STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515085	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows Center	723 Summers Street Parkersburg, WV 26101

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility failed to dispose of garbage and refuse properly. One (1) of two (2) dumpsters was found to be overflowing with garbage bags, making it impossible for the dumpster lid to properly close. The other dumpster had sliding doors that were not completely closed. This was a random opportunity for discovery that has the potential to affect every resident at the facility. Facility census: 92. Findings included:a) Disposal of Garbage / Refuse was not properly contained in dumpsters with lids or otherwise covered. On 12/16/25 at 8:38 AM, two surveyors asked the Director of Dining to take them to the trash dumpsters located outside. She acknowledged the dumpster lids should be closed at all times when not in use, and they were not.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based upon record review and staff interviews the facility failed to report the results of investigations within approved time frames to the state survey agency(SSA). This was discovered during the Long term care survey process, during the review of Facility reported incidents (FRIs). This was found to be true for one (1) out of thirty (30) residents reviewed. Resident #74 and #108. Census: 92 Finding include: a) Resident #74 During record review of Facility reported incidents (FRIs) on 12/17/25, file with this FRI #242295 was missing the five day follow up. The initial report was received 01/06/25. This would make the five day needing to be submitted by 01/11/25 at 11:59 PM at the latest. There was no record of it anywhere in the file or of a attempt to transmit a copy to anyone that is required to be notified ie. Fax transmittal sheet or email attachment by that deadline time. The file only contained four (4) statements, none are dated or signed by anyone either interviewed or doing the interviewing. As well as two (2) Performance improvement plans (PiPs), both were non disciplinary in nature and only suggested counseling no correction or follow up noted. When talking with the Administrator on 12/17/25 at approximately 11:44ˆAM about FRIs missing information and he said he will do his best to get the items that are missing for me. He knew that there are a lot of issues with them from the previous administration and is working to do better on them since he has been over the facility. Not further items for this file were presented prior to surveyors exiting the building on the final survey day of 12/22/25. b) Resident #108A record review found an allegation of physical abuse reported on 06/05/25 Resident #108 reported that she never received a breakfast tray and someone shoved her by the shoulders. A review of an investigation revealed that there is no documentation that the incident was reported to all required state agencies. Subsequent review found an extension Request filed on 06/11/25. Continued review of the reportable found no witness statements from the employees or other residents residing in the facility that may have knowledge of the allegation. Subsequent review found no documented 5-day follow-up. During the interview on 12/22/25 at approximately 9:30 AM the Administrator verified that there were no documentation or statements from all staff working at the time or other residents that may have knowledge of the allegation. He stated that there was no other documentation to provide on the incident. He also verified they have been working on other complaints that was not investigated prior to him taking over as Interim Administrator.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on resident interview, staff interview, and operation policy the facility failed to take actions to thoroughly investigate an alleged violation related to, abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and take corrective action following the investigation. Resident identifier #1, #108, #109, #98, #74, #105, #104, and #102. Facility census: 92. Findings include: Record review of the facility's policy titled, Abuse Prohibition, showed: - The Administrator, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion, injury of unknown source, exploitation, and misappropriation of property. The center must ensure that all staff are aware of reporting requirements and must support an environment in which covered individuals report a reasonable suspicion of a crime. - Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect the administrator of designee will perform the following. - Report allegations involving abuse (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made. - Report allegations to the appropriate state and local authority. - Initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent. a) Resident #1 A record review found an allegation from an interview on 08/21/25 where Resident #1 with a Brief Interivew Mental Status (BIMS) score of 15 alleged neglect within the facility. A facility reported incident was completed 09/04/25 with action notes: Investigation has been initiated at this time. A statement dated 09/04/25 from Resident #1 revealed it was a follow up from her complaint on 08/21/25 where statements were made to a staff member with regards to being left soiled for four (4) hours. She stated that she soiled herself at 3:00 PM on 08/20/25 and was not assisted until 7:00 PM. She also stated that staff did not want to assist her with meals. A review of an investigation revealed that the issue was reported to required state agencies on 09/04/25. Continued review of the reportable found no witness statements from the employees or other residents residing in the facility that may have knowledge of the allegation. Subsequent review found a 5-day follow-up stating a body audit was completed, no injury noted. After investigation, it was found to be unsubstantiated due to inconsistency in the statements between resident and staff. During the interview on 12/22/25 at approximately 9:30 AM the Administrator verified that there were (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no documentation or statements from all staff working at the time or other residents that may have knowledge of the allegation. He also verified they have been working on other complaints that was not investigated prior to him taking over as Interim Administrator. b) Resident #35 A record review found an allegation of physical abuse reported on 06/05/25 Resident #35 reported that she never received a breakfast tray and someone shoved her by the shoulders. A review of an investigation revealed that there is no documentation that the incident was reported to all required state agencies. Subsequent review found an extension Request filed on 06/11/25. Continued review of the reportable found no witness statements from the employees or other residents residing in the facility that may have knowledge of the allegation. Subsequent review found no documented 5-day follow-up. During the interview on 12/22/25 at approximately 9:30 AM the Administrator verified that there were no documentation or statements from all staff working at the time or other residents that may have knowledge of the allegation. He stated that there was no other documentation to provide on the incident. He also verified they have been working on other complaints that was not investigated prior to him taking over as Interim Administrator. c) Resident #109 A record review found an allegation of sexual abuse reported on 12/09/24 Resident #109 reported that the night shift Charge Nurse touched her and she does not feel safe. A review of an investigation revealed that there is no documentation that the incident was reported to all required state agencies. Continued review of the reportable found no witness statements from the employees or other residents residing in the facility that may have knowledge of the allegation. Subsequent review found a five 5-day follow-up on 12/17/24 with no verification it was sent to required agencies. The conclusion stated that Resident #109 asked that the male charge nurse not provide care for her. During the interview on 12/22/25 at approximately 9:30 AM the Administrator verified that there were no documentation or statements from all staff working at the time or other residents that may have knowledge of the allegation. He also verified they have been working on other complaints that were not investigated prior to him taking over as Interim Administrator. d) Resident #98 On 11/05/24, an initial reporting of an allegation of neglect regarding Resident #98 was reported to all required entities. The initial reporting stated as follows: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing assistant [NA] [#125] provided a statement on 11/2/2024 regarding the care of resident [#98]. He reported that a week and one half ago he noticed that [Resident #98] was developing a red spot on his tailbone. In his statement he reported telling the nurse [#154] that he thought the resident was developing a pressure sore. He reported after being off for a few days. He came back and when providing care to the resident, the area got worse and was starting to open. He again reported to the nurse [#154] about the area. The nurse told [NA #125] she would look at it later. [NA #125] told her again at shift change and her response was to look at it the next day. [NA #125] reported the next day he asked her if she had looked at the area. Her response was not yet and that she would. [NA #125] reported telling one of the other nurses on night shift that way they knew. Every time [NA #125] mentioned it to the nurse [#154] she did nothing about it. The allegation was thoroughly investigated and interviews were obtained. An unsigned investigative note concluded I feel as this was a communication mishap and technology error causing this event. The note stated an order for wound treatment had been entered, but the order did not carry over to the Treatment Administration Record (TAR) for nursing staff to complete the order. The corrective action was educate nursing staff regarding turning and repositioning. On 12/18/25 at 11:02 AM, the Director of Nursing confirmed