

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

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No. 0938-0391

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 07/02/2026
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.			
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and family interviews, and staff interviews, the facility failed to ensure residents received timely assessment, intervention, and treatment for acute changes in condition. Specifically, the facility failed to ensure a resident exhibiting signs and symptoms consistent with sepsis, respiratory distress, hypoxia, hypotension, tachycardia, and acute clinical deterioration received timely emergency medical evaluation and transfer to the hospital; failed to follow physician orders for skin and wound care; and failed to provide pain management as ordered. This failed practice placed residents at risk for serious injury, harm, impairment, or death and had the potential to affect all residents requiring timely assessment, treatment, and intervention for changes in condition. Resident Identifiers: #123, #129, and #4. Facility census: 118. The State Agency determined this deficient practice constituted Immediate Jeopardy beginning on 06/15/2026. The facility implemented its Immediate Jeopardy removal plan, and the Immediate Jeopardy was removed on 07/01/2026, when the facility achieved substantial compliance. Findings included: a) Resident #123 Record review of the Nurse Practitioner's acute visit, dated 06/15/26 at 1:00 PM, revealed Resident #123 was more lethargic than normal. The acute visit note stated, . responsive only to verbal stimuli before drifting back to sleep, cool and clammy, tachypneic (abnormal rapid and shallow breathing), with oxygen saturation ranging from 86-89% on room air and heart rate fluctuating to 125 beats per minute. Respiratory therapy initiated oxygen at 3 liters per minute, increasing oxygen saturation to 94%. The resident remained hypotensive with a manual blood pressure of 90/72. The assessment included septicemia, tachypnea, tachycardia, and acute hypotension. Orders were given to obtain laboratory studies including CBC, CMP, lactic acid, blood cultures, urinalysis with culture and sensitivity, KUB, initiate IV fluids, administer ceftriaxone 1 gram IV every 12 hours, and closely monitor vital signs. Record review of the After-Hours Telehealth Consult, dated 06/15/26 at approximately 7:00 PM, revealed the following: WBC (white blood count) 22.1, BUN (Blood Urea Nitrogen) 60, creatinine 2.5, GFR 19, hemoglobin 9.4, hematocrit 28.9, and platelet count 105, representing a significant decline from previous laboratory values. During the telehealth evaluation, the resident appeared acutely ill with respiratory distress, increased work of breathing, respiratory rate of 24, oxygen saturation fluctuating between 80% and 92% despite oxygen at 2 liters per minute, fever, acute kidney injury, (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	suspected infection/sepsis, and hypoxia. The assessment included acute respiratory distress with hypoxia, suspected acute infection/sepsis, leukocytosis, acute kidney injury, fever, anemia, thrombocytopenia, and significant decline from baseline laboratory values. The plan from the after hours telehealth consultant directed the resident to be transferred immediately to the emergency department for further evaluation and management. Record review revealed Resident #123 was not transferred from the facility until 06/15/26 at approximately 8:38 PM. Records dated 06/16/26 at 7:33 AM revealed Resident #123 was admitted to a local acute care facility with diagnoses of sepsis, kidney stone with obstruction, and hypoxic respiratory failure. During an interview on 06/24/26 at 1:15 PM, the facility Nurse Practitioner stated there had been been an instance in which, in her professional judgment, residents needed to be sent to the hospital and she had received pushback from the Director of Nursing (DON). The Nurse Practitioner stated during Resident #123's evaluation, she became concerned the resident was septic. The Nurse Practitioner explained that sepsis could be life-threatening and required immediate rehydration, prompt laboratory testing, initiation of broad-spectrum antibiotics, and constant monitoring. The Nurse Practitioner stated she informed the resident's family she was going to send the resident to the hospital. When exiting the resident's room, the DON (in the presence of the Administrator) stated they wanted to treat the resident in-house. The Nurse Practitioner stated the DON entered her orders into the computer. The Nurse Practitioner further stated, It was around 1:00 PM when I wanted to send her (Resident #123) out. It was sometime after I left the building at 5:00 PM when she was sent out. The Nurse Practitioner stated in her professional opinion if the resident had been sent out when she had originally asked, it had the potential to possibly change the outcome. Medical Record Review (MRR) revealed Emergency Medical Services (EMS) was contacted on 06/15/26 at 8:15 PM. When EMS arrived the resident's blood pressure was reported to be 70/40. The EMS narrative note stated that upon arrival at the facility, staff reported the patient had recently been battling a UTI (urinary tract infection) for which she was currently receiving Intravenous (IV) fluids. They stated that the patient had been having issues for a few days now, but that she got worse approximately 5 hours ago. EMS narrative note described the resident as pale, clammy, and warm to the touch. The narrative included that the resident was hypotensive (low blood pressure), tachycardic (abnormally fast resting heart rate - typically over 100 beats per minute) and her blood glucose level was 226. Resident's temperature was 101.4. She was on 4 liters of oxygen via nasal canula which the facility had placed her on due to her low oxygen levels. It was noted that the resident was not normally on oxygen. During an interview on 06/25/26 at 11:30 AM, Resident #123's sister stated the resident requested her temperature be taken on the morning of 06/15/26 and approximately one hour elapsed before nursing assessed her. The sister stated the resident's temperature initially measured 100.3 degrees F and later increased to 101.9 degrees F. The sister stated she repeatedly requested the resident be sent to the hospital. She stated nursing informed her they planned to keep the resident at the facility, start an IV, and obtain laboratory work. The sister stated the resident's breathing worsened throughout the day and she was not informed the resident would be transferred until approximately (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	degrees F) SpO2 95 % CT CHEST ABDOMEN PELVIS WO IV CONTRAST Final Result by Edi, Radresults In (06/15 2354) 1. Moderate right hydronephrosis with obstructive calculus in the distal right ureter measuring 6 mm. Additional nonobstructive right renal calculi. 