STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515066	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, resident interview and staff interview, the facility failed to ensure accommodation of needs were provided for a call light within reach for Resident #75 and a pull cord for a light for Resident #58. These were random opportunities for discovery. Resident Identifiers: #75 and #58. Facility Census: 110. Findings included: a) Resident #58 On 06/02/26 at 4:34 AM, Resident #58 was heard crying, Oh, oh, oh . repeatedly during an early morning hall observation. When the state surveyor asked what the resident needed, the resident stated, Turn my light on, honey. The resident could not reach the pull cord to turn on the light. The light cord appeared to be broken, short, and approximately three (3) feet away from the resident. Licensed Practical Nurse (LPN) #15 confirmed the resident could not reach her light cord and stated, We usually have to help her. The facility's policy and procedure for Safe and homelike Environment stated, 1.1.3.5 Perform other desired tasks such as turning a table light on and off, using the call bell, etc . and 1.5.1 Maintenance will perform periodic rounds to ensure functioning lights. b) Resident #75 On 06/01/26 at 1:51 PM, an initial interview was attempted with Resident #75. An observation of the call light cord was made, which was draped over the night stand. The resident could not reach the call light. On 06/01/26 at 1:55 PM, Licensed Practical Nurse (LPN) #66 was asked to enter the resident's room. LPN #66 confirmed the call light could not be reached by the resident. LPN #66 stated, let me fix this. On 06/01/26 at 2:05 PM, the Corporate Nurse #158 was notified and confirmed the call light should be in reach at all times.

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to ensure appropriate notices were given to residents prior to discharge from the facility. This failed practice had the potential to affect a limited number of residents. Resident identifier: #47. Facility Census: 110.Findings included: a) Resident #47 On 05/27/26, a Beneficiary Notification and Notice of Medicare Non-Coverage (NOMNC) were requested for Resident #47. At 1:41 PM, the administrator confirmed the documentation was not available. The Business Office Manager (BOM) had kept the signed and dated copies of discharge paperwork in a binder in her office. The BOM was no longer employed by the facility. The Administrator stated, I don't know where the binder is located. An email was given to the state surveyor where the clinical reimbursement coordinator had the paperwork including an exhaust letter to be signed by the resident, but a signed copy of the notifications were not found or given to the state surveyor. The facility's policy and procedure for Discharge and Transfer stated, If a patient's Medicare coverage will be ending, the Center must comply with the requirements at 483.10(g)(17) and (18).

