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	09/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 resident interview, record review, and staff interview, the facility failed to provide activities of daily living, specifically showers, to dependent residents. This deficient practice had the potential to affect one (1) of six (6) residents reviewed for the care area of activities of daily living. Resident Identifier: #34. Facility census: 157. Findings included: a) Resident #34 On 09/29/2025 at 12:50 PM, Clinical Registered Nurse (RN) #206 stated the facility did not have a policy and procedure related to resident showers. She stated residents are given two (2) showers a week unless residents refuse showers or residents would like more than two (2) showers a week. During an interview on 09/22/2025 at 9:11 AM, Resident #34 stated she was supposed to get a shower twice a week but only received a shower every three (3) or four (4) weeks. Review of Resident #34's comprehensive care plan showed the resident required assistance for activities of daily living care due to limited mobility and cerebrovascular accident. Review of the facility's shower schedule showed Resident #34 was scheduled to receive showers on Monday and Thursdays every week. Review of Resident #34's bathing task reports for 09/01/25 through 09/23/25 showed no showers documented for the time period. On 09/24/25 at 2:24 PM, Registered Nurse (RN) #138 stated the resident's bathing task reports were inaccurate. RN #138 stated showers were also documented on handwritten documents in the shower book. RN #138 provided handwritten shower book documentation showing Resident #34 received a shower on 09/22/25. RN #138 stated the shower book showed no other showers for the time period. On 09/24/2025 at 3:48 PM, the Director of Nursing confirmed there was no documentation the resident had received or been offered twice weekly showers. No further information was provided through the completion of the survey.

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 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, resident interview, and staff interview the facility failed to ensure a physician order was correctly entered into the medical record. Additionally, the facility failed to ensure insulin was administered in accordance with professional standards of care. There was no order to hold the resident's medication for fingerstick blood glucose less than 150. These were random opportunities for discovery throughout the Long-Term Care Survey Process. Resident identifiers: #122 and #99. Facility census: 157.Findings included: a) Resident #122 During a review, on 09/30/2025 at 9:45 AM, the following physician order was found in Resident #122's electronic medical record: -CBC (Complete Blood Count) Q4 months (every four months) [for] anemia/coag (coagulant) use Feb/May/Aug. CMP (Comprehensive Metabolic Panel) Q4 months (every four months) [for] HTN (Hypertension) Feb/May/Aug . During an interview on 09/30/25 at 9:51 AM, the Director of Nursing acknowledged that February, May, and August were only three (3) month intervals and did not accurately reflect a four month timespan. b) Resident #99 Review of Resident #99's physician's orders showed an order written on 09/13/24 for the following insulin injection: Admelog SoloStar Subcutaneous Solution Pen-Injector 100 Unit/ml [milliliters] (insulin Lispro). Inject 25 unit [sic] subcutaneously before meals and at bedtime for DM2 [diabetes type II] Warning! Confirm patient. Insulin pens are for use in one patient only. Notify provider if blood sugar is < [less than] 70 or > [greater than] 400. Review of Resident #99's Medication Administration Record (MAR) for September 2025 showed the Admelog insulin was not given on the following dates at the following times: - 09/02/25 at 7:30 AM; the resident's blood glucose level was 134 - 09/04/25 at 9:30 PM; the resident's blood glucose level was 145 - 09/05/25 at 7:30 AM; the resident's blood glucose level was 123 - 09/05/25 at 11:30 AM; the resident's blood glucose level was 123 - 09/06/25 at 7:30 AM; the resident's blood glucose level was 118 - 09/07/25 at 11:30 AM; the resident's blood glucose level was 124 - 09/07/25 at 4:30 PM; the resident's blood glucose level was 144 - 09/08/25 at 7:30 AM; the resident's blood glucose level was 122 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 09/09/25 at 4:30 PM; the resident's blood glucose level was 148 - 09/10/25 at 7:30 AM; the resident's blood glucose level