

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>Based on record review, resident interview and staff interviews, the facility failed to ensure food choices were obtained and honored. This was true for one (1) of six (6) residents reviewed during the annual survey process. Resident identifier: #309. Facility census: 106</p> <p>Findings included:</p> <p>a) Resident #309</p> <p>On 04/29/25 at 10:32 AM, during an interview with Resident #309, the resident stated they had not been asked about food choices. The Resident said, They just bring me whatever they want, if I like it, I eat it. If I don't like it, I just go without. When asked if anyone had told them about the Always Available menu, they were not aware of it. When asked if anyone had asked what they liked and disliked food-wise, they stated, no.</p> <p>On 05/06/25 at 10:53 AM, a phone interview was completed with the dietician. When asked to describe the process of obtaining newly admitted resident's food choices, the dietician stated that within 24 hours of admission [NAME] #124, was supposed to obtain the food preferences from the resident. The dietician further stated she did the nutritional assessment within 14 days of admission.</p> <p>During an interview with [NAME] #124 at 10:59 AM on 05/06/25, when asked about Resident #309's food choices, the [NAME] stated, I will be honest, I am supposed to get the food preferences within 24 hours of admission, but I am doing two people's jobs right now, and I have not gotten around to interviewing the resident about their food choices. [NAME] #124 said the resident could ask her Nurse Aid to obtain what the menu was for the day, and if they did not like it, then the staff could get them something else from the Always Available Menu.</p> <p>When asked how the resident would know to ask the Nurse Aid about obtaining the menu for the day, [NAME] #124 did not have an answer.</p> <p>The resident's care plan was a 24-hour baseline care plan, and no food preferences were listed on the care plan.</p> <p>A review of the facility's Person Center Choice, Food and Nutrition Services revealed Director of Dining Services/Director of Culinary Services or designee visits resident within 48 hours of admission to introduce Food and Nutrition Services, the meal offerings, and gather any food preferences. Residents may pre-select their meals by Personal Choice Menus.</p> <p>(continued on next page)</p>

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: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The conclusion is that the resident was not visited by the Dietary Department to obtain food preferences, nor was this resident given a Personal Choice Menu.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to ensure resident's rooms were a clean and homelike environment (residents' privacy curtains were stained). This is true for Resident #94 and Resident #133.</p> <p>Findings included:</p> <p>a) On 04/29/25 at 9:45 AM an observation of Resident #94's room revealed that her privacy curtain was dirty with stains.</p> <p>On 04/29/25 at 9:50 AM an interview was conducted with Licensed Practical Nurse #133 who acknowledged that the curtain in Resident #94's room needed cleaned. She stated that generally when they see them dirty they will contact house keeping to be cleaned,</p> <p>b)On 04/29/25 at 12:53 PM during an interview with Resident #103, stains on his privacy curtain were observed and he stated it was vomit.</p> <p>Based on observations and staff interviews, the facility failed to ensure a safe, clean, comfortable and homelike environment for three (3) residents. Resident identifiers: #82, #65, and #3. Room identifiers: #404, #400, #412. Facility census: 106.</p> <p>Findings include:</p> <p>a) room [ROOM NUMBER]</p> <p>04/29/25 at 1:17 PM, the following issues were observed in room [ROOM NUMBER]. In the bathroom areas there were screws sticking out of the drywall on the left side wall. There was an unfinished dry wall patch on the right-side wall. Resident #82 resided in this room.</p> <p>b) room [ROOM NUMBER]</p> <p>On 04/29/25 at 11:53 AM the following issues were observed in room [ROOM NUMBER]'s room. In the bathroom screws sticking out of the bathroom dry wall in the paint on right side wall. Resident #65 resided in this room.</p> <p>c) room [ROOM NUMBER]</p> <p>On 4/29/25 at 1:355 PM the following issues were observed in room [ROOM NUMBER]. In the bathroom there were unfinished dry wall patches to the left of the sink above the towel rack. Resident #3 resided in this room.</p> <p>During a walk through and interview with the DON on 04/30/25 at 10:55 AM, she acknowledged the bathroom areas were not in good repair for room [ROOM NUMBER], #404, #412 and stated she would report to maintenance for repairs.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on observation, record review and staff interview the facility failed to implement their abuse prohibition policy by ensuring allegations of mental/emotional abuse were reported to the required state agencies within the required time frames. This was a random opportunity for discovery for Resident #93. Resident identifier: #93. Facility Census: 106.</p> <p>Findings Include:</p> <p>a) Resident #93</p> <p>On 05/01/25 at approximately 1:20 PM while passing through the dining room this surveyor overheard a nurse (later Identified at LPN #133) say to Resident #93, You can't have your pain medicine until you eat at least half of your food. The nurse then left the dining room. This was reported to facility staff immediately after the observation. Facility staff intervened and had the nurse give Resident #93 her Tylenol. An interview with the resident in the dining room prior to the nurse returning found she did not feel like eating because her arm was hurting. She then stated, They told me I had to eat to get my medicine.</p> <p>A review of the medical record found Resident #93's order for the as needed Tylenol did not contain any special directions to indicate the resident had to eat prior to getting the medication.