

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Morgantown Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Mon General Drive Morgantown, WV 26505	
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 - 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 reviews, staff interviews, resident interviews, and observations, the facility failed to maintain an environment free from accidents and hazards by providing inadequate supervision. This deficient practice had resulted in actual physical harm to one (1) of 21 residents. Resident #65 sustained a subarachnoid hemorrhage after being knocked down by Resident #42. Resident #42 was known to the facility as having episodes of physical aggression. Resident Identifiers: #65 and #42. Facility Census: 114. Findings included: a) Resident #42 The facility's policy and procedure for Incidents/Accidents stated, It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees by minimizing possible exposure to safety hazards to the extent applicable. A Facility Reported Incident received 03/03/26 was reviewed for alleged resident-to-resident abuse. Resident-to-resident physical abuse was substantiated by the facility. The Initial Reporting of Allegations summary included: Resident #42 was found in a resident room holding Resident #65's iPad. Staff felt Resident #42 was in the victim's room rummaging through her belongings; Resident #65 attempted to take it back and, during a struggle, Resident #65 lost her balance. The report stated that Resident #65 was lying flat on her back in the doorway to her room, and she was bleeding from a wound on her head. Resident #65 was transferred to the Emergency Department for further evaluation at 11:15 PM. Resident #42 was placed on one-on-one supervision. Resident #65's Trauma History and Physical report dated 03/03/26 stated, Impression: Acute medial right frontal lobe multifocal areas of subarachnoid hemorrhage, with parafalcine and right tentorium subdural hematoma measuring up to 5 mm. No midline shift. Resident #65 was capacitated with a Brief Mental Status Score (BIMS) of 14. Resident #42 was incapacitated and a BIMS was not completed secondary to the resident hardly/never understood. Resident #42's progress notes were reviewed and summarized: On 02/16/26, the nurse's note stated that redirection was not effective; the resident was agitated, combative, and exit-seeking. On 02/18/26, an Alert Note stated Resident #42 hit another resident in the face and pulled her hair. However, further investigation by the State Surveyor of the risk assessment determined Resident #42 had gone into another resident's room and was hit in the face and her hair was pulled. On 02/19/26, Clinical Psychological Services (CPS) recommended the following: continue consistent re-direction and frequent re-orientation strategies, Utilize structured environment and limited overstimulation. Monitor for further agitation or interpersonal conflicts. On 02/21/26, an Alert Note stated the resident entered another resident's room causing agitation with other residents; both were screaming and staff intervened by removing the resident. On 02/25/26, CPS's note had no change in recommendations. On 02/27/26, the Physician Monthly Visit note documented no change in cognition and no increased nervousness or depression. On 03/02/26 at 15:14, an Alert Note documented one-on-one supervision failed. On 03/03/26 at 00:46, an Alert Note documented a resident-to-resident altercation. On 03/03/26 at 10:41, (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 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, observation, resident interviews, and staff interviews, the facility failed to ensure the menus were prepared in advance and followed to meet the nutritional needs of the residents. This failed practice affected five (5) of 21 residents. Resident Identifiers: #68, #40, #104, #111, and #65. Facility Census: 114. Findings included: a) The facility's policy and procedure for meal distribution stated, For point of service dining, the Dining Services Department staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the individual meal card and present it to the resident/patient or care staff for delivery to the resident/patient. b) On 07/27/26, the dining observation was initiated. Monday's posted menu stated the following: Chicken Stir Fry w/Vegetables, Broccoli Florets, Steamed Rice, Buttered Dinner Roll, and Pear Crisp. The menu extension for the Dysphagia Advanced diet also included poultry gravy, two (2) ounces, to be served with the meal. On 07/27/26, the following menu and tray card errors were noted for the following residents: c) Resident #68 Resident #68 stated, Tonight I probably got everything, but I usually don't. The resident did not receive eight (8) ounces of milk per her tray card and stated, I never get milk at suppertime. Licensed Practical Nurse (LPN) #126 confirmed the resident did not receive milk or a cup. The resident was asked if she wanted milk by the LPN, and the resident stated, Chocolate, when given a choice. d) Resident #40 Resident #40 did not receive poultry gravy per his tray card and menu extension. The resident's tray card stated, Poultry Gravy - 2 Oz and Buttered Dinner Roll - 2 Ea. The resident only received one (1) roll. At 12:20 PM, Nurse Aide #64 confirmed the resident did not receive the poultry gravy or two rolls and stated, That is correct. e) Resident #111 Resident #111 received a regular buttered dinner roll with her pureed meal. The resident's tray card stated, Pureed Buttered Dinner Roll - #15 Scp in pink lettering. Special instructions for tray cards are printed in a pink color. The State Surveyor intervened before the resident consumed the regular consistency roll. The resident's diet and tray card were confirmed by Nurse Aide #64, who stated, Yeah, you're right, and reported she didn't think that looked right. f) Resident #104 At 12:10 PM, Resident #104 did not receive poultry gravy. The resident's tray card stated, Poultry Gravy - 2 Oz. Account Manager #145 confirmed there was no gravy on the resident's food and went to get gravy for the resident. g) Resident #65 At 12:05 PM, Resident #65's tray card and tray were observed. The resident's tray card stated, [NAME] Crunchies Cereal - 2 Srv. The resident only received one bowl of cereal on her lunch tray. No milk was provided for the cereal. Account Manager #145 confirmed the resident's tray and tray card and stated, I'll get it, and added, Sometimes she only wants one.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, resident interviews, and observations, the facility failed to ensure that adaptive equipment and utensils were provided for residents at mealtimes as ordered by the physician. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #5, #53, #62, and #69. Facility Census: 114. Findings included: a) The facility's policy and procedure for Assistive Devices stated, 1. Appropriate assistive devices/utensils will be provided as indicated in the physician's orders and individualized plan of care. b) Resident #5 On 07/27/26 at 12:12 PM, Resident #5 was observed with no Dycem under the lunch plate. The resident reported she gets Dycem sometimes. Speech-Language Pathologist #98 confirmed there was no Dycem under the resident's plate and stated, I can get some. The resident's tray card stated Dycem highlighted in blue. The resident's order stated, Dycem with meals. c) Resident #53 On 07/27/26 at 12:35 PM, Resident #53 was observed not to have a [NAME] Cup per the blue-printed [NAME] Cup on his tray card. The resident's order stated, Blue Kennedy cup. Licensed Practical Nurse #100 confirmed the resident did not have a [NAME] Cup and reported the resident had never had a [NAME] Cup. The resident had a two-handled cup with a spouted lid. d) Resident #62 On 07/27/26 at 12:38 PM, no Dycem was observed under Resident #62's plate. Dycem was printed in blue on the resident's tray card. The resident's order stated, Dycem mat and scoop plate with all meals. Nurse Aide #56 confirmed there was no Dycem under the plate and stated the plate usually has a ring around it. this one doesn't. e) Resident #68 On 07/27/26, Resident #66 stated, Tonight I probably got everything, but I usually don't. The resident did not receive the two-handled cup with lid as printed on her tray card. Licensed Practical Nurse (LPN) #126 confirmed the resident did not receive the cup. LPN #126 stated, I've never seen it in three (3) years. The resident reported she never gets a special cup. The resident was observed to be drinking out of a regular coffee cup during the dinner meal.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interview, the facility failed to ensure an allegation of resident-to-resident abuse was reported immediately (but not later than two (2) hours for an allegation of abuse resulting in serious bodily injury), failed to notify administration immediately per facility policy, and failed to submit a Five-Day Follow-Up to the state agency. This failed practice affected two (2) of 21 residents. Resident Identifiers: #65 and #3. Facility Census: 114. Findings included: a) Resident #65 The facility's policy and procedure for WEST VIRGINIA Abuse, Neglect & Misappropriation concerning investigations stated, V1.12.a. If the events that cause the allegations involve abuse and/or serious bodily injury, the self-report must be made immediately, but no later than 2 hours after the allegation is made. A Facility Reported Incident (FRI) was reviewed for resident-to-resident abuse. The Initial Reporting of Allegations stated, Per staff interviews perpetrator was found in resident room holding the victims I-Pad. Staff felt Perpetrator was in victims room rummaging through her belongings and victim