STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and staff interview the facility failed to provide a clean comfortable, homelike environment. This was a random opportunity for discovery and had the potential to effect more than a limited number of residents during the Long-Term Care Survey Process. Resident identifiers: #5, #8, #50. Facility Census: 106.Findings include: a) Resident #5 Packaged Terminal Air Conditioner (PTAC) unit An observation on 02/09/26 at 1:03 PM, of the Packaged Terminal Air Conditioner (PTAC), unit in Resident #5's room revealed both filters in the PTAC unit to be fully covered in approximately (2) two inches of dust/debris. During an interview on 02/09/26 at 2:00 PM, Housekeeper (HK) #53 stated, The person in charge of this department is out right now. I am filling in for her from the building across the road. HK #53 confirmed the PTAC units filters were dirty and needed cleaned. During an interview on 02/09/26 at 3:20 PM, The Director of Maintenance (DM) stated, I don't have a policy or a schedule written down but we clean them monthly. We will get them cleaned. b) Resident #50 On 02/09/2026 at 12:30 PM , during the initial resident interview process the following was observed in Resident #50's room: Twall behind the bed and on the right side of the had multiple scratches with paint missing. At 1:05 PM, Licensed Practical Nurse #32 confirmed the walls were missing paint and had multiple scratches.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review, staff interview and observation, the facility failed to ensure care and services were provided in accordance with current standards of practice. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #80, #30 and #11. Facility Census: 106. b) Resident #30: During a dining room observation on 02/10/26 at At 12:10 PM, Employee #17 retrieved Resident number 30's tray, assisted him in set up, handed him his sandwich, then went back to get another resident's tray. Resident # 30 was left food unsupervised for 8 minutes. A further review of Resident's tray ticket read as follows: resident (Name) 1:1 feed assist and ordered supervision for all meals. Record Reviews: A record review on 02/11/26 at 1:30 pm, found the physician dietary order for Resident #30 that read as follows: resident is receiving regular dysphagia diet with 1:1 feed assist and is to have supervision for all meals. On 02/10/2026 at 12:28PM, a record review of Resident # 30's Care Plan stated as written: Resident is receiving a regular dysphagia pureed diet and thin liquids with 1:1 supervision at meals. Date initiated: 05/07/2025. Staff Interviews: In an interview on 02/10/26 at 12:15PM, with Employee #17 acknowledged she did take Resident #30's tray to him set up his meal then left him to eat by himself without supervision for 8 minutes She stated that's not good. In an interview with the Corporate Coordinator, she stated she was made aware of the lack of supervision for Resident # 30 in the dining room acknowledged the Physician Orders of 1:1 Feed and Supervision for all meals were not followed. Findings included: a) Resident #80 - The facility failed to document donning and doffing of contracture management devices per order. The facility's policy and procedure for SPLINT: APPLICATION OF stated, 15. Document: 15.1 Date/time splint was applied; 15.2 Type of Splint; 15.3 Medications administered, if applicable; 15.4 Patient assessment findings; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15.5 Skin condition; 15.6 Neuromuscular status of affected limb; 16.7 Provide notification, if applicable 15.8 Patient education provided The resident's orders stated:: -Contractures - Staff to don Right elbow extension splint Tues Thurs Sat x2 hours with skin checks.-Device: Staff to don Left elbow extension splint MWF x2 hours with skin checks.-Device: Staff to don Right resting hand splint MWF x2 hours with skin checks.-Device: Staff to don Left palm protector Tues Thurs Sat x2 hours with skin checks. Resident # 80's Medication Administration Record and Treatment Administration Records, Kardex and Tasks were reviewed with no documentation of the resident's splints be taking on and off with skin checks per orders found. On 02/11/2026 at 12:40 PM, the Director of Nursing stated, I don't have anything that says it was donned and doffed. c) Resident #11 A record review on 02/10/26 at 1:30 pm, found a Tube feeding order for Resident #11 that read as follows: one time a day Jevity 1.5 cal. Administer via pump at 60 ml per hour X 20 hours QD or until total nutrient delivered to provide 1200cc/1800 kcal, 76 g protein and 912 cc free water. Downtime 5am-7am and 5pm-7pm An observation on 02/10/26 at 3:00 PM, revealed Resident #11 lying in bed, his tube feeding was running. The pump was set at 55 Milliliters (ml) per hour and written on the