was 113 - 09/10/25 at 4:30 PM; the resident's blood glucose level was 97 - 09/11/25 at 7:30 AM; the resident's blood glucose level was 121 - 09/11/25 at 11:30 AM; the resident's blood glucose level was 131 - 09/12/25 at 7:30 AM; the resident's blood glucose level was 130 - 09/13/25 at 4:30 PM; the resident's blood glucose level was 140 - 09/15/25 at 4:30 PM; the resident's blood glucose level was 140 - 09/16/25 at 7:30 AM; the resident's blood glucose level was 147 - 09/18/25 at 7:30 AM; the resident's blood glucose level was 148 - 09/20/25 at 4:30 PM; the resident's blood glucose level was 98 - 09/21/25 at 7:30 AM; the resident's blood glucose level was 129 - 09/22/25 at 7:30 AM; the resident's blood glucose level was 144 - 09/22/25 at 4:30 PM; the resident's blood glucose level was 144 - 09/23/25 at 7:30 AM; the resident's blood glucose level was 120 - 09/24/25 at 7:30 AM; the resident's blood glucose level was 109 The MAR gave the notation WR on these dates at these times. On 09/24/2025 at 3:45 PM, the Director of Nursing (DON) stated WR means no coverage. She acknowledged there were no parameters based on blood glucose levels associated with this insulin order. The DON stated sometimes Resident #99 refused medication based on her blood glucose level, but she acknowledged refusals should have been documented. On 9/24/2025 at 4:00 PM, Corporate Clinical Registered Nurse (RN) #206 stated she had spoken to one of the nurses who had held Resident #99's insulin. The nurse stated he was used to orders for this insulin stating to hold the insulin for a blood glucose level less than 150. RN #206 stated the physician had been notified of the situation and Resident #99's Admelog insulin order was going to be modified to include instructions to hold the insulin for blood glucose less than 150. No further information was provided through the completion of the survey process.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure assessment and treatment of pressure ulcers in accordance with professional standards of treatment. This deficient practice had the potential to affect one (1) of eight (8) residents reviewed for the care area of pressure ulcers. Resident Identifiers: #164. Facility census: 157. Findings included: a) Resident #164 The facility's policy titled, Skin Integrity and Wound Management, with effective date 07/01/01 and revision date 09/15/25, stated wound evaluation would be completed upon admission or readmission. The policy also stated the treatment interventions needed would be identified. Resident #164 was admitted to the facility on [DATE]. A skin check was initiated on 03/28/25 at 7:33 PM and signed by the nurse on 03/31/25. The skin check documented the following: Pressure to sacrum, right heel. Abrasion to right and left outer forearm. Surgical non-removable dressing to front right hip. Healed surgical incision to chest, bilateral inner thighs. Ostomy to left lower quadrant. A progress note was generated on 03/31/25 at 1:13 PM pursuant to the skin check. The note was identified as a late entry for 03/28/25 at 7:33 PM. The note identified the skin issues identified in the skin check described above. The note also stated the wound nurse was notified. On 03/31/25 at 12:42 PM, a skin and wound evaluation was performed for a deep tissue pressure injury to the right heel present on admission. The pressure injury was measured as 8.2 cm [centimeters] in length by 3.3 cm in width by 0.1 cm in depth. There was no evidence of infection, exudate (drainage), induration, or edema. The pressure injury was described as pink or red and discolored. The edges of the pressure injury were attached. Surrounding tissue was denuded, discolored black or blue, dry/flaky, and fragile. On 03/31/25 at 12:46 PM, a skin and wound evaluation was also performed for a deep tissue pressure injury to the sacrum present on admission. No measurements were recorded. There was no evidence of infection, exudate (drainage), induration, or edema. The pressure injury was described as discolored. The edges of the pressure injury were attached. Surrounding tissue was fragile. Treatment for the right heel deep tissue injury pressure ulcer was ordered on 03/31/25. The order stated, right heel (pressure) - cleanse with hydrating foam cleanser, pat dry and apply sure prep, leave OTA [open to air] every day and night shift for pressure. Treatment for the sacral deep tissue pressure ulcer was also ordered on 03/31/25. The order stated, Sacrum (pressure) - cleanse with hydrating foam