

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Cedar Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE 302 Cedar Ridge Road Sissonville, WV 25320	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews and staff interviews the facility failed to ensure a safe clean and homelike environment. Various cosmetic imperfections were found and two (2) residents did not have bed linens. These were random opportunities for discovery and have the potential to effect more than an isolated number of residents. Room identifiers: #15, #16, #24, #28, #32, #33, #35, #36, #37, #39, and #42. Resident identifiers: #76, and #130. Facility Census: 115. a) A facility walk through on 06/17/26 at 10:35 AM, with the facility administrator found and confirmed the following environmental issues in Resident Rooms #15, #16, #24, #28, #32, #33, #35, #36, #37, #39, and #42: b) room [ROOM NUMBER]: The caulking around the sink and countertop was cracked with missing pieces and had dark, discolored debris buildup. Bathroom toilet base was blackish with missing pieces, Missing paint chips around entry door and bathroom door, Resident's wheel chair cushion with heavy food crumb and dirt buildup underneath. c) room [ROOM NUMBER]: The caulking around the sink and counter top was cracked with missing pieces and had a dark discolored debris build up, Bathroom toilet base caulking was blackish in color with missing pieces, Bathroom corners had a dirty build up of debris and cob webs around the wall edges, Chips of paint missing on the bathroom back wall. d) room [ROOM NUMBER]: Whitish stain on the privacy curtain, reddish stain on the sheet of bed #2, caulking around the sink and counter top was cracked with missing pieces and had a dark discolored debris build up. e) room [ROOM NUMBER]: The caulking around the sink and countertop was cracked with missing pieces and had dark, discolored debris build up. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m) Resident #76 06/17/26 9:23 AM a tour with the Director of Nursing (DON) at 4:47 pm on 06/16/26, found that Resident #76. and Resident #130 did not have sheets on there bariatric bed. Resident #76 stated that they often run out of sheets big enough for the bed. She stated they just look at her and say, Your just going to wet them anyway. n) Resident #130 Resident #130 stated he did not know why he did not have a sheet today but they never put one on the bed. While on the tour the director of nursing (DON) checked the linen cart and there was only one sheet on the cart. We then went to laundry and several sheets were available but had not been placed on the unit for use		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. The facility failed to revise care plans for Resident #115 and Resident #11 and failed to ensure an interdisciplinary approach to care planning for Resident #91. Resident identifiers: #115, #111 and #91. Facility census: 115. Findings included: a) Resident # 11 The Care-plan dated 05/05/25 indicated an e cigarette must be kept and charged at the nursing station. During an interview with Resident #11 on 6/16/26 at 11:00 am he stated he no longer used the e cigarette. Resident # 11 stated he only used smokeless tobacco. An interview with the Director of Nursing (DON) on 06/17/26 at 10:00 am verified the resident was only using smokeless tobacco as evidenced on the facility smoking list. b) Resident 115 Resident #11 had cataract procedure resulting in MD orders to wear an eye shield to left eye on 04/07/25. During survey observations on 06/16/26 11:00 am and 06/18/26 at 10:00 am Resident #115 was not wearing an eye shield on her left eye. Resident #115 stated the procedure was last year. The DON confirmed that Resident #115 did not have current MD orders to wear a left eye shield. The care plan had not been revised. c) Resident #91 06/16/2026 10:04 AM Resident #91 stated that she did not participate in care planning and they did not come to her room for care plan meetings. On 06/22/26 at 1:50 PM a review of the Electronic Medical Record found only two (2) notifications of care plan meetings. During the review, it was found that no representative from Dietary (RD) attended these meetings. Social Services (SS) #3 informed the survey team that there were no care plan meetings for the past several months. According to SS #3 the two Social Workers involved have been terminated and QA reviewed all care plans beginning June 1st. The facility provided a copy of the Policy & Procedure for care plans. SS #3 provided copies of care plans that had meetings since June 1 and there was no dietary representation for these care plan meetings. An interview with the NHA at 2:50 PM on 06/22/26 confirmed a systemic failure with care plans. The NHA was unaware of issues with the former social workers (SWs). He has adjusted the daily standup meeting reports so that he will know when care plans/MDS's are completed. They currently do not have a Dietary Manager for representation on the Interdisciplinary Team		