</p> <p>On 05/05/25 at 4:53 the Person in Charge (PIC), the Director of Nursing (DON), Corporate Registered Nurse (CRN) #131 was asked if this allegation was reported to the required state agencies. They all agreed it had not been reported. The DON stated, The nurse did give her the medication. However, this did not occur until after surveyor and management intervention. The PIC stated to the surveyor, If you felt like it was abuse why didn't you say that.</p> <p>According to the facility's abuse prohibition policy with an effective date of 07/01/13 and a revision date of 10/24/22 the facility will, Immediately upon receiving information concerning a report oof suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will perform the following. 7.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made 7.4 Report allegations to the appropriate state and local authority (S) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property within 24 hours after the allegation is made if the event does not result in serious bodily injury.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on observation, record review and staff interview the facility failed to ensure all allegations of mental abuse were reported to the required state agencies with in the required time frames. This was a random opportunity for discovery and as true for Resident #93. Resident Identifier: #93. Facility Census: 106.</p> <p>Findings Include:</p> <p>a) Resident #93</p> <p>On 05/01/25 at approximately 1:20 PM while passing through the dining room this surveyor overheard a nurse (later Identified at LPN #133) say to Resident #93, You can't have your pain medicine until you eat at least half of your food. The nurse then left the dining room. This was reported to facility staff immediately after the observation. Facility staff intervened and had the nurse give Resident #93 her Tylenol. An interview with the resident in the dining room prior to the nurse returning found she did not feel like eating because her arm was hurting. She then stated,They told me I had to eat to get my medicine.</p> <p>A review of the medical record found Resident #93's order for the as needed Tylenol did not contain any special directions to indicate the resident had to eat prior to getting the medication.</p> <p>On 05/05/25 at 4:53 the Person in Charge (PIC), the Director of Nursing (DON), and the Corporate Registered Nurse (CRN) #131 was asked if this allegation was reported to the required state agencies. They all agreed it had not been reported.</p> <p>The DON stated, The nurse did give her the medication. However, this did not occur until after surveyor and management intervention. The PIC stated to the surveyor, If you felt like it was abuse why didn't you say that.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>c) Resident #85</p> <p>A review of Resident #85's medical record found the following transfers to the hospital 08/09/24, 08/31/24, 09/06/24, and 10/22/24. Resident #85 went on therapeutic leave of absence on 11/27/24.</p> <p>On the afternoon of 05/06/25 the facility was asked to provide the notice of the transfer, the bed hold agreement, and the ombudsman notification for each of the aforementioned discharges.</p> <p>Later in the afternoon on 05/06/25 the Person In Charge provided two incomplete Bed Hold Notices dated 08/31/24 and 09/06/24. The only information completed on the form was the residents name and medical record number along with the nursing signature. On the form date 08/31/24 the nurse signed both the resident and the center representative space. On the form dated 09/06/24 the nurse signed the center representative space and documented a verbal notification of the resident representative. Neither form contained the number of bed hold days remaining.</p> <p>No other information was provided for the discharges. The PIC stated, This is all we have. He confirmed he could not find any of the notifications to the Office of the State Long Term Care Ombudsman. He had no other information to provide.</p> <p>d) Resident #17</p> <p>On 04/29/25 at 12:42 PM, a record review was completed for Resident #17. The review found the resident had been hospitalized on two (2) occasions for complaints of chest pain, (10/23/24 and 12/20/24). Upon further review, the Office of the State Long Term Care Ombudsman had not been notified of either hospitalization.</p> <p>On 05/01/25 at 1:20 PM, the Director of Nursing (DON) was notified and confirmed the Office of the State Long Term Care Ombudsman was not notified for either hospitalization.</p> <p>d) Resident #20</p> <p>The facility failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>05/06/25 12:35 review of Hospitalizations for Resident on 04/22/25 and 04/02/25. Bed Holds and Notice of Transfer was completed for both dates.</p> <p>3/3/25 bed hold policy was completed with no transfer notice or ombudsman notification. No record of Ombudsman notification.</p> <p>05/06/25 1:50 PM interview with Person in Charge who reported that they did not have any documentation that the transfer notice had been copied to the Ombudsman that they had changed offices and lost the book the notices were kept in.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based upon record review and staff interview, the facility failed to notify the resident and the resident's representative(s) of the transfer or discharge, including the reasons for the move in writing, in a language and manner they understood. The facility also did not send a copy of the notices to the Office of the State Long-Term Care Ombudsman. This was found to be true for 5 (five) of 6 (six) resident records reviewed during the annual survey process. Resident identifiers: #40, #66, #85, #17. Facility Census: 106.