STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515085	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS CENTER	**723 SUMMERS STREET Parkersburg, WV 26101**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS . An unannounced complaint survey was conducted at Willows Center on 07/01/19 to 07/02/19. The deficiencies contained in this report are based on observations, review of residents' clinical records, resident interviews, family interviews, and staff interviews, and/or review of other facility documentation as indicated. The facility's census on the first day of the complaint investigation survey was 96 residents. -- Complaint #22507 was unsubstantiated with unrelated deficiencies cited. -- Complaint #22781 was unsubstantiated was unsubstantiated with unrelated deficiencies cited. .	F 000	Willows Center provides this plan of correction without admitting or denying the validity or existence of the/ alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 689 SS=E	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. . Based on observation and staff interview, the facility failed to provide an environment free from accident hazards over which it had control. The facility did not secure a hot steam table, chemicals, a box cutter, an oxygen tank, and	F 689	The Maintenance Director installed a cabinet lock on the cabinet door for the controls to the Transitional Care Unit steam table on 7/1/2019 at 11:15 am. The Director of Dining Services re-educated all of the dietary staff on duty at 10:00 am on 7/1/2019 to utilize the steam tables as "dry wells" utilizing no water. Dietary staff were educated to turn on the dry wells when food is brought out for service, remain with the dry wells at all times while in use and that cabinets underneath the steam tables must be locked at all times to ensure residents are unable to turn on the steam tables.	07/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/30/2019

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	shaving razors, from residents. Room identifiers: West Hall Respiratory Room, West Hall Shower Room, East Hall Shower Room, and the Transitional Care Dining Room. Facility census: 96. Findings included: a) Transitional Care Dining Room An observation of the Transitional Care Dining Room, on 7/01/19 at 9:20 AM, revealed the room had an unsecured steam table with multiple bins. No staff or residents were present at the time of the observation. The room and the area where the steam table was located is on a resident hallway and is accessible to anyone at any time. One of the steam bins was hot to touch and was observed to be filled with approximately two inches of water. The water was also hot. The water was tested to be 125 degrees Fahrenheit with both the facility's and surveyor's thermometers. The controls for the steam table were underneath the table in an unsecured cabinet. One of the steam table's controls was set on level 4 heat. The dial has an off setting along with 1 through 7, with 7 being the hottest setting. The steam table could be reached from a sitting or standing position. An immediate interview with the Administrator, on 07/01/19 at 9:30 AM, revealed that he could not explain why the steam table was heated. The Administrator immediately turned the steam table control to off. The Administrator stated "I am not sure why there is water" in the steam table bin. The Administrator verified the Transitional Care Dining Room is open to anyone at any time. The Administrator stated the heating controls for the steam table have never been		Dietary Staff not available during this time frame will be provided re-education, including post-test to validate understanding by the Director of Dining Services/designee upon day of return to work prior to the first meal service. New dietary hires will be provided education and post-tests to validate understanding during orientation by the Director of Dining Services/designee. Education with all dietary staff was completed on 7/16/19. On 7/1/2019., the Maintenance Director F 689 i replaced the locks on the east and west shower room storage cabinets immediately upon discovery. On 7/2/2019 the Maintenance Director placed the keys to the shower room storage cabinets in a location within that shower room that is separate from the location of the cabinets. On 7/3/2019, the Maintenance Director ordered keypad locks for the east and west shower room doors. The keypad locks were installed upon delivery by Maintenance Director on 7/12/19. The Administrator met with resident council on 7/30/19 to review locking of the shower doors to maintain resident safety with no concerns voiced. On 7/1/2019, the Licensed Practical Nurse identified as LPN#1 locked the respiratory supply closet immediately upon discovery. On 7/2/2019 the Maintenance Director replaced the lock on the respiratory supply closet door with an automatic locking door knob.	

