STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Elkins Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on staff Interview and facility documentation, the facility failed to ensure that a resident residing on the facility's Alzheimer's unit was free from physical abuse, as described by nurse aide (NA) staff members who witnessed the incident. Using the reasonable person concept it can be determined that the average person would have experienced psycho-social harm as a result of the physical abuse, since an average person would not expect to be smacked in his/her own home or in a healthcare facility. This had the potential to affect a limited number of residents. Resident Identifier: Resident #1. Facility census 104.The facility's Abuse, Neglect, Exploitation policy, with a revision date of 06/23/25, outlined the following:--Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and misappropriation of resident property is more likely to occur with deployment of trained and qualified staff on each shift in significant numbers to meet the needs of the residents, and ensure that the staff assigned have knowledge of the individual residents care needs and behavioral symptoms. --Room or staffing changes, if necessary, to protect the resident from the alleged perpetrator.--Analyzing the occurrence to determine why abuse occurred, and what changes are needed to prevent further occurrences.--Defining how care provisions will be changed and improved to protect residents receiving services. --Training of Staff on changes made and demonstration of staff competency after training is implemented. --A licensed staff member suspected of abuse will be reported to his/her licensing board. The Reasonable Person Concept in Social WorkThe reasonable person concept is used to measure the severity of harm or potential harm a resident in long-term care suffers, even if the resident cannot express their feelings due to advanced dementia, focusing on what a reasonable person in that situation would experience. Abuse Involving Corporal PunishmentCorporal Punishment is the intentional application of physical force to cause bodily pain or discomfort, typically used as a disciplinary measure aiming to punish misconduct. WV State Code S61-2-29 states abuse of incapacitated adult is against the law. Findings included:a) Resident #1A facility reported incident was completed 08/23/25 at 2:05 PM with the following action notes: Allegation of physical abuse, Nurse Aide (NA) #100 reported that Licensed Practical Nurse (LPN) #200 smacked Resident #1's hand and then asked the resident how it felt to be slapped by someone. A review of a statement from NA #103 revealed that on 08/23/25 at 2:05 PM, Licensed Practical Nurse #200 touched Resident #1's hand very lightly and stated, no we don't do that, that is not nice. A continued review of the initial report of allegation revealed Resident #1 had discoloration to skin. Upon further review, the five-day follow-up investigation report stated:-No harm was noted or observed to Resident #1-The perpetrator was terminated-The incident was captured on security camera footage-Witnesses provided statements-The allegation was substantiated, with mandatory nurses training on abuse and neglect to be scheduled On 03/10/26, a review of the staff roster found LPN #200 employed at the facility. During an interview on 03/11/26 at 9:40 AM, Social Worker #103 reviewed the abuse reportable. The social worker stated she had watched the video and LPN #200 did smack Resident #1s hand. She verified her statements in the five-day follow-up investigation report. During an interview on 03/11/26 at 9:55 AM, LPN #101 stated she had watched the video for the day in question, and she observed LPN #200 smacking Resident #1s hand. She stated that there was (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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	515025	A. Building B. Wing	03/11/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slight discoloration to Resident #1's hand, but it went away shortly after. She stated that she sent LPN #200 home and sent in the initial abuse reportable to the appropriate state agencies. During a telephone interview on 03/11/26 at 12:55 PM, NA #100 revealed that she was in the hallway on the Reflections Hall (the facility's Alzheimer's Unit) and Resident #1 was trying to smack another resident when LPN #200 smacked Resident #1's hand and asked how does it feel to be smacked. NA #100 stated that she didn't feel Resident #1 was hurt in the incident indicating that Res #1 just walked off. During an interview on 03/11/26 at approximately 1:10 PM, the Director of Nursing (DON) verified that LPN #200 had been reinstated to the facility and continued to work on the facility's Alzheimer's unit. The DON also stated that LPN #200 was not reported for substantiated abuse and use of corporal punishment to the LPN Licensing Board. The DON stated she would confirm whether the individual received the required abuse training prior to returning to work. During an interview on 03/11/26 at approximately 1:25 PM, the DON and Administrator verified no abuse training was given prior to LPN #200 returning to work. The Administrator stated that LPN #200 was still in her 90 days from last date of employment and she was brought back as a continued employee.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, staff interview, electronic medical record review, and review of the facility's Abuse, Neglect, Exploitation policy, the facility failed to correctly implement their policy for a substantiated allegation of abuse. The facility failed to provide training to staff as per their five-day follow-up of an abuse investigation. Additionally, the facility failed to report a licensed staff member to his/her licensing board. This was true of one (1) of four (4) residents reviewed for abuse during a complaint survey. Resident identifier #1. Census 104.The facility's Abuse, Neglect, Exploitation policy, with a revision date of 06/23/25, outlined the following:--Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and misappropriation of resident property is more likely to occur with deployment of trained and qualified staff on each shift in significant numbers to meet the needs of the residents, and ensure that the staff assigned have knowledge of the individual residents care needs and behavioral symptoms. --Room or staffing changes, if necessary, to protect the resident from the alleged perpetrator.--Analyzing the occurrence to determine why abuse occurred, and what changes are needed to prevent further occurrences.