</p> <p>Findings included:</p> <p>a) Resident #40</p> <p>On 02/11/25, Resident #40 was transferred to an acute care hospital. A Notice of Transfer was completed on 02/11/25, but no reason for the transfer was marked on the form. The form stated the facility representative notified someone verbally, but did not provide the name of person notified. The form was not counter signed by a second person as a witness.</p> <p>A copy of the notice was not sent to the Office of the State Long-Term Care Ombudsman.</p> <p>The Bed Hold Notice and Authorization form was also initiated on 02/11/25, and stated, Verbal consent obtained. However, the form does not specify who verbal consent from obtained from.</p> <p>b) Resident #66</p> <p>Resident #66 was transferred to an acute care facility on 12/16/24. A Notice of Transfer or Discharge Form was completed on 12/16/24 by a facility representative. The form stated a verbal notification was done on 12/16/24, but did not provide the name of the person who gave the consent. The form was not counter signed by a second person as a witness.</p> <p>A copy of the Notice of Transfer or Discharge form was not sent to the Office of the State Long-Term Care Ombudsman.</p> <p>During an interview with the DON on 05/01/25, the DON stated they did not have anything to show that the Notice of Transfers for Resident #40 or #66 were sent to the Office of the State Long Term Care Ombudsman.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview and staff interview, the facility failed to develop and/or implement the care plans for three (3) of 42 sample residents. Resident identifiers: #48, #9, and #309. Facility Census: 106.</p> <p>Findings Include:</p> <p>a) Resident #48</p> <p>An interview with Resident #48 on 04/29/25 at 12:46 PM found she was a hemodialysis patient. She stated, They use the port in my groin for now, but I have one in my upper arm that needs to mature.</p> <p>A review of Resident #48's medical record found she returned from the hospital on [DATE] after the placement of an Arteriovenous Fistula (AVF) in her left upper arm.</p> <p>A review of Resident #48's care plan found it was void or any mention of the residents AVF in her left upper arm.</p> <p>An interview with the Director of Nursing (DON) on the afternoon 05/06/25 confirmed a care plan was not developed for Resident #48's AVF.</p> <p>The facility failed to develop and or implement the care plan.</p> <p>PS RL</p> <p>a) #48 AVF</p> <p>b) #9 contractures ASC</p> <p>c) #309 incomplete blanks KW</p> <p>Resident #48</p> <p>Dialysis</p> <p>698</p> <p>Based on record review, resident interview and staff interview the facility failed to ensure Resident #48 who require dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This was true for one (1) of one (1) resident reviewed for the care area of dialysis.</p> <p>656</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and staff interview the facility failed to ensure Resident #48's care plan was updated after the surgical placement of an AV fistula to her left upper arm. This was true for one (1) of care plans reviewed during the long term care survey process.</p> <p>04/29/25 12:46 PM Resident receives dialysis. She has port i her groin she said it is uncomfortable she stated she had one in her chest but she pulled it out some how. She stated that she has a graft in her left arm she states she listens too it and if she dont here it she will tell them</p> <p>Inter view with [NAME] Rn she stated that they really dont do any thing with the istuala becuse they are not using it. She said dialysis told them they did not need to do the buit and thril</p> <p>b) Resident #9</p> <p>On 04/29/25 at 10:00 AM, a record review was completed for Resident #9. The review found the resident had contractures of the left and right knee. Further review found the bilateral contractures of the knees were not listed in the care plan.</p> <p>On 04/30/25 at 1:13 PM, the Director of Nursing (DON) confirmed the bilateral contractures were not on the care plan.</p> <p>c) Resident #309</p> <p>Resident #309 was admitted on [DATE]. A review of Resident #309's care plan on 05/06/25 showed the care plan had not been personalized in terms of the assistance needed for toileting, transfers, bathing, etc. There were incomplete blanks where someone who was completing the care plan should fill in the blanks.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and staff interview, the facility failed to revise a care plan for a change in code status for Resident #99. This is true for one (1) of four (4) residents reviewed under the care area of advanced directives. Resident Identifier: #99. Facility Census: 106.</p> <p>Findings Include:</p> <p>a) Resident #99</p> <p>On 05/05/25 at 2:15 PM, a record review was completed for Resident #99. The review noted the [NAME] Virginia Physician's Order for Scope of Treatment (POST) form was Do Not Resuscitate, Comfort Measures and no artificial means of nutrition, which was dated 03/03/25. However, the care plan indicated the resident was a full code.</p> <p>On 05/05/25 at 3:10 PM, the Director of Nursing (DON) confirmed the care plan had not been revised to indicate the change in code status.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide activities of daily living for dependent Resident #259 and #35. This was true for two (2) of four (4) residents reviewed under the care area of activities of daily living. Resident identifiers: #259 and #35. Facility Census: 106.</p> <p>Findings Include:</p> <p>a) Resident #259</p> <p>On 05/06/25 at 8:15 AM, a record review was completed for Resident #259. The review found the resident did not receive showers or bed baths for the timeframe of 03/21/25 through 03/28/25; which is seven (7) days. The resident was listed as dependent for showers and bed baths on the discharge Minimum Data Set (MDS) dated [DATE].</p> <p>On 05/06/25 at 9:00 AM, the Director of Nursing (DON) confirmed there was no documentation to indicate the resident received showers and/or bed baths for the seven (7) days between 03/21/25 and 03/28/25.