attempted to take it back-during struggle victim lost her balance. The date and time when the alleged incident occurred was 03/02/26 at approximately 10:30 PM. The description of the injury stated the resident was bleeding from occipital scalp. Resident complained of nausea and positioned on her side. She did have a large emesis at that time. Resident #65 was transferred to the Emergency Department for further evaluation. Education included in the incident file was provided on 03/04/26 and 03/05/26 concerning the following: All incidents need reported to the DON/ED/Supervisor immediately to identify which events report to state and to meet the time frame for reporting. Please make sure you are reporting timely. Please sign off on the educational form with a supervisor prior to starting your next shift. Resident #65's Trauma History and Physical report stated, Impression: Acute medial right frontal lobe multifocal areas of subarachnoid hemorrhage, with parafalcine and right tentorium subdural hematoma measuring up to 5 mm. No midline shift. An initial report of the incident was emailed to the Office of Health Facility Licensure and Certification (OHFLAC) and the Ombudsman on 03/03/26 at 10:37 AM. The incident of resident-to-resident abuse was not reported within two (2) hours. On 07/27/26 at 4:44 PM, the Director of Nursing (DON) confirmed the incident was not reported within the two (2) hours and stated, So that should have been reported . within two (2) hours. The DON reported that corporate had come to the facility and completed education for reporting abuse in a timely manner. b) Resident #3 On 11/20/25, an initial reporting of allegations was made to all required entities, including the Office (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Health Facility Licensure and Certification (OHFLAC). It was reported that Resident #3 grabbed Resident #115's right arm. Fingernail marks were noted on Resident #115's right arm. Residents were separated immediately by nursing staff. Investigation was performed with resident and staff interviews. It was determined that Resident #3 screamed that Resident #115's chair was squeaking and driving him crazy. However, no five (5) day report was located in the file provided to the surveyor by the facility. On 07/28/26 at 3:00 PM, the Director of Nursing (DON) stated he was unable to locate a five (5) day report for the incident that occurred on 11/20/25. He stated he believed it had been submitted, but he did not work at the facility when the incident between Resident #3 and Resident #115 occurred. On 07/29/26 at 11:30 AM, the State Agency confirmed a five (5) day follow-up was not submitted to OHFLAC. No further information was provided through the completion of the survey process.		

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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 observation, staff interview, record review, the facility failed to revise a resident's comprehensive care plan for behavior management interventions and activities. This failed practice affected one (1) of 21 residents. Resident Identifier: #42. Facility Census: 114. Findings included: a) Resident #42. Resident #42's care plan for behaviors was reviewed. The care plan listed resident physical aggression episodes towards other residents. Additional behavioral episodes were documented on the following dates: 02/18/26, 02/21/26 and 06/20/26 and were not updated on the care plan. Interventions included the resident to be educated about potential harm to other residents when pushing or attempting to push them and education to request staff assist rather than pushing other residents. The Social Worker #50 confirmed the resident would have difficulty with comprehending the education due to cognitive status. On 07/28/26 at 1:30 PM, Social Worker #50 confirmed there was no resident to resident interventions on the plan of care. Resident #42 was incapacitated and a BIMS was not completed secondary to the resident hardly/never understood. On 07/29/26 at 10:45 AM, Activities Leader #117 reported Resident #42 had family one (1) to one (1) time. The activities leader reported that Resident #42 does not go to group activities, but likes music and church. The activities leader reported currently the facility does not provide one (1) to one (1) activities. There is an activity in the afternoon provided for each side of the building. Resident #42 was encouraged to attend activities and likes to walk up and down the halls per the activity leader's report. The resident was given packets of images for self-directed activities. The Activities Leader reported the resident is not able to attend to activities and groups for long periods of time. Resident #42's care plan was reviewed for interventions and addressing the resident's behaviors. Activities Leader #117 confirmed there were no recent updates or changes since 03/8/25 and 06/16/25.