bottle of Jevity was 55 ml. An observation on 02/11/26 at 9:10 AM, revealed Resident #11 lying in bed, his tube feeding was running. The pump was set at 55 Milliliters (ml) per hour and written on the bottle of Jevity was 55 ml. During an observation and interview on 02/11/26 at 9:20 AM, The Director of Nursing (DON) confirmed that the Jevity was set at 55 ml and order read 60 ml. The DON further stated, Let me go see what the Dietician order says and I will get back to you. During an interview on 02/11/26 at 9:40 AM, The DON stated, The Dietician had changed the order for 55ml for 12 hours and then moved it back to 60 ml. This is where the confusion come in. We are going to get it updated now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interview, the facility failed to store and administer medications according to professional standards of practice. This failed practice had the potential to affect more than a limited number of residents. Facility census: 106.Findings included:Medication administrationOn 02/12/26 at 8:25 AM , Registered Nurse (RN) #81 was observed pouring medications for a resident and then hand the poured medications to Licensed Practical Nurse (LPN) #72 who then gave the medications to the resident. When RN #81 was asked why she poured the medications and gave them to LPN #72 to administer she stated that she watched me pour them. When asked if this was the policy to pour the medications and then have another nurse administered the medications, there was no response.In an interview with the Director of Nursing (DON) on 02/12/26 at approximately 10:35 AM, she stated this was not the practice for one nurse to pour medications and another nurse to administer the medications. Medication RoomObservation of the 200 Hall medication room on 02/12/26 at 8:25 AM with RN #81 found an Emergency Kit with an orange label REFRIGERATE sitting on the cabinet for an undetermined amount of time. RN #81 could offer no explanation as to why this was not in the refrigerator. Medication Refrigerator Two (2) locked clear plastic boxes with Ativan (a controlled substance) in the lower box was found on 02/12/26 at 8:25 AM. The plastic boxes were not permanently affixed in the refrigerator. This was confirmed with RN #81.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review, staff interview and observation, the facility failed to ensure menus were followed. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #40 and #63. Facility Census: 106.Findings included: a) The facility's policy and procedure for Menus stated, 6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. b) The facility's menu given to the state surveyor included Salisbury Steak with Mushroom Gravy for Monday 02/09/26 for regular, dysphagia advanced and puree lunch meals. The tray cards for Resident #40 and #63 stated Salisbury Steak w/Mushroom Gravy. Resident #40's tray card specified Gravy-#10 scoop for the Ground Meat Salisbury Steak. Nurse Practitioner #24 confirmed there was no gravy on both resident's meat served at lunch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and policy review the facility failed to properly store food in accordance with professional standards. This is true for the facility kitchen and nourishment pantry. This had the potential to affect all residents in the facility. Facility census 106.Findings included:a) On 02/09/26 at 11:30 AM, during Initial Brief Tour of Kitchen, with Dietary Account Manager (DM) the DM acknowledged the following in the kitchen and the nourishment rooms : Walk in Cooler:-A shelved food cart of deserts that were covered without labels or dates.-A salad marked Name on it in which the Dietary Account Manager stated it belonged to an employee and removed it -The top utensil drawer was found to have a powdery white residue covering the inside bottom underneath the utensils-The bottom drawer was found to have utensils scattered not facing in the same direction -Coffee grounds were scattered and brownish spots from spilled liquids were observed on the kitchen floor in front of the shelves and around the tray line and in front of the stove- Sugar and Flour Bin lids were dusty on the top with flour and sugar with both spilled into the floor. When asked, the Dietary Account Manager acknowledged the unclean floor on 02/09/26 at 11:40 AM, and stated that the floors should have been cleaned the night before but did not have a cleaning schedule or sign off sheets. A large plastic purple cup was observed with a lid and a straw in the top cabinent shelf, in which the Dietary Account Manager stated that it belonged to an employee that should not have been in the nourishment room cabinet. It was observed 2(two) boxes filled with toiletries were observed in the bottom cabinet shelf. This box included bottles of lotions, body powder, and perfumes, a donut