STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515072	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Healthcare Center	300 Miller Road Kingwood, WV 26537

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 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 observations and staff interviews, the facility failed to maintain a clean, safe and comfortable homelike environment for the residents. The surveyors observed various maintenance issues and items requiring cleaning. Resident identifiers: #7, #29, #50, and #111. Census: 116. Findings include: a) On May 11, 2026 at approximately 11:45ˆAM during a routine walkthrough of the 300 hallway, the following was observed: A high-back wheelchair near 301 had brown stains, was visibly soiled, and showed cracks and splitting of the vinyl. Nurse Aide #116 said, Housekeeping cleans them on a schedule usually. when asked who cleans and maintains the wheelchairs. Observation revealed the sit to-stand (STS) lift at the end of the hall (300) near rehab had a sling draped across it. Interview with CNA #116 they are not supposed to be stored on the lifts, there is a space at the end of the hallways. Wall paper is torn and peeling off the wall near rehab at end of 300 hall During an interview with Nurse Aide (NA) #116 the NA said, That's been that way a while. b) Resident #50 Resident #50 has damaged/exposed plaster behind their bed. c) Resident #29 Resident #29 has damaged plaster near and behind their bed. d) Resident #7 Resident #7 had damaged/exposed plaster behind their bed. All these rooms contained visible large areas of damage to the walls and plaster surfaces. These areas were all larger than a dollar bill in size, with some having deep gouges and holes exposing the gypsum underneath. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor conducted a walkthrough with the Administrator and Director of Nursing (DON) to point out these issues and ask for more information after discovering them. The Administrator and DON were asked to provide the following policies regarding the cleaning and maintenance of the facility as well as the residential areas. Wheelchair cleaning and maintenance Wall cleaning and repair policy The Administrator stated she did not have any of the above requested policies 05/11/26 at 1:45ˆPM On 05/11/26 at 2:44ˆPM the administrator and director of nursing (DON) stated they are addressing the wallpaper damage, cleaning the wheelchair (w/c), and removing all slings for proper storage. They are also doing education for staff. e) Resident #111 On 05/11/26 at 11:29 AM, the surveyor observed that Resident #111's room contained a recliner with dried white substance smears on the seat. During a walk through with the Assistant Director of Nursing, on 05/12/26 at 1:50 PM, she acknowledged the dried white substance smears on the seat and stated she would make sure it was on the list for to be cleaned.

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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 interview. The facility failed to ensure items for resident meal use are air dried prior to use. This was found during the annual facility survey process. This failed practice had the potential to affect more than a limited number of residents. Facility census 116.Findings include: a) Policy review for ware washing included the following: Policy statement: All dishware, service ware, and utensils will be cleaned and sanitized after each use.Procedures read in part:4. All dishware will be air dried and properly stored. During the initial walk-through on 05/11/26 at around 11:30 AM with the Food Service Director in the dish tank area: wet nesting was observed with four (4) of four (4) Kennedy cups and eight (8) of twelve (12) cereal bowls. Food Service Manager verified these items remained wet During the follow-up kitchen observation with the Food Service Director on 05/12/2026 at around 10:30 AM, wet nesting was observed again in the dish tank area. Ten (10) of twelve (12) cereal bowls were placed in a bus tub, stacked on each other. The Manager reported, I thought it was ok like this since they were stacked for some space. He then reviewed the warehousing policy and reported, I will try to find something to use.The Director of Operations (DOO) was also in the dish tank area and verified the wet nesting in the cereal bowls placed in the bus tub. The DOO said, We will try to order some extra drying racks.

