STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515052	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercer Healthcare Center	1275 Southview Drive Bluefield, WV 24701

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews the facility failed to develop and/or implement plans of care related to Post-Traumatic Stress Syndrome (PTSD), Oxygen, Dementia interventions, and Epilepsy. This failure was found to be true for four (4) of 30 residents reviewed for care plan accuracy during the Long-Term Care Survey Process. Resident identifiers: #82, , #79, #5, and #9. Facility Census: 116. a) Resident #5 On 06/15/26 at approximately 3:54 PM, observation of Resident #5 revealed oxygen being administered via nasal cannula at 3.5 liters per minute. Review of the physician's order indicated the resident was prescribed oxygen at 2 liters per minute. The discrepancy was immediately brought to the attention of facility staff. At approximately 3:52 PM, RN #5 confirmed that the physician's order was for oxygen administration at 2 liters per minute. The oxygen flow rate observed was not consistent with the current physician order and resident care plan. b) Resident #82 Resident #82 was originally admitted to the facility on [DATE], and was re-admitted on [DATE]. During the course of the resident's stay in the facility, the resident was diagnosed with EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS on 03/27/2026. A review of the resident's current care plan found the care plan had not been updated with this new diagnosis as an area of focus, nor were goals or interventions/tasks put into place for this diagnosis. Surveyor asked the facility Director of Nursing (DON) who was the responsible party for completing the resident's care plan, and DON responded the MDS RN. On 06/17/2026 at 11:46 AM, surveyor approached the MDS RN #70 about epilepsy not being found on the resident's care plan. MDS RN stated yes, we should have included it, we missed this. I will correct it immediately. c) Resident #79 A record review on 06/15/2026, revealed that Resident #79 was admitted with a diagnosis of PTSD. Review of Resident #79's care plan revealed no mention of the PTSD diagnosis.During an interview on (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/17/26 at 1:15PM, The Director of Social Services (DSS) stated, She has never had any triggers that I am aware of. That is why I did not care plan it. The State Agency (SA) asked, Did you talk with the famiy about it to see if they knew the triggers? DDS responded, Yes, and they was not sure.A record review on 06/17/26 at 1:45 PM, showed that Psychiatric Evaluations had been done with Resident #79 monthly since her admission. All of the evaluations read that patient has reported no triggers for past trauma, up unitll 01/14/26 which reads patient is angry due to past trauma. The Psychiatric Evaluation from 05/12/24 reads patient reports she was in a car wreck when she was 6 and was molested by her father when she was 12.During a phone interview on 06/1726 at 2:06 PM, The SA asked the Health Care Surrogate (HCS), Do you know what or when if anything happened to indicate the diagnosis of PTSD? The HCS responded, Oh Yes, She had an car accident when she was little that caused a head injury and her stepfather molested her for a very long time.During an interview on 06/17/26 at 2:32 PM, The DSS with the Administrator present confirmed that the Psychiatric Evaluations from January 2026, and May 2026 revealed the trauma for Resident #79. d) Resident #9 The care plan for Resident #9 regarding dementia had an intervention for cup holder to wheelchair. Resident #9 was observed multiple times on 06/16/26 and 06/17/26 with no cup holder on her wheelchair. In an interview with Director of Rehab #153 on 06/17/26 at 10:01 AM, she stated the cup holder should be on Resident #9's wheelchair and it was not.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, record review, and staff interview, the facility failed to provide a program of activities to meet the needs and interest of each resident. This deficient practice had the potential to affect three (3) of six (6) residents reviewed for the care area of activities. Resident Identifiers: #35, #9, and #101. Facility Census: 116. Findings included: a) Resident #35 During an interview on 06/15/26 at 11:35 AM, Resident #35 stated he wished someone could come into his room to talk with him. When asked if anyone from the Activities Department visited him, Resident #35 stated, That hasn't happened in a long time. Review of Resident #35's comprehensive care plan showed a focus related to activities. A goal initiated on 02/27/26 and revised on 03/09/26 was as follows: Resident will participate in 1:1 [one on one] activities of choice in and out of room as tolerated by resident. Enjoys companionship for conversation during 1:1 time. The Activities Department was asked to provide a list of residents for whom they provided one-on-one activities. Resident #35 was not on the list. Resident #35's activity participation record was reviewed. For the month of May 2026, the activity participation record showed the resident received one-on-one activities on one occasion, on 05/09/26. So far for the month of June 2026, Resident #35 received one-on-one activities on one occasion, on 06/11/26. On 06/17/2026 at 2:14 PM, Activities Leader #154 stated she spent time speaking with Resident #35 while passing his meal trays and at other times throughout the day. Activities Leader #154 acknowledged Resident #35's activity participation record only documented one-on-one activities once in May 2026 and once thus far in June 2026. No further