the corrective action to educate nursing staff regarding turning and repositioning did not address the communication and technology errors that had occurred regarding Resident #98's pressure ulcer. No further information was provided through the completion of the survey process. e) Resident #74 During a record review on 12/17/25, the incident involving Resident #74 that was initially filed 01/06/25 showed multiple missing items that were required to be sent in as well as maintained in the records for each incident reported. The review revealed the initial report and five (5) day follow-up were missing. The file contained four (4) statements with handwritten names on top, none are dated or signed by anyone involved. Neither who was interviewed nor who did the interview could be confirmed by reviewing the statements. It also had two (2) performance improvement plans, noted to only be counseling with no follow-up. On 12/17/25 at approximately 11:44^AM spoke with administrator about the missing information and they said, I will do his best to get the items that are missing to me. No further information was provided prior to exiting the facility on 12/22/25. f) Resident #105 During a review of Incident with Resident #105 that Initially was reported on 08/07/25. It showed the facility filed two (2) extensions, the first one on 8/15/25 stating more time was needed to complete the investigations, and then a second on 09/05/25 due to management changes. This delayed the investigation almost one month (30 days) from the time it took place. The facility did perform skin checks on Resident #105 on 08/12/25, with no issues of note. This was four (4) days after the incident occurred. No skin issues were noted prior or after in the chart. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #105 and others took place on 09/10/25. Due to the extensions delaying the facility from talking with residents for almost thirty (30) days after the incident took place the residents were unable to recall what took place and could not verify or un-verify the allegations. The five-day follow-up revealed the incident was unsubstantiated but showed no supporting documentation on how the facility came to this conclusion, or what was done to correct the issue and prevent future occurrences form happening again. When interviewing the administrator on 12/17/25 at approximately 9:45 AM they stated, I walked into all these, and I know some were not done to the best of their ability. We are working to do a better job and ensuring all investigations are done to the best possible standard. g) Resident #104 During an audit of the Facility reported incidents (FRIs) conducted on 12/16/25 it was revealed that the facility did not take all necessary action to come to a complete conclusion and/or create a plan of action to prevent these events from occurring again. Statements were taken from multiple people, both residents and staff. These were deemed inconclusive by the facility, due to them containing conflicting information. There were no secondary interviews conducted, no follow ups to clarify discrepancies and/or verify statements given. Documentation was missing dates, times and signatures of people involved. Twenty-one (21) statements were taken, and all were missing from these pieces of information. They were all just stamped with a [NAME and TITLE] stamp on a line. The documents all contained four questions of a yes or no (closed ended) type and no follow ups asked. A five-day follow-up was completed and in file dated 10/10/25 stating a call light audit would be completed for seven (7) days and then randomly thereafter. There was no record of this being done in the file nor could it be produced when asked. During an interview with the administrator on 12/16/25 at approximately 4:12 PM they stated that they do not have a way to perform a call light audit on the system they have, but they did do manual ones as needed. The administrator was unsure if they had copies of them placed in the files. This was later confirmed that they were not in the files and copies could not be located the for this surveyor. No other information was contained in the file or presented prior to the exit on 12/22/26. h) Resident #102 On 10/04/25, Resident #102 reported she was left soiled for an extended period of time. The resident had capacity to make medical decisions. She had a Brief Interview for Mental Status (BIMS) score of 15, indicating that she was cognitively intact. An investigation was initiated. Skin checks were completed for residents with a BIMS score of seven (7) and below with no new occurrences noted. Residents with a BIMS score of eight (8) and higher were interviewed. Staff interviews were conducted as well. After investigation, the facility found their investigation to be inconclusive due to conflicting statements. IDT team determined to do a call light audit for seven (7) days then random times after to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensure call lights are answered timely. During record review, on 12/22/25 at 9:30 AM, there was no evidence that the facility had asked Resident #102 anything other than the three (3) written yes or no questions that were asked of all residents with a BIMS of eight (8) or higher: On 10/04/25, did staff leave you wet for extended periods of time? On 10/04/25, did you receive your medication in a timely manner? On 10/04/25, did you receive fresh ice water? Resident #102 was known to be cognitively intact and may have been able to identify the staff member assigned to her care on the day in question. Additionally, the resident may have been able to provide more context about how long her call light was on before being answered and if her needs had been addressed at that time. Review of the facility's call light audit for seven (7) days revealed the following dates and times: 10/10/25 at 10:00 AM 10/11/25 at 12:00 PM 10/12/25 at 1:05 PM 10/13/25 at 9:00 AM 10/14/25 at 8:00 AM 10/15/25 at 2:00 PM 10/16/25 at 5:00 PM There was no evidence additional call light audits at random times were completed as per the facility's corrective actions listed in their five (5) day follow-up. During an interview on 12/22/25 at 10:20 AM, the Surveyor pointed out: Staff had specifically asked Yes or No questions but did not supply more information in the written narrative if a resident responded with a yes. Staff had narrowed the date of ever being left wet for extended periods of time to only 10/04/25. This questioning would not have afforded a resident to answer in the affirmative if they had been left wet and unattended on a different day. Staff had completed the call light audits on day shift hours only. This would not have ensured the call lights were being answered timely at other times of the day or throughout the night. There was no evidence found during the record review that the facility had completed additional call (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	light audits at random times as per the facility's corrective actions listed in their five (5) day follow-up. The Administrator remained silent and made no comment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical and nursing needs. This was a random opportunity for discovery. Resident identifier: #38, #39. Facility census: 92.a) Resident #39 An electronic medical record review was completed on 12/18/25 at 11:00 AM. Resident #39 was admitted to the facility on [DATE]. Review of Resident #52's care plan identified the following: A Focus Area, initiated on12/08/25, which stated: Resident/Patient requires assistance/is dependent for ADL care in _____ (specify: bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Recent_____ (illness, fall, hospitalization, etc.) resulting in _____ (fatigue, activity intolerance, confusion, etc.) A Goal Area, initiated on 12/08/25, which stated: Resident/Patient will improve current level of function in: _____ (specify: bathing, grooming/personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) by next review as evidenced by improved ADL scores. An Intervention Area, initiated on 12/08/25, which stated: Provide resident/patient with _____ (specify: set-up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____. Provide resident/patient with _____ (specify: set-up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____ (specify #) for eating. Provide resident/patient with _____ (specify: set up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____ (specify #) for toileting: Provide resident/patient with _____ (specify: set-up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____ (specify #) for dressing. Provide resident/patient with _____ (specify: set-up, supervision, Partial/Moderate, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Substantial/maximal, Dependent assistance) assist of _____ (specify #) for personal hygiene (grooming). Provide resident/patient with _____ (specify: set-up, supervision, Partial/Moderate, Substantial/maximal, Dependent assistance) assist of _____ (specify #) for bathing. During an interview on 12/22/25 at 9:50 AM, the Director of Nursing (DON) acknowledged the care plan had numerous areas left blank and was not person-centered. She stated that the initial care plan should have been completed within 72 hours of admission. It is still not completed as of 12/22/25 at 9:50 AM. b) Resident #38 A record review on 12/16/25 of Resident #38's chart revealed that Resident #38 was admitted to the facility on [DATE]. The care plan on file is dated to be created on 1/18/23 with a revision date of 11/14/25. No updates to the plan were made only acknowledging the revision. The care plan also is also not specific to the resident with no mention of name, age, or gender specific information that would make this care plan person-centered. The care plan uses vague terminology such as resident, monitor for decline. On page four (4) of the care plan (CP) in the focus column it states While in the facility, resident/patient states that is important that s/he has the opportunity to. The nursing staff did not go back into the CP and edit the form to show the correct gender of Resident #38. On the same page it also states Resident will plan and choose to engage in preferred activities. But, no choices or preferences are noted. The facility uses a preformatted CP to help with initial planning for each resident. However, these documents need to be updated with correct information and preferences of each resident. This was not done for Resident #38. During an interview with the Administrator on 12/16/25 at approximately 3:42 PM they stated, All care plans should be resident specific and updated on a regular basis.