shaped seat cushion and a large case of plastic gloves On 02/09/26 at 11: 50AM, an interview with The Corporate Coordinator (CC) was completed. CC acknowledged the 2 boxes of toiletries, case of gloves, and the cushion discovered in the 200 Hall Nourishment Room and stated that was not supposed to be there and removed it. In the 200 Hall Refridgerator the following was obsered: An unopened bottle of Pepsi without a label or date belonging to an employee. The Dietary Account Manager removed it and placed it in the trash canIn the upper cabinent it was observed a packet of peanut butter had a tear in the cover exposing the peanut butter to air. On 02/09/26 at 1:45 PM a review of the facility food service policy labeled HCSG Policy 019, Food Storage: Cold Foods. Procedures, number 5 stated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, and staff interviews, the facility failed to dispose of garbage and refuse properly. This had the potential to affect more than an isolated number of residents in the facility. Facility census: 106. a) On 2/10/26, at 3:45 PM during an observation of the dumpsters, it was observed that debris and trash were scattered around and behind both dumpsters. [NAME] plastic gloves, plastic cup lids, Styrofoam cups, plastic bags were in the front and sides of both right and left dumpsters. An opened box with take-out food in was observed left opened and a clear bag of trash laying on the ground on the left side of the left dumpster. In an interview with the Director-Senior Maintenance Employee (DSME) #7, he stated he had seen the trash and debris scattered around the dumpster and would get it taken care of.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and staff interview the facility failed to ensure it had a Quality Assessment and Assurance (QAA) committee to meet at least quarterly with the required minimum staff. This failed practice was a random opportunity for discovery during the Long-Term Care Survey Process. Facility census: 106. Findings Include: a) QAA meetings A review on 02/11/26 at 9:49 PM, of the QAA sign in sheets from 01/25 to 01/26 revealed, that The Director of Nursing (DON) did not attend the 2nd quarter or 3rd quarter meetings as required. During an interview on 02/12/26 at 8:40 AM, The Administrator stated, We had the Assistant Director of Nursing (ADON), filling in as our Director of Nursing (DON) for the facility because we were in between DON's. Further review on 02/12/26 at 8:45 AM, of the QAA sign in sheets revealed that neither the ADON or the DON attended the QAA meeting for the 2nd and 3rd quarter of 2025. On 02/12/26 at 8:58 AM, The Administrator confirmed that they did not have a DON or ADON in attendance for the 2nd and 3rd quarter of 2025. b) Policy titled Quality Assurance and Performance Improvement Plan. A review on 02/12/26 at 9:30 AM, of the policy titled {Quality Assurance and Performance Improvement Plan}, under frame work, reads as follows:Committee must be comprised of DON, IP, Medical Director or designee and 3 additional team members one of which is the administrator. A consultant pharmacist is recommended to serve on the committee. This is a minimum requirements .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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	Provide and implement an infection prevention and control program. Based on record review, staff interview and observation, the facility failed to ensure an effective infection prevention and control program. was maintained. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #33, #106, #90, #96, #57, #65, #51 and #78. Facility Census: 106. On 02/09/26 at 2:24 PM, it was observed Activities Assistant #49 enter Resident #78's room with droplet precautions sign on door and a red stop sign draped across the front of the door. Activities Assistant walked into room and handed her a package without wearing Personal Protective Equipment PPE. During this time, other staff was in the room wearing PPE. On 02/09/26 at 2:30 PM, during an interview with Activities Assistant #49 when asked if Resident #78 was under precautions, she reported, She doesn't have anything. She has been going to dining room with no mask. When the sign was pointed out on the door and nurse aide whispered this resident had COVID, Activities Assistant #49 stated, Then yes, I should have been suited up. 02/09/26 1:25 PM the Hall 200 Tray Delivery and Meal Set up was observed. During this time It was observed that the Admissions Coordinator did not offer proper hand hygiene to Resident #96 and #106 when she delivered and assisted in the meal set up. On 02/09/26 at 1:28 PM, It was observed that Employee #24 did not offer proper hand hygiene to Resident #90 on the 200 Hall during lunch tray delivery and meal set up On 02/09/2026 1:25 PM, in an interview with the Admissions