STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515012	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Barbara's Memorial Nursing Home	134 St Barbaras Road Monongah, WV 26554

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to dispose of garbage and refuse properly.This failed practice had the potential to affect all residents in the facility. Facility census: 48Findings Included:a) Observation and staff interview:On 08/12/25 at 2:45PM, during an observation walk around interview with Maintenance employee # 60 who acknowledged Dumpster #2 was observed to be heavily rusted and leaking around the bottom and the right side lid was hooved up and not [NAME] closing. He stated he would call the waste company and request a replacement dumpster to be sent out.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on staff and resident interviews, and observation The Facility failed to ensure residents rights to file grievances anonymously. This deficient practice had the potential to affect more than a limited number of residents. Facility census: 48 Findings included: Based on the facilities Grievance policy and Procedure, the residents have the right to file grievances without discrimination or reprisal. The facility will notify residents individually and through postings on the right to file grievances verbally, in writing, or anonymously. During Residential Council Meeting on 8/12/2025 at 1:30 PM, residents #18, #7, #39, and #42, were in attendance with capacity stated they normally just discuss concerns at Resident Council or talk to the social worker without fear of retaliation. When asked if they could file anonymously, they stated they did not know where or how.Based on record review of Section C of the most recent MDS record, Resident Council President #42 had capacity and was cognitively intact. Based on record review of Section C of the most recent MDS record verified Residents #18, #7, #39, and #45, had capacity and were cognitively intact. On 08/12/25 at 2:15PM, during an interview with Activities Director # 20, She confirmed the facility put a suggestion box up for the residents to file grievances and verified residents probably were not aware of it being used for grievances and the grievance forms were not in the same location where residents could fill it out anonymously.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 761 Based on staff Interviews and Record review the facility failed to keep an accurate record of the medication rooms refrigerator temperature logs. This failed practice was a random opportunity for discovery, and had the potential to affect all residents residing in the long term care facility that require temperature controlled medications.Resident Identifier: All residents with medications in refrigerator Facility Census: 48The facility FAILED TO MEET THE STANDARD OF PRACTICE as evidenced by the following findings: Findings Include:Record review: 8/11/2025 Medication room refrigerator log is missing days where it was checked/signed off on. Multiple days in August (6days) and July (5 days).August days - 8/3, 8/4, 8/5, 8/7, 8/10 and 8/11 - All missing documentation showing temps were checked for those days.July days - 7/3, 7/17, 7/24, 7/27 and 7/31 - all missing temp log sign off Interview: 8/11/2025 Director of Nursing #19 stated that it is the duty of the night shift to maintain the record and ensure temps are correct. She said there would be an Inservice performed to ensure this won't be missed anymore.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and policy review the facility failed to properly store food in accordance with professional standards. This is true for the facility kitchen Coolers and also 2 staff members not wearing proper hair covering during lunch meal prep. This had the potential to affect all residents in the facility. Facility census: 48Findings included:On 08/11/25 at 11:49 AM, during Initial Brief Tour of Kitchen, with The Dietary Manager #52 who acknowledged the following: 2 staff members without proper hair covering while preparing resident's lunch, apple juice in 2 door cooler without an opening date and multiple garden salads with no date labels in the 3 door cooler. Policy and Procedures:On 08/13/25 at 1:00 PM a review Food Safety Policy, Food Storage: labeled C. Refrigerated Foods. Practices to maintain safe refrigerated storage, number's 3.C, iv. stated labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen/discarded. On 08/13/25 at 1:00 PM a review of Food Safety Policy, Staff safe hygienic practice labeled 7. e. Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling ingredients of salads.