

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Moundsville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Floral Street Moundsville, WV 26041	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and staff interview, the facility failed to ensure a complete and accurate medical record for documentation of Resident #12's incontinence status and Resident #110's care plan. This was true for two (2) of 25 residents reviewed during the survey process. Resident Identifiers: #12 and #110. Facility Census: 124. a) Resident #110</p> <p>-Activity staff had documented in resident's care plan, She does not eat meat, fish, eggs or caffeine due to her religious beliefs.</p> <p>- A dietary order stated Lacto-Ovo Vegetarian diet. A lacto-ovo vegetarian diet excludes meat, poultry, and fish but includes dairy products (lacto) and eggs (ovo). This type of vegetarianism is plant-based, with a foundation of fruits, vegetables, grains, nuts, and seeds, and it also incorporates milk, cheese, yogurt, and eggs for nutrients like protein, calcium, and vitamin B12.</p> <p>During a telephone interview on 12/10/2025 at 7:45 PM, Resident #110's Medical Power of Attorney (MPOA) confirmed that the resident did eat eggs. The MPOA communicated that eggs were an important source of protein for the resident.</p> <p>During an interview, on 12/11/25 at approximately 11:00 AM, the Director of Activities reported that the resident's care plan would need to be updated to reflect her current lacto-ovo vegetarian diet which did in fact include eggs.</p> <p>b) Resident #12</p> <p>On 12/10/2025 at 1:00 PM, a record review was completed for Resident #12. The review of the bladder incontinence from 11/11/25 through 12/10/25 under the tasks tab found multiple inaccurate issues with documentation. The resident did have an indwelling urinary catheter for obstructive uropathy. The correct documentation should be under the heading of continence not rated due to indwelling catheter. The following issues were found:</p> <p>--11/14/25 Incontinent</p> <p>--11/15/25 Incontinent</p> <p>--11/16/25 Incontinent</p> <p>--11/20/25 Incontinent</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Moundsville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Floral Street Moundsville, WV 26041	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--11/21/25 Incontinent</p> <p>--11/23/25 Incontinent</p> <p>--11/24/25 Incontinent</p> <p>--11/25/25 Continence not rated due to condom catheter</p> <p>--11/26/25 Incontinent</p> <p>--11/28/25 Continence not rated due to condom catheter</p> <p>--11/30/25 Incontinent</p> <p>--12/04/25 Incontinent</p> <p>--12/05/25 Incontinent</p> <p>--12/09/25 Continence not rated due to condom catheter</p> <p>--12/10/25 Continence not rated due to condom catheter</p> <p>On 12/10/2025 at 1:11 PM, the Director of Nursing (DON) verified the resident did have an indwelling foley catheter. The DON stated, I see I need to do training for my CNAs (certified nursing assistants) .some are new.</p>