| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515181 | A. Building<br>B. Wing | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ohio Valley Health Care | 222 Nicolette Road<br>Parkersburg, WV 26104 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>.<br><br>Based on record review and staff interview the facility failed to comply with the Medical Power of Attorneys' (MPOA) wishes regarding administration of immunizations. This was true for two (2) of six (6) immunizations reviewed during the long term care survey process. Resident identifiers: #35 and #36. Facility Census: 42<br><br>Findings included:<br><br>a) Resident #35<br><br>On 08/26/24 at 1:27 PM, a record review found Resident #35 received a COVID vaccine without consent.<br><br>Review of the Medication Administration Record shows Resident #35 received Comirnaty 2023-24 (12y up) (COVID vac 2023-24) Suspension; 30 mcg/0.3 ml, administered 0.3 ml intramuscular COVID vaccine on 02/02/24 by Registered Nurse (RN) #24.<br><br>A progress note dated 01/05/24 at 5:52 PM states Spoke with the POA son (name) regarding upcoming vaccines. Consented to RSV, Prevnar 20 (pneumonia) and Shingrix (Shingles) but no COVID vaccines were to be given This progress note was initiated and signed by RN #24.<br><br>The MPOA was notified of the administration of the COVID vaccine, as well as the Physician. According to the Incident Report and the reporting documentation to Office of Health Facility Licensure & Certification (OHFLAC) there were no adverse reactions. A new order was received from the Physician to monitor the resident for any changes in condition.<br><br>The facility provided education to the nursing staff of ensuring consents were on record for any immunizations administered. The Vaccination Consent form was redesigned in April 2024 to reflect consent or declination of all vaccines offered on one page to simplify the review of the Resident or responsible parties wishes. This was addressed in the Quality Assurance Performance Improvement QAPI meeting as well.<br><br>The above findings were confirmed with the Administrator and the Manager Quality RN #69 on 08/27/24 at 2:15 PM.<br><br>b) Resident #36<br><br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 08/26/24 at 1:26 PM, a record review found Resident #36 received a Shingrix (Shingles) vaccine on 07/22/24 by Manager Quality RN #69.<br><br>Additional record review shows Resident #36's Medical Power of Attorney signed a declination of the Shingrix (Shingles) vaccine on 06/24/24.<br><br>The MPOA was notified as well as the Physician. According to the review of the Incident Report and the reporting documentation to Office of Health Facility Licensure & Certification (OHFLAC) there were no adverse reactions. A new order was received from the Physician to monitor the resident for any changes in condition.<br><br>The facility provided education to the nursing staff of ensuring the right resident prior to administering any medication.<br><br>On 08/27/24 at 9:10 AM during an interview with the Director of Nursing she stated the nurse confused Resident #36 with another resident with a similar last name but residing on a different hall. It was confirmed at this time that the vaccine should not have been administered. |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>.<br><br>Based on record review, resident interview and staff interview, the facility failed to ensure resident safety for medication administration. Resident Identifiers: #3 and #13. Facility Census: 42.<br><br>The state agency notified the Nursing Home Administrator of the immediate jeopardy at 4:30 PM on 08/26/24. The facility submitted a plan of correction (POC) at 6:09 PM. At 6:25 PM, the POC was accepted by the state agency. The state agency verified the POC was implemented by conducting staff interviews and the immediate jeopardy was abated at 10:15 AM on 08/27/24.<br><br>Findings Include:<br><br>a) On 08/25/24 at approximately 11:25 AM, the resident was interviewed regarding receiving the wrong medication on 07/01/24. Resident #3 responded, I don't even know what medication I take, there is probably eight (8) or nine (9) of them.<br><br>On 08/26/24 at 11:30 AM, a review of the facility's reportables regarding medication errors was completed. The review found two (2) events occurred for two (2) different residents on 07/01/24 and 08/20/24. Resident #3 was administered the following medications in error: Norco 7.5/325mg (opiate for pain), Xanax 0.25mg (anti-anxiety) and Metoprolol 37.5mg (hypertension). Resident #13 was administered Lyrica 150mg (anticonvulsant used for pain control). Neither Resident #3 nor Resident #13 were ordered the medications that were administered.<br><br>On 08/26/24 at 11:50 AM, the Director of Nursing (DON) was interviewed regarding these events. The DON stated, The first event was a seasoned nurse, Registered Nurse (RN) #85 .the second event was LPN #94, who was on orientation with LPN #105.<br><br>The DON stated, There really isn't an excuse for the mistake RN #85 made, and the reason the event happened with LPN #94 is the seasoned nurse (LPN #105) was not with LPN #94 when the medication was administered.<br><br>On 08/26/24 at 12:20 PM, the DON stated, a disciplinary write-up and re-education regarding the rights of medication administration was provided to RN #85, at which time, the same education was provided to all nurses. LPN #94 was re-educated regarding the rights of medication administration as well.<br><br>On 08/26/24 at 2:00 PM, the sign-in sheets dated for 07/05/24 and 07/23/24 were reviewed. Of the 25 nurses employed by the facility, only 18 signed the acknowledgement sheets of attendance.<br><br>On 08/26/24 at 3:30 PM, Resident #13 was interviewed regarding the medication error. The resident stated, I knew something was wrong when they told me about taking my vitals all night. The nurse was scared, and she told me she was sorry for giving the wrong medication .I was afraid of what might happen to me .this has never happened<br><br>before.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The state agency notified the Nursing Home Administrator of the immediate jeopardy at 4:30 PM on 08/26/24. The facility submitted a plan of correction (POC) at 6:09 PM. At 6:25 PM, the POC was accepted by the state agency. The state agency verified the POC was implemented by conducting staff interviews and the immediate jeopardy was abated at 10:15 AM on 08/27/24.<br><br>b) Facility's Plan of Correction<br><br>IJ Abatement Plan<br><br>1. Resident #3 and Resident #13 were assessed by the Assistant Director of Nursing (ADON) on 8/26/2024 for any further possible adverse outcomes from the medication administration errors that occurred 07/01/24 and 08/20/24.<br><br>Med Pass observation to be completed by the ADON/ Designee on all current license nurses working this shift beginning on 8/26/24 at 5:30pm. Licensed nurses not available during this timeframe will be completed on their next scheduled shift.<br><br>2. All current residents of the facility have the potential to be affected.<br><br>3. The Director of Nursing (DON) will immediately initiate re-education beginning on 8/26/24 at 5:15pm to all licensed nurses that are working and prior to his/her next scheduled shift regarding medication administration process to include the 6 rights of administration to be completed by 9/5/2024. Licensed nurses not available during this timeframe will be provided reeducation including posttest prior to the next scheduled shift by the DON/ designee. New Licensed nurses during orientation will receive education prior to completion of orientation.<br><br>4. Nurse Med Pass observation will be monitored for 5 residents by the DON/ Designee daily during all shifts x 14 days then monthly during all shifts x 3 months with on-going as indicated by audits and monitoring.<br><br>The DON/ Designee will present results of medication admission audits or monitoring monthly to the Quality Improvement Committee for any additional follow up and/or in-serving . |