cleanser, apply zinc oxide paste, every day and night shift for pressure. Measurements of the right heel deep tissue injury were recorded on a skin and wound evaluation performed on 04/07/25. The right heel pressure injury measured 1.5 cm in length and 1.0 cm in width. The Director of Nursing (DON) was interviewed on 09/29/25 at 11:50 AM. She acknowledged Resident #164's deep tissue pressure injuries had not been fully assessed upon admission. She also acknowledged treatment for these pressure injuries had not been initiated upon admission. The DON stated it was the facility's standard of care to assess and initiate treatment for pressure ulcer injuries upon admission. No further information was provided through the completion of the survey process.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interview, the facility failed to accurately document the administration and refusal of medications. The facility also failed to ensure residents had current orders for medication given. These were random opportunities for discovery. Resident Identifiers: #51 and #34. Facility census: 157. Findings included:a) Resident #34 Review of Resident #34's physician's orders showed an order written on 07/25/25 for gabapentin 100 mg two (2) times a day for neuropathy. Both the Medication Administration Record (MAR) and the Controlled Drug Record - Individual Patient's Narcotic Record were reviewed for July 2025. The following discrepancy was found: On 07/28/25, the MAR documented the resident received the scheduled gabapentin dose at 9:00 AM. However, the Controlled Drug Record did not document removal of gabapentin from the resident's supply. The resident was noted to occasionally refuse gabapentin. On 09/30/25 at 2:30 PM, Clinical Registered Nurse (RN) #206 stated she could not explain why the MAR documented the gabapentin was given but the Controlled Drug Record did not document a dose was removed. She stated the MAR might be in error and the resident might have refused gabapentin on 07/28/25 at 9:00 AM. No further information was provided through the completion of the survey process. b) Resident #51Review of Resident #51's physician's orders showed an order written on 08/13/25 for gabapentin 100 mg two (2) times a day for neuropathy for eight (8) days. The medication was started on 08/14/25 and was completed after eight (8) days on 08/21/25. Both the Medication Administration Record (MAR) and the Controlled Drug Record - Individual Patient's Narcotic Record were reviewed for August 2025. The following discrepancies were found:On 08/14/25 at 9:00 AM, the Controlled Drug Record documented a gabapentin capsule had been removed from the resident's supply. However, gabapentin was not documented as given on the MAR. The area on the MAR to indicate the medication had been given was blank. On 08/15/25 at 9:00 AM, the Controlled Drug Record documented a gabapentin capsule had been removed from the resident's supply. However, gabapentin was not documented as given on the MAR. The area on the MAR to indicate the medication had been given was blank. On 08/18/25 at 9:00 AM, the Controlled Drug Record documented a gabapentin capsule had been removed from the resident's supply. However, gabapentin was not documented as given on the MAR. The area on the MAR to indicate the medication had been given was blank. On 08/18/25 at 9:00 PM, the Controlled Drug Record documented a gabapentin capsule had been removed from the resident's supply. However, gabapentin was not documented as given on the MAR. The area on the MAR to indicate the medication had been given was blank. Following 08/21/25, when the eight (8) days of prescribed medication was completed, the medication continued to be signed out as removed on the Controlled Drug Record on the following dates: 08/22/25 at 9:00 AM and 9:00 PM08/23/25 at 9:00 AM08/24/25 at 9:00 AMThe MAR was marked with an X for these dates and times because the medication was not ordered for these dates. Gabapentin was reordered for the resident on 08/25/25. On 09/30/25 at 2:30 PM, Clinical Registered Nurse (RN) #206 confirmed gabapentin had not been documented as given on the MAR despite being signed out as removed on the Controlled Drug Record on 08/14/25, 08/15/25, and 08/18/25. She also confirmed gabapentin had been signed out as removed on the Controlled Drug Record on 08/22/25, 08/23/25, and 08/24/25, despite the resident not having an order for the medication on these dates.