</p> <p>b) Resident #35</p> <p>During an interview with resident on 04/29/25 at 01:38 PM she reported that she would like a shower at least once per week and that she does not currently get one that often.</p> <p>On 04/30/25 at 4:31 PM a review of the Minimum Data Set Assessment (MDS) section F dated 03/05/25. Question C. How important is it to you to choose between a tub bath, shower, bed bath or sponge bath. The resident's recorded response was entered 1.Very important.</p> <p>On 05/05/25 at 11:06 a review of care plan for resident revealed the following:</p> <p>Focus:</p> <p>Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: limited mobility.</p> <p>Interventions: Provide resident/patient with Substantial/ maximal assist of one for personal hygiene (grooming).</p> <p>On 05/05/25 a review of shower tasks shows that resident had a shower on 04/10/25 and did not receive another shower until 04/28/25.</p> <p>On 05/06/25 at 11:00 AM. Interview with Director of Nursing DON who acknowledge that Resident did not have showers between 04/10/25 and 04/28/25 and that resident would prefer at least one shower per week and not just bed baths.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>b) Resident #20</p> <p>A review of the Resident #20's medical record on the after noon of 04/30/25 found Resident #20 sustained a fall on 03/12/25 at 5:30 PM. The incident report indicated neurological assessments were done per policy. The facility was asked to provide the completed neurological assessments related to this fall.</p> <p>On 05/01/25 at 9:08 AM the Director of Nursing (DON) stated they could not locate the neurological assessments for this fall.</p> <p>Based on record review and staff interview, the facility failed to discontinue wound treatment for Resident #21, when the wound was healed and failed to complete neurological (neuro) checks for Resident #20. This was true for two (2) of 42 residents reviewed during the survey process. Resident Identifiers: #21 and #20. Facility Census: 106.</p> <p>Findings Include:</p> <p>a) Resident #21</p> <p>On 05/06/25 at 2:55 PM, a record review was completed for Resident #21. The review found an active physician's order for wound care to the resident's left gluteus. The wound treatment was cleanse left gluteus with IHWC (in-house wound cleanser), pat dry. Apply hydrogel and an Opti foam dressing every 3 (three) days and PRN (as needed). (Typed as written.) However, the wound was resolved on 04/07/25. The facility continued to treat the abrasion 10 more times before the physician's order was discontinued.</p> <p>On 05/06/25 at 3:30 PM, an interview was held with Registered Nurse (RN) #32. RN #32 stated, The wound was resolved on 04/07/25 .I should've discontinued the order .it was my fault.</p> <p>On 05/06/25 at 3:50 PM, the Director of Nursing (DON) was notified and confirmed the wound treatment should have been discontinued on 04/07/25.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record review staff interview and resident interview the facility failed to ensure Resident #21, and Resident #22 received the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. This was true for two (2) of 10 residents reviewed for the care area of pain during the long-term care survey process. Resident identifiers: #21, and #22. Facility Census: 106.</p> <p>Findings Include:</p> <p>a) Resident #21</p> <p>On 04/29/25 at 1:36 PM Resident #21 stated, she had been asking them for pain medication, and they had not given her any yet. The resident was asked to rate her pain on a scale from zero (0) to ten (10) with zero (0) being no pain and ten (10) being the worst pain ever. Resident #21 stated that her pain was an eight (8). The surveyor immediately reported Resident #21's pain level to Registered Nurse (RN) #10. RN #10 stated, I told her she could not have any just yet because it had not been 12 hours since her last dose. RN #10 then stated, Well I guess I could call the Doctor to see if I can give her a dose now.</p> <p>Less than five (5) minutes later RN #10 returned to Resident #21's room and stated, The doctor changed your pain meds to one (1) every eight (8) as needed instead of every 12 hours. The resident stated I'm glad they changed it, but I wish they would have done it sooner.</p> <p>A review of Resident #21's medical record on 05/05/25 found it included the following physician orders pertaining to pain management:</p> <p>-- OXY Codone 5 milligrams every 12 hours as needed for pain. This order began on 01/29/25 and ended on 04/29/25.</p> <p>-- OXY codone 5 milligrams every eight (8) hours as needed for pain. This order began on 04/28/25 and ended on 05/01/25.</p> <p>-- OXY Codone 5 milligrams every eight (8) hours as needed for pain. This order began on 05/01/25 and was the current order at the time of this review.</p> <p>Further review of the medical record found when the resident receives a pain medication which is documented on the Medication Administration Record (MAR) the facility will document the pain level at the time of administration and a half to one (1) hour later will evaluate the effectiveness of the pain medication.</p> <p>Upon further review of Resident #21's medical record, a comparison of the MAR and the controlled substance log was completed. This comparison revealed the following days and times Resident #21's oxycodone was signed out on the controlled substance log but the nurse failed to document it as administered on the MAR therefore the effectiveness of the medication was not evaluated. The dates and times are as follows:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-- 02/14/25 - 3:30 pm</p> <p>-- 02/18/25 - 8:00 am</p> <p>-- 03/01/25 - 2:25 PM</p> <p>-- 03/07/25 - 9:00 AM</p> <p>-- 03/11/25 - 8:00 PM</p> <p>-- 03/14/25 - 4:30 PM</p> <p>-- 03/23/25 - 8:00 am</p> <p>-- 04/06/25 - 12:00 am.</p> <p>An interview with the Director of Nursing (DON) on 05/6/25 at 1:00 PM confirmed the above findings. She stated, I'll look to see if I can find anything where we evaluated the effectiveness of the PRN pain medication on these dates. No further information was provided prior to the time of exit on 05/06/25.