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 637 Based on staff Interviews and Record review the facility failed to maintain proper MDS documentation after a significant change in condition (CIC), specifically a wound to the Right Heel of resident #4. This failed practice was a random opportunity for discovery and effected 1:16 residents sampled in the facility.Resident Identifier: #4 Facility Census: 48The Facility FAILED TO MEET THE STANDARD PRACTICE, as evidenced by the following findings:Findings Include: Change of Condition There was a wound found on Resident #4 R heel on 2/3/25 that should have triggered a MDS change in condition being filed within 14 days. This was not done. There were also errors on the next MDS filed on 2/20/25, there was no mention of this wound on the heel. 08/11/2025 3:14 PM Record review: Chart Review: 8/11/252/3/2025 - Wound found, no CIC MDS filed2/3/25 wound found - noted in skin eval notesweekly checks performed. from 2/3 - resolution date 5/21 Healing partners - noted consistent progress on wound condition in notes on 5/21/ MDS review: 8/11/252/3/25 NO change in condition (CIC) MDA filed when wound found 2/20/25 Quarterly - section M (skin) section M0100 -no pressure wound noted stated there were no pressure wounds noted. (M0300) no open areas on feet noted (M1040) The R heel wound was not resolved at this time. 5/22/25 Annual - section M (skin) ^section M0100 -pressure wound noted ^section (M0300) - G1 - Deep tissue injury noted ^no open areas on feet noted (M1040) Observation: 8/11/25Wound appears resolved on residents heel. No open areas or discoloration noted Interview: 8/11/25 Wound care nurse #36 - She said that they try to coordinate with the MDS nurse weekly in a meeting about any changes or issues of note with residents so that they can ensure the charting / MDS stay up to date.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview, the facility failed to update the Resident Pre-admission Screening(PASARR) after admission to the facility, resident #2 was diagnosed with a major mental disorder. This was true for one (1) of six (6) residents reviewed for PASARRs during the survey process. Resident Identifier #2 Facility census: 48.Findings Included:Resident #2 Record Review:On 08/12/2024, a review of Resident #2's medical record was performed including diagnoses and Resident's Pre-admission Screening (PASARR). His last updated PASARR was completed on 07/262024. Resident #2 was noted to have received a diagnosis of Psychotic Disorder on 05/28/25. An updated PASARR has not been completed since 07/26/2024. Staff Interview:At approximately10:40 AM on 08/12/2025, an interview was conducted with the Administrator concerning the PASARR for Resident #2, she confirmed the absence of an updated PASARR.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review, and interview, the facility failed to update the resident's Preadmission Screening and Resident Review (PASARR) with a new diagnosis of mental illness. This was true for one (1) of four (4) residents sampled. Resident Identifier #15. Facility Census: 58. Findings Include Resident #1508/11/2025 10:22 PM PASSAR 07/25/16No MI documented Record review on 07/11/25 at approximately 2:52 PM revealed that the most recent PASSAR for Resident #15 was dated 07/25/16. The PASSAR noted that there were no mental illness or mental retardation (MI/MR) diagnoses for the resident. Ongoing record review on 07/11/25 at 3:06 PM revealed that the resident was diagnosed with the following on 07/01/25: UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH PSYCHOTIC DISTURBANCEDELUSIONAL DISORDERS Further record review revealed that the facility failed to update the PASSAR with the new diagnosis. During an interview with the Director of Nursing and Administrator on 07/13/25 at 11:23 AM, the stated that they had performed a whole house review and updated the resident's PASSAR's during the month of March 2025. They further stated that their understanding was that the PASSAR did not have to be updated for a diagnosis of dementia. During an interview with the Social Worker (SW) #55 on 07/13/25 at approximately 1:15 PM, SW confirmed that Resident #15's PASSAR had not been updated since 07/25/16. SW #55 stated that he would review the resident's diagnoses and update the PASSAR.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. 684 Based on staff Interviews and Record review the facility failed to maintain proper MDS documentation ensuring the quality of care was maintained. This failed practice was a random opportunity for discovery and effected 1:16 residents sampled in the facility.Resident Identifier: #4 Facility Census: 48The Facility FAILED TO MEET THE STANDARD PRACTICE, as evidenced by the following findings:Findings Include: There was a wound found on Resident #4 R heel on 2/3/25 that should have triggered a MDS change in condition being filed within 14 days. This was not done. There were also errors on the next MDS filed on 2/20/25, there were no mention of this wound on the heel. The annual MDS filed on 5/22/25 does mention the R heel wound. 08/11/2025 3:14 PM Record review: Chart Review: 8/11/252/3/25 wound found - noted in skin eval notesweekly checks performed. from 2/3 - resolution date 5/21 Healing partners - noted consistent progress on wound condition in notes on 5/21/25 MDS review: 8/11/252/3/25 NO change in condition (CIC) MDA filed when wound found 2/20/25 Quarterly - section M (skin) section M0100 -no pressure wound noted stated there were no pressure wounds noted. (M0300) no open areas on feet noted (M1040) The R heel wound was not resolved at this time. 5/22/25 Annual - section M (skin) ^section M0100 -pressure wound noted ^section (M0300) - G1 - Deep tissue injury noted ^no open areas on feet noted (M1040) Observation: 8/11/25Wound appears resolved on resident's heel. No open areas or discoloration noted Interview: 8/11/25 Wound care nurse #36 - She said that they try to coordinate with the MDS nurse weekly in a meeting about any changes or issues of note with residents so that they can ensure the charting / MDS stay up to date.