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	locked. The Administrator verified anyone can turn the heat on and off for the steam table. An interview with the Dietary Aide (DA) #1, on 07/01/19 at 10:20 AM, revealed she had turned the steam table on at 9:00 AM in the Transitional Care Dining Room. The DA stated she usually returns to the Transitional Care Dining Room at 10:30 AM to start lunch preparation. The DA stated she turns the steam table with the bin of water on at 9:00 AM in efforts to achieve a temperature between 140 and 160 degrees Fahrenheit by the time she returns at 10:30 AM for lunch preparation. The DA stated she does not stay in the dining room to oversee the steam table from 9:00 AM to 10:30 AM. The DA stated this is a daily practice for her. An interview with the Administrator, on 07/01/19 at 10:45 AM revealed he had no idea the dietary staff were heating the steam table and not securing it. The Administrator agreed the heat controls needed secured and stated he was in the process of getting the cabinets locked. The Administrator stated the heated steam table should have never been left unsecured or unsupervised once turned on. b) West Hall Respiratory Room An observation of the West Hall Respiratory Room, on 07/01/19 at 9:00 AM, revealed the room was unlocked. The room contained a box cutter lying on a shelf with the blade exposed. An interview with Licensed Practical Nurse (LPN) #1, on 07/01/19 at 9:05 AM, revealed the room is always unlocked. The LPN stated she had no idea where the box cutter came from.		On 7/2/19 the Director of Nursing (DON) removed the oxygen cylinder and the uncapped razors from the east hall shower room. 2) All residents of the facility have the potential to be affected. The Nursing Home Administrator (NHA) audited all dining areas in the facility equipped with steam tables on 7/1/2019 at 10:00 am with no additional corrective action required. On 7/24/19 the DON completed a review of all resident incident reports from 5/1/2019 to 7/24/19. No residents were identified as having experienced a burn from touching a steam table. The NHA audited all storage supply closets and shower room cabinets on 7/2/2019, with any corrective action immediately upon discovery. The DON and NHA audited all shower rooms on 7/22/19 for oxygen cylinders and uncapped razors with any corrective action immediately upon discovery. 3) The Director of Dining Services/designee re-educated all of the dietary staff on duty beginning at 10:00 am on 7/1/2019 through 7/31/19 to utilize the steam tables as "dry welts" and to stay with the steam tables at all times when in use with a posttest completed to validate understanding. Dietary Staff not available during this time frame will be provided re-education, including posttest to validate understanding, by the Director of Dining Services/designee upon day of return to work prior to the first meal	

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	c) West Hall Shower Room An observation of the West Hall Shower Room, on 07/01/19 at 9:10 AM, revealed the room was unlocked. Inside the room there were unlocked cabinets that contained the following items: -Two (2) containers of "Virex 256 Disinfectant Cleaner and Deodorizer" with the warning "Keep out of reach of children-Avoid contact with skin and eyes." -Five (5) containers of "Medspa Shave Cream" with the warning "Keep out of reach of children." -Three (3) containers of "Remedy Phytoplex Cleanser" with the warning "For external use only." -One (1) container of "Jovan White Musk" with the warning "Inhalation can be fatal." An interview with LPN #1, on 07/01/19 at 9:12 AM, revealed the shower rooms are never locked. The LPN stated the cabinets are "usually locked." The LPN stated she would ensure the cabinets were locked. d) East Hall Shower Room An observation of the East Hall Shower Room, on 07/01/19 at 9:14 AM, revealed the room was unlocked. Inside the room there were unlocked cabinets that contained the following items: -Two (2) containers of "Virex 256 Disinfectant Cleaner and Deodorizer" with the warning "Keep out of reach of children-Avoid contact with skin and eyes."		service. New Dietary employees will be provided education and posttests to validate understanding during orientation by the Director of Dining Services/designee. The DON/designee will re-educate all staff members on or before 7/31/2019 regarding the requirement to ensure that the resident's environment remains free of accident hazards as is possible to include that all storage closets, shower room cabinets and doors are locked in order to prevent unmonitored resident access and to ensure oxygen cylinders are not stored in the shower rooms, and items that contain the warnings "for external use only, keep out of reach of children-Avoid contact with skin and eyes, inhalation can be fatal" and uncapped razors are secured and stored appropriately. Staff not available during this timeframe will be provided reeducation, including post-test to validate understanding, by the DON/designee upon day of return to work. All new employees will be provided education and post-test to validate understanding during orientation by the DON/designee. The Director of Dining Services/designee will audit beginning on 7/2/2019 all areas of the facility equipped with steam tables across all meals daily X 2 weeks, including weekends and holidays, then 3 days per week X 2 weeks, then randomly thereafter, to ensure that steam tables are being used as "dry wells" and that	

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	-One (1) oxygen tank stored on the back of a wheelchair. -Two (2) uncapped razors. An interview with LPN #2, on 07/01/19 at 9:16 AM, revealed the shower room is not locked. The LPN stated she was unaware the cabinets in the shower room were unlocked. The LPN stated she would ensure they secured. An interview with the Director of Nursing (DON), on 07/02/19 at 8:30 AM, revealed she was not aware the oxygen tank was in the shower room. The DON stated she would ensure it was stored appropriately. A review of the facility policy "NSG225 Oxygen: High Pressure Cylinders" with a review date of 03/01/16, was reviewed on 07/02/19. The policy stated "full and empty oxygen cylinders in a storage area must be properly supported in a cylinder stand, cart, or secured to the wall with a chain." . 483.20(f)(5); 483.70(i)(1)-(5) Resident Records -		staff remain with the steam tables white turned on. The NHA/designee will audit beginning on 7/8/2019 all storage supply closets and shower room cabinets across all shifts daily x 2 weeks, including weekends and holidays, then 3 x per week, then randomly thereafter to ensure that closets and cabinets are locked in order to prevent unmonitored resident access. The DON/designee will audit all shower rooms beginning 7/23/19 across all shifts daily x 2 weeks, including weekends and holidays, then 3 x per week, then randomly thereafter to ensure shower rooms are locked when unattended by staff, oxygen cylinders are not stored in shower rooms, and items that contain the warnings "for external use only, keep out of reach of children-Avoid contact with skin and eyes, inhalation can be fate and uncapped razors are secured and stored appropriately. 4) The results of audits will be reported by the NHA/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the (VC committee.	