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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. Based on record review and staff interview the facility failed to follow physician's orders to ensure residents received proper treatment and care to maintain mobility. This was true for one (1) of one (1) residents reviewed related to positioning and wearing splints/orthotics. Resident Identifiers: Resident # 10. Facility Census: 115. Findings Included: a) Resident #10 Resident #10 has a diagnosis code of M24.571, which is a contracture of the right ankle. Resident #10 has orders that state Medex boots to Bilateral Lower Extremity (BLE) licensed nurse to remove and assess skin integrity every shift. It was observed on 06/18/2026 at 12:05 PM no boots were on Resident #10. The Treatment Administration Record (TAR) reviewed for June 2026 revealed that the assessment was done and boots removed at the following times: 01:17, 10:40, and 19:05. This was signed off by Employee #67. Resident #10's tasks were also reviewed for 06/18/26: Preventative skin care (protectors heel/elbow) were documented at 10:40 AM and 7:05 PM by Employee #102 these items were completed. It was observed during the 10:40 AM time that Resident #10 was not wearing anything on either foot. Then on 06/22/26 at 10:30 AM, it was observed Resident #10 was not wearing Medex boots on either lower extremity. In an observation with the Nursing Home Administrator (NHA), on 06/22/2026 at 11:45 AM, this was confirmed. Speaking with the NHA, the Medex boots could not be found to put on the resident. Employee #114 noted the boots were applied to resident at 11:04 AM, but this was observed to not be true. When speaking with Director of Nursing on 06/22/2026 at 12:37 PM, it was discussed she will have discussion with Medical Director to discontinue this order because Resident #10 was non compliant; however, the tasks or TAR did not show that.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review and staff interview the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. There was an issue with lawncare equipment that could potential injure a resident being present and accessible to residents in the courtyard and a screw protruding through the arm rest on a resident's wheelchair. Resident identifiers: #34 and #102. Facility Census: 115. Findings included: a) Resident #34 Observation of Resident #34 in the courtyard at approximately 11:30 am revealed Resident #34 was opening a storage bench and taking out what appeared to be pruning shears. He used the pruning shears to clear out some weeds away from the gazebo. He then returned the shears to the storage bench. The resident left the courtyard. The surveyor went to the courtyard and opened the storage bench and found there was one (1) pair of Pruning Shears, one (1) hand held metal [NAME] shovel with a pointed end, one (1) hand held shovel with a rounded end, and a small rake. The surveyor then asked the Director of Nursing and the Nursing Home Administrator to come into the courtyard at 11:47 am on 6/22/26 and they agreed the items did not need to be in the storage bench in the courtyard. They confirmed the courtyard is not locked and was accessible to all residents. The Director of Nursing Confirmed there were several residents who would be able to get into the courtyard without the staff assistance. b) Resident # 102 On 06/15/26 at 1:35 PM It was observed that Resident #102's wheelchair with rips and tears all across the seat pad and had a screw coming through her left arm pad. Resident #102 stated it scratched her arms and her wheels had metal wheels inside the circle and bumped her knuckles. In an interview with the facility Director Of Nursing (DON) at 1:40 PM, she confirmed a screw was protruding through the left arm pad and stated she would get the resident another wheelchair. At 3:30 PM the DON reported the facility removed the w/c and ordered a temporary replacement.		

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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 record review, policy review, resident interviews and staff interviews, the facility failed to ensure all food was temped before leaving the kitchen, to ensure safe and appetizing temperatures of the food to prevent foodborne illness. The facility failed to ensure all foods were palatable. This failed practice had the potential to affect more than a limited number of residents. Resident identifiers: #14 and #63. Facility census: 115 Findings include: a) Healthcare Services Group (HCSG) policy #6 titled Food Quality and Palatability stated: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served in a manner, form, and texture to meet resident's needs. Proper safe and appetizing temperature: Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimize the risk for scalding and burns. HCSG policy #16 titled Food Preparation states: All foods are prepared in accordance with the FDA Food Code. On 06/17/26 at 12:25 PM, the surveyor asked the Dietary Account Manager #11 to see the food temperature logs for the month of June 2026. After review, this surveyor noticed that the kitchen was only taking the temperatures of the main and the alternate meal items and not the always available items. This surveyor asked Dietary Account Manager #11 if any resident had ordered any food items off of the always available menu this month. He stated Not that I am aware of, I do not take the orders. The surveyor asked to see the food temperature logs for the month of May 2026, and they also did not have any recorded food temperatures for the always available menu items. The surveyor asked Dietary Account Manager #11 if any resident had ordered any items off of the always available menu in the month of May 2026 and he stated Only the cold sandwiches and we do not temp them. This surveyor then asked Dietary Account Manager #11 if any resident had ordered a hot food item off of the always available menu this year (2026) and he stated, I have already answered your questions, we have made hot always available menu items this year, but I do not remember when we did. This surveyor requested copies of the food temperature logs for this year (2026), but they had no recorded temperatures for any of the always available menu items. b) Resident #14 On 06/15/26 at 2:45 PM, Resident #14 stated, the food is bad and is burnt often. Test Tray # two (2) On 06/18/26 at 12:30 PM, a test tray was delivered to the survey team. The fiesta corn was flavorless and overcooked. This was true for three (3) out of (3) surveyors that tasted the fiesta corn. c) Resident #63 On 06/22/26 at 11:25 AM, Resident #63 came to the surveyors and stated the food is overcooked often.		

