

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER Putnam Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Seville Road Hurricane, WV 25526	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>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.</p> <p>Based on record review, observation and staff interview, the facility failed to ensure a clean, safe, comfortable, home-like environment by not preventing odors throughout the building. This was a random opportunity for discovery and this failed practice had the potential to affect more than a limited number of residents. FACILITY:FACILITY. Facility Census:116.Findings included:a) On 10/27/2025, upon initial entrance to the building, the state surveyors observed a strong, unpleasant odor throughout the building. The odor was identified by the state surveyors during their initial tours and investigations in the facility. On 10/28/2025 at 09:35 AM, the state surveyor again smelled a strong odor throughout the facility when making rounds in the facility.b) On 10/27/2025 at 05:50 PM, the state surveyor interviewed the Corporate Registered Nurse nurse concerning odor/smell in the hallways observed by the state surveyors. The Corporate Registered Nurse confirmed the odor and stated, Almost smells like they have someone that's going somewhere. I'll have them look into it. c) The facility's policy and procedure for Resident Room Cleaning and Floor Care Policy stated, the Healthcare Services Group is committed to providing a safe, clean and hygienic environment for residents, staff, and visitors in accordance with regulatory guidance and industry best practices.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on record review and staff interview, the facility failed to ensure residents were free from neglect, and verbal abuse. This was true for seven (2) of nine (9) residents reviewed during the survey process. Resident Identifiers: #47, and #102. Facility Census: 116.</p> <p>Findings include:</p> <p>b) Resident #47 and #102</p> <p>On 10/27/25 at approximately 3:00 PM, a review of a FRI dated 07/19/25. The review of the FRI found the allegation of neglect was made by Resident #102 and #47. The allegation was that neither resident had received incontinence care since 5:00 AM on 07/19/25. The residents reported this to NA #116 upon delivery of the lunch trays. NA #116 got another NA #130 to assist with the incontinence care for both residents at 1:00 PM. Assigned NA #135 was noted to be on her personal phone at the nurses' station and was rounding on the other residents on her hall. NA #135 stated, I was told I had to go to the dining room before I finished my last residents. However, NA #135 did not notify the other NAs regarding the need for incontinence care for the residents. After the investigation was completed, NA #135 was terminated. However, the investigation was found to be unverified. Upon completing the review of the investigation, the witness statements as well as the resident statements, did verify the allegation of neglect.</p> <p>On 10/30/25 at 9:30 AM an interview with Resident # 102's wife was held via telephone about an incident she reported on 08/04/25.</p> <p>She reported she walked into resident's room after lunch time on the morning of the incident. Resident's brief was so full it was crumbling and laying in pieces after having fallen apart. She stated a nurse was cleaning it up from the floor and cleaning her husband. She stated that he was red down there and the nurse was angry stating this was not acceptable. Resident's wife stated resident very rarely had redness in the groin area while living at home and they treated it but his skin was not red when he entered the facility. She stated no one told her the facility did not substantiate the complaint. She reported when she spoke with the administrator, he stated that he would take care of it and she has had no further complaints about her husband's care in that regard. She reported that he is not being bathed often.</p> <p>An Interview on 10/30/25 at 10:52 AM with Licensed Practical Nurse (LPN) #36 revealed the following</p> <p>LPN #36 reported she had been completing nursing duties earlier in the day and passing meds around 8:30 AM when she encountered Resident #102 who was covered with blankets. She did not check him or see anyone check him at this time, although she did see a nurse aide go into his room. She reported she took over nurse aide duties around 11:30 AM and was not given report before she took over the assignment. When she walked into Resident 102's room, he was wearing no brief, it smelled of foul odor of urine, parts of the brief all over the floor, and she had to ask housekeeping to help her clean it up. She stated that resident was a little reddened and she did not remember if the facility had already been giving him nystatin at that point or if he was prescribed a cream after.