2. Small right and trace left pleural effusions. 3. Large hiatal hernia with partially intrathoracic stomach. 4. Avascular necrosis of the right femoral head and moderate degenerative joint disease of the right Medical Decision Making [AGE] year-old female patient presenting to emergency department complaint of weakness. Patient presenting here from local nursing facility (name of facility) patient reporting 3 days of generalized weakness malaise not feeling well fast heart rate. Patient reporting that she has had some abdominal pain reports she has colitis but it has not been confirmed. Patient also reporting that she thinks she's still has a urinary tract infection that she had been treated for. EMS reporting that the patient had low-grade fever at the facility. Patient's physical exam reveals a ill-appearing pale appearing elderly female patient that has generalized weakness appearance with irregular rate and rhythm, abdomen exam is benign, left-sided deficits present Please see ED course below for details the patient's laboratory and image findings. Patient taken to exam room [ROOM NUMBER] rather quickly after triage secondary to tachycardia and hypotension. Patient ordered 30 per kg IV fluid resuscitation that is adjusted full were concerns for potential heart failure. As can be seen below patient's laboratory workup reveals multiple abnormalities most significant in his leukocytosis 17.2 patient's creatinine at 1.99 patient's urinalysis shows abnormalities as below. Patient's initial lactate is 4.0. Patient has never been to this facility before unable to compare labs to what baseline is for this patient. I did scan the patient chest abdomen pelvis given the patient was now requiring oxygen does not typically require oxygen but her renal function does not support IV contrast for CT angiogram therefore without contrast as chest abdomen pelvis was performed reveals abnormalities as seen below. Patient covered with sepsis protocol treatments if foods and antibiotics. Sepsis protocol was satisfied. Patient's case was discussed with Urology which has recommended NPO status may require stent placement tomorrow. Patient's case then discussed with the hospitalist which did agree with admission of the patient. Critical Care Attestation: As the ED physician, I have provided critical care for this patient. This patient has high probability of imminent life or limb threatening deterioration due to acute renal failure, acute respiratory failure, and sepsis d) Center for Disease Control According to the Center for Disease Control, If an individual is suspected of having sepsis, the healthcare provider overseeing care of the resident/patient should immediately be alerted. Antibiotics should be started as soon as possible. Resident/patient progress should be checked frequently. Treatment requires urgent medical care, usually in an intensive care unit in a hospital, and includes careful monitoring of vital signs and often antibiotics (https://www.cdc.gov/sepsis/hcp/clinicalcare/index.html#cdc_clinical_care_treatment_care_specific-treatment) A resident with sepsis might have one or more of the following signs or symptoms: -Clammy or sweating skin, -Extreme pain or discomfort, -Fever, -High heart rate, -Low blood pressure, -New onset or increased confusion or disorientation, -Shortness of breath. Immediately alert the doctor, physician assistant, or nurse practitioner overseeing the resident's care. In most cases, a resident who is suspected of having sepsis, or who may be developing sepsis, will need to be transferred quickly to a hospital to receive intensive evaluation and treatment. (https://www.cdc.gov/sepsis/media/pdfs/Factsheet-Longterm-care-sepsis-nurses 508.pdf) (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility administration was informed of the immediate jeopardy on 06/30/26 at 5:09 PM. A plan of correction was accepted on 06/30/26 at 5:09 PM. The immediate jeopardy began on 06/15/26 when the Nurse Practitioner's request to send the resident out for acute care treatment was not followed up on by the Director of Nursing (DON). The immediate jeopardy was abated on 07/01/26 at 8:40 AM. The abatement plan of correction is listed below: All residents of the facility have the potential to be affected. NHA and IDON were Re-educated by the market team on the escalation process on 6/30/26 with a post test. Nurse Practitioner Re-educated on 6/30/26 concerning orders to send residents to the hospital with a post test. The Director of Nursing/designee completed an audit on 6/30/26- to ensure residents are not showing signs and symptoms of sepsis with immediate correction upon discovery. Reeducation will be provided by the Director of Nurses (DON)/designee to all licensed nurses beginning on 6/30/26 to ensure residents are provided timely follow up of care and escalation process. Post test completed to validate understanding. Any facility staff not available during this time frame will be provided reeducation, including posttest by the DON/designee upon the beginning of next shift to work. New facility staff will be provided education, including posttest during orientation by the DON/designee. The Director of Nursing (DON)/designee will monitor starting on 7/1/26 to ensure all residents are not showing signs and symptoms of sepsis by reviewing progress notes, vital signs, ACS reports, missed antibiotics and IVF and lab results daily for 2 weeks including weekends and holidays, then 3 times a week for 2 weeks then randomly thereafter. Results of monitors will be reported by the DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the QIC committee. Physician Orders: Must be carried out timely, including oxygen, IVF, labs, hospital transfers, medications and documented in the medical record Family/POA Requests: Resident and/or POA request for resident to be sent to the hospital. staff must carry out the order timely with physician notification Escalation and Notification Protocol: If the nurse providing care does not agree with the physician/DON/Administrator, the escalation process will be activated. The employee should notify the Market Clinical/Regulatory team. e) Resident #129 Record review completed on 07/01/26 of the Treatment Administration Record (TAR) revealed the following dates were not signed of as being completed or refused: Skin tear treatment: 03/07/26, 03/15/26, 03/29/26, 04/11/26 Stage two (2) pressure ulcer treatment: 03/07/26, 03/15/26, 03/29/26, 04/11/26 Wound care to Left Lower Limb: 04/11/26 During an interview on 07/01/26 with the Interim Director of Nursing (IDON), the IDON confirmed the (continued on next page)		