information was provided through the completion of the survey process. b) Resident #9 The care plan dated 05/29/26 included an intervention for behaviors to offer and encourage attendance and involvement in facility activities. The care plan also included a focus that reads: [Resident #9] is self directed for activities. The Minimum Data Set (MDS) dated [DATE] shows Resident #9 has a Brief Interview for Mental Status (BIMS) of one (1) indicating she is severely impaired in the ability to make daily decisions. Section F of that same MDS indicates it is somewhat important for Resident #9 to do things with groups of people and go outside when the weather is good. The activity participation log shows Resident #9 has participated in two (2) group activities within the last three (3) months. All other listed activities are documented as independent. There are no listed refusals of group activities. During an interview with Activities Leader #154 at 2:00 PM on 06/17/26, she stated Resident #9 is difficult to deal with outside and wanders in and out of activities but does (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not spend enough time in the activity to document participation. c) Resident #101 In an interview with Resident #101 on 06/16/26 at 8:50 AM, he stated he is not attending church services and group activities because he is not being told about them. A review of the MDS section F dated 06/03/26 shows it is very important for Resident #101 to do things with groups of people and to participate in religious services or practices. A review of the Activity Preferences Interview dated 06/04/26 shows Resident #101 has current interests in games, Bible study, and group social activities. A review of the Activity Participation log shows Resident #101 has participated in two (2) group activities. On 06/11/26, the log shows he participated in a social time group and on 06/12/26 it shows he participated in a snack cart group. The activities calendar for June 2026 had a religious activity on 06/04/26 and there was an impromptu religious group activity on 06/15/26. Resident #101 did not attend either activity and the log does not show that he refused these activities. In an interview with Activities Leader #154 at 2:00 PM on 06/17/26, she stated that she goes in each morning and informs Resident #101 of the day's activities and he shows interest in them. However, she states that when she returns to get him for those activities he states he is tired and will participate the next day. Activities Leader #154 confirmed the Activity Participation log did not show any refusals.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure Resident #83's [NAME] Virginia Physician's Orders for Scope of Treatment (POST) form was signed by his medical power of attorney (MPOA) while Resident was lacking capacity. This was true for one (1) of nine (9) residents sampled for advance directives during the Long-Term Care Survey process. Census: 116 Resident identifier: #83Findings included: a) Resident #83 The POST form dated [DATE] was signed by Resident #83. The last capacity evaluation dated [DATE] showed Resident #83 did not have [NAME] to make decisions based on disorientation and an inability to process information due to dementia. An interview with Director of Nursing (DON) on [DATE] at approximately 11:00AM confirms Resident #83 did not have capacity on [DATE] but signed his POST form changing his end of life wishes. The previous POST form dated [DATE] was signed by Resident #83's MPOA and designated he should receive full treatments and Cardiopulmonary resuscitation (CPR).

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to provide adequate notice of last covered Medicare A days to Resident #127's Medical Power of Attorney (MPOA). This was true for one (1) of three (3) residents sampled for beneficiary notification during the Long-Term Care Survey process. Census: 116 Resident identifier: #127Findings included: a) Resident #127 A policy titled Policies and Standard Procedures states, this notice [NOMNC] will be provided at least [two] 2 days in advance of the last covered day to allow for adequate time to appeal, if the beneficiary so chooses. The Notice of Medicare Non-Coverage (NOMNC) reads as follows: Medicare coverage of your current skilled services will end on date: 03/04/26. The telephone notification per the NOMNC was made on 03/06/26 at 10:00AM to the Medical Power of Attorney (MPOA). In an interview with Social Services Designee #55 on 06/17/26 at 9:15AM, she confirmed Resident #127's MPOA was not notified of Medicare coverage of skilled services ending at least two (2) days in advance.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interview, the facility failed to provide required information for continuity and coordination of care when a resident was transfered, including a list of resident's medication and when it was last given. This was found to be true for two (2) of three (3) residents reviewed during the long term care survey process. Resident identifiers: #10, #120. Facility census: 116. Findings included: a) Resident #120 Resident #120 had an unplanned, acute transfer to an emergency room (ER) at the local facility on 04/27/26, after experiencing abnormal vital signs. The facility utilized an Interact Hospital Transfer Form to convey information to the acute care facility. The facility failed to include the following information which would be necessary for the continuity of care: -A copy of the Resident's Advanced Directives-A list of medications the Resident was taking and when last administered, or the Medication Administration Record (MAR). The facility utilizes