</p> <p>An interview with Administrator on 10/30/25 12:30 PM revealed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administrator reported they do not always review the results of the incident investigations with the complainants unless they ask. He stated that he did try to take all sides into consideration and if there were other witnesses or if the alleged perpetrator was involved in any other investigations.</p> <p>Review of Documentation on 10/30/25 for Resident #102 found:</p> <p>Review of Progress Note dated 08/08/25 at 8:57 AM revealed a new, acquired in-house wound to the groin/genital area and describes it as Moisture Associated Skin Damage: Incontinence Associated Dermatitis MASD: IAD.</p> <p>Review of document titled Five-day Follow-up dated for 08/07/25 revealed an interview with alleged perpetrator, who is no longer employed by the facility, reported that she had checked to see if resident was dry twice on the day of the incident before 8:00 AM and once again at 9:30 AM.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and staff interview, the facility failed to thoroughly investigate allegations of neglect. This was true for two (2) of nine (9) residents reviewed during the survey process. Resident Identifiers: #47 and #102. Facility census: 116. Findings Include: b) Neglect On 10/27/25 at approximately 3:00 PM, a review of a FRI dated 07/19/25. The review of the FRI found the allegation of neglect was made by Resident #102 and #47. The allegation was that neither resident had received incontinence care since 5:00 AM on 07/19/25. The residents reported this to NA #116 upon delivery of the lunch trays. NA #116 got another NA #130 to assist with the incontinence care for both residents at 1:00 PM. The assigned NA #135 was noted to be on her personal phone at the nurses' station and was rounding on the other residents on her hall. NA #130 stated, I was told I had to go to the dining room before I finished my last residents. However, NA #130 did not notify the other NAs regarding the need for incontinence care for the residents. After the investigation was completed, NA #135 was terminated. However, the investigation was found to be unverified. Upon completing the review of the investigation, the witness statements as well as the resident statements, did verify the allegation of neglect. An interview was held on 10/28/25 at approximately 10:00 AM, with the Administrator. The Administrator stated, I see what you are saying.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and staff interview, the facility failed to revise a care plan for a residents fall interventions. This failed practice had the potential to affect a limited number of residents . Resident Identifier: #66. Facility Census: 116.Findings included: Resident # 66:On 10/27/2025 at 05:55 PM, an observation was completed for Resident #66. A low bed, fall mats to right side of the bed and the left side of the bed was against the wall. The resident was receiving 1:1 supervision initiated this date as reported by Nursing Assistant #51.The resident was ordered 1:1 for safety every day and night shift with a start date of 10/27/2025, floor mats x2 both right side of bed every day and night shift with a start date of 10:27/2025. No orders for low bed with parameter mattress was found. The only fall intervention on the resident's care plan was for a low bed parameter mattress. Both floor mats to the left side of the bed, bed against the wall or 1:1 supervision were not documented in the resident's care plan. On 10/28/2025 at 12:15 PM, the orders and care plan were confirmed by the Director of Nursing and the Corporate Registered Nurse</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on resident interview, staff interview and record review, the facility failed to ensure activities of daily living (ADLs) were provided to dependent residents. This was true for three (3) of three (3) residents reviewed during the survey process. Resident Identifiers: #93, #8, and #102. Facility Census: 116. Findings Include:</p> <p>a) Resident #93</p> <p>An interview was held with Resident #93 on 10/30/25 at 10:35 AM. Resident #93 stated, I have been trying to get a shower since Monday (10/27/25) so maybe I will get one tomorrow. I have had problems before with getting my showers but I think they are getting it worked out.