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and staff interviews, the facility failed to designate one or more qualified Infection Preventionists responsible for the facility's Infection Prevention and Control Program in accordance with regulatory requirements. Specifically, the facility failed to ensure the individual(s) responsible for infection prevention had completed specialized infection prevention training while overseeing the Infection Prevention and Control Program. This failed practice had the potential to affect all residents residing in the long-term care facility. Facility census: 118. Findings Included: During the facility entrance conference the Administrator reported the facility did not have an official Infection Preventionist at this time. The Administrator indicated that the Clinical reimbursement Coordinator held an Infection Preventionist certification. Further record review revealed Registered Nurse (RN) #139, Clinical Reimbursement Coordinator, had completed Infection Preventionist (IP) certification; however, she was not functioning as the facility's designated Infection Preventionist. During an interview on 07/01/26 at approximately 11:00 AM, RN #139 stated her only infection prevention responsibility was completing the weekly National Healthcare Safety Network (NHSN) reporting. During an interview on 07/01/26 at approximately 12:00 PM, the Administrator stated the Director of Nursing (DON) and other clinical managers performed the facility's infection prevention and infection control responsibilities. The Administrator further stated those staff members had not completed the specialized Infection Preventionist training, confirming the facility had not designated a qualified Infection Preventionist to oversee the Infection Prevention and Control Program as required.		

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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 direct observation and interview with the Facility Maintenance Director (#119), the facility failed to consistently maintain ambient temperatures within the required range in the 100/200 Nurses' Station and the 300/400 Nurses' Station. This was a random opportunity for discovery and had the potential to affect more than a limited amount of residents. Facility census: 118. Findings included: a) On 06/30/2026, at approximately 4:08 PM, the State Surveyor observed and documented the wall-mounted thermostat located at the 100/200 Nurses' Station, which displayed a temperature reading of 83 F. The temperature reading was obtained through direct visual observation of the facility's wall-mounted thermostats in the respective locations at the time of survey observation. On 06/30/2026, at approximately 4:25 PM, the State Surveyor conducted an environmental observation of the facility's ambient temperatures in resident care areas in the presence of the Facility Maintenance Director (#119). During the observation, the surveyor requested that the Facility Maintenance Director obtain ambient temperature readings utilizing the facility's temperature monitoring device to verify the temperatures within the observed areas. The surveyor observed and verified the Maintenance Director performing the temperature checks and confirmed the readings displayed. At that time, the Facility Maintenance Director obtained a temperature reading at the 100/200 Nurses' Station, which measured 82.2 F, and a temperature reading at the 300/400 Nurses' Station, which measured 83.0 F. The surveyor observed and verified both readings as they were obtained. During the same observation, the State Surveyor observed facility residents seated in common areas in close proximity to the 100/200 Nurses' Station and the 300/400 Nurses' Station. Residents were observed remaining in these areas during the period in which ambient temperatures were noted to be above the recommended comfort range.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on record review, resident interviews and staff interviews, the facility failed to ensure all food was temped before leaving the kitchen, to ensure safe and appetizing temperatures of the food and to prevent foodborne illness. The facility failed to ensure all foods were palatable, hot foods were served hot, and cold foods were served cold. This failed practice was also true for one (1) of one (1) meal tray's tested throughout the survey process. This failed practice had the potential to affect more than a limited number of residents. Facility census: 118. Findings Included: a) Healthcare Services Group (HCSG) Policy #6 titled, Food Quality and Palatability states: -Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served in a manner, form, and texture to meet resident's needs.-Proper safe and appetizing temperature: Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimize the risk for scalding and burns. b) HCSG Policy #16 titled, Food Preparation states: -All foods are prepared in accordance with the FDA Food Code. c) Food Temperature Logs On 06/29/26 at 11:01 AM this surveyor asked the Healthcare Services Group (HCSG) Dietary Account Manager (DAM) for a copy of the food temperature logs for the month of June 2026. She stated I cannot find it. The State Agency Surveyor then asked for any food temperature logs for this year (2026). The DAM stated I have checked the trash and everywhere, and I cannot find the temperature logs. On 06/29/26 at 12:12 PM, before starting the tray line, the dietary staff only took and wrote down four (4) regular consistency food item temperatures. Temperatures were taken for the BBQ Chicken, Coleslaw, [NAME] Beans, and the Ham & Cheese Sandwich. d) Test Tray. On 06/29/26 at 12:50 PM, a regular consistency test tray was made and sent to Dogwood Hall at 12:51 PM. The HCSG Director of Operations (DO) took the temperature of the following foods at 1:02 PM. The temperatures were: -Ham & Cheese Sandwich - 67.5 degrees Fahrenheit (F)-Coleslaw - 68 degrees F-Lettuce and Tomato - 79.3 degrees F-Mixed Fruit - 55.2 degrees F At the time of receipt by the resident, foods should be at a temperature of no less than 120 F for hot foods and no more than 50 F for cold foods, per the food code. e) Resident Council Resident Council was held on 07/01/26 at 10:30 AM. The residents in attendance stated, If we eat in our rooms, the cold food is hot and the hot food is cold. If we want it to be the correct temperature, we have to eat in the dining room.		

