

WV DHHR, Office of Health Facility Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2021
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MEMORIES (ALR/ALZ)	STREET ADDRESS, CITY, STATE, ZIP CODE 301 WILSON LANE Elkins, WV 26241
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E 423	<p>Activities.</p> <p>Provide a monthly calendar that lists the type, time, and duration of all social and recreational activities for the residents and documentation that activities did or did not take place. (Class III)</p> <p>Based on documentation review and interview, the facility failed to ensure to provide a monthly calendar that listed the duration of all social and recreational activities for the residents and documentation that the activities did or did not take place in a six (6) month period. This practice had the potential to affect all residents who resided on the assisted living side of the facility. Facility census: 39.</p> <p>Findings included:</p> <p>1. Documentation review of assisted living monthly calendars, dated November and December 2020 and January, February, March, and April 2021 revealed no documented evidence of the duration of all social and recreational activities for the residents or documentation that the activities did or did not take place.</p> <p>2. In an interview, on 04/08/20 at 10:45 a.m., Executive Director #29 verified the assisted living monthly calendars, dated November and December 2020 and January, February, March, and April 2021 contained the start time, but not the duration of all social and recreational activities for the residents or documentation that the activities did or did not take place.</p>	E 423	<p>Date of Survey: 04/08/21</p> <p>Plan of Correction:</p> <p>E423</p> <p>The Executive Director met with the Activities Director(s) and Assistant to discuss this requirement.</p> <p>All were made aware of the immediate need to add duration of each activity to the calendar.</p> <p>Also, to place a Y (yes) and/or N (no) next to each activity listed on the calendar indicating if the activity was performed or cancelled.</p> <p>Lastly, the Activity Director and/or Assistant are to initial after the Y or N, showing who was responsible for the implementation or cancellation of the activity.</p> <p>Completed by Executive Director 04/20/21.</p>	04/20/21
E 398	Accident, Illness, and Major Incident Procedure	E 398	Date of Survey:	04/30/21

Office of Health Facility Licensure and Certification LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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04/30/2021

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	<p>Staff shall monitor and document the resident's condition at least once every eight hours for a period of 24 hours following the accident or the onset of the illness, more frequently if specified by the licensed health care professional, or at least every four hours if the resident suffers from Alzheimer's disease or a related dementia and cannot communicate his or her condition or needs. (Class II)</p> <p>Based on record review and interview the staff failed to monitor and document the resident's condition following an accident, every four hours for three (3) residents who suffered from Alzheimer's disease or a related dementia, for a period of 24 hours. Resident identifiers: #5, #12, and #17. Facility census: 12.</p> <p>Findings included:</p> <p>Record Review:</p> <p>a) Resident #5</p> <p>On 04/06/21 at 12:00 PM: Review of "Unusual Incident/Injury Report" on Resident #5, on 09/18/20 at 9:05 PM revealed an unwitnessed fall. Resident stated that "she hit the left back side of her head, her left knee, and her left side torso (rib cage area). She denied any pain or discomfort at this time but stated that she would probably have a headache later" A nurses note at 09/18/20 at 9:48 PM documented the fall. At 9:54 PM the facility notified residents medical power of attorney. No further documentation until 09/19/20 at 9:44 AM. Fall follow-up was documented and at 3:29 PM documented resident denied pain of discomfort.</p> <p>b) Resident #12</p>		<p>04/08/21</p> <p>E398</p> <p>1. DON met with all LPN's at the time of inspection and discussed the 4/8 hour charting requirements.</p> <p>On 4/20/21, all LPN's were inserviced on deficiencies and are aware of the 4 hour charting for any resident with a diagnosis of alzheimers disease or dementia which applies to both Memory Care Program and Assisted Living Program.</p> <p>Completed by Executive Director and DON 4/22/2021.</p> <p>2. DON developed a Neuro Checklist for all LPN's to use when charting on the resident's condition after an incident DON will monitor incident reports and neuro checklist for all residents daily.</p> <p>Completed by DON daily and ongoing 04/09/21.</p>	

