STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515074	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Martinsville Health & Rehab	225 Russell Avenue New Martinsville, WV 26155

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, resident representative interview, and staff interview, the facility failed to notify Resident #97's legal representative when he passed away in the facility and notify the resident representative of a new medication. This was a random opportunity for discovery. Resident identifiers: #97 and #76. Facility census: 93.Findings included: a) Resident #97 On [DATE] at 8:55 AM, an electronic record review revealed: Resident #97’s legal representative’s home telephone number Resident #97’s legal representative’s mobile phone number A Physician Orders for Scope of Treatment (POST) form dated [DATE] The POST form listed the legal representative’s mobile phone number A Care Conference note, dated [DATE] at 10:00 AM, indicated Resident #97’s legal representative participated in the meeting A Nursing Note, dated [DATE] 2:40 PM, which indicated the nurse had made Resident #97’s legal representative aware of a new skin issue A Nursing Note, dated [DATE] at 8:57 PM, indicated the legal representative was made aware of a new physician order for occupational therapy to evaluate and treat resident A Nutrition/Dietary note, dated [DATE] at 3:42 PM, indicated Resident #97’s legal representative was made aware of a new dietary supplemental order for resident A Nursing Note, dated [DATE] at 4:13 Am, indicated that the legal representative had visited the building the day prior and was aware of a new dietary order A Nursing Note, dated [DATE] at 11:52 AM, indicated that the resident’s family had taken resident out of the building to attend a family reunion (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Note, dated [DATE] at 3:54 PM, indicated the resident had returned to the facility with two (2) skin tears to the top of left hand. A Nursing Note, dated [DATE] at 4:46 PM, indicated the nurse spoke to Resident #97’s legal representative about the new skin tears. A Nursing Note, dated [DATE] at 1:13 PM, indicated the resident’s legal representative had visited the facility on this date. Palliative care services, a specialized form of medical care that focuses on improving the quality of life for people with serious or life-limiting illnesses, were discussed. A Nursing Note, dated [DATE] at 8:53 PM, indicated the nurse had attempted to call resident’s legal representative to let the individual know the resident was not doing well. The note indicated the nurse was unable to reach the legal representative at either number listed. A Nursing Note, dated [DATE] at 12:59 AM, indicated a Nurse Aide (NA) called the nurse to Resident #97’s room. Upon assessment, the resident was not breathing, no breath sounds were heard, and the resident had no pulse. A Nursing Note, dated [DATE] at 1:56 AM, indicated the nurse attempted both numbers for resident’s legal representative but was unable to reach the representative. The nursing note also documented that the funeral home was notified of resident’s death at 1:09 AM. Additionally the note indicated resident’s watch and silver bracelet were sent to the funeral home with resident. Review of the facility’s policy, entitled “Death of a Resident – Documenting”, outlined the appropriate documentation that should be make in the clinical record concerning the death of a resident. The guidance listed: 1. A resident may be declared dead by a licensed physician or registered nurse with he physician authorization in accordance with state law. 2. All information pertaining to a resident’s death (i.e., date, time of death, the name and title of the individual pronouncing the resident death etc.) will be recorded on the nurses’ notes. 3. The attending physician will record the cause of death in the medical record and will complete and file a death certificate with the appropriate agency in accordance with state law. 4. The licensed nurse or designee will inform the resident’s family and/or resident representative of the resident’s death. 5. Nursing services will be responsible for preparing the deceased resident for discharge. 6. A physician’s order to release the body will be obtained and documented in the medical record. 7. The licensed nurse / designee must notify the mortician, as identified in the resident’s medical record, to pick up the deceased resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 9:30 AM, Resident #97’s legal representative reported that she had never received a telephone call from the nursing home regarding her loved one’s death. The legal representative reported she had caller ID and voicemail and that she never showed a missed call from the facility nor did she have a voicemail message from the facility. She reported she had been home all evening and all night. The legal representative reported she received a call from the funeral home at approximately 9:30 AM stating they had her loved one’s body and wanting to discuss funeral arrangements. This was reportedly the first time she learned that her loved one had passed away at the nursing home. The legal representative reported she was devastated to get the news in that manner. She went on to report that she waited the entire day to receive a call from the facility but never did. In an interview on [DATE] AM at 11:40 AM, the Administrator acknowledged Resident #97’s legal representative had been actively involved in the resident’s care both via telephone calls and visits to the facility. Additionally, The Administrator acknowledged the nursing staff was unable to produce evidence that they had successfully notified Resident #97’s legal representative of his death. The Administrator stated it was a terrible oversight and had been addressed with the staff involved. b) Resident #76 On [DATE] at approximately 3:30 PM, a record review was completed for Resident #76. The review found the resident had seen MindCare Psychiatric Evaluation via video on [DATE]. The progress note dated [DATE] at 8:50 AM, stated, Vistaril 25mg (milligram) by mouth every eight (8) hours as needed for 14 days for anxiety. However, upon further review, the resident's Medical Power of Attorney (MPOA) was not notified. There was no change in condition completed. An interview was held with the resident's representative on [DATE] at approximately 4:15 PM. The MPOA was asked, do you feel the (Name of Resident) is anxious or having problems with anxiety? The MPOA replied, no, I don't. On [DATE] at approximately 4:30 PM, the Administrator was interviewed regarding the change of condition for the resident and the adding of a new medication. The Administrator stated, there should be a change in condition and a note stating the MPOA was notified.