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, resident, and staff interview. The facility failed to assist dependent Residents with activities of daily living (ADL's) in accordance with the resident's assessed needs for care. This is true for three (3) of eight (8) residents reviewed for ADL's care. Resident Identifiers: #30, #49 and #72. Facility census: 92. Findings Included:a) Resident #49 On 12/15/23 at 11:28 AM Resident #49 stated that she does not get showers or baths as ordered or her preference. She stated that she is supposed to get two showers a week. She continued to state that the staff say they don't have enough staff to give her a shower. A review of Resident #49's ADL documentation found only two (2) showers on 11/21/25 and 12/09/25 also noted seven bed baths noted in 30 days. No Refusals noted.During an Interview on 12/17/23 at 10:30AM the Director of Nursing (DON) verified there was no documentation that Resident #49 received showers as scheduled. b) Resident #30Observation on 12/15/25 at 12:23 PM of Resident #30 found his hair appeared oily, dirty and uncombed.During an interview 12/15/25 at 12:23 PM, Resident #30 stated that he does not get very many showers. Subsequent Observation on 12/17/25 8:45 AM found that his hair still appeared oily, dirty and uncombed. A review of Resident #30's ADL documentation found only one (1) shower on 12/02/25 and four (4) bed baths noted in 30 days. No refusals were noted. During an Interview on 12/17/23 at 10:30AM the Director of Nursing (DON) verified there was no documentation that Resident #30 received showers as scheduled. c) Resident #72 During an interview 12/16/25 at 11:12 AM, Resident #72s medical power of attorney (MPOA) stated that the resident does not get showers. She continued to say that the staff tell her that Resident #30 does not like to get up, so they just do bed baths. She stated that her mom needed her showers and always preferred to get a shower and to be clean. A review of Resident #72's ADL documentation found only two (2) showers on 11/29/25 and 12/12/25 also eight (8) bed baths noted in 30 days. No refusals noted. During an Interview on 12/17/23 at 10:30 AM the Director of Nursing (DON) verified there was no documentation that Resident #72 received showers as scheduled.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and staff interview, the facility failed to provide care in accordance with accepted professional standards of practice. This deficient practice had the potential to affect five (5) of 28 residents reviewed in the long-term care survey sample. For Resident #3, the facility failed to obtain vital signs as ordered by the physician. For Resident #69, the facility failed to follow physician-ordered medication parameters. For Resident #96, the facility failed to perform neurological checks after unwitnessed falls. For Residents #38 and #72, the facility failed to ensure coordination of care for residents receiving hospice services. Resident Identifiers: #3, #69, #96, and #38. Facility Census: 92. Findings included: a) Resident #3 On 09/28/25 at 9:16 PM, a nursing progress note stated Resident #3 reported chest pain. The resident's pulse rate was 104 beats per minute and irregular. The on-call provider was notified. According to the progress note, the provider ordered vital signs every four (4) hours for 48 hours. The on-call provider note written on 09/28/25 at 1:00 AM stated the physician had been contacted on 09/28/25 at 9:16 PM. The physician recommended more frequent vital signs (every four hours) for at least the next 48 hours to monitor heart rate. No order for vital signs every four (4) hours was entered. Review of Resident #3's vital signs showed vital signs had been obtained on the following dates and at the following times: - 09/28/25 at 9:16 PM - 09/28/25 at 9:33 PM - 09/29/25 at 2:00 AM - 09/29/25 at 9:38 AM - 09/29/25 at 10:50 AM On 9/29/2025 at 10:50 AM, the resident was transferred to the hospital at his request. The resident remained in the hospital until 10/02/25. On 12/17/2025 at 10:04 AM, the Director of Nursing (DON) stated she was unable to find documentation of vital signs for Resident #3 between 09/29/25 at 2:00 AM and 9:38 AM. The DON confirmed Resident #3's vital signs were not obtained every four (4) hours as ordered by the physician. No further information was provided through the completion of the survey process. b) Resident #69 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #69's physicians' orders showed an order written on 10/01/25 for hydralazine 50 milligrams (mg) by mouth every 24 hours as needed for hypertension for systolic blood pressure greater than 150 or diastolic blood pressure greater than 90. The medication was to be held on dialysis days. The resident received dialysis treatments on Mondays and Fridays. Review of Resident #69's Medication Administration Records (MARs) for 10/01/25 through 12/17/25 showed physicians' orders were not followed on the following dates: - On 10/08/25, the resident's blood pressure was 156/86, but the resident did not receive hydralazine as ordered. - On 10/17/25, the resident received hydralazine for blood pressure of 162/87. However, this was a Monday, a dialysis day, when the medication was ordered to be held. - On 10/27/25, the resident received hydralazine for blood pressure of 162/87. However, this was a Monday, a dialysis day, when the medication was ordered to be held. - On 10/31/25, the resident received hydralazine for blood pressure of 152/83. However, this was a Friday, a dialysis day, when the medication was ordered to be held. - On 11/08/25, the resident's blood pressure was 155/71, but the resident did not receive hydralazine as ordered. - On 11/14/25, the resident received hydralazine for blood pressure of 153/82. However, this was a Friday, a dialysis day, when the medication was ordered to be held. - On 11/28/25, the resident received hydralazine for blood pressure of 159/88. However, this was a Friday, a dialysis day, when the medication was ordered to be held. - On 12/07/25, the resident's blood pressure was 165/77, but the resident did not receive hydralazine as ordered. On 12/17/25 at 12:32 PM, Registered Nurse (RN) #54 confirmed physicians' orders were not followed regarding Resident #69's hydralazine. No further information was provided through the completion of the survey process. c) Resident #96 The facility's policy titled, Falls Management with effective date 09/15/01 and revision date 10/01/25 stated any patient who sustained an injury to the head from a fall and/or has a fall unwitnessed by staff would be observed for neurological abnormalities by performing neurological checks. Resident #96 experienced a fall on 10/03/24 at 1:27 PM. The progress note stated, This nurse observed resident lying on his left side in his floor beside his bed. Vitals obtained and resident assisted back to bed X 2 assist via Hoyer lift. Resident states that he was trying to pick up his water pitcher out of the floor. Water pitcher observed busted in floor. Xray of thoracic/lumber/right hip/right ankle ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The e-interact change in condition for this fall stated, This is resident's second fall today. First fall at 0800. There was no progress note or change in condition for this fall. However, there was an incident report for 10/03/24 at 8:45 AM which stated, This nurse was called to resident room due to resident being observed sitting in the floor beside his bed. Vitals obtained and resident assisted back to bed x 2 assist via Hoyer lift. Resident states that he slid out of bed trying to pick up his cup that fell in the floor.No injuries observed at time of incident. The resident's medical records contained no documentation of neurological checks following the resident's falls on 10/03/24. On 12/22/2025 at 11:09 AM, the Director of Nursing (DON) was unable to provide neurological checks obtained after the resident's falls on 10/03/25. She confirmed these falls were documented as being unwitnessed. A change in condition note written on 11/05/25 at 7:17 PM stated in part, Staff notified this nurse resident was on the floor this nurse observed resident laying on his left side on the floor resident c/o [complained of] pain 10/10 in his rt [right] arm and rt ankle received an order to transfer resident to ED [emergency department] for evaluation. The incident form for 11/05/24 stated, This nurse was in the soiled laundry room, heard a yell, came out and in the room across the hall saw the resident on the floor with [staff name redacted] entering the room. Pt [patient] was lying on his left side and stated that his ankle hurt. I saw that he had a skin tear on his right upper arm and was later wrapped with abd pad and Kerlix. There was a knot on the back of his head. Resident stated he was reaching for the floor and landed on the floor. The resident's medical records contained no documentation of neurological checks following the resident's fall on 11/05/24. On 12/18/2025 at 10:36 AM, the DON was unable to provide neurological checks after the resident's fall on 11/05/24. She agreed neurological checks should have been documented immediately after the fall, before the resident was transferred to the hospital, due to the resident's hematoma to the back of the head. No further information was provided through the completion of the long-term care survey process. d) Resident #38 A record review on 12/16/25 of Resident #38's chart revealed that Resident #38 was admitted to the facility on [DATE] with a fair prognosis under skilled nursing care and then immediately ordered hospice care under (name of hospice) for the diagnosis of Terminal DX for Comfort. The facility has no record of the Hospice admission agreement or any other documentation