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based upon record review and staff interview, the facility failed to complete a drug regimen review at least once a month by a licensed pharmacist, and the facility's medical director failed to act upon irregularities reported by the pharmacist. This was found to be true for three (3) of five (5) residents reviewed during the long-term care survey process. Resident identifiers: #1,#10, #100. Facility census: 157. Findings included: a) Policy Review A review of the facility's Medication and Regimen Review and Reporting policy revealed the following statement, The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly. The nursing care center follows up on the recommendations to verify the appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record.b) Resident #100 A review of the medical record documents Resident #100 has the following psychosocial diagnoses: The Resident had the following psychotropic medication orders: Xanax Oral Tablet 1 MG (Alprazolam)Give 1 mg by mouth three times a day for anxiety disorderPharmacy Active: 09/09/25 Quetiapine Fumarate ER Oral Tablet Extended Release 24 Hour 150 MG Give 1 tablet by mouth at bedtime for bipolar disorder with psychosisPharmacy Active: 09/09/25 Citalopram Hydrobromide Tablet 10 MGGive 3 tablet by mouth one time a day for depression (Brand name Celexa) Give 30 mg PO daily. Pharmacy Active: 08/06/25 Wellbutrin XL Oral Tablet Extended Release 24 Hour 150 MG (Bupropion HCl)Give 1 tablet by mouth one time a day for depression AEB refusing care and cryingPharmacy Active: 03/30/25 lamotrigine Oral Tablet 100 MG Give 100 mg by mouth two times a day for bipolar disorder mood changes and cryingPharmacy Active: 03/29/25 A review of the monthly pharmacist medical regimen reviews (MRR) for the calendar year 2025 in the medical record revealed there was no consultant pharmacist MRR for the month of April 2025. The surveyor asked the DON on 09/24/25 around 9:30 AM if there had been one conducted, and she replied that she would check. Later that afternoon, the DON stated she was unable to locate a MRR for April 2025. Further review of the medical record, there was a recommendation from the consultant pharmacist dated 08/01/25 on his MRR, reminding the physician of the need for a gradual dose reduction review of psychotropic medications. The Medical Director did not review, did not sign, or did not acknowledge recommendation. c) Resident #10A review of the medical record documents Resident #1 has the following psychosocial diagnoses:The Resident was prescribed these medications:Divalproex Sodium Oral Tablet Delayed Release 250 MGGive 1 tablet by mouth two times a day for bipolar disorderPharmacy Active: 09/08/25bupropion HCl ER (SR) Oral Tablet Extended Release 12 Hour 150 MG Give 2 tablet by mouth one time a day for MDD Increased to 300 mg PO by in-house psychiatry Pharmacy Active: 09/09/25Venlafaxine HCL ER 150 MG CAPGive 1 capsule by mouth one time a day for behaviorsPharmacy Active: 07/15/25Buspirone HCl Tablet 5 MGGive 1.5 tablet by mouth two times a day for anxietyPharmacy Active: 07/15/25 Seroquel Oral Tablet 100 MG (Quetiapine Fumarate)Give 1 tablet by mouth at bedtime for schizoaffective disorderPharmacy Active: 06/17/25A review of the medical record for the consultant pharmacist medication regimen reviews (MRR), shows the pharmacist consistently reviewed medications monthly. However, there was an irregularity report completed on 08/01/25, which stated According to CMS guidance under F605 (Chemical Restraints), For any resident who is receiving a psychotropic medication, the facility must show evidence that a gradual dose reduction has been attempted unless clinically contraindicated. Please consider a trial dose reduction on one of these medications. Medications were listed as Citalopram Hydrobromide Oral Tab 40 MG, lamotrigine Oral Tablet 100 MG, Seroquel Oral Tab 50 MG, Wellbutrin XL Oral Tablet 150 MG, and Xanax Oral Tablet 1 MG.This recommendation was never reviewed, acknowledged, or any (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	action taken by the Medical Director in accordance with the facility policy.The surveyor reviewed this finding with the DON on 09/24/25, and she was asked if there was any additional information she could provide related to the 08/01/25 MRR recommendation for GDR. A progress note was then provided by the DON dated 09/03/25 by Nurse Practitioner (NP) #302 whereby a GDR review was not recommended at the present time due to the resident experiencing symptoms of significant distress, as evidenced