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NAME OF PROVIDER OR SUPPLIER Dunbar Center		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Caldwell Lane Dunbar, WV 25064	
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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 and staff interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional food safety standards. Additionally, the facility failed to follow proper sanitation practices for the kitchen. This practice had the potential to affect more than a limited number of residents. Facility census: 118. Findings Included: a) Department Staffing Policy Healthcare Services Group (HCSG) Policy #2 titled, Department Staffing states: -The Dining Services will employ sufficient staff, with appropriate competencies and skill sets to carry out the functions of food and nutrition services in a manner that is safe and effective. -Adequate staffing will be provided to prepare and serve palatable, attractive, nutritionally adequate meals, at proper temperatures, at appropriate times and to support proper sanitary techniques being utilized. -All employees will be provided with job descriptions and appropriate education and tools for executing their duties. b) Food Preparation Policy HCSG Policy #16 titled, Food Preparation states: -All foods are prepared in accordance with the FDA Food Code. -Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. -All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use. -Separate cutting boards for meat, poultry, and produce will be maintained. c) Food Storage: Dry Goods Policy HCSG Policy #18 titled, Food Storage: Dry Goods states: -All dry goods will be appropriately stored in accordance with the FDA Food Code. -The Dining Services Director or designee regularly inspects the dry storage area to ensure it is well lit, well-ventilated and not subject to sewage or wastewater backflow or contamination by condensation, leakage, rodents or vermin. -All packaged and canned food items will be kept clean, dry, and properly sealed. -Toxic materials will not be stored with food. d) Food Storage: Cold Foods Policy HCSG Policy #19 titled, Food Storage: Cold Foods states: -All Time / Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. -All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. e) Storage: Chemicals Policy HCSG Policy #20 titled, Storage: Chemicals states: -All chemicals will be properly stored. -All chemicals will be in separate / secured area. -All chemicals will be retained in their original containers. If chemicals are not in original container, the holding container will be clearly labeled with the name corresponding with the Safety Data Sheet (SDS). f) Ice Policy HCSG Policy #21 titled, Ice states: -Ice will be prepared and distributed in a safe and sanitary manner. -The Dining Services Director will coordinate with the Maintenance Director to ensure that the ice machine will be disconnected, cleaned and sanitized quarterly and as needed, or according to manufacturer guidelines. g) Equipment Policy HCSG Policy #27 titled, Equipment states: -All food service equipment will be clean, sanitary, and in proper working order. -All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. -All staff members will be properly trained in the cleaning and maintenance of all equipment. -All food contact equipment will be cleaned and sanitized after every use. -All non-food contact equipment will be clean and free of debris. h) Environment Policy HCSG Policy #28 titled, Environment states: -All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. -The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. -The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces. -All food (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contact surfaces will be cleaned and sanitized after each use.-The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces.-All trash will be contained in covered, leak proof containers that prevent cross contamination.i) Ware Washing Policy HCSG Policy #22 titled, Ware Washing states: -All dishware, service ware, and utensils will be cleaned and sanitized after each use.-All dishware will be air dried and properly stored. j) Kitchen Observations The following concerns were observed during the initial walkthrough of the kitchen on 06/29/2026 at 10:00 AM:1.One (1) soiled cleaning cloth located in the handwashing sink, near the toaster.2.Debris on the knife rack.3.There was one (1) cutting board that had green bell peppers, onions and strawberries that were all being cut on the same board.4.The drip pan under the stove was soiled.5.The stove top was soiled with built up food debris.6.The inside of the convection oven was soiled.7.There was no use by date on one (1) opened container of quick oats.8.There was one (1) employee 20 oz Pepsi soda pop located on the table beside the vinegar and spices in the kitchen.9.The meat slicer had some older food debris located on it.10.The top of the inside of the microwave was soiled with food debris.11.The bottom of the reach-in refrigerator had water pooling with one (1) case of opened Mighty Shakes sitting in the water.12.There was no use by date on one (1) case of Mighty Shakes that were sitting in the pooling water.13.There were six (6) outdated vanilla yogurts located in the reach-in refrigerator with a use by date of 06/28/26.14.There were five (5) sandwiches not labeled and did not have a use by date in the reach-in refrigerator.15.No use by date on one (1) case of opened bacon located in the walk-in refrigerator.16.No open or use by date on one (1) case of blueberries located in the walk-in refrigerator.17.One (1) bag of opened sliced potatoes located in the walk-in refrigerator without a label.18.One (1) cut onion outdated in the walk-in refrigerator with a use by date of 06/26/26.19.One cut tomato outdated in the walk-in refrigerator with a use by date of 06/25/26.20.There was ice buildup in the walk-in freezer.21.Six (6) cases of ice cream cups located in the walk-in freezer that had been thawed and refrozen.22.The ice machine located in the service hall has a black substance on the inside near the top of the machine.23.There was a brown liquid in the floor located in the dry food storage room.24.There was one (1) case of bleach on the same shelf beside one (1) case of food thickener.25.There were four (4) packages of hotdog buns with a green substance on the buns in the dry food storage room.26.Two (2) packages of outdated flour tortillas located in the dry food storage room with a use by date of 06/23/26.27.The handwashing sink located in the dish room was soiled and needs repairs completed to the hot faucet.28.No paper towels at the handwashing sink located in the dish room.29.One package of outdated hotdog buns located in the kitchen with a use by date of 06/26/26.30.No open or use by dates on four (4) loaves of bread located in the kitchen.31.There was one (1) gallon of 2% milk located in the Maple pantry that was outdated with a use by date of 06/26/26.32.The microwave located in the Dogwood pantry was soiled with food debris.33.The facility staff are not taking PM shift temperatures of the refrigerators and freezers located in both pantries.On 06/29/26 at 11:35 AM, during a follow-up visit to the kitchen additional observations included:1.One (1) soiled cloth sitting on the countertop near the meat slicer.2.Dishware on the clean side of the dish room are not being stored properly. They were not stored upside down and had lint and particles located on the interior well.3.There was one (1) soiled tray located on a clean cup / tumbler rack.4.There was a soiled black cart sitting beside the griddle.5.The grease trap for the exhaust vent is soiled with grease and cobwebs.6.There was one (1) spray bottle without a label located at the three-compartment sink.7.The kitchen ceiling is dirty with lint and pest particles and needs to be cleaned and painted.8.There is a hole located in the ceiling near an electrical pole above the steam table with a cleaning cloth sticking out of it.9.There was one (1) steam table pan sitting on the floor underneath (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the steam table.10.The trays used for the residents' lunch meals were wet.11.One (1) set of soiled gloves laying on the countertop beside the toaster.12.The toaster had crumbs in the tray.13.There is wall damage above the electrical box measuring about fourteen inches long.14.There was debris on the floor behind the stove, steamer and oven.15.There was one (1) bottle of unlabeled chemical in a spray bottle sitting on the floor behind the steamer.16.There was a soiled cloth laying on the countertop beside the three-compartment sink.17.One drawer beside the coffee maker had dried coffee grounds spilled in it.18.One drawer with clean serving utensils had the handles going in all different directions near the toaster.These observations were verified by the Healthcare Services Group (HCSG) Regional Chef (RC) and/or the HCSG Dining Account Manager (DAM).		