signed by either Resident #38, their medical power of attorney (MPOA) and/or the facilities medical / social service staff, in either electronic format or in the hard copy binders for each resident. The only signed document on file was a long term care status form denoting routine hospice care. Also, the facility did not have any record of the Amedisys Hospice treatment plan for Resident #38; the expected medication set for a Hospice patient was not on Resident #38's MAR. The only orders pertaining to comfort on record in Resident #38's E-chart were as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This order was placed in the chart on 11/4/25: OXYCODONE HCL 100 MG/5 ML CONC GIVE 1 ML BY MOUTH EVERY 1 HOUR(S) AS NEEDED (20MG) - ordered by MD and signed off electronically by the pharmacy. There is no indication that these medications were given per the MAR or paper documentation. This order was placed on 11/8/25: DO NOT RESUSCITATE (DNR). Selective treatments. No artificial means of nutrition desired. During an Interview with social worker #105 on 12/16/25 at approximately 2:41 PM they stated, All the hospice records are placed into a hard chart behind the nurses' desk of the hall that resident is on. They then walked the surveyor to the area and searched for the file (it wasn't there). They then stated they would call the hospice agency and make sure they get all the paperwork for the Resident #38 as soon as possible. Follow up with Social Worker (SW) #105 at approximately 3:35 PM, They stated there is a file on E-chart called Long term care Status form uploaded on 11/6/25. It showed (name) as the hospice provider. Review of document titled Long term care status form: Shows (name of hospice) as the provider, but no outline of care plan or actions to be taken. Just Routine hospice is checked. Requested hospice agreement from (name of hospice) copy of orders and care plan. Nothing received from facility before exit on 12/22/25

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review, resident interview, and staff interview, the facility failed to provide services to dialysis residents in accordance with professional standards of practice. There was no documentation that the resident's dialysis access site was monitored for one (1) of two (2) residents reviewed for the care area of dialysis. Resident Identifiers: #69. Facility Census: 92. Findings included:a) Resident #69 The facility's policy titled Dialysis: Hemodialysis External Catheter Evaluation and Maintenance with effective date 07/01/01 and revision date 07/01/25 stated, The licensed nurse is responsible for evaluating and maintaining the external hemodialysis catheter site for patients with an external hemodialysis catheter. The facility's policy titled Dialysis: Hemodialysis (HD) Provided by a Certified End-Stage Renal Disease (ESRD) Facility with effective date 10/01/18 and revision date 08/07/23 stated, After receiving dialysis, Center staff must provide monitoring and documentation of: the patient's vascular access site(s) to observe for bleeding or other complications. On 12/15/2025 at 1:09 PM, Resident #69 stated he received dialysis through a Permacath dialysis catheter (a tunneled catheter) in his right chest area. He stated he also had an arteriovenous fistula (access beneath the skin) in his left arm that was not being used for dialysis yet. Review of Resident #69's physicians' orders showed orders to monitor the arteriovenous fistula site for bleeding, edema, and signs and symptoms of infection. The arteriovenous fistula was also to be assessed for bruit (a sound of blood flow heard with a stethoscope) and thrill (a palpable vibration). The presence of a bruit and thrill indicate the fistula is safely functioning. There were no orders to monitor the site or the dressing of the Permacath for complications such as infection or bleeding. The resident was not care planned for monitoring of the Permacath. The medical records contained no documentation of monitoring for the Permacath site. On 12/17/25 at 12:32 PM, Registered Nurse (RN) #54 confirmed there was no documentation that Resident #69's Permacath site was monitored.No further information was provided through the completion of the survey process.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles. Multiple medications stored in a medication cart and the medication room were unlabeled and undated. This practice had the potential to affect more than a limited number of residents. Facility census: 92.Findings include:a) Medication room [ROOM NUMBER]An observation of the facility's Main Medication Room, on [DATE] at 9:30 AM, revealed a refrigerator contained the following:-One (1) box Influenza Vaccine open, not dated or labeled.-One (1) opened container of Hepatitis B Vaccine not dated or labeled.-One (1) opened container of Covid 19 Vaccine not dated or labeled.An interview with Registered Nurse (RN) #21, on [DATE] at 9:30 AM, revealed the medications should have been labeled with a name and an open date as soon as they were opened by the staff.b) 100 Hall Medication roomAn observation of the 100 Hall Medication, on [DATE] at 9:45 AM, revealed the following:-One (1) opened container of [NAME] expired [DATE].-Two (2) Ear wax removal expired [DATE]-One (1) opened container of Vancomycin not dated or labeled.-One (1) zynormef Infusion tubing expired [DATE]An interview with Registered Nurse (RN) #21, on [DATE] at 7:55 AM, revealed all the medications should have been labeled with a name and an open date as soon as they were opened by the staff.

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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 food tray temperatures and resident interviews, the facility failed to serve food to residents that was palatable and at an appetizing temperature. Based on resident interview and staff interview, the facility failed to ensure hot foods were served hot and cold foods were served cold. This failed practice was true for four (4) of five (5) hallways tested for milk temperatures on the beverage carts and food tray temperatures for one (1) of one (1) meal trays tested throughout the survey process Facility census: 92.a) This surveyor asked the Director of Dining to temp the milk that was located on the west hall beverage cart on 12/15/25 at 12:45 PM. The temp was 54 degrees F. The Director of Dining acknowledged the temp was above the Food and Drug Administration (FDA) food code temp of 41 degrees F. On 12/17/25 at 12:15 PM the surveyor asked employee #152 for the temperatures of the lunch menu food items. He stated that the cook writes them on the production sheet. He then gave me a copy of the production sheet and stated that the cook did not write them down. 12/15/2025 at 12:00 PM , Resident #58 said, The food is terrible, they have not updated any meal preferences with me, I asked the manager almost (3) three months ago The food is cold, we are last to get meals sometimes they run out , I usually do not get what I ask for. When they send us food, generally it is all mixed together. 12/15/25 at 12:50PM , Resident #58's meal was served. Resident #58's meal was Turkeyburger, with lettuce, tomato and baked beans on plate, observation: baked beans running on plate under Hamburger Bun. Resident #58 informed this surveyor I wish they would have put those beans in a bowl. 12/15/25 1:30PM , Resident #58.Staff interview with Food Service Director, questioned her if she or anyone had updated Resident #58's meal preferences, she informed this surveyor, No I have not Spoke with Food Service Director (FSD), reviewed meal presentation for this lunch- she viewed the plate for Resident #58 and FSD confirmed the baked beans were running into the hamburger bun,

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, resident interviews and staff interviews, this facility failed to ensure meal preferences were obtained, updated and followed per policy and or best practice as provided per District Manager for Food and Nutrition. This was a random finding during the Annual Long Term Care Survey Process. Facility Census 92 Resident identifiers #58, #31, #37Findings include: 12/15/2025 12:00PM , Resident #58. Resident interview The food is terrible, they have not updated any meal preferences with me, I asked the manager almost (3) three months ago to come talk with me 12/15/25 12:50PM , Resident #58, meal served, Resident meal was Turkeyburger, with lettuce, tomato and baked beans on plate, per resident This is what I ordered, I am glad ,observation: baked beans running on plate under Hamburger Bun. Resident #58 informed this surveyor I wish they would have put those beans in a bowl. 12/15/25 1:30PM Staff interview with Food Service Director, questioned her if she or anyone has updated resident #58 meal preferences, she informed this surveyor No I have not Spoke with Food Service Director, reviewed meal presentation for this lunch-Food Service Director viewed the plate for Resident #58 and confirmed the baked beans were running into the hamburger bun, 12/17/25 1:00PM Record review, resident interview, staff interview. Meal preferences have not been updated, resident # 58 complaining no updates were made and she requested for the food service director to meet with her, #37 complaining no one has met with her for awhile, and #31 complaining no one has met with him. (no capacity), Resident # 37 initial meal preference done 10/19/21, an update on 03/25/22 and update on 04/02/24. Resident #58 initial preference done 03/21/25. Resident #31 has not had a preference done, written on form no capacity. Staff interview with Dining Service Director and District Manager for food service regarding these concerns. District manager informed this surveyor Our best practice is to meet with the resident initially, then follow up if concerns, requests or significant changes occur. If a resident lacks capacity we still attempt to interview for preferences, if unable to interview social services are made aware and they attempt or reach out to family Policy for Dining and Food Preference in part reads The Dining Service Director, or designee, will interview the resident or resident representative to complete a Food Preference Interview within 72 hours of admission.