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review, facility incident report review, and staff and resident interviews, the facility failed to ensure that necessary activities of daily living (ADL) services, specifically bedtime hygiene and incontinence care, were provided for the residents. This was discovered during the Long Term Survey complaint review process and affected one (1) of 21 residents. Resident Identifier #76. Census: 114. The facility was in past non-compliance. The facility identified the deficient practice on 07/27/26, implemented comprehensive corrective actions, completed staff education, and monitored implementation prior to the start of the survey on 07/28/26. Findings included: a) Resident #76 Review of the medical record for Resident #76 revealed a care plan initiated on 11/04/25, and revised on 04/23/26, which stated: Assistance required with ADL's may fluctuate based on time-of-day, mood, pain, or fatigue. Adjust and document as indicated. Report significant changes to charge nurse. Place call light within reach. Remind Resident to call for assistance. Resident will use call light if they need something at night. She doesn't want to be disturbed during her sleep. Review of a facility-reported incident (FRI) log dated 07/27/26, at 2:35 PM, detailed an allegation of resident neglect. The initial report indicated that Resident #76 was left overnight in soiled clothing without bedtime care. The facility's investigation concluded that the resident was left in her daytime street clothing overnight and was found wet/soiled by the oncoming morning shift. The internal investigation noted that night shift staff misunderstood the resident's care plan (did not want to be disturbed during her sleep) to mean that no evening preparation, bedtime hygiene, or clothing changes were required because the resident did not illuminate her call light. On 07/28/2026 at 9:30 AM an interview was conducted with Resident #76. The resident was able to recall the incident. She confirmed that she was left in her street clothes overnight and slept in a soiled brief. She stated, The morning staff got me all taken care of though. Resident Follow-Up Interview (07/28/2026 at 1:56 PM): Resident #76 clarified her preferences regarding her care plan, stating, I ask them (staff) not to come in at all hours of the night. They come in every two hours and annoy me and I can't sleep. She further noted she expects assistance getting ready for bed before she goes to sleep, and enjoys staff assistance picking out clothes from her closet. Written statements from the morning shift staff confirmed that Resident #76 was still dressed in the prior day's clothing and was heavily saturated with urine when they assumed care. The night-shift Certified Nursing Assistant (CNA), [Perpetrator], provided a statement contradicting the incident and stated, I ensured that Resident #76 was changed and in a nightgown and dry before they went to bed. The facility's investigation found [Perpetrator]'s statements to be false based on the matching independent testimonies of the resident and the oncoming morning staff, alongside the physical evidence of the resident being found in heavily saturated street clothing. Past Non-Compliance and Corrective Actions The facility's failure to differentiate between preventing sleep disruptions during the night shift and providing standard evening hygiene and bedtime ADLs resulted in the resident being left overnight in her soiled clothing until the next morning. However, the facility successfully demonstrated that it corrected this deficiency before the survey team arrived. The survey team validated the following components of the facility's corrective actions, implemented between 07/27/26 and 07/28/26. The facility placed the implicated staff member on administrative leave pending the investigation. A verbal warning was executed and placed in her personnel file. Adult Protective Services (APS) and the local Police Department (PD) were immediately notified per state reporting mandates. The facility conducted comprehensive physical and skin assessments for all residents assigned to that unit/shift to ensure no other residents were left soiled, wet, or missing bedtime care. No other negative outcomes or omissions were identified. Immediate education was (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given for nursing and CNA staff. The training focused on interpreting care plans accurately-clarifying that a resident's right to undisturbed sleep does not eliminate the requirement to offer or perform nighttime care, clothing changes, and evening toileting prior to a resident going to sleep. The facility instituted administrative tracking and shift-change audits to ensure PM and AM care handoffs accurately communicate residents' current clothing and continence status.		