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

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and staff interviews, the facility failed to store and dispose of garbage and refuse properly. This was a random opportunity for discovery. The failed practice had the potential to affect more than a limited number of residents at the facility. Facility census: 118. Findings Included: a) Environment Policy The Healthcare Services Group (HCSG) Policy #28 titled Environment states: -All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.-All trash will be contained in covered, leak-proof containers that prevent cross-contamination. b) Garbage and Refuse Policy The HCSG Policy #30 titled Dispose of Garbage and Refuse states: -All garbage and refuse will be collected and disposed of in a safe and efficient manner.-The Dining Services Director will ensure that: Appropriately lined containers are available within the food services area for disposal of garbage or other refuse. Garbage and refuse is removed from the kitchen area routinely during the day and at the end of the workday.c) Observations On 06/29/26 at 10:05 AM, the State Agency Surveyor found a box full of garbage sitting on the wet floor under the three-compartment sink. On 06/29/26 at 10:30 AM, the trash receptacle located beside the handwashing sink in the dish room did not have a liner but contained trash. On 06/29/26 at 11:45 AM the trash receptacle located in the dish room that had a blue lid was soiled and needed to be cleaned on the outside. During an interview at 11:46 AM the Healthcare Services Group (HCSG) Director of Operations the observations and that the trash receptacle was soiled on the outside and needed cleaning.		