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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 record review, observation and staff interviews, the facility failed to ensure a safe and sanitary environment was provided to prevent the development and transmission of communicable diseases and infections. This failed practice had the potential to affect more than a limited number of residents. Resident identifiers: #3, #111. Facility Census: 116. a) Resident #111 On 05/11/26 at 11:19 AM, during an interview with Resident # 111, staff observed a hole in the bottom edge of his walker seat's plastic cover, exposing the inner padding. During a facility walkthrough with the Assistant Director of Nursing (ADON), on 05/12/26 at 1:55 PM, she acknowledged Resident #111's walker seat with the hole and exposed inner padding and stated she would report it so the seat cover could be repaired. b) On 05/11/2026 at around 2:15 PM the surveyor observed two resident ice packs with names on them in the freezer in the nourishment room on the 300 hall. The surveyor also observed residents' personal food items (ice cream, frozen foods) in the freezer. A reminder notice hanging on the side of the freezer stated, Do not place residents' ice packs in the nutrition station freezer. They may be placed in the small one, just inside the door, in therapy. Licensed Practical Nurse (95) verified these items should not be in there, reporting, I will remind the nursing assistants to keep these in the therapy room. c) During an initial walkthrough of the facility on 05/11/26 at 11:30 AM the surveyor identified the following infection control concerns: Two (2) sit to stand lifts on the 200 hallway both had a transfer sling still attached. The surveyor asked Nurse Assistant (NA) #109 if transfer slings were allowed to be stored on the sit-to-stand lifts in the hallway when not in use, and she stated, No, we have a storage location for them. The surveyor also asked Licensed Practical Nurse (LPN) #56 if transfer slings were allowed to be stored on the sit-to-stand lifts in the hallway when not in use, and she stated I am not sure, I will find out for you. d) On 05/11/26 at 11:40 AM one (1) Geri chair located on 100 hallway was soiled with food debris. One (1) wheel chair located on the 100 hallway was soiled with debris. One (1) wheelchair located on the 100 hallway had a seat that had a tear in the fabric and would not be easily cleanable. e) Observation on 05/11/26 at 11:45 AM revealed: two (2) sit to stand lifts on the 100 hallway both with a transfer sling still attached. The surveyor asked the Registered Nurse (RN) Unit Manager #12 if transfer slings were allowed to be stored on the sit-to-stand lifts in the hallway when not in use, and she stated It shouldn't be on it, I would say. f) On 05/11/26 at 11:50 AM eight (8) dining room chairs were damaged and not easily cleanable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g) On 05/11/26 at 11:55 AM two (2) sit-to-stand lifts on the 400 hallway both had a transfer sling still attached. h) On 05/11/26 at 11:56 AM one (1) sit-to-stand lift on the 300 hallway still had a transfer sling attached. i) One (1) Geri chair on the 300 hallway was soiled and had a tear that would not be easily cleanable. j) On 05/12/26 at 11:15 AM, two (2) Geri chairs on the 100 hallway were soiled with debris. The surveyor asked LPN #59 if one (1) of the Geri chairs looked clean to her, and she stated, I don't think it is, I will take it and clean it now. On 05/12/26 at 12:35 PM the ADON gave the surveyor a policy for laundering the transfer slings, but did not have a policy for storing them. She stated, The transfer slings should be stored in the residents room that the sling is being used on at that time. The ADON also stated, We do not have a policy on cleaning and storing wheel chairs and Geri chairs, but we do clean them every day on night shift. She acknowledged that some were missed and said we will get a better process in place. k) On 05/13/26 at 9:00 AM the six (6) chairs surrounding the table in the internet cafe room were all damaged and not easily cleanable. On 05/13/26 at 10:15 AM the surveyor interviewed the Administrator about the damaged chairs located in the internet cafe and the dining room. After showing her the damaged chairs, she stated, I agree that these chairs are damaged and need to be replaced. I will order new ones soon.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review, observation, staff interview and resident interview, the facility failed to ensure a resident's call light was within reach. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #117. Facility Census: 116.Findings included:a) Resident #117The facility's policy and procedure for Resident Rights stated, c. To have a method to communicate needs to staff. i. Call light or bell access will be within reach of the resident as one method to communicate needs to staff. On 05/12/26 at 11:20 AM, during an interview with Resident #117, he was reaching around his bed looking for something. I asked him if he was looking for his call light, and he stated, No, but it is hanging up there, I don't know why they put it up there. Resident #117 was referring to his call light hanging on his over-the-bed light, which was located behind and above his bed.Registered Nurse (RN) #96 entered the room with Resident #117's lunch meal tray. I asked her if she thought Resident #117 could reach his call light? She stated, No, he can't. Then she moved it to his bed on his left side. Resident #117 was pleased with the location to which Employee #96 moved it.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, record review, and staff interview the facility failed to provide dental services for Resident #110. Resident Identifier #110. Facility Census 116.Findings include:a) Resident #110 On 05/11/2026 at 3:08 PM, during initial interview with Resident #110, she had concerns about having a dental appointment for dentures. Review of records and staff interviews showed her last dental appointment was scheduled for 01/23/25. It was documented that Resident #110 was sick and did not attend the appointment. The appointment was never rescheduled. Assistant Director of Nursing verified this appointment was not rescheduled on 05/13/26 at 11:10 AM.