residents fall from their bed and become pinned against the surface of the unit.</li> <li>Various combustible materials (i.e., furniture, curtains, decorations, bedding, etc.) were situated within close proximity of the heating unit in Resident #51's room and other rooms observed creating the possibility of fire.</li> <li>The administrator and maintenance director reported to the surveyor all Roma heating units were the same in the residents' rooms.</li> </ol>		<p>are untouchable by anyone other than the appropriate personnel but still allows for the appropriate atmospheric temperatures. or replacing the units with a safe alternative.</p> <ol style="list-style-type: none"> <li>All combustible materials including, furniture, beds and bedding, decorations, curtains, etc., must be restricted to a distance of no less than three feet (3 ft.) away from the the heating units.</li> <li>The surface temperatures of the heating units and the surrounding walls and the aforementioned distance requirements in all resident rooms must be monitored for compliance daily by the administrator or designee and a log kept for surveyor review.</li> <li>A policy must be written and implemented to include, at a minimum, the distance requirements, the daily logs, and family notification of the requirements.</li> </ol> <p>Completion Date: February 11, 2010</p>	