by PTSD, anxiety and hallucinations. NP did prescribe a change to Seroquel Oral Tablet 100 MG (Quetiapine Fumarate) to Seroquel XR 150 MG, which was an increase to resident's psychotropic medication.d) Resident #1A review of resident #1's medical record for medication regimen reviews (MRR) included a new admission review by the consultant pharmacist dated 07/05/25. In this MRR, the pharmacist requested clarification for the current order for Bupropion SR 150 MG for antidepressant. Pharmacist recommendation was Please clarify indication for use. The medical director did not acknowledge, review or act upon this recommendation.This was reviewed with the DON on the afternoon of 09/09/25. The DON was asked if she had any additional information to provide on the MRR. The DON had nothing to add.

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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, record review, and staff interview, the facility failed to store medications within accepted standards of care. A multi-use vial of tubersol injection had been in use over 30 days. These was a random opportunity for discovery. Facility census: 157. Findings included: a) Multi-use vial of Tubersol On 09/23/2025 at 10:48 AM, the medication storage room in the Transitional Care Unit was inspected with the Director of Nursing (DON) in attendance. A multi-use vial of Tubersol (tuberculin purified protein derivative, or PPD) located in the refrigerator was noted to have an opening date of 08/19/25. The box stated to discard 30 days after opening. Tubersol is used in a skin test to help diagnose tuberculosis (TB) infection. The DON acknowledged the Tubersol multi-use vial should have been discarded 30 days after opening. The Tubersol package insert, available on-line of the Food and Drug Administration Website, stated, A vial of Tubersol which has been entered and in use for 30 days should be discarded.No further information was provided through the completion of the survey process.

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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 upon Observation and Staff interviews the facility failed to ensure that dishware and serving items are kept in clean and sanitary area once cleaned. They were stored in the hallway to finish drying, allowing for possible recontamination. The hallway was in a main intersection of the first floor and had lots of foot traffic and people moving through it. This was a random opportunity for discovery that has the potential to effect more then one resident. Facility census: 157. On 09/29/25 at 9:03 PM an observation revealed dishes, cups, tray tops and glasses left out in hallway (main hall outside dining area). The dishes were exposed to possible recontamination. This hallway is in the main intersection on the first floor and has lots of foot traffic and items passing through it daily. The area is also under a vent that can allow dust to fall upon the clean dishes.During an interview with Kitchen Staff (KS) #3 on 09/29/25 at 9:05 PM KS#3 stated that they wash them and sanitize them, but because the room is so small they need to leave them in the hallway to dry. Then they put them away for use later. KS #3 said, We never thought about them getting dirty from being out there.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon Observation and Staff interviews the facility failed to ensure use of proper infection control practices to prevent the potential spread of disease through improper/non use of PPE while in a Enhanced Barrier Protection room. This was observed on more than one occasion. Resident identifiers: #80, #9 and #14. Census: 157. a) Resident #80 During med pass LPN #38 did not use PPE while giving resident #80 her medications. Resident is currently on enhanced barrier precautions (EBP) and the sign is present on door with marking for who it applies to. The LPN did sanitize hands, but did not apply PPE per policy. She had direct contact with resident, LPN adjusted resident in bed as well as hugged resident before leaving room. When asked what they do if a room is marked with EBP sign LPN #189 stated that if they will have direct patient contact they need to put on PPE, gloves gown, mask ect . b) Resident #9On 09/24/25 8:45 AM a nurse and an aide were in in room [ROOM NUMBER]-A doing morning Activities of Daily Living (ADLs) and clearing up Resident #9 without using proper PPE. No gown, gloves or masks observed. Both residents in room [ROOM NUMBER] beds A Resident #9 and B Resident #14 were on EBP precautions. Resident #9 was on EBP due to having a chest port for dialysis. Resident #14 was on EBP due to abnormal blood chemistry, An observation revealed a sign on the door of room [ROOM NUMBER] with room and beds effected listed. A PPE cart was observed outside room [ROOM NUMBER] and was stocked with appropriate PPE needed Administrator #200 was asked who the two nurses were in the room with Resident #9. Administrator #200 stated that it was Nurse #165 and the Wound care Licensed Practical Nurse (LPN) #195. Administrator #200 said they should have both been in proper PPE per policy when in direct contact with a resident.