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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 store, prepare, distribute and serve food in accordance with professional standards for food safety. Additionally, the facility failed to follow the proper sanitation practices for the kitchen and the food preparation equipment. This practice had the potential to affect more than an isolated number of residents. Facility census: 92. Findings include: a) 12/16/25 8:30 AM during an observation of food delivery carts five (5) of five (5) each had food debris on the bottom shelves, outside of the cart along bottom of doors, and along outside of each cart was a dried substance. 12/16/25 9:00 AM during a staff interview, district manager for food and nutrition, reviewed the five (5) of five (5) food delivery carts and confirmed there was food debris on the bottom shelves, outside of the cart along bottom of doors, and along outside of each cart dried substance. On 12/15/25 at 11:40 AM the surveyor completed an initial walkthrough of the kitchen. The Director of Dining (DOD) accompanied the surveyor during and acknowledged the following findings to be accurate. The dish machine log was missing temperatures for two (2) meals. The toaster had debris and needed to be cleaned. One (1) box of food thickeners was open to air and did not have an open or use by date. One (1) trash can located near the preparation table with the can opener did not have a lid on it while not in use. The mixer bowl was not covered while not in use. The knife rack was soiled. One (1) block of margarine sitting on the countertop were open to air and was not dated properly. One (1) package of hamburger buns did not have an open date. The outside of the coffee maker was soiled. There was one (1) measuring cup of sugar open to air and not labeled or dated properly. The can opener was soiled. One (1) opened package of white cake mix with no open or use by date. Three (3) opened packages of grape drink mix without an open or use by date. One (1) bowl of tossed salad not labeled or dated properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Two (2) steam table pans with sliced and diced ham not labeled or dated properly. There was no liner in the trash can locate at the handwashing sink. There was no lid on the trash can located near the steam table while not in use. While the lunch meal is being served. Three (3) food storage containers were sitting directly on the floor under the prep sink. The meat slicer was not covered while not in use. The food storage container lids were wet nesting in a bussing bin. One (1) outdated container of tomato soup in the walk-in cooler dated for use by 12/14/25. One (1) container of cream of wheat in the walk-in cooler dated for use by 12/14/25. One (1) container of chicken & dumplings in the walk-in cooler dated for use by 12/12/25. One (1) container of ranch dressing in the walk-in cooler dated for use by 12/13/25. One (1) container of ricotta cheese in the walk-in cooler dated for use by 12/13/25. The fan cover in the walk-in cooler has debris present. Four (4) cases of frozen food sitting directly on the freezer floor. One (1) opened bag of chicken tenders in the freezer without an open or use by date. One (1) Ziploc bag of raisin toast located in the kitchen outdated with a use by date of 12/08/25. The ceiling vents located in the kitchen were dusty and rusty. This surveyor asked the Director of Dining to temp. the milk that was located on the west-hall beverage cart at 12:45 PM. The temp was 54 degrees F. The Director of Dining acknowledged the temp was above the FDA food code temp of 41 degrees F. One (1) gallon of whole milk outdated in the East / [NAME] nourishment room refrigerator with a use by date of 12/14/25. One (1) pint of whole milk outdated in the South nourishment room refrigerator with a sell by date of 11/21/25. On12/26/25 at 8:38 AM two surveyors were accompanied by the Director of Dining outside to where the two (2) trash dumpsters were located. One of the sliding doors was not completely closed on one dumpster and the lids were not completely closed on the second dumpster. The Director of Dining stated the doors should be closed and are not. 12/17/25 at 8:55 AM (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This surveyor made a second visit to the kitchen. On 12/17/25 at 8:55 AM observation revealed the fan in the dish room was soiled with debris. There were four (4) full size sheet pans sitting directly on the floor in the dish room. There was one (1) clean tray of 9 oz bowls sitting on top of the hand-washing sink in the dish room. Employees are documenting wrong sanitizer PPM on the low temperature dish machine log. Ecolab test strips indicate these four options 10 ppm, 50 ppm, 100 ppm and 200 ppm. For the month of December, they documented 150, 160, 170, 175 and 180 for every PPM that was documented. The surveyor spoke to the Registered Dietician (RD), Director of Dining, District Manager. The RD, Director of Dining and the District Manager acknowledged the deficient practice and said they would educate the staff on the proper way to test and document per their policy and procedure. On 12/17/25 at 11:42 AM observation revealed the cornstarch containers lid was not on securely and Employee #81 verified it should be and fixed the issue. On 12/17/25 at 11:48 AM the three (3) compartment sink log was not filled out for dinner ware washing on 12/16/25 or breakfast ware washing today 12/17/25. It was currently being used. Employee #152 verified that it should have been temped and the sanitizer PPM should have been documented. 12/17/25 at 12:00 PM On 12/17/25 at 12:00 PM there was no lid on the trash can in the dish room. Employee #152 stated it should be on when not in use, and he put it on.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 complete and accurate medical records. This deficient practice affected three (3) of 28 residents reviewed in the long-term care survey sample. Resident identifiers: #2, #96 and #69. Facility census: 92. Findings included: a) Resident #2 Record review on 12/17/25 at 10:36 AM revealed the facility failed to ensure an accurate care plan for Resident #2. The wrong name was used in this resident's care plan. This finding was confirmed with the administrator on 12/17/25 at 10:30 AM. b) Resident #69 Review of Resident #69's physician's orders showed an order written on 10/23/25 for No BP (blood pressures) or needle sticks in left or right arm due to dialysis access. Utilize thigh cuff for BP. This order was written because the resident had an arteriovenous (AV) dialysis fistula in his left arm and a Permacath dialysis catheter in his right chest area. On 12/17/2025 at 11:38 AM, Resident #69 stated staff used his leg and not his arms to obtain blood pressure readings. He stated his left arm was used for blood pressures until the fistula was placed in October 2025. After the fistula was placed, his leg was used to obtain blood pressure readings. Resident #69's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 10/21/25 showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #69's physician's evaluation of capacity dated 05/07/25 showed the resident had capacity to make medical decisions. Resident #69's vital signs summary documented the resident's arm was used for blood pressure readings on the following dates at the following times: - On 12/09/25 at 9:51 AM, the left arm was documented as being used. - On 11/27/25 at 8:31 AM, the right arm was documented as being used. - On 11/09/25 at 7:44 AM, the right arm was documented as being used. - On 11/08/25 at 8:05 AM, the right arm was documented as being used. - On 11/07/25 at 8:12 AM, the right arm was documented as being used. - On 11/06/25 at 8:55 AM, the right arm was documented as being used. - On 11/05/25 at 8:33 AM, the right arm was documented as being used. - On 11/04/25 at 7:59 AM, the right arm was documented as being used. - On 11/02/25 at 8:29 AM, the right arm was documented as being used. (continued on next page)

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Willows Center	723 Summers Street Parkersburg, WV 26101

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 11/01/25 at 8:42 AM, the right arm was documented as being used. - On 10/31/25 at 7:27 AM, the right arm was documented as being used. - On 10/30/25 at 7:43 AM, the right arm was documented as being used. - On 10/29/25 at 7:48 AM, the right arm was documented as being used. - On 10/28/25 at 12:28 PM, the right arm was documented as being used. - On 10/27/25 at 7:32 AM, the right arm was documented as being used. - On 10/26/25 at 7:54 AM, the right arm was documented as being used. - On 10/25/25 at 7:38 Am, the right arm was documented as being used. On 12/17/25 at 12:32 PM, Registered Nurse (RN) #54 stated the documentation was incorrect for the above-listed blood pressure readings. She stated the resident would not have allowed staff to use his arm for blood pressure readings. She stated these blood pressure readings should have indicated the resident's leg was used to obtain the blood pressure readings. No further information was provided through the completion of the survey process. b) Resident #96 Review of Resident #96's medical records showed a Physician Determination of Capacity form signed by the physician on 06/02/24. The portion of the form for the physician to check whether the resident has or lacks sufficient mental or physical capacity to appreciate the nature and implication of health care decisions was not completed. Both the option that the resident has capacity and the option that the resident lacks capacity were blank. However, diagnoses that deem the resident incapacity were checked, along with the nature of the incapacitation. The diagnoses were chronic obstructive pulmonary disorder and cardiovascular disease. The nature of incapacitation was cognitive loss and inability to understand or make medical decisions. The expected duration of incapacity was long term. A previous Physician Determination of Capacity form dated 06/04/23 indicated Resident #96 did not have capacity to make medical decisions. On 12/18/25 at 10:38 AM, the Director of Nursing confirmed Resident #96's Physician Determination of Capacity form was not fully completed. No further information was provided through the completion of the survey process.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility documentation and staff interviews, the facility failed to have required quarterly meetings. Additionally, the facility did not have required attendees present or sign in at the Quality Assessment and Assurance (QAA) meeting. This failed practice had the potential to affect all residents residing at the facility. Facility Census: 93.Findings included: a) QAA Record review of the facility's documentation of QAA Meeting Agenda and Minutes revealed no meeting was conducted in the first quarter or the third quarter of 2025.During an Interview 12/22/25, at 11:30 AM the Administrator verified the required members did not sign in for the quarterly QAA meetings and there was no documentation of QAA meetings in the first and third quarter. No other information was provided prior to the end of the survey.