</p> <p>04/29/25 01:36 PM Resident stated at 1 pm that she had been asking them for Pain medicine and they have not gave it to her yet she rated her pain at an 8. Told the RN on duty that the resident was asking for her pain medication. She stated that it had not been a full 12 hours since she had her last dose she said it was almost time. She then stated that she would call the Dr. She came in within minutes. And told the resident that she called the dr and it was now going to be every 8 hours . The resident was pleased but did not understand why they did not do it sooner.</p> <p>Interview with the DON 05/06/25 09:41 AM she stated that it was a cycle with her they tried therapy, and she said that hurt. Then they set up an ortho appointment and then she refused to get out of bed to go to the ortho she stated that she had refused so much that the ortho will not see her anymore. She confirmed the meds are signed out on the controlled substance log and the MAR stated that the pain was assessed when it puts it in the e-mar.</p> <p>b) Resident #22</p> <p>During an interview with Resident #22 on 04/29/25 at 2:28 PM she stated she had been having a lot of trouble with pain. She stated she had a pill this morning, but it had worn off and her leg was still hurting badly. She indicated she still had to do therapy, and she was worried she would not be able to.</p> <p>A review of Resident #22's medical record found the resident sustained a fall at home and fractured her hip. During her hospital stay they indicated the resident was not a candidate for surgical repair and left the hip unrepaired. She was sent to the facility for therapy with the goal of returning home.</p> <p>During the review of the medical record on 05/05/25 the following orders were found pertaining to pain management:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-- Oxycodone 5-325 every four hours as needed for pain. This was the effective order from 04/03/25 to 04/05/25. (Resident was admitted to the facility on [DATE]).</p> <p>-- Oxycodone 10-325 milligrams (MG) every six (6) hours as needed for pain. This was the effective order from 04/05/25 to 04/09/25.</p> <p>-- Oxycodone 10-325 milligrams (MG) every six (6) hours as needed for pain for five (5) days. This was the effective order from 04/09/25 to 04/13/25.</p> <p>-- Oxycodone 7.5 mg every 6 hours as needed for pain. This was the effective order from 04/14/25 to 04/21/25</p> <p>-- Oxycodone 5 mg every 12 hours as needed for pain. This was the effective order from 04/24/25 to 04/29/25.</p> <p>-- Oxycodone 5 mg every 6 hours beginning on 04/29/25 and was the current order at the time of this review.</p> <p>Upon further review of Resident #22's medical record a comparison of the MAR and the controlled substance log was completed. This comparison found on the following days and times Resident #22's oxycodone was signed out on the controlled substance log, but the nurse failed to document it as administered on the MAR therefore the effectiveness of the medication was not evaluated. The dates and times are as follows:</p> <p>-- 04/13/25 at 8:00 PM</p> <p>-- 04/18/25 at 2:00 PM</p> <p>During an interview with the Director of Nursing (DON) on 05/06/25 at 9:41 AM, the DON indicated Resident #22 really liked her pain pills. When asked about the fractured hip which had not been repaired the DON stated, She waited three weeks to go to the hospital so her tolerance for pain must be high. The DON indicated the resident had refused to take Ultram. When asked to provide documentation to indicate the resident had refused Ultram, she was unable to do so.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview and staff interview the facility failed to ensure Resident #48 who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This was true for one (1) of one (1) residents reviewed for the care area of dialysis during the long-term care survey process. Resident identifier: #48. Facility Census: 106.</p> <p>Findings Include:</p> <p>a) Resident #48</p> <p>A review of Resident #48's medical record on 05/05/25 found the resident received dialysis on Monday, Wednesday and Friday at a local dialysis center. Each day the facility completed and sent with the resident a Hemodialysis communication sheet.</p> <p>The sheet consisted of three (3) Sections. The first and third were to be completed pre and post dialysis by the facility's nurse. The middle section is to be completed by the dialysis center.</p> <p>A review of the electronic medical record found the following missing dialysis communication sheets:</p> <p>03/03/25</p> <p>03/14/25</p> <p>03/17/25</p> <p>04/02/25</p> <p>04/25/25</p> <p>The facility had the following sheets however they were not completed in their entirety:</p> <p>03/24/25</p> <p>03/31/25</p> <p>04/04/25</p> <p>04/28/25 and</p> <p>05/02/25.</p> <p>The post dialysis section was blank and not completed by the nurse upon the residents return to the facility.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This was confined with the Director of nursing on the afternoon of 05/06/25.</p> <p>An interview with Resident #48 on 04/29/25 at 12:46 PM found she was a hemodialysis patient. She stated, They use the port in my groin for now, but I have one in my upper arm that needs to mature.</p> <p>A review of Resident #48's medical record found she returned from the hospital on [DATE] after the placement of an Arteriovenous Fistula (AVF) in her left upper arm.</p> <p>A nursing note in the medical record indicated the resident had asked nursing staff to write it down so they would remember to monitor her AVF because she forgot her stethoscope at the hospital and was having anxiety over this.</p> <p>Further review of the record found no physician order and/or care plan to monitor the AVF for the Bruit and thrill as requested by the hospital.</p> <p>This was confirmed with the DON on the afternoon of 05/06/25.