an Acute Care Transfer Document Checklist which lists Documents Recommended to Accompany Resident/Patient and instructs the person completing the form to check all that apply. The form had no checkmarks indicating what information accompanied the resident to the receiving provider. A review of the resident's progress notes for the date of transfer also did not convey what information was sent to the receiving provider. Surveyor asked the Director of Nursing (DON) to provide copies of what was sent to the receiving provider for the resident's transfer on 04/27/26. The DON provided a copy of the Hospital Transfer Form, the Acute Care Transfer Document Checklist, and a list of the resident's current diagnoses. The surveyor pointed out the checklist was not marked. The DON stated, Our staff know to send all the forms listed on the checklist.This discussion occurred on 06/16/26 at 3:05 PM. The Corporate RN for Clinical Operations was also present. b) Resident #10 This resident lacks capacity to make medical decisions and has impaired communication skills. Resident #10 had two transfers out of the facility: 02/06/26 to 02/11/26 and 01/03/26 to 01/07/26. Both transfers were to an acute care facility for acute respiratory symptoms.The facility utilized an Interact Hospital Transfer Form to convey information to the acute care facility on both occasions. The facility failed to include the following information which would be necessary for the continuity of care:-A copy of the Resident's Advanced Directives-A list of medications the Resident was taking and when last administered, or the Medication Administration Record (MAR).The facility utilizes an Acute Care Transfer Document Checklist which lists Documents Recommended to Accompany Resident/Patient and instructs the person completing the form to check all that apply. The form had no checkmarks indicating what information accompanied the resident to the receiving provider.A review of the resident's progress notes for the dates of the transfers also did not convey what information was sent to the receiving provider.Surveyor asked the Director of Nursing (DON) to provide copies of what was sent to the receiving provider for the resident's transfers on 01/03/26 and 02/06/26. The DON provided copies of the Hospital Transfer Form, the Acute Care Transfer Document Checklist, and a list of the resident's current diagnoses.The surveyor pointed out the checklist was not marked. DON stated, our staff know to send all the forms listed on the checklist. Surveyor then stated that yes, staff may know, but due to turnover, new staff may not be told timely, or someone may not be aware and it is good practice to either mark the checklist or document in the medical record progress notes what was sent to the receiving provider. This discussion occurred on 06/16/26 at 3:05 PM. The Corporate RN for Clinical Operations was also present.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the Minimum Data Set (MDS) included a diagnosis of Epilepsy. This was found to be true for one (1) of 30 residents reviewed during the long term care survey process. Resident identifer: #82. Facility census: 116. Findings included: a) Resident #82 Resident #82 was most recently admitted to the facility on [DATE]. On 03/27/26, the resident was diagnosed with-EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUSMedical Management 03/27/2026 DX #8 During Stay The last quarterly Minimum Data Set (MDS) was completed on 04/30/26. Epilepsy is one of the choices on the MDS Section I Current Diagnoses. For Resident #82, Epilepsy was not check marked, showing the resident as having this diagnosis. The resident's MDS was reviewed with the MDS RN #70 on 06/17/2026 at 11:33 AM. When asked about epilepsy not being on the MDS, she stated let me look into this and I will get back with you. On 06/17/2026 at 11:46 AM, MDS RN stated yes, we should have marked Epilepsy, we missed this.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to include a diagnosis of major depressive disorder on the most recent Preadmission Screening and Resident Review (PASARR). Failure to coordinate the PASARR and the Minimum Data Set (MDS) can lead to duplicative effort and treatment. This was found to be true for two (2) of seven (7) residents reviewed during the long term care survey process. Resident identifiers: #52, #82. Facility census: 116. Findings included: a) Resident #52 Resident #52 was admitted to the facility on [DATE]. Among the list of diagnoses, the resident had the following: -VASCULAR DEMENTIA, MILD, WITH MOOD DISTURBANCE 07/23/25 DURING STAY -MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD 07/23/25 -ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF EMOTIONS AND CONDUCT 10/23/2024 admission The most recent PASARR for the resident was completed on 10/16/24 at an acute care facility. In Section III, Question 30 asks the person completing the PASARR to check all current diagnoses that apply. The person completing the PASARR checked number (n) Other related conditions and specified them as Behavioral Disturbance and Adjustment Disorder. However, major depressive disorder was not checked. Question 47 of the PASARR asks for the primary diagnosis and Dementia was checked. Even though the list of diagnoses included major depressive disorder, single episode, the resident is and has been receiving an anti-depressant since 08/29/25. Resident's orders:-Escitalopram Oxalate Tablet 20 MGGive 1 tablet by mouth one time a day for DepressionPharmacy Active 8/29/2025 A review of the most recent Minimum Data Set (MDS) completed on 05/07/26 had the following diagnoses checked:-Non-Alzheimer's