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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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to follow accepted standards of practice related to enhanced barrier precautions. Facility staff also failed to perform hand hygiene between residents while giving the residents ice and failed to maintain the ice cart in a clean and sanitary manner. These were random opportunities for discovery that had the potential to affect more than a limited number of residents. Resident Identifiers: #5, #69, and #3. Facility Census: 92. Findings included: a) Policy ReviewThe facility's procedure titled Enhanced Barrier Precautions with effective date 08/01/23 and revision date 05/01/25 stated Enhanced Barrier Precautions apply to residents with chronic wounds and/or indwelling medical devices (e.g., central line, urinary catheter, enteral feeding tube, tracheostomy, ventilator). The procedure also said an Enhanced Barrier Precautions sign would be posted on the residents' room doors. The facility's infection control policy and procedure titled Enhanced Barrier Precautions with effective date 01/06/20 and revision date 11/14/25 defined chronic wound as a wound that is not healing as expected or that has been present for more than 30 days.b) Resident #5 Resident #5 had a pressure ulcer wound to her sacrum that had been present since August 2025. The current dressing change order, written on 11/13/25, was to cleanse the stage II pressure injury with wound cleanser and pat dry, apply a thin layer of Z-Guard and cover with a bordered gauze dressing every day shift and as needed. Resident #5 did not have an order for Enhanced Barrier Precautions. On the door to Resident #5's room was a sign stating, Stop Very Important! Enhanced Barrier Precautions Attention: Caregivers, Staff, & Visitors Patient may come out of the room Perform Hand Hygiene before and after patient contact, contact with environment, and after removal of PPE [personal protective equipment]Wear gown and gloves prior to these activities: During high-contact resident care activitiesDressingBathing/showeringTransferringProviding hygieneChanging linensChanging briefs or assisting with toileting Device care or use of a device (i.e. central lines, urinary catheters, feeding tubes, tracheostomies, ventilators) Wound care: any skin opening requiring a dressingChange PPE before caring for another resident/patient. Face protection may also be needed if performing activity with risk of splash or spray. Use dedicated or single use disposable equipment and maintain in patient's room. When dedicated equipment is not possible, disinfect shared patient equipment with EPA [Environmental Protection Agency] approved disinfectant See care plan for additional information. On 12/17/25 at 1:34 PM, observation of the resident's sacral pressure ulcer dressing change was made. Registered Nurse (RN) #65 performed the dressing change with assistance from Nursing Assistant (NA) #13. NA #13 assisted the resident in turning in bed so the sacral area was exposed for the dressing change. NA #13 also assisted to remove the resident's brief and to reposition the resident and arrange the bedding following the procedure. Neither RN #65 nor NA #13 wore a gown at any time during the dressing change. Following the dressing change, RN #65 acknowledged Resident #5 had an Enhanced Barrier Precautions sign outside her room and agreed that she and NA #13 should have worn gowns for the procedure. c) Resident #3Review of Resident #3's physicians' orders showed an order written on 10/06/25 for Infection Precautions - Enhanced Barrier. Further review of the resident's physicians' orders showed the resident had an indwelling urinary catheter and orders for a dressing change to a stage III pressure ulcer to the left heel. The pressure ulcer developed in August 2025. On 12/15/2025 at 1:32 PM, the resident did not have a sign on his door or outside his room to indicate he was on enhanced barrier precautions. On 12/15/2025 1:50 PM, Registered Nurse #54 confirmed Resident #3 was in enhanced barrier precautions but did not have a sign outside his room. She stated she would get an enhanced barrier precautions sign for Resident #3's room. d) Resident #69 On 12/15/25 at 12:35 PM, Resident #69 stated he received dialysis treatments through a Permacath dialysis catheter placed in the right side of his chest. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #69 did not have a sign on his door or outside his room to indicate he was on enhanced barrier precautions. Review of Resident #69's physicians' orders showed the resident did not have an order for enhanced barrier precautions. On 12/15/2025 1:50 PM, Registered Nurse #54 confirmed Resident #69 should be in enhanced barrier precautions due to his dialysis catheter. She stated she would obtain an order for enhanced barrier precautions and place an enhanced barrier precautions sign outside the resident's room.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interview the facility failed to ensure two (2) residents received a dignified dining experience. This failed practice was a random opportunity for discovery. Resident identifiers: #95 and #3. Facility census: 92. Findings include: a) Resident #95 On 12/17/25 at 11:40 AM the lunch meal observation revealed Resident #52 was served a meal at table with Resident #95. Staff did not serve Resident #95 until 11:50 AM. Staff were observed serving other tables prior to serving Resident #95. During the the interview with Staff #23 the staff said, His tray must still be in the kitchen. b) Resident #3 The facility's procedure titled Feeding a Patient/Resident with effective date 08/31/20 and revision date 03/01/24 gave instructions to sit in a chair at eye level with the resident when feeding a resident. On 12/15/25 at 12:47 PM, Registered Nurse (RN) #65 was observed feeding Resident #3 in his room. Resident #3 was in his bed and RN #65 was standing beside him while she used a spoon to put food into the resident's mouth. There was a chair at the bedside. When questioned, RN #65 acknowledged she should be seated to feed the resident. No further information was provided through the completion of the survey process.