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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 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 resident interviews, record review and staff interviews, the facility failed to report allegations of abuse between Resident #62 and Resident #113 as well as Resident #62, Resident #13 and Nurse Aide (NA) #3. This is true for two (2) of two (2) residents reviewed under the care area of abuse. Resident Identifiers: #62, #113, and #13. Facility Census: 110. Findings Include: a1) Resident #62 On 05/27/26 at 1:00 PM, an interview was held with Resident #62 regarding a complaint of alleged abuse. Resident #62 stated, I have told staff about Resident #113 constantly threatening me and trying to intimadate me. I told Social Worker (SW) #162. He doesn't work here anymore. But SW #162 would say, There is nothing I can do .just stay away from her. I told different staff members .they knew what she was doing and no one would do anything. A record review revealed a progress note dated 02/27/26 completed by the after-hours telehealth physician which stated, history of present illness: Nurse reports that patient is requesting Vistaril, had a dose last night for anxiety. Patient had Vistaril 25mg (milligram)-reported that it worked well for symptoms. Patient reports having increased anxiety because of behaviors from another resident. (Typed as written.) An additional progress note dated 03/04/26 at 12:00 AM completed as a psychiatric follow up states, The resident also expressed frustation regarding another resident who she reports has been verbally offensive and instigating conflict; staff are aware of the situation. Patient who appears to provide a reliable history. (Typed as written.) An interview of Resident #62 took place in the conference room with two (2) State surveyors, the Administrator and the Director of Nursing (DON) on 05/27/26 at 3:00 PM. Resident #62 stated, I told everyone when Resident #113 would not leave me alone. She was constantly threatening me and trying to intimidate me. She would make comments to me when no one else was around. For example, she would say I love fucking with you. She would try to start something with me all the time. SW #162 was told and he told me to stay away from her that there was nothing he could do. I was fearful because I didn't know what she might do. At this time, the Administrator stated, We will get these allegations reported, I don't know why it wasn't reported then. b) Resi On 05/27/26 at 1:00 PM, an interview was held with Resident #62 regarding a facility-reported incident (FRI) dated 12/01/25. The resident stated, Nurse Aide (NA) #3 came into my room because I yelled for help, I was sliding to the edge of the bed, she grabbed me by my pants and threw me into the bed. I told the staff about how she was rough. The Administrator did an investigation and said NA #3 would not be my aide and would not be working on this hall. She constantly comes over to see the nurse, I think he is her boyfriend, and just her voice upsets me. Then, this weekend she was over here and said to me, I can go wherever I want .there is new administration and the same rules don't apply. I don't feel safe and they (Administration) will not protect me. I told (Name of facility scheduler) about it this morning. An interview was held with the Facility Scheduler (FS) #111 on 05/27/26 at approximately 2:00 PM. The FS #111 was interviewed regarding NA #3's assignments. FS #111 stated, I have put on the hard copy that NA #3 is not to work on the hallway where Resident #62 resides. NA #3 should not be assigned to the resident. The resident has not told me anything regarding NA #3 being on the hallway. An interview was held in the conference room on 05/27/26 at 3:00 PM with two (2) surveyors, as well as Resident #62, #13, the Administrator and the DON. At this time, Resident #62 expressed her fear and not feeling safe due to NA #3. Resident #13, who is Resident #62's roommate, collaborated the event with NA #3 did take place. Resident #13 stated, I don't feel safe and I feel I am unable to protect my roommate if (Name of NA #13) tries to do something. When Resident #62 was yelling and cursing NA #3, all the staff, including the nurses, were laughing at Resident #62 and were threatening to call 911. The NA should not have been on our hallway or picking up our trays. She came in smiling and told Resident #62 she could go anywhere she wanted, that rule did not apply anymore. At this time, the Administrator stated, We will get these allegations reported.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to ensure the Annual Minimum Data Set (MDS) was correct regarding tobacco use for Resident #23. This was true for one (1) of two (2) residents under the care area of smoking. Resident Identifier: #23. Facility Census: 110. Findings Include: a) Resident #23 On 06/01/26 at approximately 3:00 PM, Resident #23 was observed smoking with staff present. On 06/01/26 at 3:10 PM, a record review was completed for Resident #23. The Annual MDS dated [DATE] section J Health Conditions was reviewed. Under J1300, current tobacco user, the code entered was 0 (zero). Zero (0) indicates the resident does not smoke. On 06/01/26 at 3:30 PM, an interview was held with the Clinical Reimbursement Coordinator (CRC) #65. The CRC #65 confirmed the MDS dated [DATE] was incorrect regarding tobacco use. The CRC #65 stated, I will send in a modified MDS and correct this.

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	515066	A. Building B. Wing	06/02/2026

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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. Based on record review and staff interview, the facility failed to develop and implement the care plan for Resident #69. This was true for one (1) of one (1) residents reviewed under the care area of pressure ulcers. Resident Identifier: #69. Facility Census: 110. Findings Include: a1) Resident #69 On 06/01/26 at 12:15 PM, a record review was completed for Resident #69. The care plan was reviewed and found multiple blank areas under the interventions of the focus area of risk for decreased ability to perform ADL(s) (activities of daily living) in: bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, toileting related to limited mobility. The following interventions were left blank: --Provide resident/patient with _____(specify: set-up, supervision, partial/moderate, substantial/maximal, dependent assistance) assist of (specify #) for bed mobility. --Provide resident/patient with _____(specify: set-up, supervision, partial/moderate, substantial/maximal, dependent assistance) assist of (specify #) for eating. --Provide resident/patient with _____(specify: set-up, supervision, partial/moderate, substantial/maximal, dependent assistance) assist of (specify #) for toileting. --Provide resident/patient with _____(specify: set-up, supervision, partial/moderate, substantial/maximal, dependent assistance) assist of (specify #) dressing. --Provide resident/patient with _____(specify: set-up, supervision, partial/moderate, substantial/maximal, dependent assistance) assist of (specify #) for personal hygiene (grooming). --Provide resident/patient with _____(specify: set-up, supervision, partial/moderate, substantial/maximal, dependent assistance) assist of (specify #) for bathing. In addition, under the focus area for risk for falls: impaired mobility, the goal states, Resident will have no falls with injury x ____ days. The number of days were left blank. On 06/01/26 at 1:10 PM, the Director of Nursing (DON) confirmed the care plan had multiple blank areas. a2) Resident #69 On 06/01/26 at 12:15 PM, a record review was completed for Resident #69. The care plan was reviewed and found an intervention, under the focus area of risk for skin breakdown, were not being implemented. The interventions states, Assist resident in turning and repositioning every 2-3 hrs. (Typed as written.) At this time, a review under the tasks tab was completed. The following dates did not include documentation regarding turning and repositioning each shift: --04/18/26 night shift--04/20/26 night shift--05/01/26 evening shift--05/01/26 night shift--05/05/26 night shift --05/11/26 night shiftOn 06/01/26 at 3:25 PM, the DON confirmed the care plan intervention was not implemented. The Corporate Nurse #158 stated, there should be three times documented for each date.