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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. Based on observation, record review and staff interview, the facility failed to maintain an infection control program during medication administration. These were random opportunities for discovery and had the potential to affect more than a limited amount of residents. Resident Identifiers: #90, #105, and #29. Facility Census: 118. Findings Include: a) Medication Administration On 07/02/26 at 8:35 AM, Registered Nurse (RN) #154 was observed during medication administration. RN #154 did not complete hand hygiene prior to preparing the medication for Resident #90. After preparing the medication, hand hygiene was not completed before entering the resident's room. RN #154 sat the Spiriva Inhaler box on the over-the-bed table without using a barrier. After medication administration to Resident #90, hand hygiene was not completed prior to preparing Resident #105's medication. Hand hygiene was not completed after preparing or administering the medication to Resident #105. RN #154, then, left the medication cart to obtain a medicated cream from the treatment cart. Upon returning to the medication cart, hand hygiene was not completed prior to or after medication administration to Resident #29. During this time of medication preparation, RN #154 touched multiple items and surfaces with bare hands. Hand hygiene was not completed at any time during this process. On 07/02/26 at 9:20 AM, RN #154 confirmed hand hygiene was not completed throughout the medication administration process. On 07/02/26 at approximately 9:30 AM, Corporate Registered Nurse (RN) #175 confirmed hand hygiene should be completed throughout the medication administration process and a barrier used when sitting medication and/or boxes on the resident's surfaces.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation and staff interview, the facility failed to ensure an effective pest control program was in place. This was discovered throughout the completion of the kitchen pathway during the Long-Term Care Survey Process. This failed practice had the potential to affect more than a limited number of residents. Facility census: 118. Findings Included: a) Pest Control Policy Healthcare Services Group (HCSG) Policy #29 titled Pest Control states: -A program will be established for the control of insects and rodents for the Dining Services Department.-The Dining Services Director coordinates with the Director of Maintenance to arrange pest control services on a monthly basis, or as needed.-All food preparation, service, and storage areas will be monitored regularly for any signs of pest / vermin. The center staff will be notified immediately of any concerns verbally and in writing.-Where applicable, bulk foods will be removed from their original packaging and stored in containers with tight-fitting lids. b) Kitchen Observation On 06/29/26 at 10:31 AM during the initial walkthrough of the kitchen, the State Agency Surveyor found four (4) packages of hamburger buns located on the bread rack in the dry storage room that had what appeared to be multiple bite markings from a rodent. The plastic and the hamburger buns had multiple chewing / bite marks and droppings. On 06/29/26 at 10:33 AM, the HCSG Regional Chef (RC) verified the surveyor's observations and noted he agreed a rodent created the damage to the hamburger buns on the bread rack. On 06/29/26 at 12:00 PM, during a follow-up visit to the kitchen the State Agency Surveyor noticed that the ceiling had multiple tiny dark spots consistent with digested organic waste left behind by drain flies. The HCSG Dietary Account Manager (DAM), at 12:01 PM, stated, I will put it in the TELS system for maintenance to be cleaned and painted.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to obtain informed consent for psychotropic medication for Resident #1 . This was true for two (2) of five (5) residents reviewed under the care area of unnecessary medications. Resident Identifier: #1 . Facility Census: 118. Findings Included: a) Resident #1 On 07/01/26 at 2:15 PM, a record review was completed for Resident #1. The review found the resident had been admitted to the facility on [DATE]. The resident was prescribed Cymbalta, an antidepressant. The facility did not obtain informed consent for the psychotropic medication. The resident did have medical-decision making capacity. On 07/02/26 at 9:35 AM, the Corporate Registered Nurse (RN) #175 confirmed the consent for Cymbalta had not been completed. The Corporate RN stated, We will get the consent right now.		

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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 provide the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF-ABN) form and/or the Notice of Medicare Non-Coverage (NOMNC) form to two (2) of three (3) residents reviewed for the facility's beneficiary protection notification practice throughout the Long-Term Care Survey Process. This failure placed the residents at risk of not being informed of their rights prior to the end of Medicare Part A covered services. Resident identifiers: #128 and #29. Census: 118. Findings included: a) Resident #128 Resident #128 was discharged to home following her last covered day of Part A Service on 03/06/26. There was no evidence in the electronic medical record that a NOMNC had been issued prior to the resident's discharge to home. b) Resident #29 Resident #29 remained in the facility following his last covered day of Part A Service on 03/01/26. There was no evidence in the electronic medical record that a SNF-ABN and a NOMNC had been issued prior to the resident's discharge from skilled care. c) Interview with Business Office Manager During an interview on 06/30/26 at 5:15 PM, the Business Office Manager (BOM) reported that the facility was unable to produce any evidence that the appropriate beneficiary notifications forms had been given to Resident #128 and Resident #29.		