</p> <p>A review of Resident #48 medical record on 05/06/25 found a diet order which indicated the resident should not have tomatoes and oranges. The care plan did indicate the resident would at time request tomato soup or a food item with tomatoes in it.</p> <p>A review of the menu for the noon time meal on 05/06/25 found the two (2) choices were option 1 tomato soup and a grilled cheese or option 2 Taco with Mexican Rice. Both options came with oranges as the fruit. Both options also contained tomato products.</p> <p>An observation of Resident #48's lunch meal found she was served the taco with tomatoes and lettuce on the side along with the Mexican rice. Also on her tray was a cup of oranges. She was also served a bowl of chicken noodle soup. Resident #48 looked at her meal and stated, I did not ask for the taco and rice. I just wanted this soup and some pudding. She then opened the lid to the oranges and stated, I can't have this. I wanted pudding. Nurse Aide #26 confirmed what was on the residents tray and indicated she would go get her a pudding.</p> <p>The previous Nursing Home Administrator #92 later in the afternoon of 05/06/25 brought in a meal selection sheet and indicated the resident had chosen option 2 this morning with the activities department. The form she provided also had written on it chicken noodle soup and pudding. NHA #92 indicated that was what she told them she wanted for dinner. When it was pointed out that both meal options contained tomatoes NHA #92 remained silent.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based upon record review and staff interview, the facility failed to provide accurate daily staffing posting for actual hours worked. This was found to be true for 14 (fourteen) of 15 (fifteen) days of staffing data reviewed during the annual survey process. Facility census: 106</p> <p>Findings included:</p> <p>Nursing staffing data and time and attendance reports were reviewed for the following dates: 04/25/25, 04/26/25, 03/21/25, 03/22/25, 03/23/25,02/20/25, 02/21/25, 02/22/25, 02/23/25 01/01/25, 01/02/25, 01/03/25, 12/31/24, 11/25/24, 11/27/24</p> <p>Examples of staffing data not aligning with time and attendance reports:</p> <p>On 11/27/24, posted nurse staffing data showed 258 total hours worked for RNs, LPNS, and Certified Nurse Aides.</p> <p>A review of the time and attendance report for the same date, showed 227.78 hours worked.</p> <p>On 12/31/24, posted nurse staffing data showed 264 total hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>A review of time and attendance reports for the same date shows 231.40 total hours worked.</p> <p>On 04/26/25, posted nurse staffing data showed 243 total hours worked for RNs, LPNs, and Certified Nurse Aides.</p> <p>A review of time and attendance reports for the same date shows 197.21 total hours worked.</p> <p>This data was reviewed with the Director of Nurses (DON) on 05/06/25. When asked about the differences, the DON did not have a response.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Based upon record review and staff interview, the facility failed to ensure they maintained the requirements of their policy for the time allotted for the physician to respond to gradual dose reduction recommendations from the pharmacist. The facility also failed to ensure the pharmacist identified the need for possible gradual dose reduction for a resident receiving an antidepressant. This was found to be true for 1 (one) of 42 (forty-two) residents reviewed during the annual survey process. Resident identifier: #50. Facility census: 106.</p> <p>Findings included:</p> <p>a) Resident #50</p> <p>Record review revealed the resident had a physician's order for:</p> <p>Mirtazapine Tablet 7.5 MG</p> <p>(Remeron)</p> <p>Give 2 tablets by mouth at bedtime for depression</p> <p>The Medication Regimen Review reports for 02/27/25 and 12/28/24, had a notation which revealed there was a more detailed report.</p> <p>On the detailed report for 12/28/24, the pharmacist recommended a Gradual Dose Reduction (GDR) review for Mirtazapine. The attending physician failed to provide the response within the facility's 30 calendar day time-frame per their Medication Regimen Review and Reporting Policy. When the physician failed to provide feedback on the recommendation, the pharmacist followed up with the attending physician on 02/27/25. The physician provided a response on 03/05/25 to maintain current dosage, with note See physician progress notes for clinical rationale.</p> <p>The last gradual dose reduction was 05/2024.</p> <p>On 04/30/25 at 1:47 PM, the surveyor requested to see if there were any more GDR reviews after 05/2024. DON responded around 3:30 pm on the same day, There were no GDR reviews after 12/28/24, and provided a printed GDR Summary Report. This report documented the next intended GDR review was due in 02/25. DON stated she would need to follow-up with the Pharmacist to see what happened that this was not completed. No further information was provided prior to the survey exit.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, resident interview and staff interview the facility failed to ensure Resident Meals were served, which were palatable and at an appetizing temperature. This failed practice has the potential to affect more than an isolated number of Residents. Facility Census: 106</p> <p>a) Resident #6</p> <p>During an interview with Resident #6 on 04/29/25 at 10:27 AM, Resident stated food was terrible here. When I asked her if it was not the proper temperature, did not taste</p> <p>b) Resident #11</p> <p>On 04/29/25 at 1:43 PM during an interview, Resident #11 reported the food has no taste, sometimes it is too cool, and she was concerned about the nutritional status. She went on to report on the facility does not serve fresh fruits or veggies and the food has no seasoning and is not appealing.</p> <p>c) Resident #35</p> <p>On 04/29/25 at 1:38 PM during an interview, Resident #35 reported the food does not taste good. She also reported that she has never been told about an always available menu.