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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 record review and staff interview, the facility failed to revise and review a comprehensive care plan for a long term care resident. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #47. Facility Census: 110.Findings included: a) Resident #47's Resident #47's care plan was reviewed. The care plan stated focus and goals for a short term stay. The resident's date of admission was 12/17/25. The Director of Nursing (DON) reported the resident's plans were for long term care. The DON confirmed the resident's care plan was not revised for long term care placement. Resident #47's care plan stated, Resident/patient has potential for discharge, or is expected to be discharged , related to :admission for skilled short-term stay. and Make referrals to community-based agencies, providers, and services communicating the residents/patients needs and barriers to care. An updated care plan was given to the state surveyor. Resident #47's care plan initiated 05/27/26 following surveyor intervention, stated, Resident/RP have chosen to transition to long-term care due to health and physical needs that can no longer be safely managed in the community. A progress note was completed on 03/04/26 by the Social Worker confirming the resident's discharge plan is for long term care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and staff interview, the facility failed to ensure pressure ulcer prevention was in place. This was true for one (1) of two (2) residents reviewed under the care area of pressure ulcers. Resident Identfier: #69. Facility Census: 110.a) Resident #69 On 06/01/26 at 12:15 PM, a record review was completed for Resident #69. The care plan was reviewed and found an intervention, under the focus area of risk for skin breakdown, were not being implemented. The interventions states, Assist resident in turning and repositioning every 2-3 hrs. (Typed as written.) Therefore, the pressure ulcer prevention was not in place. At this time, a review under the tasks tab was completed. The following dates did not include documentation regarding turning and repositioning each shift: --04/18/26 night shift--04/20/26 night shift--05/01/26 evening shift--05/01/26 night shift--05/05/26 night shift --05/11/26 night shiftOn 06/01/26 at 3:25 PM, the DON confirmed the care plan intervention was not implemented, which did not put pressure ulcer prevention in place. The Corporate Nurse #158 stated, there should be three times documented for each date.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, resident interviews and staff interview, the facility failed to ensure hydration was available at bedside for Resident #11, Resident #31, Resident #88 and Resident #108. This was true for four (4) residents residing on the 300 and 400 halls. Resident Identifiers: #11, #31, #88 and #108. Facility Census: 110. Findings Include: a) 400 Hall On 05/27/26 at 11:40 AM, an initial interview was held with Resident #11. Resident #11 was asked, do you have any water? Resident #11 stated, no, I don't have any ice water. On 05/27/26 at 11:44 AM, Resident #31 was unable to be interviewed, however, no water was observed at bedside. On 05/27/26 at 12:00 PM, Nurse Aide (NA) #81 stated, I have passed some water but I haven't been able to finish, I have been doing showers. On 05/27/26 at 12:03 PM, Registered Nurse (RN) #39 stated, they didn't tell me they needed water. On 05/27/26 at 12:15 PM, the Corporate Nurse #158 was notified. Corporate Nurse #158 stated, they should have given the residents water on their drink pass this morning. b) 300 Hall On 05/27/26 at 11:50 AM, an interview was held with Resident #88 and Resident #37, who are roommates. Resident #88 stated, I don't have any. Resident #37 nodded her head in agreement with Resident #88. On 05/27/26 at 11:55 AM, an interview was held with Resident #108. Resident #108 stated, they never give us any .I would like to have some, I would drink it. On 05/27/26 at 12:07 PM, Licensed Practical Nurse (LPN) #15 confirmed the residents did not have water available to them. On 05/27/26 at 12:15 PM, the Corporate Nurse #158 was notified. Corporate Nurse #158 stated, they should have given the residents water on their drink pass this morning.

