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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515066 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER Dunbar Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 501 Caldwell Lane Dunbar, WV 25064 | |

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) |
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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation and staff interview, the facility failed to ensure confidentiality of medical records. This was a random opportunity for discovery. Facility census: 116. Findings included: a) 300 hallway medication screen. On 01/28/26 at 11:13 AM, the computer screen on the medication cart in the 300 hallway was noted to be displaying resident information. A resident's list of medications to be administered was visible. The cart was located midway down the hallway, and no staff was in attendance. On 01/28/26 at 11:16 AM, Licensed Practical Nurse (LPN) #41 confirmed the computer screen was displaying resident medication and locked the screen so it was no longer visible. No further information was provided through the completion of the investigation.</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and staff interview the facility failed to ensure medications were administered in a timely manner as ordered. This was true for 1 (one) of 6 (six) residents reviewed for medication administration. Resident identifier: #84. Facility census: 116. Findings included: a) Resident #84 During an investigation for a complaint that the facility failed to ensure residents with elevated blood sugars received adequate care and the facility failed to ensure the residents receive their medications on time a physicians order was found for Fingerstick blood glucose Notify MD if blood sugar greater than 400, if blood glucose is below 70 initiate hypoglycemic protocol two times a day for DM - start date- 02/17/2025. The resident did not receive these Finger sticks on 12/25/25. This is evidenced by no blood sugar being charted in the vitals section (blood sugar summary) of his medical record, the medication administration record (MAR) or in the progress notes for the date noted. This has potential to harm the resident due to not knowing if his blood sugar levels are within appropriate range for the day. A physician's order for insulin glargine-yfgn subcutaneous solution pen injector 100 unit/ml inject 24 unit subcutaneously in the evening for DM. A physician's order for insulin glargine-yfgn subcutaneous solution pen injector 100 unit/ml inject 46 unit subcutaneously in the morning for diabetes. A physician's order for HumaLOG KwikPen subcutaneous solution pen-injector 100 unit/ML (insulin Lispro) inject 4 unit subcutaneously one time a day for DM. A physician's order for Hypoglycemia Protocol Observe Sign / Symptoms of hypoglycemia as needed if blood glucose is less than 70 mg/dl or ordered low parameter follow Hypoglycemia protocol. Start date - 02/05/2025 During an interview with the Director of Nursing (DON) and the Administrator at 11:00 AM on 01/29/2026 these findings were discussed. The administrator and DON both verified that Resident #84 did not receive his finger sticks for blood glucose or any insulin on 12/25/25.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to store clorox wipes in an area to maintain a safe environment in room [ROOM NUMBER]. This was a random opportunity for discovery. Facility Census: 116. Findings Include: a) room [ROOM NUMBER] Upon the initial tour of the facility on 01/28/26 at 11:55 AM, a container of clorox wipes was observed sitting on the bathroom sink in room [ROOM NUMBER]. On 01/28/26 at 11:58 AM, Licensed Practical Nurse (LPN) #21 confirmed the container of clorox wipes should not be in the resident's bathroom. LPN #21 stated, Let me get these out of here. On 01/28/26 at 12:20 PM, the Administrator was notified and confirmed the clorox wipes should not be in a resident's bathroom.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to maintain infection control standards for storage of a bed pan in room [ROOM NUMBER]. This was a random opportunity for discovery. Facility Census: 116. Findings Include: a) room [ROOM NUMBER] Upon the initial tour of the facility on 01/28/26 at 11:55 AM, a bed pan was observed laying on top of trash can in the bathroom, which was not bagged or labeled in room [ROOM NUMBER]. On 01/28/26 at 11:58 AM, Licensed Practical Nurse (LPN) #21 confirmed the bed pan was not labeled or stored in a storage bag. On 01/28/26 at 12:20 PM, the Administrator was notified and confirmed the bed pan should have been labeled and stored in a storage bag.</p> | | |