</p> <p>d) Resident #21</p> <p>During an interview with Resident #21 on 04/29/25 at 1:30 PM the resident indicated the food here is terrible. She stated, sometimes its cold when we get it and she was supposed to have yogurt with every meal but most of the time she does not get it.</p> <p>The surveyors tasted the lunch meal on 05/05/25. The meal consisted of fried potatoes, pinto beans, macaroni and cheese and broccoli. The meal was tasted by four (4) surveyors. All four agreed the Macaroni and Cheese was overcooked and not seasoned, and the broccoli also was overcooked and not seasoned.</p> <p>On 05/05/25 at 12:53 PM the corporate dietary manager obtained the temperatures of a test tray. The temperatures were taken immediately after the last resident received their meal. All items were at the proper temperature except for fried potatoes. The temperature of the potatoes was 113 degrees Fahrenheit.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** e) Reheated food during the noon time meal service o 05/05/25.</p> <p>An observation of the noon time meal on 05/05/25 at 12:35 PM, found [NAME] #124 reheated broccoli which was previously held for service but fell below the acceptable temperature of 135 degrees Fahrenheit (F). She reheated the broccoli to a degree of 160 degrees f. Dietary Account Manager #96 told her 160 degrees F was an acceptable temperature and it was okay to serve the broccoli. [NAME] #124 then served the reheated broccoli.</p> <p>An interview with the corporate account manager at 2:04 PM on 05/05/25 confirmed the broccoli should have been reheated to 165 degrees F. He stated, They told me that but there was not much to do about it after the fact.</p> <p>Based on observation, resident interview, and staff interviews, the facility failed to distribute and serve food in accordance with professional standards for food service safety, to ensure meals were served at a palatable, appetizing and temperature, safe and sanitary manner, preventing the spread of food-borne illnesses, and also failed to reheat food to the required temperature prior to serving. These were random oppotunities of discovery with the potential to effect a great number of residents. Facility Census 106</p> <p>Findings include:</p> <p>Dining Room:</p> <p>Based on observations and staff interviews, the facility failed to distribute and serve food in accordance with professional standards for food service safety regarding to:</p> <p>Dining room observation of drinks being served without proper hand hygiene:</p> <p>04/20/25 During the dining room observation at 12:35PM, Employee #82 walked from the counter where the food was being served over to resident # 81 and touched her on the shoulder then over to resident #54 picked up a cup and went back to the counter poured a drink into the cup and served it to resident #54 without washing or sanitizing her hands.</p> <p>Staff interview:</p> <p>04/29/25 at 12:43PM in an interview with The Person in charge, he acknowledged the employee should have sanitized her hands before serving the resident.</p> <p>Kitchen</p> <p>a) Hairnets and beard nets not worn in the kitchen:</p> <p>04/29/25 10:12 AM</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the initial visit to the kitchen, The Dietary Account Manager was working in the kitchen, wearing a ballcap but not wearing a hairnet nor a beard net. The hair on the back of his head was visible and not covered completely.</p> <p>Intital Kitchen Visit Staff Interview:</p> <p>In an interview with the Dietary Account Manager, at approximately 10:30 Am on 4/29/25, He stated he was not aware that he had to have a hairnet on if he wore a hat. He also stated that his beard was very short and thought it had to be longer to have to wear a beard net.</p> <p>2nd Kitchen Visit:</p> <p>4/30/25 11:45 During the follow up kitchen visit, the cook was working in the kitchen wearing a ball cap exposing hair around the back of the neck, not completely covered. He also had a beard that was not covered.</p> <p>2nd Visit Staff Interview:</p> <p>In an interview with the District manager on 4/30 25 at 1150 PM, He stated he was not aware the ball cap was not a sufficient covering but, he stated, the cook should have been wearing his beard net.</p> <p>b) 400 Hall Nourishment Room Observations: Staff personal belongings, drink cups, and open containers:</p> <p>On 4/30/25 1:45PM, during a check in the Nourishment room on the 400 hall, it was observed there were drinks in [NAME] cups, a restaurant drink cup with a straw, an opened can drink on the counter, also a purse on the counter, and under the counter in the lower cabinet, bottles of Coke and a Fairmont State University shirt and other articles of clothing were found. It was observed a sign on the door of the refrigerator stating no staff items to be in the nourishment rooms or refrigerators.</p> <p>In an interview with the DON, on 4/30/25 at 1:53 PM, she acknowledged the staff items located in the the 400 hall Nourishment Room and stated staff personal items should have been in the staff break room instead.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>b) Resident #102</p> <p>An observation on the afternoon of 05/05/25 found Resident #102's 10:00 AM mighty shake still sitting at the nurses' station unopened.</p> <p>A review of the Medication Administration Record (MAR) found Registered Nurse (RN) #10 had documented Resident #102 had consumed 100 percent of his 10:00 am mighty shake.</p> <p>An interview with RN #10 immediately following the record review found she should have documented refused on the mighty shake.</p> <p>c) Resident #78</p> <p>An observation on the afternoon of 05/05/25 found Resident #78's 10:00 am mighty shake still sitting at the nurses' station unopened.</p> <p>A review of the Medication Administration Record (MAR) found Registered Nurse (RN) #10 had documented Resident #78 had consumed 100 percent of his 10:00 am mighty shake.