--Defining how care provisions will be changed and improved to protect residents receiving services. --Training of Staff on changes made and demonstration of staff competency after training is implemented. --A licensed staff member suspected of abuse will be reported to his/her licensing board. Findings included:a) Resident #1A facility reported incident was completed 08/23/25 at 2:05 PM with the following action notes: Allegation of physical abuse, Nurse Aide (NA) #100 reported that Licensed Practical Nurse (LPN) #200 smacked Resident #1's hand and then asked the resident how it felt to be slapped by someone. A review of a statement from NA #103 revealed that on 08/23/25 at 2:05 PM, Licensed Practical Nurse #200 touched Resident #1's hand very lightly and stated, no we don't do that, that is not nice. A continued review of the initial report of allegation revealed Resident #1 had discoloration to skin. Upon further review, the five-day follow-up investigation report stated:-No harm was noted or observed to Resident #1-The perpetrator was terminated-The incident was captured on security camera footage-Witnesses provided statements-The allegation was substantiated, with mandatory nurses training on abuse and neglect to be scheduled On 03/10/26, a review of the staff roster found LPN #200 employed at the facility. During an interview on 03/11/26 at 9:40 AM, Social Worker #103 reviewed the abuse reportable. The social worker stated she had watched the video and LPN #200 did smack Resident #1s hand. She verified her statements in the five-day follow-up investigation report. During an interview on 03/11/26 at 9:55 AM, LPN #101 stated she had watched the video for the day in question, and she observed LPN #200 smacking Resident #1s hand. She stated that there was slight discoloration to Resident #1's hand, but it went away shortly after. She stated that she sent LPN #200 home and sent in the initial abuse reportable to the appropriate state agencies. During a telephone interview on 03/11/26 at 12:55 PM, NA #100 revealed that she was in the hallway on the Reflections Hall (the facility's Alzheimer's Unit) and Resident #1 was trying to smack another resident when LPN #200 smacked Resident #1's hand and asked how does it feel to be smacked. NA #100 stated that she didn't feel Resident #1 was hurt in the incident indicating that Res #1 just walked off. During an interview on 03/11/26 at approximately 1:10 PM, the Director of Nursing (DON) verified that LPN #200 had been reinstated to the facility and continued to work on the facility's Alzheimer's unit. The DON also stated that LPN #200 was not reported for substantiated abuse and use of corporal punishment to the LPN Licensing Board. The DON stated she would confirm whether the individual received the required abuse training prior to returning to work. During an interview on 03/11/26 at approximately 1:25 PM, the DON and Administrator verified no abuse training was given prior to LPN #200 returning to work.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, staff interview, electronic medical record review, and review of the facility's Abuse, Neglect, Exploitation policy, the facility failed to take appropriate corrective action, as a result of investigation findings which substantiated physical abuse of a resident. The facility failed to provide additional training to staff as per their five-day follow-up of an abuse investigation. Additionally, the facility failed to report a licensed staff member to his/her licensing board. This was true of one (1) of four (4) residents reviewed for abuse during a complaint survey. Resident identifier #1. Census 104.The facility's Abuse, Neglect, Exploitation policy, with a revision date of 06/23/25, outlined the following:--Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and misappropriation of resident property is more likely to occur with deployment of trained and qualified staff on each shift in significant numbers to meet the needs of the residents, and ensure that the staff assigned have knowledge of the individual residents care needs and behavioral symptoms. --Room or staffing changes, if necessary, to protect the resident from the alleged perpetrator.--Analyzing the occurrence to determine why abuse occurred, and what changes are needed to prevent further occurrences.--Defining how care provisions will be changed and improved to protect residents receiving services. --Training of Staff on changes made and demonstration of staff competency after training is implemented. --A licensed staff member suspected of abuse will be reported to his/her licensing board. Findings included:a) Resident #1A facility reported incident was completed 08/23/25 at 2:05 PM with the following action notes: Allegation of physical abuse, Nurse Aide (NA) #100 reported that Licensed Practical Nurse (LPN) #200 smacked Resident #1's hand and then asked the resident how it felt to be slapped by someone. A review of a statement from NA #103 revealed that on 08/23/25 at 2:05 PM, Licensed Practical Nurse #200 touched Resident #1's hand very lightly and stated, no we don't do that, that is not nice. A continued review of the initial report of allegation revealed Resident #1 had discoloration to skin. Upon further review, the five-day follow-up investigation report stated:-No harm was noted or observed to Resident #1-The perpetrator was terminated-The incident was captured on security camera footage-Witnesses provided statements-The allegation was substantiated, with mandatory nurses training on abuse and neglect to be scheduled On 03/10/26, a review of the staff roster found LPN #200 employed at the facility. During an interview on 03/11/26 at 9:40 AM, Social Worker #103 reviewed the abuse reportable. The social worker stated she had watched the video and LPN #200 did smack Resident #1s hand. She verified her statements in the five-day follow-up investigation report. During an interview on 03/11/26 at 9:55 AM, LPN #101 stated she had watched the video for the day in question, and she observed LPN #200 smacking Resident #1s hand. She stated that there was slight discoloration to Resident #1's hand, but it went away shortly after. She stated that she sent LPN #200 home and sent in the initial abuse reportable to the appropriate state agencies. During a telephone interview on 03/11/26 at 12:55 PM, NA #100 revealed that she was in the hallway on the Reflections Hall (the facility's Alzheimer's Unit) and Resident #1 was trying to smack another resident when LPN #200 smacked Resident #1's hand and asked how does it feel to be smacked. NA #100 stated that she didn't feel Resident #1 was hurt in the incident indicating that Res #1 just walked off. During an interview on 03/11/26 at approximately 1:10 PM, the Director of Nursing (DON) verified that LPN #200 had been reinstated to the facility and continued to work on the facility's Alzheimer's unit. The DON also stated that LPN #200 was not reported for substantiated abuse and use of corporal punishment to the LPN Licensing Board. The DON stated she would confirm whether the individual received the required abuse training prior to returning to work. During an interview on 03/11/26 at approximately 1:25 PM, the DON and Administrator verified no abuse training was given prior to LPN #200 returning to work.