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NAME OF PROVIDER OR SUPPLIER Morgantown Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Mon General Drive Morgantown, WV 26505	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on staff interview , observation and record review, the facility failed to ensure a resident was provided an ongoing program to support the resident in their choice of group and individual activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of the resident. Resident Identifier: #42. Facility Census: 114. Findings included: a) Resident #42 The facility's policy and procedure for Activities Program Policy stated, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional need and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The Procedures for the activity process included: c. Consists of individual and small and large group activities which are designed to meet the needs and interests of each resident and includes at a minimum: viii. Individual activities. The activities are to be comprised of individual and group activities. Following an investigation of a Facility reported Incident of resident to resident abuse involving Resident #42. The resident's medical chart was reviewed. The following progress notes were reviewed and summarized: Resident #42 was incapacitated and a BIMS was not completed secondary to the resident hardly/never understood. On 02/16/26, the nurse's not stated that re-direction wasnot affective, Resident agitated, combative and exit seeking. On 02/18/26, an Alert Note stated Resident #42 hit another resident in the face and pulled her hair. However, further investigation by the State Surveyor of the risk assessment determined Resident #42 had gone into another resident's room and was hit in the face and her hair was pulled. On 02/19/26, Clinical Psychological Services (CPS) recommended the following: continue consistent re-direction and frequent re-orientation strategies, Utilize structured environment and limited overstimulation. Monitor for further agitation or interpersonal conflicts. On 02/21/26, an Alert /note stated the resident entered another resident's room causing agitation with other residents, both screaming and staff intervened by removing the resident. On 02/25/26, CPS's note had no change in recommendations. On 02/27/26, the Physician Monthly Visit note documented no change in cognition and no increased nervousness or depression. On 03/02/2 at 15:14, an Alert Note documented one on one failed. On 03/03/26 at 00:46, an Alert Note documented a Resident to Resident altercation. On 03/03/26 at 10:41, a note documented the resident was deemed safe and removed from one(1) on one(1) supervision. On 03/03/26 at 23:05, an Alert Note documented the resident was: Agitating residents, taking belongings, verbal abusive to staff, 1:1 with limited success. On 03/06/26, a Nurse's note documented the resident was difficult to re-direct. On 03/08/26, a Nurse's Note documented Resident #42 was entering other resident's rooms and was up all night. On 03/19/26, an Activities Note stated that the resident prefers to be self-directed. On 06/21/26, a Social Services Note documented a Resident to Resident altercation on 06/20/26. No Progress Note about incident documented. On 06/22/26, an Alert Note documented attempts to re-direct failed as needed (PRN) Ativan given. On 06/22/26, a CPS Note mentions the resident to resident incident and recommendations were the same as 02/29/26. On 06/23/26, an Alert Note was documented by the Nurse Practitioner (NP) and that the NP addressed resident's behaviors and PRN Ativan not always effective. A new order for trazodone was given. On 07/01/26, an Alert Note reported behaviors of playing in bowel movement, increased agitation, attempting to hit staff, exhibited agitation towards husband, the nurse provided intervention and PRN Ativan was given. Frequent documentation of wandering throughout facility was documented in the resident's progress notes. On 07/27/26 at 6:10 PM, the State Surveyor observed Resident #42 wandering in the hallways from E Hall, D Hall and C Hall re-directed back to E Hall x2 by staff. On 07/28/26, Registered Nurse/Minimum Data Set Coordinator (RN/MDS) #130 reported (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #42's behavioral interventions were a hit or miss and the resident can sometimes communicate. The social worker updates the care plan for resident to resident behaviors. The RN/MDS coordinator #130 confirmed the only update on the care plan for behaviors was for wander guard on 03/06/26 and reported unit nurses update care plans for daily changes. No intervention edited/revised from 2024. Resident #42. care plan for behaviors was reviewed. The care plan listed resident physical aggression episodes towards other residents. Additional behavioral episodes were documented on the following dates: 02/18/26, 02/21/26 and 06/20/26 and were not updated on the care plan. Interventions included the