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	<p>Review of "Unusual Incident/Injury Report" on Resident #12, on 01/04/21 at 11:25 AM had an unwitnessed fall with complaint of "pain and some discomfort to head" Neuro checklist was documented once on day shift once on evenings and once on nights.</p> <p>c) Resident #17</p> <p>Review of "Unusual Incident/Injury Report" on Closed Record #17. Resident fell 11/28/20, he had a change of neuro status and was sent to the hospital. The form the facility used for "Neuro Checklist" were for every 8 hours shifts, there was documentation on 11/27/20, 11:00 PM to 7:00 AM shift and 11/28/20, 7:00 AM to 3:00 PM shift. Then out of facility on the 3:00 PM to 11:00 PM. There was no other documentation found to suggest the neuro checks were completed every 4 hours as mandated for residents with cognitive impairments.</p> <p>During a review of above documentation with Director of Nursing (DON) #50 she said she was not aware that residents with Dementia's were to be documented on every four (4) hours and she would change the "Neuro Checklist" to be documented on every 4 hours. Spoke with Director of Memory Care, Licensed Practical Nurse (LPN) #2 . He too said he was not aware this was to be done every 4 hours on those with dementia's.</p> <p>At 2:00 PM the DON brought in the new "Neuro Checklist" which was to be completed every four (4) hours to meet the regulations. She said she had destroyed all the old forms and replaced them with the new ones and would educate the staff of the changes.</p>			

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E 382	<p>Medications and Treatments.</p> <p>A prescription or written or verbal order from a professional authorized by state law to prescribe medications is required for obtaining, altering, discontinuing, and administering or self-administering prescription and over-the-counter medications, treatments, and therapies. The licensee shall keep copies of the prescriptions or written orders in the resident's record. (Class I)</p> <p>Based on record review and interview, the facility failed to obtain a written or verbal order from a nurse practitioner a for the discontinuation of an order prior to dosage adjustment for two (2) of 12 residents. Resident #3 had two current orders for Levothyroxine but was only receiving one of the medications. Resident #4 had two (2) current orders for Vitamin D3 1000 units. Resident identifiers: #3, and #4. Facility census: Assisted Living: 39. Memory Care: 12.</p> <p>Findings included:</p> <p>a) Resident #3</p> <p>Reconciliation of Medication Administration Records (MAR), with the Physician's orders revealed: Resident #3, had an order for Levothyroxine 150 microgram (mcg) daily, order date 01/12/21 and Levothyroxine 175 mcg daily, order date 03/02/21 on the MAR. These two orders for Levothyroxine was also on the current Physician's Orders, current orders as of 04/08/21 9:13 AM.</p> <p>The MAR had both medications signed off as given. This information was shown to Director of Nursing #50 who reviewed the chart and could</p>	E 382	<p>Plan of Correction:</p> <p>Date of Survey: 04/08/21</p> <p>E382</p> <p>1. Michelle Sigley, RN DON spoke with the NP who did not D/C the initial orders, before writing the second.</p> <p>NP said she understood the need to discontinue the 1st order prior to writing the 2nd order.</p> <p>Completed by Michelle sigley on 4/8/2021</p> <p>2. All LPN's were inserviced on the deficiency on 4/20/21 by the Exective Director and DON.</p> <p>The LPN's are to be diligent and alert to all medication listed on the MAR.</p> <p>Completed by ED and DON 4/20/2021.</p> <p>3. The DON will complete a monthly medication review of all residents and all medication, to assure all orders are correct and accurate. Completed by DON 4/20/2021 and on going.</p> <p>4. PCC (Point Click Care) is now our Community Healthcare software. The program is designed to recognize potential med errors, including 2 orders for the sam medication.</p> <p>A red flag will show for this and the</p>	04/30/21