</p> <p>A review of showers from 09/01/25 through 10/30/25 was completed on 10/30/25 at 09/12/25-09/19/25 at 10:50 AM. The review found the following:</p> <p>No showers from 10/03/25 to 10/14/25 which was 11 days.</p> <p>No showers from 10/23/25 to 10/30/25 which was seven (7) days.</p> <p>On 10/30/25 at 10:45 AM, Nurse Aide (NA) #24 was assisting this Surveyor with the shower book and schedule. NA #24 stated, I know why she didn't get one on Monday .the NA left at 3:00 PM and the next NA coming on should have gave her a shower.</p> <p>On 10/30/25 at 11:00 AM, the Director of Nursing (DON) stated, I recently went around and asked the residents' preferences and redid the shower schedule. understand your concern .it looks like she went a long time without showers.</p> <p>On 10/30/25 at 12:03PM, the DON stated, we don't have a policy or procedure regarding how often showers or bed baths are to be given .we offer biweekly showers .if the resident wants less or more we will do that .if the resident refuses it should be documented.</p> <p>b) Resident #8</p> <p>On 10/30/2025, Resident #8's shower care plan and tasks were reviewed. The resident's care plan indicated the resident was dependent for bathing. No showers were documented for the month of September 2025. and one (1) shower was documented for the month of October on 10/28/2025. On 10/30/25 at 11:03 AM, the Director of Nursing (DON) reported the staff should be documenting a bed bath everyday if no shower was given. It was their policy for a bed bath to be given everyday unless it is a shower day. On 10/30/2025 at 11:59 AM, the DON confirmed Resident#8 did not have showers and /or bed baths documented daily and reported there is no written policy for frequency of bed baths or showers, but residents are to be offered showers two (2) times a week and bed baths daily. Refusals would be documented under responses per the DON.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #8's shower days are listed as every Wednesday and Sunday. No documentation of bed baths and/or showers for September and October were found on the following dates.: 09/01/2025, 02/-2/2025, 09/09/2025, 09/10/2025, 09/11/2025, 09/12/2025, 09/13/2025, 09/15/2025, 09/16/2025, 09//29/2025, 09/30/2025, 10/01/2025, 10/02/2025, 10/03/2025, 10/04/2025, 10/05/2025, 10/06/2025, 10/07/2025, 10/14/2025, 10/16/2025, 10/19/2025, 10/21/2025, 10/22/2025, and 10/27/202.</p> <p>c) Resident #102</p> <p>Interviews:</p> <p>During an interview with Resident's wife on 10/30/25 at 9:30 AM she reported the facility does not give resident enough showers. She stated that she had talked to staff about trying different times with him and they tell her he refuses.</p> <p>During an interview with Director of Nursing on 10/30/25 at approximately 12:30 PM she reported she had looked for documentation of shower refusals from Resident #102 and could not find any.</p> <p>Document Review:</p> <p>A review of Resident #102's Task section GG Bathing, Question 2 (two) for the month of October 2025, Resident had was given a shower on the following days:</p> <p>10/01/25</p> <p>10/08/25</p> <p>10/28/25</p> <p>On 10/30/25 review of resident's care plan he was up to dependent assist for bathing.</p> <p>Review of shower schedule on 10/30/25 reveals resident is scheduled to receive showers on Day Shift, Wednesdays and Saturdays.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on record review, staff interview, and resident interview, the facility failed to ensure continuity of care by not seeking order clarification from the physician regarding oral medication orders for a resident who was NPO (nothing by mouth) and failed to ensure respiratory equipment was obtained for a newly admitted resident. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #66, #93, #8 and #121. Facility Census: 116. Findings included: The facility's policy and procedure for Medication Administration stated, Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record. The Job Aid: Physician Review v2004, given to the state surveyor by the facility, stated the physician orders will be reviewed on a nightly basis to ensure accuracy, completeness: compliance with State, Federal and JACHO requirements and that they are accurate and true reflection of the plan of care.)n 10/29/2025, the Director of Nursing reported there is no monthly review of orders by the nursing staff and the orders are just left for the physician to sign.a) Resident #66: The resident had an order for NPO (nothing by mouth) diet NPO texture, NPO consistency, for Diet. Review of the resident's order summary revealed the resident had an order for Insta-Glucose Gel 77.4% (Glucose) Give 1 dose by mouth as needed for BG less than 70. Pt arousable conscious and able to swallow and an order for Milk of Magnesia Suspension 400MG/5ML (Magnesium Hydroxide) Give 30ml by mouth as needed for Constipation give at bedtime of no BM in 3 days. On 10/28/2025, at 12:15 PM, the orders were confirmed by the Director of Nursing and the Corporate Registered Nurse. The resident's order for NPO remained effective 05/10/2025 to current date. A review of the Medication Administration Record from 5/10/2025 to 10/28/2025 revealed the following medications were documented as given by mouth: 1) Xanax from 05/27/2025 through 06/24/2025. 2) Miralax Powder from 05/10/2025 through 06/26/2025. 3) Prozac from 05/30/2025 through 06/01/2025. 4) Vistaril from 05/24/2025 through 05/26/2025. 5) Potassium from 07/08/2025. b) Resident #93: The resident was NPO from 07/31/25 through 09/25/2025. The Medication Administration Record had PO (oral) meds given in the month of August 2025 for Acetaminophen Tablet 325mg - Give 2 tablet by mouth every 6 hours as needed for pain, Escitalopram Oxalate Tablet 10 MG - Give by mouth one time a day for Depression, and Lasix Oral Tablet 40 MG - Give 1 tablet by mouth one time a day for Acute hypoxic respiratory failure. The Medication Administration Record had an PO meds given in the month of September 2025 for Escitalopram Oxalate Tablet 10 MG - Give by mouth one time a day for Depression. On 10/29/2025 at 11:00 AM, the DON reported the medication was given via tube and that all the nurses know the patients that are NPO. c) Resident #8: The resident had an NPO order from 11/04/2024. with the most recent order clarified on 07/16/2025. The Medication Administration Record for 07/15/2025 through 10/28/2025 (discharged by mouth after surveyor intervention) had BusPiRone 5 mg 1 tablet by mouth every 12 hours for anxiety. On 10/29/2025 at 11:00 AM, the DON reported the medication was given via tube and that all the nurses know the patients that are NPO. d) Resident #21: On 10/27/2025 at 01:55 PM during an interview conducted by phone, Resident #121 reported the facility couldn't hook up the (Continuous Positive Airway Pressure) CPAP machine until next day and that there were no orders for me to even be there per nursing staff. Orders were reviewed from the hospital consult from 07/04/2025: The orders stated: Obstructive sleep apnea - Continue patient's home CPAP. On 10/28/2025 at 10:15 AM, the Director of Nursing (DON) stated that she wasn't sure if there was an order for the CPAP machine in the resident's admission orders. The policy is to have the equipment here when the patient arrives. The DON reported she was going to look at the paper trail. The DON also stated, Sometimes they don't have the settings for the C-Pap because Lincare sends them to the facility preset according to order from the hospital. On 10/28/2025 at 11:26 AM, the DON reported Lincare did not send the CPAP nor did they have the order. On 10/28/2025 at 01:25 PM, the DON confirmed the resident was discharged back to the hospital before physician orders, diagnosis list and care plan were initiated.</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>Based on observation, record review and staff interview, the facility failed to provide an environment free of accident hazards due to medication being at bedside for Resident #60. This was a random opportunity for discovery. Resident Identifier: #60. Facility Census: 116. Findings Include:a) Resident #60On 10/27/25 at 5:40 PM, an observation was made of the medication Clotrimazole & Betamethasone % cream in a tube at bedside. At this time, Licensed Practical Nurse (LPN) #69 was notified and removed the medication from the nightstand.On 10/27/25 at 5:48 PM, the Corporate Registered Nurse # 132 was notified and stated, let me have them check that there is no other medications at bedside.