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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 resident interview, staff interview and observation the facility failed to provide a safe, clean, comfortable, homelike environment for residents. This is true for residents #58, #79, #87, and #40. Facility Census 93.Findings Included:a) Resident #58 Interview with Resident # 58 on 08/20/2025 at 2:38 PM who reported a black area on the tile on and around the base of the wall behind resident’s toilet. Observed area around resident's toilet at 2:41 PM and Nurse Aide (NA) #35 acknowledged the area and agreed to notify housekeeping/maintenance. b) Resident #79 On 08/20/2025 at 10:47 AM during an interview with Resident #79, he stated pieces of dry wall had been removed from the bathroom wall around the pipes to the toilet for approximately one month. The toilet is now working but he did not have access to his toilet for two weeks, he had to use the toilet at the nurse’s station. c) Resident #87 Observed on 08/20/2025 10:53 AM a large hole in ceiling exposing unfinished wood underneath. d) Resident #40 On 08/20/25 at 1:20 PM observed Resident's toilet lid sitting on the floor beside the toilet. On 08/20/25 at 1:24 PM interview with Nurse Aide #72 who reported as far as she knew, the toilet was broken. On 08/20/25 at approximately 1:30 PM during an interview with Regional Director of facilities for Maintenance #116, he acknowledged the hole in ceiling to Resident #87 room, Resident #79 dry wall in bathroom, the toilet lid and dirty bathroom to Resident #40 room and acknowledged the black substance on tile and rubber base board of the wall in bathroom of Resident #58 bathroom. He began working to correct these issues immediately.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview, the facility failed to provide a Pre-admission Screening (PAS) which included all psychiatric diagnoses for Resident #10. This was true for one (1) of three (3) residents reviewed during the survey process. Resident Identifier: #10. Facility Census: 93. Findings Include: Based on record review and staff interview, the facility failed to provide a Pre-admission Screening (PAS) which included all psychiatric diagnoses for Resident #10. This was true for one (1) of three (3) residents reviewed during the survey process. Resident Identifier: #10. Facility Census: 93. Findings Include: a) Resident #10 On 08/25/25 at 2:00 PM, a record review was completed for Resident #10. The review found the PAS dated 07/01/24 did not include the diagnosis of generalized anxiety disorder (GAD). The diagnosis of generalized anxiety disorder was added during the stay at the facility on 06/16/23. On 08/25/25 at 2:58 PM, the Social Service Worker #22 confirmed the diagnosis of generalized anxiety disorder was not on the PAS dated 07/01/24. The Social Services Worker #22 stated, I'll get this corrected.

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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 kitchen failed to store food in accordance to professional standards for food safety. Facility census: 93.Findings Included: a) During initial kitchen walk through on 08/20/25 the following items we found in the walk-in refrigerator: six (6) quarts of cranberry juice with a use by date of 08/08/25 five (5) Fruit Punch pitcher use by date of 08/18/25 three (3) grape drinks use by 08/15/25 four (4) sugar free drink use by 08/18/25 Unsweet tea use by 08/18/25 Interview with Kitchen Manager at 7:50 AM who acknowledged the drinks found in the walk-in refrigerator. Review of document titled, Receiving and Storage of Food, Policy: Foods shall be received and stored in a manner that complies with safe food handling practices. Specific Procedures/Guidance, Number eight (8) states the following: All foods stored in the refrigerator or freezer will be covered, labeled and dated (used by date). Dry food storage during initial walk through: - 6.63 lb. Sysco Classic Spaghetti Sauce dented During an interview with Kitchen Manager (KM) at 7:50 AM the KM acknowledged the dented can. Nourishment Rooms were observed on 08/21/25 and the following were found: Pantry near first hall had 70 [NAME] crackers individually wrapped, undated and in an unmarked drawer with other foods and snacks such as peanut butter. Pantry near second hall had 25 [NAME] Crackers individually wrapped, undated and in an unmarked container. On 08/21/25 at 11:10 AM during an interview with the Regional Kitchen Manager (RKM) RKM reported that when lunch snacks were taken to the nourishment rooms, the boxes were labeled and dated as far as the lunch cakes were concerned. RKM was not aware as to why the graham crackers were not labeled and continually placed in the drawer but would do an in-service. A review of a document titled Receiving and Storage of Food revealed Foods shall be received and stored in a manner that complies with safe food handling practices. Guidance #7 Dry foods that are stored in bins will be removed from original packaging, labeled and dated use by date.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, policy review, and staff interview the facility failed to properly contain kitchen waste in garbage dumpsters in a safe and sanitary manner. Facility Census: 93.Findings Included:On 08/20/25 at 10:15 AM, facility dumpsters were observed overflowing, lids would not close on any dumpster, soiled gloves, bags and miscellaneous trash were around all sides of the dumpster. On 08/20/25 at 10:21 AM, the Administrator was notified and confirmed the dumpsters were overflowing, lids would not close and miscellaneous trash was around dumpsters. The Administrator stated, I'll call them they will make a special trip .they usually come on Tuesdays, Thursdays and Saturdays.Document titled Food-Related Garbage and Refuse Disposal was reviewed and revealed the following: Policy: Food-related garbage and refuse are disposed of in accordance with current state laws. Specific Procedures/Guidance under #7 stated Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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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 provide an accurate and complete medical record for Resident #5. This was true for one (1) of five (5) residents reviewed under the care area of unnecessary medications. Resident Identifier: #5. Facility Census: 93.On 08/25/25 at 2:30 PM, a record review was completed for Resident #5. The review found a physician's order for Lamictal 200mg (milligram) one (1) tablet by mouth at bedtime for seizures. A review of the resident's diagnoses did not find the diagnosis of seizures.On 08/25/25 at 3:30 PM, the Minimum Data Set (MDS) Licensed Practical Nurse (LPN) #13 confirmed the resident did not have seizures and the correct diagnosis should be mood disorder. On 08/25/25 at 3:45 PM, the MDS LPN #13 stated, We will get this corrected.