STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515060	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Center	101-13th Street Huntington, WV 25701

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 interviews, the facility failed to provide a safe, clean, comfortable, homelike environment. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Facility census: 156. Findings Include:a) 3rd floor dining roomAn observation on 05/19/26 at 8:45 AM of the 3rd floor dining room found a set of cabinets. The bottom cabinet was full of trash such as wrappers, napkins, etc., and lots of food crumbs. The drawer on the right side was stuffed with a dirty brief.During an interview on 05/19/26 at 9:00 AM, The Administrator and Director of Nursing both confirmed that the cabinet was dirty. The DON stated, I am so embarrassed.b) 2nd floor lounge areaAn observation on 05/19/26 at 10:00 AM, of the 2nd floor found a resident lounge. In the corner beside the pop machine, there were two broken pictures on the floor along with a headboard of a bed, several leg rests, two tubes of Zinc oxide paste, and wheelchair cushions.During an interview on 05/19/26 at 10:20 AM, the Director of Nursing (DON) confirmed the items should not be there and stated, I will get someone to put this stuff up.c) Homestead (Alzheimer's Unit)An observation on 05/19/26 at 10:30 AM, of the Homestead (Alzheimer's Unit),revealed in the dining room a plate in the sink, that was accessible to residents that was full of chewed up meat, peas and a half eaten roll . Inside The refrigerator in the unit was covered in a brown red like substance on the bottom with what appeared to be dirty paper towels stuck to itDuring an interview on 05/19/26 at 10:45 AM, the Homestead Program Director stated, That is gross. I will take care of it.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to provide and document sufficient preparation and orientation to Resident #158 and caregiver to ensure safe and orderly discharge from the facility. This was true for one (1) of three (3) residents sampled for discharges during the complaint investigation. Census: 156 Resident identifier: #158Findings include:a) Resident #158During a phone interview with Resident #158's daughter at 4:00PM on 05/19/26, she stated the facility contacted her two (2) hours after the appeal deadline to notify her of discharge plans, which occurred the day before her father's discharge. Complainant states at that time, the facility representative also said they did not yet have the admission paperwork signed and asked if they could email her the paperwork. She reports the facility representative stated that they had seen her brother several times, but was never able to catch him for the paperwork. She stated she was very unhappy with the social worker who called with this information and asked to speak to someone above her or be given the contact information for complaints, but that was not provided. She also reported that her father had an ostomy, a catheter, and wounds, and the family received no education on managing these conditions.A record review of the Notice of Medicare Non-Coverage (NOMNC) reveals the facility attempted to call Resident #158's son four (4) times on 04/03/26, but was unable to reach him. The facility was unable to provide proof of mailing the NOMNC nor that they attempted to contact his daughter on this day. Per the Physician Determination of Capacity dated 03/06/26, Resident #158 did not have capacity to understand or make medical decisions. The Discharge Transition Plan shows the discharge destination as home alone and states the resident is responsible for self and makes own decisions. It also indicates Resident #158 needs assistance with toileting, household tasks, and transfers from bed to chair. A general progress note dated 04/07/26 at 1:09PM states the following: Resident to [discharge] DC home today. resident educated on all current wounds noted and treatments to be provided, resident able to verbal repeat back treatment orders in place and expressed verbal understanding regarding current wound status and treatments. A review of the Durable Power of Attorney paperwork shows Resident #158's son as the primary power of attorney (POA) and the daughter/complainant as the alternate health care agent. A Non-Completion Affidavit also shows that the admission packet dated 04/30/26 had not been signed.In an interview with Specialist-Social Services #253 at 9:10 AM on 05/20/26, she stated when she attempted to reach Resident #158's son initially, she did not have any other numbers available. She stated she found the daughter's number on the paperwork in the chart on 04/07/26 which is when she called her. She also stated that to her knowledge, the family was not educated on wound care or ostomy/catheter care which caused her to send an Adult Protective Services referral upon discharge. A review of the Post Discharge Follow-up form reveals Resident #158 was admitted to the VA hospital the day after discharge from the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interviews and record review, the facility failed to ensure dependent residents had assistance with activities of daily living regarding assistance with eating and showers. Resident identifier: #20, #102, and #112. Facility census: 156. Findings include:a) Resident #20On initial tour of facility on 05/19/26, Resident #20 was observed in the third floor dining room with a tray of food in front of him at 8:49AM. The tray ticket designated the resident as requiring assistance with