Coordinator, she acknowledged she did not offer hand sanitizer to Resident #96, and #106. ON 02/09/26 1:28 PM, during an interview with Employee #24, she acknowledged she forgot to offer the proper hand hygiene. She stated she usually was very good at remembering that. On 02/10/26 at 1:45 PM, during dining room observation, it was observed that Employee #47 carried Resident #33's plate with his thumb resting in the inside of the plate's food's barrier. In an interview with Employee # 47 he acknowledged he had placed his thumb too far into the plate's food barrier while carrying Resident # 33's plate. In an interview with the Corporate Coordinator, on 02/10/26 at 2:25 PM, she acknowledged the staff's lack of proper hand hygiene in the 200 hall on 02/09/26 and the dining room on 02/10/26. Findings included: a) The facility's policy and procedure for Exhaust System Inspection stated that exhaust fans for soiled and clean laundry rooms should be inspected monthly and ensure that air flow is sufficient enough to hold a piece of paper to the vent when operating. On 02/11/2026 at 2:20 PM, an investigation of the laundry room was initiated with the Life Safety Surveyor and the Maintenance Director. It was observed that the air was not pulling from clean side to the soiled side of the door with the tissue test. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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	The facility's policy and procedure for Special Contact and Droplet Precautions stated, 2. Keep the patient's door to the room closed unless doing so would endanger the patient. Multiple doors to covid positive resident rooms were observed to be open on two halls on 12/09/2026 during the initial survey process. On 02/10/2026 at 11:30 AM, the state surveyor and the Infection Preventionist Registered Nurse observed two covid positive room doors opened. In one, the nurse reported the resident wears a mask and leaves his room. In the other room, the door was closed by the nurse during the 200 hall observation. c) The facility's policy and procedure for Special Contact and Droplet Precautions stated, 4. Wear proper PPE including respiratory protection (N95 respirator), gown, and gloves prior to entering the room of those who require Special Contact and Droplet Precautions. Eye Protections is highly recommended for encounters with positive patients, and is required for use during aerosol-generating procedures (AGP). On 02/09/2026 at 12:40 PM, the Occupational Therapist was observed with no eye protection on while inside a covid positive patient's room When asked if they had a face shield or glasses, the Occupational Therapist stated, No, I don't have it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interview, the facility failed to ensure education was offered for all staff for Covid-19 vaccines. The failed practice had the potential to affect more than a limited number of residents. Facility Census: 106.Findings included: a) The federal guidelines stated that education must be provided for all staff for the risks and benefits of the vaccine and the Covid-19 vaccine should be offered by the facility or the facility should offer information on how to obtain the vaccine. b) HealthStream education system provided to staff was reviewed for five nursing assistants by the surveyor assigned staffing No documentation was found for education on the covid vaccine. On 02/11/2026 at 12:00 PM, the Infection Preventionist Registered Nurse reported she only gives information to staff if they request it for the Covid-19 vaccine 02/12/26 at 10:42 AM, the Infection Preventionist Registered Nurse stated, there was Nothing in HealthStream.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on electronic medical record review and staff interview, the facility failed to accurately complete section N of the annual Minimum Data Set (MDS) for one (1) of 34 residents. Resident identifier: #16. Facility census: 106. Findings included: a) Resident #16 On 02/11/26 at 10:14 AM a review of the annual MDS with an Assessment Reference Date (ARD) of 12/29/25 found Section N was marked as Resident #16 was receiving insulin. A review of the current physician orders and the Medication Administration Record (MAR) did not find an order for insulin or that insulin had been administered.An interview with the MDS Coordinator at 11:04 AM on 02/11/26 confirmed the MDS Section N had been marked incorrectly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview the facility failed to include all appropriate diagnosis on the most recent Pre-admission Screening and Resident Review (PASARR). This failed practice was found true for (2) two of (5) five residents reviewed for PASARR accuracy during the Long-Term Care Survey Process. Resident identifiers: #5, and #10. Facility Census: 106. a) Resident #10 A record