resident to be educated about potential harm to other residents when pushing or attempting to push them and education to request staff assist rather than pushing other residents. The Social Worker #50 confirmed the resident would have difficulty with comprehending the education due to cognitive status. On 07/28/26 at 1:30 PM, Social Worker #50 confirmed there was no resident to resident interventions on the plan of care. Resident #42 was incapacitated and a BIMS was not completed secondary to the resident hardly/never understood. On 07/29/26 12:30 PM, the incident resulting in harm between Resident #65 and Resident #42 was reviewed with the Administrator and the Director of Nursing (DON) including interventions, resident supervision, progress notes and care plans for Resident #42. The Administrator reported he thought there were no issues with the care plans and he would follow-up with the care plan nurse. The DON reported the resident was seen by psych services this date. On 07/29/26 at 1:00PM, the State Surveyor reviewed the findings with the Regional Director of Operations (RDO) including interventions, progress notes and care plans for Resident #42. On 07/29/26 at 1:30 PM, the DON reported there was no additional information concerning supervision and interventions for Resident #42. Resident #42's Activity Participation Log was reviewed. Activities were not provided for the following dates: February 2026 - 02/04/26, 02/07/26, 02/11/26, 02/12/26, 02/13/26, 02/20/26, 02/21/26, 02/22/26, 02/25/26, 02/26/26, and 02/28/26. March 2026 - 03/02/26, 03/03/26, 03/05/26, 03/06/26, 03/07/26, 03/08/26, 03/10/26, 03/11/26, 03/13/26, 03/17/26, 03/18/26, 03/26/26, 03/29/26, and 03/30/26. April 2026 - 04/05/26, 04/06/26, 04/08/26, 04/09/26, 04/12/26, 04/13/26, 04/17/26, 04/18/26, 04/19/26, 04/20/26, 04/24/26, 04/25/26, and 04/26/26. May 2026 - 05/01/26, 05/03/26, 05/11/26, 05/12/25, 05/13/26, 05/14/26, 05/15/26, 05/16/26, 05/17/26, 05/17/26, 05/18/26, 05/20/26, 05/23/26, 05/25/26, 05/27/26, 05/29/26, 05/30/26, and 05/31/26. June 2026 - 06/02/26, 06/04/26, 06/05/26, 06/06/26, 06/07/26, 06/07/26, 06/08/26, 06/10/26, 06/12/26, 06/14/26, 06/16/26, 06/16/26, 06/17/26, 06/06/19/26, 06/20/26, 06/21/26, 06/23/26, and 06/30/26. July 2026 - 07/04/26, 07/05/26, 07/06/26, 07/07/26, 07/08/26, 07/09/26, 07/10/26, 07/11/26, 07/13/26, 07/15/26, 07/16/26, 07/15/26, 07/16/26, 07/19/26, 07/20/26, and 07/25/26. On 07/29/26 t 10:45 AM, Activities Leader #117 confirmed the missing activities on the Activity Participation Log. Activities Leader #117 reported Resident #42 had family visitors frequently for one (1) to one (1) time The activities leader reported the resident doesn't go to group activities often, but likes music and church. Activities Leader #114 stated that currently the facility does not provide individual one (1) to one (1) activities for the residents in the facility. She reported there is an activity in the afternoon for each side of the building. The activities leader reported the resident is encouraged to attend activities and that she likes to walk up and down the halls. The resident is given packets of images to look through for self-directed activities. No further information was provided through the completion of the survey process.		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on record review, staff interview, resident interview and observations, the facility failed to ensure a resident who experienced a traumatic event received appropriate treatment and services. This failed practice affected one (1) resident. Resident identifier: #65. Facility Census: 14. Findings included: a) Resident #42 a) Resident #65 A Facility Reported Incident received 03/03/26 was reviewed for alleged resident to resident abuse. Resident to resident physical abuse was substantiated by the facility. The Initial Reporting of Allegations summary included: Resident #42 was found in resident room holding Resident #65's I-Pad. Staff felt Resident #42 was in victims room rummaging through her belongings and Resident #65 attempted to take it back and during a struggle Resident #65 lost her balance. The report stated that Resident #65 was lying flat on her back in the doorway to her room. and she was bleeding from a wound on her head. Resident #65 was transferred to the Emergency Department for further evaluation at 11:15 PM. Resident #42 was placed on one (1) to one (1) supervision. Resident #65's Trauma History and Physical report dated 03/03/26 stated, Impression: Acute medial right frontal lobe multifocal areas of subarachnoid hemorrhage, with parafalcine and right tentorium subdural hematoma measuring up to 5 mm. No midline shift. Resident #65 was capacitated with a Brief Mental Status Score (BIMS) of 14. Resident #42 was incapacitated and a BIMS was not completed secondary to the resident hardly/never understood. On 07/28/26 at 9:50 AM, Resident #65 was interviewed by the surveyor concerning the reported abuse incident resulting in a major