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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 evidence that it conveyed the required information to the hospital at the time of transfer. The facility was unable to provide documented evidence that the receiving health care institution received, at a minimum, residents' advance directives, physician orders, and comprehensive care plan upon transfer to a hospital as required for a safe transition of care. This was true for two (2) of two (2) residents reviewed under the hospitalization pathway throughout the Long-Term Care Survey Process. Resident Identifiers: #98 and #115. Facility census: 118. Findings included: a) Resident #98 An electronic medical record review, completed on 07/01/2026 at 7:08 PM, revealed Resident #98 had been admitted to the facility on [DATE]. Resident #98's eInteract Transfer form and progress notes indicated the resident was discharged to the hospital on [DATE]. The reason for the transfer form was listed as: Shortness of Breath (bronchitis, pneumonia). However, further review of the facility's progress notes and the eInteract transfer form revealed no documented evidence that the receiving health care institution received, at a minimum, the resident's advance directives, physician orders, and comprehensive care plan, as required for a safe transition of care. During an interview on 07/02/26 at 8:35 AM, the Interim Director of Nursing (DON) indicated that when a resident is sent to the hospital, the facility's process is to send documents such as the face sheet, advance directives, physician orders, and the Medication Administration Record (MAR). However, the Interim DON reported that there was no documentation in the medical records to accurately reflect what information had been sent. b) Resident #115 An electronic medical record review, completed on 07/01/2026 at 6:11 PM, revealed Resident #115 had been admitted to the facility on [DATE]. Resident #115's eInteract Transfer form and progress notes indicated the resident was discharged to the hospital on [DATE] due to a fall with hematoma (often referred to as a severe bruise, it usually forms a firm, rubbery lump under the skin). During an interview on 07/02/26 at 8:40 AM, the Interim Director of Nursing (DON) indicated that when a resident is sent to the hospital, the facility's process is to send documents such as the face sheet, advance directives, physician orders, and the Medication Administration Record (MAR). However, the Interim DON reported that there was no documentation in the medical records to accurately reflect what information had been sent.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and staff interview, the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASARR) was maintained to reflect a resident's diagnosed serious mental illness for one (1) of one (1) residents reviewed for PASARR requirements. Resident identifier: #28. Facility census: 118. Findings included:a) Resident identifier: #28Record review of the resident's clinical record revealed a diagnosis of Post-Traumatic Stress Disorder (PTSD) with a documented diagnosis date of 02/26/2026. Further review of the resident's PASARR, dated 03/05/2026, revealed PTSD was not identified or documented on the PASARR screening.During an interview, conducted on 06/30/2026 at approximately 10:10 AM, the Nursing Home Administrator (NHA) confirmed the resident had a diagnosis of PTSD and acknowledged the diagnosis was not reflected on the PASARR dated 03/05/2026.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident. This was a random opportunity discovered during the completion of the Hospitalization and Discharge pathways conducted throughout the Long-Term Care Survey Process. Resident Identifiers: #115 and #117. Facility census: 118. Findings included:a) Resident #115 An electronic medical record review, completed on 07/01/2026 6:11 AM, revealed Resident #115 was admitted to the facility on [DATE] and discharged from the facility on 04/18/26. Resident #115's medical history included, but was not limited to, the following medical diagnoses:-METABOLIC ENCEPHALOPATHY-HYPOKALEMIA-DEHYDRATION-ATHEROSCLEROSIS OF CORONARY ARTERY BYPASS GRAFT(S) WITHOUT ANGINA PECTORIS-PERSONAL HISTORY OF TRANSIENT ISCHEMIC ATTACK (TIA), AND CEREBRAL INFARCTION-ACUTE KIDNEY FAILURE WITH TUBULAR NECROSIS-HYPOTHYROIDISM-HYPEROSMOLALITY AND HYPERNATREMIA-NEUROCOGNITIVE DISORDER WITH LEWY BODIES-DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC-DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY-PARKINSON'S DISEASE WITHOUT DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS-PULMONARY HYPERTENSION-DYSPHAGIA, OROPHARYNGEAL PHASE-UNSPECIFIED PROTEIN-CALORIE MALNUTRITION Review of Resident #115's Baseline Care Plan revealed there were blanks related to the level of assistance the resident would need in the areas of eating, toileting, dressing, grooming. and bathing. The baseline care plan had the following incomplete interventions listed:-Provide resident/patient with _____ (specify: set-up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____ (specify #) for eating. Date Initiated: 04/08/2026Created on: 04/08/2026-Provide resident/patient with _____ (specify: set up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____ (specify #) for toileting. Date Initiated: 04/08/2026Created on: 04/08/2026-Provide resident/patient with _____ (specify: set-up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____ (specify #) for dressing. Date Initiated: 04/08/2026Created on: 04/08/2026-Provide resident/patient with _____ (specify: set-up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____ (specify #) for personal hygiene (grooming). Date Initiated: 04/08/2026Created on: 04/08/2026 On 06/30/26 at approximately 4:30 PM, in the absence of the MDS Coordinator, the Interim Director of Nursing (DON) was interviewed regarding the blanks in the baseline care plan. The Interim DON acknowledged the care plan was not thoroughly completed and failed to specify the level of assistance Resident #115 required. b) Resident #119 An electronic medical record review, completed on 07/01/2026 6:40 AM, revealed Resident #119 was admitted to the facility on [DATE] and discharged from the facility on 05/25/26. Resident #119's medical history included, but was not limited to, the following medical diagnoses:-PARKINSON'S DISEASE-OTHER SEIZURES-CHRONIC OBSTRUCTIVE PULMONARY DISEASE-ESSENTIAL (PRIMARY) HYPERTENSION-ALTERED MENTAL STATUS,-HALLUCINATIONS, UNSPECIFIED-TREMOR-UNSPECIFIED PROTEIN-CALORIE MALNUTRITION Review of Resident #119's Baseline Care Plan revealed there were blanks related to the level of assistance the resident would need in the area ambulation. The baseline care plan had the following incomplete intervention listed:-Provide resident/patient with Partial/Moderate assistance) assist of _____ (specify #) for (continued on next page)		

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

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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 07/02/2026
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)		
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ambulation using a _____ (specify: walker, rolling walker, quadcane, straight cane, no device, etc.) _____ times per day. Date Initiated: 05/22/2026 Created on: 05/22/2026 On 06/30/26 at approximately 4:33 PM, in the absence of the MDS Coordinator, the Interim Director of Nursing (DON) was interviewed regarding the blanks in the baseline care plan. The Interim DON acknowledged the care plan was not thoroughly completed and failed to specify the level of assistance Resident #119 required.		