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	<p>not find an order to discontinue the 03/02/21 order prior to starting the 04/08/21 medication. She agreed it was a strange order and she would notify Nurse Practitioner (NP) #61 to see the intended dosage for this medication.</p> <p>At 10:00 AM, DON #50 said she had spoken with NP #61 who was only intending for resident to receive the Levothyroxine 175 mcg daily. She said she thought she had written a change order. DON #50 told her, "no such order existed." DON #61 checked the actual medications in the resident's bubble-pack and it contained only the Levothyroxine 175 mcg. She then clarified with the pharmacy that they were only sending the Levothyroxine 175 mcg. Pharmacy confirmed they had not been receiving any double dose of the medication; but it was not removed from the electronic MAR. She said the nurses were "clicking off both doses as given when, in actuality, was only receiving the Levothyroxine 175 mcg." She said she was going to address this with the nurses. She had received a fax from NP #6 discontinuing the order for the Levothyroxine 150 mcg.</p> <p>b) Resident #4</p> <p>Reconciliation of Medication Administration Records (MAR), with the Physician's orders revealed Resident #4 had an order for Vitamin D3, 1000 Units, take 2 tablets by mouth daily originally written on 04/05/21 and an additional order for Vitamin D3, 1000 Units take 1 tablet by mouth daily prescribed 07/06/20. Both medications were documented as given. Showed this information to DON #50 who reviewed the chart and could not find an order to discontinue the 07/06/20 order prior to starting the 04/05/21 medication. She agreed it was a</p>		<p>LPN/RN will not be able to continue routine without addressing the red flag.</p> <p>The DON is notified of any and all red flags.</p> <p>Completed by DON 4/30/21</p>	

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E 001	<p>strange order and she would notify NP #61 to see the intended dosage for this medication.</p> <p>At 10:00 AM, DON #50 said she had spoken with NP #61 who was only intending for resident to receive the Vitamin D3, 1000 Units take 2 daily. She said she thought she had written a change order. DON #50 told her, "no such order existed." DON #61 checked the actual medications in the resident's bubble-pack and it contained only the Vitamin D3, 1000 Units 2 tablets. She then clarified with the pharmacy that they were only sending the Vitamin D3, 1000 Units 2 pills daily. Pharmacy confirmed the resident had not been receiving any double dose of the medication; but it was not removed from the electronic MAR. She said "the nurses were clicking off both doses as given when was only receiving the Vitamin D3, 1000 Units 2 tablets daily." She said she was going to address this with the nurses. She had received a fax from NP #6 discontinuing the order for the Vitamin D3, 1000 Units, \bd tablet daily but the order was still unclear and she had sent for further clarification on this order. She said she was going to review all the residents MARs for accuracy.</p> <p>Initial Comments</p> <p>CHOW survey</p> <p>Enter: 04/05/21 at 9:15 a.m.</p> <p>Exit: 04/08/21 at 1:00 p.m.</p> <p>Census: AL - 39 MC (Terrace Club only) - 12</p>	E 001	<p>Plan of Correction:</p> <p>Date of Survey: 04/08/21</p> <p>E382</p> <p>1. Michelle Sigley, RN DON spoke with the NP who did not D/C the initial orders, before writing the second.</p> <p>NP said she understood the need to</p>	04/30/21

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			<p>discontinue the 1st order prior to writing the 2nd order.</p> <p>Completed by Michelle sigley on 4/8/2021</p> <p>2. All LPN's were inserviced on the deficiency on 4/20/21 by the Exective Director and DON.</p> <p>The LPN's are to be diligent and alert to all medication listed on the MAR.</p> <p>Completed by ED and DON 4/20/2021.</p> <p>3. The DON will complete a monthly medication review of all residents and all medication, to assure all orders are correct and accurate. Completed by DON 4/20/2021 and on going.</p> <p>4. PCC (Point Click Care) is now our Community Healthcare software. The program is designed to recognize potential med errors, including 2 orders for the sam medication.</p> <p>A red flag will show for this and the LPN/RN will not be able to continue routine without addressing the red flag.</p> <p>The DON is notified of any and all red flags.</p> <p>Completed by DON 4/30/21</p>	