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	515066	A. Building B. Wing	06/02/2026

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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 on observation, record review, and staff interview, the facility failed to ensure liquids were distributed and served in accordance with professional standards for food service safety. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 110. Findings included: a) On 06/01/26 at 12:47 PM, a red liquid in a pitcher was observed at the beginning of Hall 300 on a cart for lunch service. Drinks had not been passed for lunch. The pitcher was not iced or placed in ice to stay cold. The pitcher of red liquid was not labeled or dated. Licensed Practical Nurse #36 confirmed the pitcher was not labeled, dated or on ice and stated, I'll label and get ice on it. At 1:10 PM on Hall 400, a pitcher, labeled 'koolaid' was sitting on the cart, not in ice. Licensed Practical Nurse #161 confirmed the drink passed to the resident did not contain ice and the pitcher was not on ice during tray service. Resident #13 stated the' koolaid' was room temperature, but that was the way she drinks it. b) The facility's policy and procedure for Food Storage: Cold Foods stated, 5. All foods will be stored wrapped or in a covered containers, labeled and dated and arranged in a manner to prevent cross-contamination. c) The facility's policy and procedure for Meal distribution stated, Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner.

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	515066	A. Building B. Wing	06/02/2026

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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. Based on record review and staff interview, the facility failed to ensure an accurate and complete medical record for Resident #111. This was true for one (1) of two (2) residents reviewed under the care area of falls. Resident Identifier: #111. Facility Census: 110. Findings Include: a) Resident #11 On 06/01/26 at 2:00 PM, a record review was completed for Resident #111. The review found the fall risk evaluation dated 03/31/26 was not complete. The following sections were left blank: Section Gait/balance Gait/balance: Observe the Resident's gait/balance, have them/they stand on both feet without holding onto anything, if safe to do so. If assistive devices are required, provide the device and then proceed. Walk straight forward, walk through a doorway; and make a turn. Check the response below that best describes the resident abilities. --Gait/balance Normal --Balance problem while standing--Balance problem while walking--Decreased muscular coordination--Change in gait pattern when walking through doorway--Jerking or unstable when making turns--Requires use of assistance devices (i.e. cane, wheelchair, walker, furniture)--N/A-not able to perform function There was no indication if any of these choices were made. Section Medications Medications: Respond based on the following types of medications: Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics. Medication--None of these medications (or medication classes) taken currently and/or within last 7 days--Takes 1-2 of these medications (or medication classes) currently and/or within last 7 days--Takes 3-4 of these medications (or medication classes) currently and/or within last 7 days There was no indication if any of these choices were made. Resident has had a change in medication (or medication classes) or change in dosage in the past 5 days. There was no indication if the resident had any change in medication in the past 5 days. Score 10 or higher indicated the resident is at high risk of fall The score was not documented anywhere on the Fall Risk Evaluation. Risk for Falls Focus: Risk for fallsGoal: Resident will be free of falls.Intervention: Assist Resident with ambulation and transfers, utilize therapy recommendations.Intervention: Determine Residents ability to transfer.Intervention: Evaluate fall risk on admission and PRN (as needed).Intervention: If fall occurs, alert provider.Intervention: If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. There was no indication if any of these choices were made. Visual Impairment Intervention: If Resident is a fall risk, initiate fall risk precautions. Focus: Discharge PlanningGoal: Resident will attain their highest quality of life at discharge.Goal: Resident will be prepared to return to community upon discharge. Intervention: Identify necessary home modification.Intervention: Identify need for home or community resources There was no indication if any of these choices were made. Focus: Sensory/Perception Alterations: VisualGoal: Resident to achieve maximum functional status withing limits of visual impairments.Intervention: Avoid making unnecessary changes in room or environment.Intervention: Communicate Resident's abilities to staff and educate re: necessary aides or accommodations.Intervention: Evaluate Resident's ability to function safely within limits of visual impairment.Intervention: If Resident smokes tobacco, utilize smoking apron for safety.Intervention: Remove possible environmental barriers to ensure safety. There was no indication if any of these choices were made. Clinical Suggestions--Utilize personal/pressure sensor alarms.--Rubber-soled shoes or nonskid slippers worn for ambulation.--Utilize toileting program. There was no indication if any of these choices were made. On 06/01/26 at 3:30 PM, Corporate Regional Manager #159 confirmed the document was not complete and several sections did not indicate which choice was made.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interview, the facility failed to maintain an infection control program regarding disposal of a soiled brief and linen. This was a random opportunity for discovery. Resident Identifier: #69. Facility Census: 110. Findings Include: a) Resident #69 On 06/02/26 at 4:23 AM, an observation was made of a soiled brief and soiled wash cloth laying on the floor at the foot of Resident #69's bed. On 06/02/26 at 4:25 AM, Nurse Aide (NA) #160 approached the resident's room and removed the soiled brief and wash cloth. NA #160 stated, let me take care of this. At this time, Licensed Practical Nurse (LPN) #18 observed the NA picking up the items and confirmed the soiled brief and wash cloth should have been disposed of correctly. On 06/02/26 at approximately 5:00 AM, the Director of Nursing (DON) was notified and confirmed the items should have been disposed of properly.