</p> <p>An interview with RN #10 immediately following the record review found she should have documented refused on the mighty shake.</p> <p>Based on record review and staff interview, the facility failed to ensure an accurate and complete record for Resident #37's skilled nursing evaluation, documentation of supplements for Resident #102 and #78, and a Physician's Order for Scope of Treatment (POST) form for Resident #86. This was true for four (4) of 42 residents reviewed during the survey process. Resident Identifiers: #37, #102, and #78. Facility Census: 106.</p> <p>Findings include:</p> <p>a) Resident #37</p> <p>On 04/30/25 at 10:15 AM, a record review was completed for Resident #37. The review found a physician's order dated 11/15/24, Enteral feed order: Jevity 1.5 cal. Administer via pump at 65ml(milliliter) per hour x 20 hours QD (every day) or until total nutrient delivered to provide 1300ml/1950 kcal (kilocalorie), 82.9gm (gram) PO (protein) QD, downtime 5am-7am and 5pm and 7pm. (Typed as written.)</p> <p>Upon further review, a skilled nursing evaluation dated 04/15/25, indicated the resident was taking nutrition and hydration orally. No complaints of thirst. No signs/symptoms of a swallowing disorder. Mucous membranes moist. The resident was noted as NPO (nothing by mouth) and received all nourishment through a gastrostomy (G-tube) tube.</p> <p>On 05/01/25 at 8:15 AM, Corporate Registered Nurse #132 and #133 confirmed the resident received nutrition from his G-tube and not orally.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review and staff interview, the facility failed to maintain infection control standards during wound care for Resident #61, storage of a nebulizer and mask for Resident #60 and maintaining a wheelchair for Resident #19. These were random opportunities for discovery. Resident identifiers: #61, #60 and #19. Facility Census: 106.</p> <p>Findings include:</p> <p>a) Resident #61</p> <p>On 05/01/25 at 10:08 AM, an observation of the wound care provided by Registered Nurse (RN) #32 was completed.</p> <p>As RN #32 provided the wound care to the right gluteal fold, RN #32 touched her glasses multiple times.</p> <p>On 05/01/25 at 10:30 AM, Nurse Aide (NA) #25 set a bath basin of water and wash cloths on the over-the-bed table which was the sterile field for the wound care.</p> <p>On 05/01/25 at 10:42 AM, an interview was held with RN #32. RN #32 was asked, Did you realize you touched your glasses multiple times during the wound care? RN #32 stated, No, I didn't realize.</p> <p>RN #32 was asked, Do you think the bath basin of water placed on the over-the-bed table disturbed your sterile field? RN #32 stated, I appreciated NA #25 assisting me, but I don't think it should have been placed there.</p> <p>On 05/01/25 at 11:00 AM, Corporate Registered Nurse (CRN) #132 was notified. CRN #132 did confirm these events during wound care was a breach of infection control.</p> <p>b) Resident #60</p> <p>On 04/29/25 at 9:12 AM, an observation revealed a nebulizer machine and mask sitting on the floor by Resident #60's bed.</p> <p>On 04/29/25 at 9:17 AM, Registered Nurse (RN) Supervisor #56 was notified of the observation of the nebulizer machine and mask sitting on the floor.</p> <p>On 04/29/25 at 9:19 AM, RN Supervisor #56 immediately removed the machine and mask from the room. RN Supervisor #56 stated, Let me get this out of the floor.</p> <p>c) Resident #19</p> <p>During facility entry on 04/29/25 at 12:10 AM, Resident #19's wheelchair was found to have a tear/crack in the covering on the top of the back rest, exposing the inner padding.</p> <p>04/29/25 at approximately 12:20 PM, during an interview with Nurse Aide (NA) #127, she acknowledged the crack in seat of the wheelchair.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/29/25 at 12:40 PM, during an interview with the Infection Control Manager (ICM), she acknowledged the crack in the seat, and stated she would remove and replace the wheelchair. She further stated, and stated, I did not know it was in this condition.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	

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)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observations and staff interviews, the facility failed to maintain an effective pest control program so the facility is free of pests and rodents. This was a random opportunity for discovery with the possibility of affecting multiple residents. Facility census: 106.</p> <p>Findings include:</p> <p>a) During a walk-through of the dish room side of the kitchen, on 04/30/25, at 12:00 PM, many mature gnats were observed swarming around the drain area under the dishwasher table.</p> <p>In an interview with the district manager on 04/30/25 at 12:15 PM, he acknowledged the gnats and stated the facility had contacted the extermination for advice a week ago, but the facility had not yet been treated for the gnats.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Tygart Center at Fairmont Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1539 Country Club Road Fairmont, WV 26554	
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)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based upon record review and staff interview, the facility failed to ensure nurse aides completed 12 hours of required education annually. This was found to be true for one (1) of five (5) nurse aide personnel files reviewed during the annual survey process. Staff identifier: #46. Facility census: 106.</p> <p>Findings included:</p> <p>a) Nurse Aide (NA) #46</p> <p>Nurse Aide #46 completed 9 hours and 34 minutes of education during the calendar year 2024. She completed 24 minutes of education on dementia.</p> <p>This was reviewed with the DON on the morning of 05/06/25, and asked if she had any additional education for this Nurse Aide to support the 12 hours required training, to please provide it</p> <p>No additional education was supplied prior to the survey exit.</p>		