injury. The resident recalled the incident from March 2026 and reported that Resident #42 took her blanket and threw it. The resident said, I fell down. My head bumped. I didn't wake up. When asked what staff does when Resident #42 comes into her room, Resident #65 stated, They take her away. She reported she was afraid she would have to have surgery if something happened. The resident reported she had angels watching over her. Resident #65 again reported she was afraid, but said Name (Resident #42) don't know what's going on. and They don't have no medicine for her. The resident reported she was afraid when Resident #42 comes in her room and stated, I was afraid. Big woman. You have to watch her. Even a man would. It's dangerous. Resident #65 was capacitated with a Brief Mental Status Score (BIMS) of 14. Resident #42 was incapacitated and a BIMS was not completed secondary to the resident hardly/never understood. Resident #42's progress notes were reviewed and summarized: On 02/16/26, the nurse's note stated that redirection was not effective; the resident was agitated, combative, and exit-seeking. On 02/18/26, an Alert Note stated Resident #42 hit another resident in the face and pulled her hair. However, further investigation by the State Surveyor of the risk assessment determined Resident #42 had gone into another resident's room and was hit in the face and her hair was pulled. On 02/19/26, Clinical Psychological Services (CPS) recommended the following: continue consistent re-direction and frequent re-orientation strategies, Utilize structured environment and limited overstimulation. Monitor for further agitation or interpersonal conflicts. On 02/21/26, an Alert Note stated the resident entered another resident's room causing agitation with other residents; both were screaming and staff intervened by removing the resident. On 02/25/26, CPS's note had no change in recommendations. On 02/27/26, the Physician Monthly Visit note documented no change in cognition and no increased nervousness or depression. On 03/02/26 at 15:14, an Alert Note documented one-on-one supervision failed. Resident #65 reported Resident #42 still comes in her room even with stop sign and two (2) nights ago slept in her roommates bed all night. The resident reported she was afraid and she tried to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stay up, but she fell asleep. Reported the stop sign works sometimes. Resident #65 stated, I'm praying hard, she don't know. The resident reported she still has residents coming into her room even with the 'Stop Sign' across the door. Resident #65's progress notes were reviewed. On 03/05/26, the resident denied any needs at that time. Social Worker progress noted dated 03/10/26 documented the resident denied having any psychosocial needs. No additional documentation of psychosocial needs were found. Additional progress notes reviewed included: 4/14/26 - Increased anxiety documented with Buspar ordered. 4/14/26 - eInteract change of condition for anxiety. 7/11/26 - Verbally agitated wit staff. Resident's #65's care plan stated, Resident had a R subdural hemorrhage in March 2026. Interventions/Tasks included: Observe for changes in mental status. Report Abnormal findings to medical provider; resident/resident representative. On 07/28/26 at 1:30 PM, Social Worker #50 reported there was no documentation of monitoring psychosocial impact for Resident #65. On 07/29/26 12:30 PM, the Director of Nursing reported the resident was seen by psych services this date.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record review, staff interview and observation, the facility failed to ensure food was provided in a form designed to meet individual needs for a resident ordered a pureed diet. This failed practice had the potential to affect a limited number of residents. Resident identifier: #111. Facility Census: 114. Findings included: a) The facility's policy and procedure for Therapeutic Diets stated the definition of a Therapeutic Diet is a diet ordered by a physician, or delegated registered or licensed dietitian, as part of the treatment for a disease or clinical condition. One of the purposes of a therapeutic diet is to provide food that a resident is able to eat (e.g., mechanically altered diet). b) Resident #111 Resident #111's diet order stated, Regular Diet Dysphagia Puree texture, Thin liquids consistency, fortified cereal breakfast, fortified soup lunch and dinner, two-handled cup with lid with meals. On 07/27/26, during the dining room observation, Nurse Aide #64 served the resident her lunch tray in the dining room. A regular consistency roll was buttered by staff and given to the resident. The State surveyor intervened prior to the resident eating the roll and had Nurse Aide #64 remove the regular roll. Nurse Aide #64 confirmed the resident was on a puree diet and should not have received a regular roll. Nurse Aide #64 stated, Yeah, you're right, and reported she didn't think that looked right.		