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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 to one (1) of three (3) residents reviewed for the facility's beneficiary protection notification practice during an annual survey. This failure placed the resident at risk of not being informed of her rights prior to the end of Medicare Part A covered services. Resident identifier: #72. Facility census: 92.a) Resident #72 Resident #72 reamined in the facility after 07/10/25 whcih was the last day of Medicare Skilled Coverage. The NOMNC was issued on 07/08/25 but there was no evidence that the SNF ABN was ever issued. During an interview on 12/18/25 at 11:25 AM, Bookkeeper #72 stated, I don't think so. I can check After searching in the electronic medical record, checking in the business office files, and then checking in the Administrator's office, she returned with the Business Office Manager. The Business Office reported that a SNF ABN had NOT been issued.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for one (1) of ten (10) resident rooms observed during the long-term care survey process. room [ROOM NUMBER]. Facility Census: 92.Findings included: a) room [ROOM NUMBER]During the initial tour of the facility, on 12/15/25 at 2:30 PM, the following issue was identified:-The wall beside Resident #52's bathroom was in poor repair. There were unfinished joint compound layers on top of the drywall without paint covering it, approximately 12 inches in width and spanning approximately 2 1/2 feet up the wall.-The ceiling right above Resident #52's bed had unfinished joint compound layers on top of the drywall without paint covering it, approximately 15 inches long.-The rest of the room has multiple small areas of wall and paint damage that measure 1 - 2 inches in size.-The Air conditioner / heater filter was soiled with about three eights inch (3/8) thick of dust and debris.The Administrator at accompanied two surveyors to the room on 12/17/25 at 1:40 PM to observe the above-mentioned concerns and stated the condition of the room was not a homelike environment and the facility has a four week plan to repair certain rooms in the facility. He acknowledged that room [ROOM NUMBER] was not on his list to get repaired and would add it as soon as possible.b) room [ROOM NUMBER]During the initial tour of the facility on 12/15/25 at 2:45 PM, the following issue was identified:The air conditioner / heater filter was soiled with about a quarter inch (1/4) thick of dust and debris.c) room [ROOM NUMBER]During the initial tour of the facility, on 12/15/25 at 2:52 PM, the following issue was identified:The air conditioner / heater filter was soiled with about a quarter inch (1/4) thick of dust and debris.d) room [ROOM NUMBER]During the initial tour of the facility, on 12/15/25 at 3:00 PM, the following issue was identified:The air conditioner / heater filter was soiled with about a quarter inch (1/4) thick of dust and debris.On 12/15/25 at 3:05 PM Employee #27 stated that the filters are cleaned once per month on the air conditioner/heaters in the residents' rooms.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to complete a new Pre-admission Screening and Resident Review (PASARR) for residents with a newly evident or a possible serious mental health disorder. This was true for two (2) out of three (3) sampled residents reviewed under the PASARR pathway during the Long-Term Care Survey Process. Resident identifiers: #1 and #6. Facility census: 92Findings included:a) Resident #1A record review, completed on 12/17/25 at 11:09 AM, revealed:Resident #1 was admitted to the facility on [DATE].On 06/27/25, the resident was given a Bipolar diagnosis.The only PASARR on file was dated 05/02/25. This PASARR did not reflect the resident's Bipolar diagnosis During an interview on 12/17/25 at 11:29 AM, the Director of Social Services (DOSS) reported a new PASARR had not been completed to capture Resident #1's diagnosis of Bipolar. b) Resident #6 On 12/16/2025 10:27 AM the record review for Resident #6, noted WV Pre-admission Screening and Resident review (PASARR) completed 09/02/25, Diagnosis of Bipolar Disorder on 10/17/25. 12/16/25 10:50 AM Interview with Social Service Director #44, questioned policy regarding updating and or ensuring accuracy of Pre-admission Screening and Resident review (PASARR)s, Social Service Director #44 informed this surveyor ,Usually the Gals in the front office let me know when I need to do a PASARR or update them. I do check upon admission if the hospital one and ours match. 12/16/25 10:55 AM, Social service Director #44, came to this surveyor with policy and informed this surveyor After speaking with the front office, we normally do an update if there is an added diagnosis. Policy for PASSAR reads in part from Practice Standards: Social services will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if: 1:1 It is learned after admission that the Pre-admission Screening and Resident review (PASARR) was not completed or is incorrect, or 1:2 There is a significant change in status that results in new evidence of possible mental disorder, intellectual disability or a related condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interview, the facility failed to revise residents' care plans when treatment changed. This deficient practice had the potential to affect two (2) of 28 residents reviewed in the long-term care survey sample. Resident identifiers: #69 and #52. Facility census: 92. Findings included:Findings included: a) Resident #52. During a record review on 12/16/25 at 2:00 PM, the following physician order for one-on-one was found, Provide one-on-one supervision, 24 hours per day.The order began on 09/19/25 and was discontinued on 9/26.25. Care Plan printed on 12/16/25 showed one-to-one supervision, 24 hours a day.During an interview with Director Nursing (DON) on 12/16/25 at 3:44 PM, the DON acknowledged that the one-on-one Supervision ended in September 2025 and the care plan was not updated to reflect that. a) Resident #69 Review of Resident #69's physicians' orders showed an order written on 10/23/25 for No BP [blood pressure] or needle sticks in left or right arm due to dialysis access. Utilize thigh cuff for BP. On 12/15/2025 at 1:09 PM, Resident #69 stated he had a permacath dialysis catheter in the right side of his chest and a fistula for dialysis in his left arm. Review of Resident #69's comprehensive care plan showed the following focus initiated on 06/26/25, Resident exhibits or is at risk for impaired renal function and is at risk for complications related to hemodialysis. A goal initiated on 06/26/25 was Hemodialysis access will remain patent through next review. An intervention initiated on 10/21/25 was Do not take BP or labs in left arm. There were care planned interventions to monitor the fistula site but no interventions to monitor the permacath site. On 12/17/25 at 12:32 PM, Registered Nurse (RN) #54 confirmed Resident #69's comprehensive care plan incorrectly gave an intervention to not use his left arm for blood pressure or blood draws when the orders stated not to use both arms. RN #54 also confirmed Resident #69's comprehensive care plan did not include an intervention to monitor the resident's permacath site. No further information was provided through the completion of the survey process.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** PS & Findings [NAME] The facility failed to ensure residents received the appropriate treatment and assistive devices to maintain a resident's vision abilities for one (1) of one (1) resident reviewed for communication/sensory issues. Resident identifier: #59. Facility census: #92 Findings included: a) Resident #59 The facility failed to ensure resident #59 received proper treatment and assistive devices to maintain vision abilities. During an interview on 12/15/2025 at 12:32 PM Resident #59 reported that she had been in the facility for approximately two (2) months. When she arrived here, staff put some of her belongings in storage. She reported her $300 glasses have not been given back to her and she has reported this to the social worker. She said she would like for them to either be found or replaced. She said currently did not have any glasses to use. On 12/16/2025 1:41 PM a review of the grievance log showed no grievances listed in regards to missing glasses for resident. On 12/16/2025 2:45 PM during an nterview with the Social Worker in regards to resident's glasses the social worker stated ,We did the whole grievance, inventory thing we need to call and schedule an appointment. We have a resident we call sticky finger, not to his face. I don't know if he took them or if she even came with them, This surveyor asked to see resident's grievance and inventory list upon arrival. The two social workers could not find them. The social worker reported that she was unsure when a she was notified of the missing glasses but said she was notified by a nurse aide not long after she arrived here. Social Worker eported the next step was to schedule an appointment with a local frames shop to make frames. If they find the facility to be at fault, they will ask the facility to replace the glasses. On 12/16/2025 at 3:29 PM during an interview with Social Worker who who reported resident's sister stated resident's glasses were missing since the she was at the hospital prior to her admission to this facility. When asked about the magnifier/telescope glasses listed on her care plan she stated that she had no knowledge and would look into this and get back to the surveyor. 12/16/2025 at 3:53 PM during an Interview with the Social Worker she reported she spoke with the nurse who writes the care plans and stated the magnifier/telescope glasses were just a recommendation.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to assess and treat pressure ulcers within accepted standards of care. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of pressure ulcers. Resident Identifier: #98. Facility census: 92. Findings included: a) Resident #98The facility's policy titled Skin Integrity and Wound Management with effective date 07/01/01 and revision date 09/15/25 stated wound evaluations would be performed for new in-house acquired wounds. The resident was admitted to the facility on [DATE] and was receiving hospice services. On 10/31/25, a nurse practitioner note stated, in part, Resident does have a stage II pressure ulcer to sacrum. No sign of infection noted .Pressure ulcer of sacral region, stage 2. Continue to cleanse with wound cleanser. Pat dry. Apply Sure Prep to periwound and under adhesive contact areas. Cover with Optifoam Gentle every 3 days and as needed. Will monitor and manage as appropriate.The following order was written on 10/31/24, Cleanse sacrum with wound cleanser. Pat dry. Apply Sure Prep to periwound and under adhesive contact areas. Cover with Optifoam gentle every 3 days and PRN. Neither Resident #98's Treatment Administration Records (TARs) nor Medication Administration Records (MARs) for October and November 2024 included this order. On 11/02/24 a skin check was performed which stated, in part, New skin Issue. Location: Coccyx. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Wound is new. Signs and symptoms of infection: None. Length (cm): 5.9 Width (cm): 4.6 Depth (cm): 0 Area (cm2): 14.1 Undermining: No. Tunneling: No. Cleansing solution: Generic wound cleanser. Primary dressing: Foam. This was the first full assessment in the medical records of the coccyx pressure ulcer identified on 10/31/24.The 11/02/24 skin check also identified a new deep tissue injury to the right heel and a new blister to the left scapula. The following orders were written on 11/02/24: Cleanse area to right heel with wound cleanser and apply skin prep cover with foam dressing check every shift, change every three (3) days and as needed.Heel boots to be worn bilaterally to prevent further skin breakdown and release pressure. Check every shift and as needed. Neither of these orders were included on the resident's TAR or MAR for November 2024. Resident #98 passed away on 11/07/24. On 12/18/25 at 11:02 AM, the Director of Nursing (DON) confirmed a full assessment of the resident's coccyx pressure ulcer was not documented at the time of discovery on 10/31/24. She stated the assessment on 11/02/24 was the first documented full assessment of the pressure ulcer. The DON also confirmed the orders for treatment to the coccyx pressure ulcer and the heel pressure ulcer and for heel boots were not included on the TAR or MAR. She provided no documented evidence that the physician's orders regarding the dressing changes or application of the heel boots were followed. No further information was provided through the completion of the survey process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515085	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows Center	723 Summers Street Parkersburg, WV 26101

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide care and services within accepted standards of practice for falls. The facility failed to document falls. The facility also failed to assess fall risk and failed to conduct appropriate post fall analyses to prevent further falls. This deficient practice had the potential to affect one (1) of four (4) residents reviewed for the care area of falls. Resident Identifier: #96. Facility Census: 92. Findings included:a) Resident #96 The facility's policy titled Falls Management with effective date 09/15/01 and revision date 10/01/25 gave the following instructions: - All residents would be assessed for risk of falls upon admission, with reassessments routinely (e.g., quarterly, post fall). - An assessment would be completed after falls to determine possible injury. - Resident-centered interventions would be implemented and documented. - The circumstances of the fall, post-assessment, and resident outcome would be documented in the risk management portal and as a change in condition. Review of Resident #96's medical records showed the resident had a fall on 10/01/24. A progress note written on 10/01/24 at 2:11 AM stated, This nurse and charge nurse heard resident yell out and found resident laying in the hallway in front of his room on his right side with his walker in front of him and his blanket on the floor. X-rays showed a fifth metatarsal fracture of the left foot. The resident experienced another fall on 10/03/24 at 10:18 PM. The progress note stated, This nurse observed resident lying on his left side in his floor beside his bed. Vitals obtained and resident assisted back to bed X 2 assist via hoyer lift. Resident states that he was trying to pick up his water pitcher out of the floor. Water pitcher observed busted in floor. Xray of thoracic/lumber/right hip/right ankle ordered.The e-interact change in condition stated, This is resident's second fall today. First fall at 0800. There was no progress note or change in condition for an earlier fall on 10/03/24. There were two (2) risk management reports for 10/03/24.The first risk management report stated was timed for 8:45 AM, This nurse was called to resident room due to resident being observed sitting in the floor beside his bed. Vitals obtained and resident assisted back to bed x 2 assist via Hoyer lift. Resident states that he slid out of bed trying to pick up his cup that fell in the floor.No injuries observed at time of incident. The sections of the form to record predisposing environmental physiological, and situational factors had not been completed. The second risk management report was timed for 1:00 PM and stated, This nurse observed resident lying on his left side in his floor beside his bed. Vitals obtained and resident assisted back to bed x 2 assist via Hoyer lift. Resident states that he was trying to pick up his water pitcher out of the floor. Water pitcher observed busted in floor.No injuries observed at time of incident.pain to back, right hip and right ankle. X-ray ordered. The sections of the form to record predisposing environmental physiological, and situational factors had not been completed. A physiatry progress note was written on 10/28/24 and stated as followed, I was asked to see patient today due to fall last night. Patient was trying reach for something and fell out of his low bed onto his left knee. There was no documentation, assessment, or risk management report regarding a fall that occurred on 10/27/25. A change in condition note written on 11/05/25 at 7:17 PM stated in part, Staff notified this nurse resident was on the floor this nurse observed resident laying on his left side on the floor resident c/o [complain of] pain 10/10 in his rt [right] arm and rt ankle received an order to transfer resident to ED [emergency department] for evaluation.The incident form for 11/05/24 stated, This nurse was in the soiled laundry room, heard a yell, came out and in the room across the hall saw the resident on the floor with [staff name redacted] entering the room. Pt [patient] was lying on his left side and stated that his ankle hurt. I saw that he had a skin tear on his right upper arm and was later wrapped with abd pad and Kerlix. There was a knot on the back of his head. Resident stated he was reaching for the floor and landed on the floor. The resident had a fracture of the left tibia and fibula and required surgery. He returned to the facility on [DATE].A fall risk assessment on 12/01/24 showed the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515085	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows Center	723 Summers Street Parkersburg, WV 26101

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was at risk for falls. No additonal fall risk assessment were located in the resident's electronic health record. During an interview on 12/18/25, the Director of Nursing (DON) confirmed the following:The fall risk assessment on 12/01/24 was the only fall risk assessment in the medical record for Resident #96. The fall occurring in the morning of 10/03/25 was not recorded in the medical record. The fall reported by the therapist on 10/28/24 was not recorded in the medical record. No assessment was recorded. Predisposing environmental physiological, and situational factors were not documented. The DON stated, We weren't doing those things back then. No further information was provided through the completion of the survey process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515085	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview the facility failed to ensure quality and continuity of care was arranged for an provided for a resident receiving hospice services. Resident identieir: #38. Facility census: 92. a) Resident #38A record review on 12/16/25 of Resident #38's chart revealed that Resident #38 was admitted to the facility on [DATE] with a fair prognosis under skilled nursing care and then immediately ordered hospice care under (name of hospice) for the diagnosis of Terminal DX for Comfort. The facility has no record of the Hospice admission agreement or any other documentation signed by either Resident #38, their medical power of attorney (MPOA) and/or the facilities medical / social service staff, in either electronic format or in the hard copy binders for each resident.The only signed document on file was a long term care status form denoting routine hospice care. Also, the facility did not have any record of the Amedisys Hospice treatment plan for Resident #38; the expected medication set for a Hospice patient was not on Resident #38's MAR. The only orders pertaining to comfort on record inR esident #38's E-chart were as follows:This order was placed in the chart on 11/4/25: OXYCODONE HCL 100 MG/5 ML CONC GIVE 1 ML BY MOUTH EVERY 1 HOUR(S) AS NEEDED (20MG) - ordered by MD and signed off electronically by the pharmacy. There is no indication that these medications were given per the MAR or paper documentation.This order was placed on 11/8/25: DO NOT RESUSCITATE (DNR). Selective treatments. No artificial means of nutrition desired. During an Interview with social worker #105 on 12/16/25 at approximately 2:41 PM they stated, All the hospice records are placed into a hard chart behind the nurses desk of the hall that resident is on. They then walked me to the area and searched for the file (it wasn't there). They then stated they will call the hospice agency and make sure they get all the paper work for the resident asap.Follow up with Social Worker (SW) #105 at approximately 3:35 PM, They stated there is a file on E-chart called Long term care Status form uploaded on 11/6/25. It showed (name) as the hospice provider.Review of document titled Long term care status form:Shows (name of hospice) as the provider, but no outline of care plan or actions to be taken. Just Routine hospice is checked.Requested hospice agreement from (name of hospice) copy of orders and care plan.Nothing received from facility before exit on 12/22/25