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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 on record review and staff interview, the facility failed to develop care plan regarding the diagnosis of depression and the use of a psychotropic medication. This was true for one (1) of five (5) residents reviewed under the care area of unnecessary medications. Resident Identifier: #1. Facility Census: 118. Findings Included: a) Resident #1 On 07/01/26 at 2:15 PM, a record review was completed for Resident #1. The resident had been admitted to the facility on [DATE]. The review found the care plan had not been developed regarding the diagnosis of depression and the use of an antidepressant, Cymbalta. On 07/02/26 at 9:35 AM, the Corporate Registered Nurse (RN) #175 confirmed the care plan had not been developed regarding the diagnosis of depression and the use of an antidepressant, Cymbalta. The Corporate RN #175 stated, We will get this taken care of now.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview, the facility failed to follow the physician's order regarding a monthly pharmacy recommendation for Resident #1. This was true for one (1) of five (5) residents reviewed under the care area of unnecessary medications. Resident Identifier: #1. Facility Census: 118. Findings Included: a) Resident #1 On 07/01/26 at 2:15 PM, a record review was completed for Resident #1. The review covered monthly pharmacy recommendations from 03/11/26 through 05/08/26. The monthly pharmacy review dated 03/11/26 included two (2) separate recommendations. The second recommendation concerned an alternate treatment using a Beta-3 agonist (Vibegron) instead of an anticholinergic medication for overactive bladder. The facility physician agreed to switch the therapy to the Beta-3 agonist Vibegron. The pharmacy recommendation and the facility physician's order were not followed as ordered. On 07/02/26 at 9:35 AM, the Corporate Registered Nurse (RN) #175 confirmed the second recommendation and the facility physician's order was not followed as ordered. The Corporate RN #175 stated, The second recommendation and facility physician's order got missed. the Nurse Practitioner did review it. It will be completed right away.		

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NAME OF PROVIDER OR SUPPLIER Dunbar Center		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Caldwell Lane Dunbar, WV 25064	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review and staff interview, the facility failed to ensure freedom of significant medication errors during medication administration for Resident #105. This was true for one (1) of three (3) residents reviewed under the care area of medication administration. Resident Identifier: #105. Facility Census: 118. Findings Included: a) Resident #105 On 07/02/26 at 9:00 AM, an observation of medication administration by Registered Nurse (RN) #154 for Resident #105. Resident #105 takes her medication crushed in applesauce. Upon preparation of Resident #105's medication, the resident received Cardizem CD (controlled dose) 120mg (milligrams) by mouth every day. The extended release medication cannot be crushed due to the special time-release mechanism causing the entire dose to hit the bloodstream at once. There is a risk of toxicity, overdose and rendering the medication ineffective for the rest of the day. On 07/02/26 at 9:10 AM, RN #154 did not review the Do not crush list provided by the facility. RN #154 stated, Oh, I forgot about that. On 07/02/26 at approximately 9:30 AM, Corporate Registered Nurse (RN) #175 was notified. Corporate RN #175 stated, We will provide education immediately. b) Medication Administration General Guidelines On 07/02/26 at 10:15 AM, the facility policy entitled, Medication Administration General Guidelines was obtained from the Interim Director of Nursing (IDON). Section 5f states, .Crush medications if indicated for this resident only after referring to the Medications Not To Be Crushed List. The Facility, also, provided the list entitled, Oral Medications That Should Not be Crushed or Altered. After reviewing the list, Cardizem CD was found on the list.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, and staff interview, the facility failed to prepare food in the form to meet the individual needs of Resident #62 as ordered by the physician. Resident #62 was ordered an Advanced Dysphagia diet and was served a regular diet. This was a random opportunity for discovery. Resident Identifier: #62. Facility Census: 118. Findings Included: a) Resident #62 Healthcare Services Group (HCSG) Policy #6 titled, Food Quality and Palatability states: -Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. -Food and liquids are prepared and served at a safe and appetizing temperature. -The Dining Services Director and [NAME] are responsible for food preparation. Menu items are prepared according to the menu, production guidelines, and standardized recipes. -Food and liquids / beverages are prepared in a manner, form and texture that meets each resident's needs. b) Resident #62 Resident #62 was ordered a Dysphagia Advanced texture diet on 05/28/26. The resident was care planned for a Dysphagia Advanced texture diet. c) Lunch Meal On 06/29/26 at 12:26 PM, Resident #62 was served a regular texture lunch meal. The [NAME] Clerk Unit Employee #124 identified this error from the dietary staff and sent the tray back before Resident #62 could consume it. The Healthcare Services Group (HCSG) Director of Operations (DO) verified the consistency was wrong and sent a new tray with the correct consistency.		

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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 quarterly smoking safety assessments were completed in accordance with the facility's smoking policy for one (1) of one (1) residents reviewed for smoking safety. This failed practice had the potential to place residents at risk for smoking-related accidents and injuries. Resident Identifier: #38. Facility census: 118. Findings Included: a) Resident #38 Record review, completed on 06/29/26, of the facility's smoking policy revealed, All residents upon admission, readmission, and with change in condition should have a smoking assessment completed if they wish to smoke in the facility. This assessment cannot have any missing documentation and must match the clinical admission assessment also completed upon admission. If they remain in the facility this will be done quarterly. Further record review of Resident #38's smoking assessments revealed the December 2025 quarterly smoking assessment was initiated; however, it was not completed or signed. During an interview with the Interim Director of Nursing (IDON), on 06/29/26 at approximately 3:00 PM, the IDON confirmed the quarterly smoking assessment for Resident #38 had not been completed.		