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based upon record review and staff interview, the facility failed to inform the resident or resident's representative in advance, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This was found to be true for two (2) of five (5) residents reviewed for psychotropic medication use during the long-term care survey process. Resident identifiers: # 1, #10. Facility census: 157. Findings included:a) Resident #10The resident had the following pharmacy orders: Xanax Oral Tablet 1 MG (Alprazolam) Give 1 mg by mouth three times a day for Anxiety Disorder Pharmacy Active 9/9/2025 Quetiapine Fumarate ER Oral Tablet Extended Release 24 Hour 150 MG (Quetiapine Fumarate) (Brand name Seroquel)Give 1 tablet by mouth at bedtime for bipolar disorder with psychosisPharmacy Active: 09/09/25 Citalopram Hydrobromide Tablet 10 MG (brand name Celexa)Give 3 tablet by mouth one time a day for depression Give 30 mg PO daily. Pharmacy Active: 08/06/25 Upon review of the medical record, informed consents for the use of Xanax, Celexa, and Seroquel were not located. The Surveyor requested to see informed consents on 09/24/25 at approximately 11:37 AM from RN Clinical Lead #206. Around 2:10 PM, the informed consents had not been provided and these were requested again. Approximately thirty minutes later, the DON presented an informed consent for Xanax, Celexa, and Seroquel. The informed consent was dated 09/24/25, which documented the resident or resident's representative had not been informed in advance of receiving these drugs of the risks and benefits, or provided other treatment options. The DON stated the facility had apparently missed getting the consent.b) Resident #1A review of Resident #1's medical record documents the following pertinent diagnoses: Resident #1 had the following pharmacy orders: Bupropion HCl ER (SR) Oral Tablet Extended Release 12 Hour 150 MG. Give 2 tablet by mouth one time a day for MDD Increased to 300 mg PO by in-house psychiatry. Pharmacy Active 9/9/2025 Buspirone HCl Tablet 5 MG Give 1.5 tablet by mouth two times a day for anxietyPharmacy Active 7/15/2025 Upon review of the medical record, the surveyor was unable to find informed consents for the use of Wellbutrin or Buspar. The surveyor asked the facility to provide an informed consent for these two medications on 09/25/25 at 9:18 AM. At approximately 2:10 PM on 09/25/25, when surveyor asked again about the informed consents, the DON stated the facility failed to initiate the informed consents and stated, We will get this completed immediately.

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	09/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide a Notice of Transfer/Discharge, and a written Bed Hold notice to a resident and/or the resident's legal representative when the resident was transferred to the hospital. This was true for one (1) of nine (9) residents reviewed for hospitalizations. Resident identifier: #177. Facility census. 157.Findings included: a) Resident #177 A record review, completed on 09/29/25 at 6:30 PM, revealed the following information: Resident #177 was sent out to the hospital on [DATE] at 2:06 PM. There was no evidence in the electronic medical record the facility had notified the resident or the resident's representative of the transfer/discharge and the reasons for the transfer in writing. Additionally, there was no evidence the facility provided a written notice which specified the duration of the bed-hold, if any, during which the resident would be permitted to return to the nursing home. During an interview, on 09/20/25 at approximately 12:45 PM, Regulatory Compliance Officer (RCO) #157 confirmed the facility was unable to produce evidence that a Notice of Transfer/Discharge and a Bed Hold Notice had been given for Resident #177's discharge to the hospital on [DATE].