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Based on record review and staff interview, the facility failed to ensure the pharmacist reported any irregularities to the attending physician, the facility's medical director and the director of nursing and the reports were acted upon. This failed practice was identified for three (3) out of three (3) residents with an NPO (nothing by mouth) order. Resident Identifier: #66, #93, and #8. Facility Census: 116. Findings included:a) The facility's Policy and Procedure for Medication Monitoring: Medication Regimen Review and Reporting stated, The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regiment and ensure that the medications each resident receives are clinically indicated. Identification of irregularities may occur by the consultant pharmacist by utilizing a variety of sources including medication administration records (MAR), prescriber's orders, progress notes, nurse's notes, the Resident Assessment Instrument (RAI), Minimum Data Sheet (MDS), laboratory and diagnostic test results, behavior monitoring information and information from the nursing care center staff and other health professionals involved in the resident's care.b) On 10/29/2025 at 12:24 PM, Pharmacist #138 was interviewed by a state surveyor via phone. The pharmacist reported the resident's ordered medications were reviewed for dosage and route and reported. Pharmacist #138 reported we look closely at the physician's order and if there is a discrepancy, we reach out to the facility or make a comment on our review. The pharmacist reported if she found documentation concerning discrepancies for Resident #66, Resident #8 and Resident #93's medication routes she would contact the state surveyor. c) The following orders and MARs were incorrect for the NPO (nothing by mouth) residents who were ordered medication by mouth:1. Resident #66:The resident had an order for NPO (nothing by mouth) diet NPO texture, NPO consistency, for Diet. Review of the resident's order summary revealed the resident had an order for Insta-Glucose Gel 77.4% (Glucose) Give 1 dose by mouth as needed for BG less than 70. Pt arousable conscious and able to swallow and an order for Milk of Magnesia Suspension400MG/5ML (Magnesium Hydroxide) Give 30ml by mouth as needed for Constipation give at bedtime of no BM in 3 days. On 10/28/2025, at 12:15 PM, the orders were confirmed by the Director of Nursing and the Corporate Registered Nurse.The resident's order for NPO remained effective 05/10/2025 to current date. A review of the Medication Administration Record from 5/10/2025 to 10/28/2025 revealed the following medications were documented as given by mouth:- Xanax from 05/27/2025 through 06/24/2025.- Miralax Powder from 05/10/2025 through 06/26/2025.- Prozac from 05/30/2025 through 06/01/2025.- Vistaril from 05/24/2025 through 05/26/2025.- Potassium from 07/08/2025.No route discrepancies were indicated or reported on the resident's Medication Regimen Reviews.2. Resident #93:The resident was NPO from 07/31/25 through 09/25/2025. The Medication Administration Record had PO (oral) meds given in the month of August 2025 for Acetaminophen Tablet 325mg -Give 2 tablet by mouth every 6 hours as needed for pain, Escitalopram Oxalate Tablet 10 MG - Give by mouth one time a day for Depression, and Lasix Oral Tablet 40 MG - Give 1 tablet by mouth one time a day for Acute hypoxic respiratory failure. The Medication Administration Record had an PO meds given in the month of September 2025 for Escitalopram Oxalate Tablet 10 MG - Give by mouth one time a day for Depression. On 10/29/2025 at 11:00 AM, the DON reported the medication was given via tube and that all the nurses know the patients that are NPO.No route discrepancies were indicated or reported on the resident's Medication Regimen Reviews.3. Resident #8:The resident had an NPO order from 11/04/2024. with the most recent order clarified on 07//16/2025. The Medication Administration Record for 07/15/2025 through 10/28/2025 (discharged by mouth after surveyor intervention) had BusPiRone 5 mg 1 tablet by mouth every 12 hours for anxiety. On 10/29/2025 at 11:00 AM, the DON reported the medication was given via tube and that all the nurses know the patients that are NPO.No route discrepancies were indicated or reported on the resident's Medication Regimen Reviews.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER Putnam Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Seville Road Hurricane, WV 25526	