review on 02/10/26 revealed that Resident #10 has a current diagnosis of Schizophrenia with a start date of 10/30/25. Further record review of Resident #10's most recent PASSAR completed on 05/02/22, revealed that Schizophrenia is not indicated on section 30, or listed in any other section of the PASSAR. During an interview on 02/10/26 at 2:12 PM, The Licensed Social Worker (LSW) #59, confirmed that Resident #10 had a diagnosis of Schizophrenia and that it is not indicated on the most recent PASSAR. LSW #59 stated, We just missed it. We are starting an audit now. Findings Include: a) Resident #5 A record review on 02/10/26 at 1:25 PM, revealed that Resident #5 has a current diagnosis of Epilepsy and is currently being treated for the Epilepsy with Lacosamide oral tablet 100 Milligrams (MG) (2) two times a day. Further record review of Resident #5's most recent PASSAR completed on 04/02/25, revealed that Epilepsy is not indicated on section 30, or listed in any other section of the PASSAR. During an interview on 02/10/26 at 2:12 PM, The Licensed Social Worker (LSW) #59, confirmed that Resident #5 has a diagnosis of Epilepsy and that it is not indicated on the most recent PASSAR. LSW #59 stated, We just missed it. We are starting an audit now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and staff interview the facility failed to develop and/or implement care plans related to physician dietary orders and Auditory needs. This failed practice was a random opportunity for discovery during the Long-Term Care Survey Process. Resident identifiers: #30, and #104. Facility census: 106. Findings Included:a) Resident # 30 On 02/10/2026, at12:06 PM, During Dining Room tray pass, It was observed that Resident #30's meal ticket stated, 1:1 Feed Assist and Supervision for all meals. Employee #17 retrieved Resident #30's tray, assisted in set up, then went back to get another resident's tray leaving Resident # 30 unsupervised for 8 minutes. Record Reviews:On 02/10/2026 at 1:15PM, a completed record review of Resident #30's Physician Orders coincided with the meal ticket stating resident was a 1:1 feed assist and ordered supervision for all meals.On 02/10/2026 at 1:28PM, a record review of Resident # 30's Care Plan stated as written:Resident is receiving a regular dysphagia pureed diet and thin liquids with 1:1 supervision at meals. Date initiated: 05/07/2025.Staff Interviews:In an interview on 02/10/26 at 12:15PM, with Employee #17 acknowledged she did take Resident #30's tray to him set up his meal then left him to eat by himself without supervision for 8 minutes She stated, That's not good. In an interview with the Corporate Coordinator, she stated she had heard about Resident # 30's tray set up and the lack of supervision for 8 minutes. She acknowledged the Physician Orders:of 1:1 Feed and Supervision for all meals were not followed for Resident #30. b) Resident #104:On 02/09/26 at 2:45 PM, during facility entry interview, Resident #104 stated she was not able to hear and has had a hard time communicating with others. During the interview written notes were used, She read and verbally responded her answers. she stated she had 2 hearing aides but they do not work well. On 02/10/26 at 3:20PM A record review of the resident's Physician Orders and Care Plan found no mention of her auditory needs or of her wearing hearing aides. On 02/10/26 at 3:45PM, Employee #81 was observed talking very loudly to Resident # 104, but stated to the surveyor she was not aware of resident having trouble with her hearing and she said, She seems to hear me ok. When asked in the presence of Employee # 81, Resident # 104 said she was not able to hear what was being said. Upon checking, Employee #81 discovered a hearing aid in the resident's left ear but nothing in the right ear. During an interview with the DON on 02/10/26 at 3:55 PM, She acknowledged the Care Plan failed to include Resident #104's auditory needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, and staff interviews, the facility failed to ensure a resident's care plan was revised in the areas of discontinued physician orders and for resident advance directive status. Resident identifiers: #4 and #11. Facility Census:106 a)Resident #4 A record review on 02/11/26 at 10:00 AM, of Resident #4's Care Plan stated : Focus: Name is receiving antibiotic treatment for a Urinary Tract Infection. Interventions: Administer medication(s) as ordered. date initiated 01/21/26 A Further record review of Resident #4's Physician Orders, an order for the antibiotic could not be found. During an interview on 02/11/26 at 2:55 PM, The Director of Nursing (DON) She provided the discontinued Physician Order written below: Physician Orders were as follows: Fosfomycin Tromethamine Oral Packet 3GM Give 1 packet by mouth one time only for UTI for 1 day. start date 