feeding. The food on the tray was cold and the oatmeal was congealed. Reported to Director of Nursing (DON) at 9:05AM, who confirmed Resident #20 has not been assisted with eating. A new tray was ordered and was delivered at 9:22 AM.b) Resident #102Resident #102 was observed at 9:37 AM with an uneaten breakfast tray at bedside. Her ticket indicated she required assistance with feeding. At 9:41 AM, it was confirmed by Licensed Practical Nurse (LPN) #1 that Resident #102 had not been assisted with feeding. She stated she thinks that is an old order and she no longer required assistance. c) Resident #112During an interview with Resident #112's daughter at 9:10AM, she reported that she and her sisters come to the facility daily to assist with feeding Resident #112 her breakfast and her dinner as this has been an issue with her mom not being fed. She stated there were multiple times she would come to the facility and find the breakfast tray on the bedside table with cold food. Resident #112 was observed on 05/20/26 at 12:30 PM with full lunch tray on bedside table with no assistance being provided. An interview with Nurse #23 confirmed no assistance was provided for Resident #112 to eat her meal at 12:39 PM on 05/20/26. A review of the care plan for Resident #112 shows an intervention that reads, provide resident with partial/moderate assist for eating.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and family interviews, the facility failed to keep the resident environment as free of accident hazards as possible, by not ensuring Resident #157 had assistive devices in place to prevent avoidable accidents. The State Agency (SA) determined that the potential for harm occurred on 12/24/25 when Resident #157 changed rooms and his bed rails did not go with him. Actual harm occurred on 12/26/25 when Resident #157 had a fall from bed resulting in a confirmed brain bleed. The facility was back in compliance on 12/30/25 after the last current staff member had been re-educated. This failed practice was found true for (1) one of (3) residents reviewed for fall prevention safety during the Complaint Survey. Resident identifier: #157. Facility Census: 156.Findings include:a) Resident #157 A record review on 05/19/26 at 9:40 AM, of the reportable log from 11/2025 to present found a reportable for Resident #157 dated 12/26/25 for a fall with major injury.Further review of the reportable five day follow-up summarizes the incident as follows: On 12/26/25, (Resident #157 name) had an unwitnessed fall with potential for serious bodily injury. A report was made to OHFLAC, APS, and Ombudsman. An investigation was initiated.During the investigation, the staff caring for (Resident #157 name) were interviewed and provided the following information: (Resident #157 name) was found by staff lying on the floor on his stomach beside his bed. The nurse was notified and a head to toe evaluation and vitals were completed. (Resident #157) was unable to recall what had happened due to poor cognition, which is consistent with his baseline. He had no complaints of pain or visual injuries noted. Staff noted that (Resident #157) bed was in the lowest position with call light in reach. (Resident #157 was assisted back to bed by staff x2 via mechanical lift. The facility provider was notified and neuro checks were started. His health care surrogate was notified and later in the morning came to visit (Resident #157 name). He requested for (Resident #157) to receive x-rays, but did not want to wait for an outside x-ray provider to be in the facility. He ultimately requested for him to be sent to the ER for evaluation. The facility provider was notified and (Resident #157) was sent to the ER for further evaluation per the HCS request. It was noted during the investigation that the night shift nurse had last checked on (Resident #157 name)around 5:30AM and at that time he was asleep in bed.While at the hospital, (Resident #157 name) received a CT of spine cervical w/o contrast, CT spine lumbar trauma, CT spine thoracic trauma, and CR port chest single. The results showed an intracranial hemorrhage that was present during a recent hospitalization before admitting to (Current Center name). It also showed a small left occipital hemorrhage without significant mass effect or shift. The CT spine showed a T2 compression deformity that was present on a CT from 11/25. (Resident #157 name) was admitted to the ICU for q1 neuro checks. He remains in the hospital at this time.The IDT team met to review the fall, (Resident #157 name) was found on the floor of his room. He had not pain or injuries noted at the time of the fall. His Health Care Surrogate was notified and requested for the resident to be sent to the ER for further evaluation. (Resident #157 name) was admitted to the ICU. Should (Resident #157 name) return to our facility, a care plan intervention has been added to include a perimeter mattress to his bed. This incident is verified for an unwitnessed fall with serious bodily injury. This incident is not related to abuse or neglect.A review on 05/19/26 at 10:15 AM found an order for Resident #157 dated 12/19/25 that read as follows: Bed rails 1/2 as an enabler for turning and repositioning in bed.Further record review revealed a Bed Safety Evaluation dated 12/19/26, under section 2a. That read as follows: Rails at top of bed to aid in turning and repositioning and be more safe when exiting the bed.Resident #157 was moved from room [ROOM NUMBER] to room [ROOM NUMBER] on 12/24/25.Further record review of the eInteract Change