STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515025	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkins Rehabilitation & Care Center	2533 Beverly Pike Elkins, WV 26241

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 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515025	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkins Rehabilitation & Care Center	2533 Beverly Pike Elkins, WV 26241

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 Level of Harm - Actual harm Residents Affected - Few	Based on record review and staff interview the facility failed to provide care and services in accordance with current standards of practice by administering Resident #115 a Benzodiazepines that she was not ordered. The State Agency (SA) confirmed that this failed practice caused harm to Resident #115. After Resident was given the Benzodiazepines she fell, resulting in a sprained hip. The incident occurred on 07/06/24 and was corrected on 07/08/24, therefore it is cited at past non-compliance.In a addition the facility failed to ensure it followed its policy and procedure for Resident #45 on weight management. This failed practice was found true for (2) of (27) residents investigated for quality of care during the Long-Term Care Survey Process. Resident identifiers #115 and #45. Facility Census #103.Findings Include: a) Resident #115A review 0N 08/27/25 at 1:40 PM of an Facility Reported Incident dated 07/08/25, revealed a description of an incident that is summarized as follows: On 07/06/25 at approximately 11:00 AM, Nurse administered narcotic without a physician's order to Resident #115. The medication belonged to another resident. Nurse reported that she was attempting to control the resident's behaviors. Resident #115 then fell and was sent to the local emergency room where it was determined that she had a sprained hip. The nurse was terminated on 07/08/24 after admitting to administering the medication. The facility substantiated the incident. A record review on 08/27/25 at 2:15 PM, revealed an incident report dated 07/06/24 that describes an incident as follows:Resident was standing in the doorway between hallway and common room when another resident attempted to come by in her wheelchair. Resident went to move and lost her balance and slid down the doorway onto the floor. Resident fall was witnessed by this nurse and (2) two Nursing Assistants (NA). Resident sent later in the day to emergency room for pain and a bruise to right elbow and hip. Further record review revealed a nurses note dated for 07/06/24 at 6:42 PM that reads as follows:Resident back to facility via stretcher with RCEMT from (local emergency room named). Resident skin warm pink dry and intact and shows no sign or symptoms of discomfort or distress. Residents D/C summary states that she has a right hip sprain and she should follow up with her doctor in 2 days. A review of Resident #115's orders for Ativan shows that at the time of the incident Resident #115 did not have an order for Ativan.During an interview on 08/27/25 at 2:49 PM, with the Director of Nursing (DON), The administrator, and the Licensed Social Worker (LSW), The DON stated, We did not put it all together that this had happened. A CNA came forward and we reviewed the cameras and found out that the resident was given this medication. On the video it shows the nurse getting the Ativan out of another resident's medications and then putting other medications out of the drawer in a strawberry ice cream and making a milkshake in which she had the resident drink. Not long after that (Resident #115 named) fell and had to go out. We immediately fired that nurse. b) Resident #45 A record review on 08/27/25 at 8:43 AM, revealed that Resident #45 weighed 166.6 pounds (lbs.) on 05/09/25 and on 08/17/25 weighed 143 lbs. A review on 08/27/25 at 9:15 AM of the policy titled {Weight Policy/Assessment/Interventions}, under procedure number, reads as follows: The resident's first weight will be obtained by CNA on admission and readmission. The next two weights will be obtained by the shower team. Resident will be weighed for a total of three days following admission/readmission. Then weekly for four weeks. Monthly after that by the shower team. If there is a weight difference of 5 lbs., shower team will weight the following day to verify if there has been a change in the weight.Further record review of Resident #45's weights, revealed that on 07/11/25 Resident #45 weighed 154.4 lbs. and on 07/24/25 weighed 150.5 lbs. Which is a (5) five pound weight loss. Resident #45 was not re-weighed until 07/27/25. During an interview on 08/27/25 at 9:42 AM, The Administrator confirmed that Resident #45 had not been re-weighed the next day for a (5) five pound weight loss like it says to do in the policy.