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to develop a person-centered comprehensive care plan, and implement the plan to meet the resident's preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. This was found to be true for three (2) of thirty-four (34) residents reviewed during the long-term care survey process. Resident identifiers: #8, #100. Facility census: 157. Findings included: A) Resident #8 A personalized care plan was developed for this resident, but was not carried out. The Care Plan included a focus area pertaining to a risk for skin breakdown due to the resident's decreased activity, frail fragile skin, impaired cognitive function, impaired mobility. One intervention was to turn and position the resident every 2-3 hours. This intervention was developed on 05/15/24, and revised on 02/19/25. Among the resident's diagnoses were a facility-acquired Stage 3 pressure ulcer of other site diagnosed on [DATE], and a non-pressure chronic ulcer of other part of right foot, diagnosed on [DATE] also acquired during stay. The medical record was reviewed to see if the care plan intervention for turning and positioning was being carried out. According to the medical record, turning and positioning were only completed on one (1) shift on the following dates:07/01/25, 07/03/25, 07/06/25, 07/08/25, 07/09/25, 07/10/25, 07/11/25, 07/14/25, 07/15/25, 07/18/25, 07/20/25, 07/19/25, 07/23/25, 07/25/25, 07/26/25, 07/27/25, 08/02/25, 08/07/25, 08/12/25, 08/16/25, 08/27/25, 09/08/25, and 9/29/25. Turning and positioning were not completed on any shift on the following dates:07/05/25, 07/13/25 The turning and positioning documentation and care plan were reviewed with the DON on 09/30/2025 at approximately10:00 AM. The DON acknowledged there was no documentation for turning and positioning for the above shifts, and turning and positioning had only been documented on one shift on the other dates listed above, thus not carrying out the personalized care plan for the resident. B) Resident #100 Resident #100 has impairment on left side of upper and lower extremities On 09/15/25, resident was diagnosed with bilateral Stage 2 pressure ulcers to both buttocks. The Resident is dependent upon staff for dressing, toileting, bathing, personal hygiene, and requires set up assistance for eating. The medical record also documents the following pertinent diagnoses related to range of motion: CONTRACTURE, LEFT WRIST Non-Surgical Orthopedic/Musculoskeletal 1/5/2022 During StayCONTRACTURE, LEFT ELBOW Non-Surgical Orthopedic/Musculoskeletal 1/5/2022 During StayCONTRACTURE, LEFT HAND Non-Surgical Orthopedic/Musculoskeletal 6/11/2018 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Admission/Readmission The resident's orders for improvement of range of motion included: Physical Therapy (PT)- Evaluation & treatment as recommended No directions specified for order Other Active 2/26/2025Resident to wear left palm protector or wash cloth when splint is off as tolerated; may be removed for skin checks and hygiene licensed nurse to remove and assess skin integrity every shiftevery day and night shiftOther Active 6/10/2024Occupational Therapy to evaluate and treat as needed.No directions specified for order.Other Active 6/14/2022A personalized care plan was developed for the resident. One focus area was the prevention of skin breakdown. Interventions included:Assist resident to turn and reposition every 1 - 2 hours while in bed and/or chair with up to maximum assist. Date initiated 04/10/23Assist resident in turning and repositioning every 2 - 3 hours. Date initiated 05/08/24Documentation for turning and positioning of he resident were requested for the months of July, August, and September of 2025, as a sample for determining if the care plan was being carried out. On the the following dates, turning and positioning were only completed on one shift:07/02/25, 07/07/25, 07/09/25, 07/10/25, 07/11/25, 07/13/25, 07/15/25, 07/19/25, 07/21/25, 07/26/25, 08/18/25, 09/11/25