Dementia-Depression An additional diagnosis of Adjustment Disorder with Mixed Disturbances of Emotions and Conduct was typed in. A review of the resident's care plan documents depression and dementia as focus areas. Surveyor asked the Nursing Home Administrator (NHA) who in the facility was responsible for ensuring the PASARRs were kept up to date, the NHA stated the Director of Admissions. The PASARR was then reviewed with the Director of Admissions on 06/17/2026 at 12:50 PM. b) Resident #82 Resident #82 was originally admitted to the facility on [DATE], and had a re-admission on [DATE]. A review of the resident's medical record documented the resident to have the following pertinent diagnoses: -MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD 11/25/2025 Principle(#67)Admission-UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY 09/12/2025 Admission-EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS 03/27/2026 During Stay-GENERALIZED ANXIETY DISORDER 05/19/2026 During Stay The most recent Preadmission Screening and Resident Record (PASARR) was completed on 09/10/25 by the facility. Question 30 asks the person completing the PASARR to check all diagnoses that apply. Only #n Other related conditions was marked. Below the entry, it specified dementia. Major Depression was not marked on the PASARR under Question 30. Question 47 asks for the primary diagnosis and Dementia was marked. A review of the most recent Minimum Data Set (MDS), completed on 04/30/26, had the following diagnoses marked: -Non-Alzheimer's Dementia-Depression-Major Depressive Disorder, recurrent, mild was added under other active diagnoses. The MDS and the PASARR diagnoses do not match, as Major Depression was not on the PASARR. Surveyor asked the Nursing Home Administrator (NHA) who in the facility was responsible for ensuring the PASARRs were kept up to date, the NHA stated the Director of Admissions. The PASARR was then reviewed with the Director of Admissions on 06/17/2026 at 12:50 PM.

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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. Based on record review and staff interview, the facility failed to notify the physician when Resident #130's blood sugars were outside of the ordered parameters. This was found during a complaint investigation. Census: 116 Resident identifier: #130Findings included:a) Resident #130A review of the orders reveals an order with a start date of 06/04/25 that reads: notify [Medical Doctor] MD if blood sugar is less than 60 and/or greater than 400.During a review of the Medication Administration Record for June 2025, the following dates had blood sugars outside of the parameters and the physician was not notified according to the progress notes:06/07/25-42406/11/25 -4806/20/25-47606/21/25-431During an interview with the Director of Nursing on 06/18/26 at 1:30PM, she confirmed according to the progress notes, the physician was not notified of blood sugars outside of the ordered parameters.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. The facility failed to ensure oxygen therapy was administered in accordance with physician orders and the resident's care plan for 1 of 1 resident reviewed for oxygen administration Resident #5. Facility census: 116. Findings include:a) Resident #5During observation on 06/15/26 at approximately 3:52 PM, Resident #5 was observed receiving supplemental oxygen via nasal cannula. The oxygen concentrator was checked and found to be set at 3.5 liters per minute. Review of the physician's order revealed Resident #5 was prescribed oxygen at 2 liters per minute via nasal cannula.The oxygen flow rate observed was 1.5 liters per minute greater than the physician-ordered setting. The discrepancy was immediately brought to the attention of facility nursing staff RN #5. The oxygen concentrator setting was subsequently verified and adjusted to the physician-ordered rate of 2 liters per minute.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to ensure Resident #83's medical record was accurately completed. This was true for one (1) of nine (9) residents reviewed for advance directives and two (2) of five (5) residents. Resident identifiers: #83 and #9. Census: 116. Resident identifier: #83.a) Resident #83 A Physician's Determination of Capacity form dated 11/18/25 showed Resident #83 lacked capacity due to a diagnosis of dementia and disorientation and inability to process information. Resident #83 has a surrogacy selection form designating a Medical Power of Attorney (MPOA) as his healthcare surrogate that was dated 11/17/25. Resident #83 was admitted to hospice care on 12/3/25 and the hospice Long Term Care Status Form was signed by Emergency Contact #2, the resident's sister. In an interview with Director of Nursing at 2:40PM on 06/16/26, she confirmed the hospice admission paperwor was not signed by Resident #83's MPOA. b) Resident #9 Resident #9 was observed throughout the facility on 06/16/26 and 06/17/26 by surveyor wandering in her wheelchair down A Hall and into several other residents' rooms.An interview with Licensed Practical Nurse (LPN)#2 at 2:20PM on 06/17/26 confirmed Resident #9 wandered the halls and into other residents' rooms frequently. The care plan with a revision date of 05/26/26 has a focus that reads, Resident wanders in her wheelchair throughout facility. Resident will go into others rooms and needs to be redirected. The June 2026 the Behavior Monitoring log for Resident #9 showed she had no behaviors of wandering and rummaging in other resident's rooms. In an interview with Director of Nursing (DON) on 06/17/26 at 2:25PM, she confirmed the documentation was not correct.