01/21/26 and confirmed that the care plan was not revised to reflect Resident #4's antibiotic treatment for the Urinary tract infection had been discontinued. b) Resident #11 A record review on 02/11/26 at 9:00 AM, of Resident #11's ordered, revealed that Resident #11 was changed from a full code status to a Do Not Resuscitate (DNR) on 02/02/26. Further record review of Resident #11's current Advance Direct care plan read as follows: Focus: Full code- Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatment as indicated to attempt to prolong life including intensive care. Provide feeding through new or existing surgically-placed tubes. with a revision date of 01/06/26. During an interview on 02/11/26 at 10:17 AM, The Director of Nursing (DON) confirmed that the care plan did not reflect Resident #11's current code status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, staff interview and observation, the facility failed to ensure the residents' environment remained as free of accident hazards as possible. Resident Identifier: #80. Facility Census: 106. Findings included:a) Resident #80 The facility failed to ensure suction equipment was in place with the suction machine at the resident's bedside. On 02/09/26 at 2:00 PM, during the initial interview process, Resident #80 had a suction machine on his bedside table. No canister was in the suction machine or around the machine. On 02/09/26 observation of Suction machine at bedside revealed no canister was attached. At 2:05 PM, Nurse Aide #3 verified there was no canister in the suction machine. On additional observations during the Long Term Care Survey Process, a package containing the sterile catheter, container and gloves was hanging on the resident's bedside table. On 02/11/2026 Nurse Educator #81 reported they were looking at getting the order discontinued for the suction machine. The Director of Nursing and Nurse Educator reported they don't set the suction machines up except the sterile equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 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 electronic medical record review, and staff interview, the facility failed to ensure two (2) of four (4) resident's Pre admission Screening and Resident Review (PASARR) was current and accurate. This failed practice had the potential to affect a limited number of residents. Resident identifiers: #16, #67. Facility census: 106. a) Resident # 67 On 02/10/26 at approximately 2:55PM, a record review found that Resident # 67 was diagnosed with vascular dementia, moderate, with anxiety was not updated in the PASARR. In an interview with the DON on 02/10/26 at 3:25 PM, she acknowledged Resident # 67's PASARR was not updated r/t (related to) the diagnosis of vascular dementia, moderate, with anxiety. She stated she was aware that PASARRs facility wide were in need of updating and an audit was started to rectify the issue. b) Resident #16 On 02/12/26 at 12:15 AM a review of Resident #16's medical record found a PASARR dated 12/23/24. Under physician recommendations was marked as the resident eventually returned home or be discharged in less than three (3) months. The physician specified 90 days. In an interview with the Social Worker (SW) on 02/10/26 at 2:44 PM, the social worker stated the PASARR for Resident #16 was not current as the resident is still in the facility. The SW stated an updated PASARR would be completed immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515053	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Center at Fairmont Campus	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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on record review, staff interview and observation, the facility failed to ensure call lights were within the resident's reach for two (2) residents. Resident Identifiers: #40 and #50. Facility Census: 106.Findings included: a) Resident #40 The policy and procedure for Call Lights stated, 4. Staff will ensure the call light is within reach of the patient and secured as needed. On 02/09/2026 at 12:45 PM, Resident #40's call light was observed not to be within the resident's reach. Nurse Practitioner #24 confirmed the call light was not in reach, unwrapped the call light from the bedrail and placed the call light within the resident's reach. b) Resident #50 On 02/02/26 at 12:30 PM, Resident #50's call light, tv remote and bed remote were observed on the floor. The resident's lunch tray was passed. At 1:05 PM, the resident's call light, tv remote and bed remote remained on the floor beside the resident's bed. Licensed Practical Nurse # 32 confirmed the resident's call light was in the floor and not within reach and stated, I'm sorry. The policy and procedure for Call Lights stated, 4. Staff will ensure the call light is within reach of the patient and secured as needed.