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 the resident's medical record was accurate for physician orders for fall interventions and the medication route does not follow the physician's order for NPO (nothing by mouth). This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #66, #93, and #8. Facility Census: 116. Finding included:a) Resident # 66:On 10/27/2025 at 05:55 PM, an observation was completed for Resident #66. A low bed, fall mats to right side of the bed and the left side of the bed was against the wall. The resident was receiving 1:1 supervision initiated this date as reported by Nursing Assistant #51.The resident was ordered 1:1 for safety every day and night shift with a start date of 10/27/2025, floor mats x2 both right side of bed every day and night shift with a start date of 10:27/2025. No orders for low bed with parameter mattress was found. The only fall intervention on the care plan was for a low bed parameter mattress. The orders and care plan were confirmed by the Director of nursing and the Corporate Registered Nurse on 10/28/2025 at 12:15 PM.The resident had an order for NPO (nothing by mouth) diet NPO texture, NPO consistency, for Diet. Review of the resident's order summary revealed the resident had an order for Insta-Glucose Gel 77.4% (Glucose) Give 1 dose by mouth as needed for BG less than 70. Pt arousable conscious and able to swallow and an order for Milk of Magnesia Suspension400MG/5ML (Magnesium Hydroxide) Give 30ml by mouth as needed for Constipation give at bedtime of no BM in 3 days. On 10/28/2025, at 12:15 PM, the orders were confirmed by the Director of Nursing and the Corporate Registered Nurse.The resident's order for NPO remained effective 05/10/2025 to current date. A review of the Medication Administration Record from 5/10/2025 to 10/28/2025 revealed the following medications were documented as given by mouth:1) Xanax from 05/27/2025 through 06/24/2025.2) Miralax Powder from 05/10/2025 through 06/26/2025.3) Prozac from 05/30/2025 through 06/01/2025.4) Vistaril from 05/24/2025 through 05/26/2025.5) Potassium from 07/08/2025.b) Resident #93:The resident was NPO from 07/31/25 through 09/25/2025. The Medication Administration Record had PO (oral) meds given in the month of August 2025 for Acetaminophen Tablet 325mg -Give 2 tablet by mouth every 6 hours as needed for pain, Escitalopram Oxalate Tablet 10 MG - Give by mouth one time a day for Depression, and Lasix Oral Tablet 40 MG - Give 1 tablet by mouth one time a day for Acute hypoxic respiratory failure. The Medication Administration Record had an PO meds given in the month of September 2025 for Escitalopram Oxalate Tablet 10 MG - Give by mouth one time a day for Depression. On 10/29/2025 at 11:00 AM, the DON reported the medication was given via tube and that all the nurses know the patients that are NPO.c) Resident #8:The resident had an NPO order from 11/04/2024. with the most recent order clarified on 07//16/2025. The Medication Administration Record for 07/15/2025 through 10/28/2025 (discharged by mouth after surveyor intervention) had BusPiRone 5 mg 1 tablet by mouth every 12 hours for anxiety. On 10/29/2025 at 11:00 AM, the DON reported the medication was given via tube and that all the nurses know the patients that are NPO.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER Putnam Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Seville Road Hurricane, WV 25526	
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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<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>Based on observation, and staff interview, the facility failed to establish and maintain an effective infection prevention and control program designed to provide a sanitary environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to serve meals in a sanitary manner by serving a cup that had been dropped on the floor to a resident during meal time. This was true during a random opportunity of discovery for Resident #102. Facility Census 116. Findings Included: a) On 10/29/25 at 11:52 AM Registered Nurse RN #130 was observed walking out of the kitchen holding a cup can a lid. She dropped the lid the the floor of the dining room, bent down to pick it up. She then placed it on the counter as she filled the cup with ice and drink and handed it to Nurse Aide #81 who had just walked over to her. Nurse Aide #81 then placed the lid onto the cup and handed it to Resident #102. This Surveyor asked Nurse Aide to replace the drink before resident drank out of it as it had been dropped in the floor and Nurse Aide did so. b) Interview with Director of Nursing on 10/29/25 at approximately 1:20 PM who acknowledged failure to maintain sanitary eating environment for this resident. c) Interview with RN #130 on 10/29/25 at approximately 3:20 PM, when asked about giving resident the dropped cup she reported that she did not realize she had done it until after. She stated that it was stupid.</p>		