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and staff interview, the facility failed to obtain lab services in a timely fashion for a resident. This was true for one (1) of five (5) residents reviewed for unnecessary medications throughout the Long-Term Care Survey Process. Resident identifier: #6. Facility census:157.Findings included: a) Resident #6 During a record review, completed on 09/29/2025 at 9:15 AM, there was no evidence in Resident #6's electronic medical record that blood work had been completed in the month of July 2025 as per a physician's order. The Director of Nursing (DON) was interviewed on 09/29/2025 at 12:00 PM. The DON confirmed there had been an active physician order stating, HGA1C (a blood test that provides an average of your blood sugar levels), CMP (Comprehensive Metabolic Panel) and CBC (Complete Blood Count) every 4 months - March, July, November. The DON reported the facility was unable to produce evidence that the lab work had been completed as ordered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that were accurately documented. This was a random opportunity for discovery. Resident #6. Facility census: 157.Findings included: a) Resident #6 A medical record review, completed on 09/29/2025 at 9:15 AM, revealed the following details: - Resident #6 transferred to room [ROOM NUMBER]-B on 04/09/25.- On 04/20/25 there was an Encounter Note which incorrectly documented Resident #6 was in room [ROOM NUMBER]. - On 05/15/25 there was an Encounter Note which incorrectly documented Resident #6 was in room [ROOM NUMBER].- On 05/17/25 there was an Encounter Note which incorrectly documented Resident 36 was in room [ROOM NUMBER]. - Resident #6 transferred to room [ROOM NUMBER]-B on 06/26/25.- On 08/14/25 there was an Encounter Note which incorrectly documented Resident #6 was in room [ROOM NUMBER].- On 08/16/25 there was an Encounter Note which incorrectly documented Resident #6 was in room [ROOM NUMBER].- On 08/16/25 there was a second Encounter Note which incorrectly documented Resident #6 was in room [ROOM NUMBER]. During an interview with the Director of Nursing on 09/29/25 at 12:05 PM, she acknowledged the aforementioned encounter notes had listed the incorrect room number for Resident #6.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide pneumococcal vaccinations in accordance with professional standards of practice. This deficient practice had to potential to affect one (1) of five (5) residents reviewed for the care area of vaccinations. Resident Identifier: #34. Facility Census: 157. a) Resident #34 The facility's policy titled Pneumococcal Vaccination with effective date 05/04/15 and revision date 09/15/25 stated pneumococcal vaccinations in adherence with current recommendations of the Advisory Committee on Immunizations Practices (ACIP) as set forth by the Centers for Disease Control and Prevention. The CDC publication titled Pneumococcal Vaccine Timing for Adults dated March 2025, which is available on-line, stated adults 50 years or older who have only received the pneumococcal conjugate vaccine (PCV) 13 should receive a single dose of PCV 21 or PCV 20 at least one year after the PCV 13 dose. Resident #34 was over [AGE] years old. Review of Resident #34's medical records showed a pneumococcal vaccine informed consent signed by the resident and dated 06/01/25. The option I hereby give the Center permission to administer the (list type) pneumococcal vaccine, based upon my vaccination history, vaccine guidelines, and/or my physician's recommendations. After list type, there was a blank line to list the type of pneumococcal vaccine to be given. The words Up to date - does not need were handwritten in the line after list type. Resident #34's vaccination record in the electronic health records, showed the resident had recieved pneumococcal conjugate vaccination (PCV) 13 on 03/18/16. No further pneumococcal vaccines were documented. On 09/24/25 at 8:26 AM, the Infection Preventionist confirmed Resident #34 was not fully vaccinated for pneumococcal disease. She agreed the resident should have been offered a Prevnar 20 injection. The Infection Preventionist stated she offered Resident #34 a Prevnar 20 injection that morning after surveyor intervention. The resident refused the vaccination. No further information was provided through the completion of the survey process.