in Condition Evaluation, reveals that Resident #157 had a fall from bed on 12/26/25 and was sent to the emergency room per Health Care Surrogate (HCS) request. There is no mention of the side rails being in use when the fall occurred from bed. Physician's emergency room (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	ReportA review on 05/19/26 at 10:30 AM, found a Physician's emergency room report, under Patient chief complaint reads as follows: Fall from bed, head trauma The patient is an [AGE] year old male with a past medical history significant of CAD, CHF, diabetes mellitus, hypertension, hyperlipidemia, ischemic cardiomyopathy, and prostate malignancy who presents to the ED for evaluation after falling from his bed at a local nursing facility. According to EMS, the patient fell from his bed, striking his head and landing on his left shoulder, however nursing facility staff did not witness the incident. They told EMS that the patient is more drowsy currently than at his baseline. He is not on any anticoagulants. Further history is limited at this time due to patient's ability to provide history.Radiographic imaging of CT to head or brain without contrast found the following:Interval hemorrhage within the left occipital lobe.Marked improvement in previous intraventricular hemorrhage and larger more anterior focus of intraparenchymal hematoma left optical lobe.During a phone interview on 05/19/26 at 11:45 AM, the Health Care Surrogate (HCS) for Resident #157 said that his dad was transferred to this nursing home on December 18th. The family requested the facility to use side rails and fall mats for his bed due to past fall history. The side rails were placed on his bed. His dad had a room change and the side rails and floor mats did not go with him. I got a call that my dad had fallen and the facility said there were no injuries. When I got there, my dad was telling me how much he hurt. I also noticed that no side rails were on his bed at this time. I had them send him to the Emergency Room, and he had a brain bleed and was put in ICU. From the hospital he went to the Hospice house on January 16th and passed away on January 17th.During an interview on 05/19/26 at 2:00 PM, The State Agency (SA) asked the Administrator to tell us about the incident with Resident #157. The Administrator said that it is always standard practice when a resident moves rooms that the bed with all of its equipment goes with them so nothing gets missed. With this particular move the Resident and his roommate had an altercation and a bed next door was empty, and the resident moved themselves to that bed. The administrator confirmed that the side rails were not moved with this resident.The administrator further said that they immediately put a plan in place to ensure this does not happen again. A review on 05/19/26 at 3:15 PM revealed a Plan In Place (PIP) that is as follows:The Director of Nursing (DON) completed an audit on 12/29/25 to ensure residents have a bed safety evaluation and a bed safety evaluation follow up, if bed rails indicated, obtain order, care plan and consent obtained from resident/responsible party with any corrective action immediately upon discovery.The maintenance/designee conducted an audit on 12/29/25 to ensure correct installation of bed rails, including adherence to manufacturer's recommendations and/or specifications with any corrective action immediately upon discovery.Re-education was provided by the DON/Designee to licensed nurses and maintenance department on or before 12/30/25 regarding the bed safety evaluation will be completed upon admission, readmission, quarterly change in bed or mattress, and with a significant change in condition in the patient's self-performance of bed mobility. If indicated for bed rails in use, an order, consent from resident/responsible party to be obtained, and care planned. A post-test to validate understanding. Any nursing staff not available during this time frame will be provided re-education, including post test by DON/designee prior to the beginning of the next shift to work. New nursing staff will be provided education, including post-test during orientation by the DON/designee.Re-education was provided by the NHA/Designee to the maintenance department on or before 12/29/25 regarding the Maintenance will ensure inspections (audits) will occur at a minimum of annual and with any change in bed frame, mattress, or bed rail with post-test to validate understanding. Any maintenance staff not available during this time frame will be provided re-education, including post-test by NHA/designee prior to the beginning of the next shift to work. New maintenance staff will be provided education, including post-test during orientation by the NHA/designee.The DON/designee will monitor starting on 12/29/26 new admissions/readmissions, any resident with a new mattress or bed or a significant change to ensure bed safety evaluation is completed with order for bed rails, consent, and care plan daily for 2 weeks including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then randomly (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	thereafter.The Maintenance Director/designee will monitor starting on 12/29/26 residents with any change in bed frame, mattress, or bed rail will be inspected and documented in TELS daily for 2 weeks including weekends and holiday then 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then randomly thereafter.Further review of the PIP, revealed that all of the above action had been completed by 12/30/25.