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F 842 SS=D	Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors,	F 842	1) On 7/3/2019, the Health information Coordinator entered the required information of dates and allergies onto the April 2019 Medication Administration Record (MAR) for resident #6. 2) All residents of`the facility have the potential to be affected. On or before 7/31/2019, the Health Information Coordinator audited all MARS from January 2019 to April 2019 ensure that the correct information, Including dates of the month/year of the record is at the top of the MAR, with any corrective action immediately upon discovery. On 4/28/2019, Willows Center began using an electronic medical records system, including electronic MARS, that automatically places the required information onto the residents MAR. 3) The Director of Nursing (DON)/designee will re-educate all licensed nursing staff on or before 7/31/2019 regarding maintain medical records that are complete and accurately documented to ensure that MARs include all appropriate information, including date of month/year of the record with a posttest to validate understanding. Licensed Nursing Staff not available during this time frame will be provided re-education, including post-test to validate understanding by the DON/designee upon day of return to work. New licensed nursing staff will be provided education and post-test to validate understanding during orientation by the DON/Designee.	07/31/19

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	and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. . Based on medical record review and staff interview, the facility failed to maintain complete and accurate medical records. A resident's Medication Administration Record (MAR) did not contain dates for the month of April 2019. This practice affected one (1) of six (6) residents reviewed. Resident identifier: #6. Facility census: 96. Findings included:		The Director of Nursing/designee will audit beginning on 7/8/2019 all resident electronic MARs, including new admission and readmissions MARS monthly X 3 months then randomly thereafter to ensure that all information is included on the MAR, including dates of month/year. 4) The results of audits will be reported by the DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and/or in- , servicing until the issue is resolved and randomly thereafter as determined by the QIC committee.	

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	a) Resident #6 A review of the Resident's medical record, on 07/01/19 at 1:15 PM, revealed "Medication Administration Records" (MARs) with no dates as to which month the record was for. An interview with the Director of Nursing (DON), on 07/02/19 at 8:00 AM, revealed the MARS were for April of 2019. The DON stated "I have no idea why these are not dated." The DON stated she would ensure the records were dated accurately. .			
F 880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to	F 880	1) Licensed Practical Nurse (LPN) identified as LPN #7 placed the "STOP: Please see Nurse before entering the room" sign on the door of resident #7's room on 7/1/2019. 2) All residents of the facility have the potential to be affected. On 7/1/2019 the Nursing Home Administrator audited the facility to ensure that "STOP: Please see nurse before entering the room" signs were in, place for residents on contact precautions. During the time of the audit, there were no additional residents in the facility on contact precautions. 3) The Director of Nursing (DON)/designee will re-educate on or before 7/31/19 all nursing staff regarding the requirement that the facility must establish and maintain an infection prevention and control program	07/31/19

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	§483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.		designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections including ensuring that "STOP: Please see Nurse before entering the room" sign are placed onto the door frame of the residents room when a resident receives an order for contact precautions. Nursing Staff not available during this timeframe will be provided re-education, including post-test to validate understanding by the DON/Designee upon day of return to work. New Nursing staff hires will be provided education and post-test during orientation by the DON/Designee. The DON/Designee will audit beginning on 7/8/2019 all resident rooms with residents who are on contact precautions across all shifts daily x 2 weeks, including weekends and holidays, then 3 x per week x 2 weeks, then randomly thereafter to ensure that the "STOP: Please see Nurse before entering the room" sign is placed on the door frame when a resident is placed in contact isolation. 4) The results of audits will be reported by the DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC committee.	

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§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
.
Based on observation, medical record review, staff interview, and policy review, the facility failed to provide a safe and sanitary environment that prevented the development and transmission of communicable diseases and infections. A resident on contact precautions did not have a sign on the door advising anyone entering the room to stop and to see the nurse before doing so. This was a random observation. Resident identifier: #7. Facility census: 96.

Findings included:

a) Observation

A random observation of the East Hallway, on 07/01/19 at 8:55 AM, revealed an isolation cart outside the door of Resident #7. There was no sign on the door advising anyone what to do before entering the room.

b) Interview

An interview with Licensed Practical Nurse (LPN) #2, on 07/01/19 at 8:58 AM, revealed Resident # 7 is on contact precautions. The LPN stated there should be a stop sign on the door advising anyone entering the room to see the nurse. The LPN obtained a sign from the isolation cart by the room and posted it on the door.

c) Record Review

A medical record review for Resident #7, on

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	07/01/19 at 11:00 AM, revealed the Resident had the physician order "Contact Precautions" dated 06/29/19. d) Policy Review A review of the facility policy "IC301 Contact Precautions" with a revision date 06/15/19, was conducted on 07/01/19. The policy stated "Place a STOP-Please see nurse before entering the room sign on the door" for residents on contact precautions. .			