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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 record review, resident interviews and staff interviews, the facility failed to provide food that accommodates resident preferences and appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice. Resident identifiers: #32, #40 and #9. Facility Census: 115. Findings Included: a) Dining and Food Preferences policy statement: During a record review of the facility dining and food preference policy statement #8 indicated Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverages will be offered an alternative selection of comparable nutrition value. and policy statement #9 stated The alternative meal and/or beverage selection will be provided in a timely manor. b) Resident #32 Upon facility entrance interview with Resident #32, on 06/16/26 at 12:30 PM, she stated she liked boiled eggs but kept getting scrambled. She stated she doesn't get the food she orders because the kitchen staff never answers the phone. She stated she makes sure to order before the cut-off time. She said, I don't think they check the messages down there. c) Resident #40 In an interview on 06/16/26 at approximately 3:45P M Resident #40, reported The food here is terrible. They serve too much fish and chicken. I try to call the kitchen but nobody answers the phone down there. I have to leave messages but I still don't get what I asked for. He stated he left a message on the kitchen voicemail on Sunday (06/15/26) requesting a fried bologna sandwich for Monday's (06/16/26) lunch, ensuring his order was placed before the 10 am cut-off time, but he received the regular tray instead of the fried bologna sandwich he wanted. d) Resident #9 Resident #9 was also interviewed on 06/17/26 at approximately 10:55 AM. She reported she was having issues with not getting what she ordered for meals and had called the kitchen to place orders for the meals but no one answered the kitchen phone. She had left messages but still did not receive what she had ordered. In an Interview with the Administrator on 06/18/26 at 10:45 AM. He stated he would check with the kitchen to find out why residents complained the kitchen was not answering and why they were not receiving their orders. On 06/18/26 at 1:55 PM the administrator returned and reported he had discovered the kitchen phone line for the residents to call in the preference orders for their meals was disconnected from the wall which confirmed resident's requests and preferences were not being met.		

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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, record review and staff interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional food safety standards. Additionally, the facility failed to follow proper sanitation practices for the kitchen. This practice had the potential to affect more than a limited number of residents. Facility census: 115 Findings include: a) Healthcare Services Group (HCSG) policy #22 titled Ware washing states: All dishware, service ware, and utensils will be cleaned and sanitized after each use. All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high-temperature or low-temperature machines. Temperature and / or sanitizer concentration logs will be completed, as appropriate. HCSG policy #25 titled Authorized Kitchen Personnel stated: All authorized personnel must wear appropriate head coverings while in the kitchen or production (hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained). HCSG policy #19 titled Food Storage states: All Time / Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A follow-up visit to the kitchen on 06/17/26 at 11:59 AM revealed the dish machine temperature log lacked recorded temperatures for today's breakfast dishes. The HCSG District Manager (DM) #6 verified that they were not recorded today. She stated I had to send two employees home today for poor attitudes. The handwashing sink had a substance in it that looked like coffee grounds. The Dietary Account Manager #11 stated, It is coffee grounds that must have fallen out of the trash can. There was one (1) package of shredded mild cheddar cheese located in the walk-in refrigerator that was not sealed tightly. The HCSG DM #6 verified this finding and stated, I will take care of it. At 12:06 PM this surveyor noticed Dietary Aide #8 not wearing a hair restraint over his face. He had facial hair that was not being covered while working in the kitchen. I let Health Care Services Group Dietary Manager #6 know this, and she told Dietary Aide #8 to, Go put on a beard net.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, record review, policy review, and staff interviews, the facility failed to store and dispose of garbage and refuse properly. Trash was found on the sidewalk outside the facility service entrance. The lid for the kitchen trash can was off during three (3) different observations of the kitchen, during the survey process. This failed practice had the potential to affect more than a limited number of residents at the facility. Facility census: 115. Findings include: a) Healthcare Services Group policy #28 titled Environment states: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. All trash will be contained in covered, leak proof containers that prevent cross-contamination. An observation on 06/17/26 at 12:01 PM revealed the trash can located in the kitchen near the handwashing sink was full of garbage and the lid was not secured. The Dietary Account Manager #11 closed the lid. Some coffee grounds from the overflowing trash had spilled into the handwashing sink. At 12:11 PM on 06/17/26, an observation revealed the trash can in the kitchen near the handwashing sink was full of garbage and the lid was not secured. The Dietary Account Manager #11 closed the lid again. An observation on 06/17/26 at 12:21 PM revealed the trash can near the kitchen handwashing sink was full of garbage and the lid was not secured. The Dietary Account Manager #11 closed the lid again and moved the trash container out of the kitchen into the service hallway. An observation on 06/23/26 at 11:55 AM revealed a clear bag of trash on the sidewalk outside the service entrance door. The bag remained there until 12:15 PM. Two (2) staff members Employee Registered Nurse #74 and Physical Therapist #19 confirmed the bag on the ground outside the service entrance door. Employee # 19 removed the bag and placed it into the dumpster. In an interview with the Facility Administrator on 05/23/26 at 12:20 PM, he acknowledged the bag of trash was left outside the service entrance door.		

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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 observation, record review and staff interview the facility failed to ensure the medical record was complete and accurate. This was true for four (4) of 41 sampled resident reviewed during the long term care survey. Resident #10's medical record was inaccurate pertaining to Medex Boots. Resident #11's medical record was inaccurate pertaining to a left arum support cushion. Resident #101 and #117's medical record was inaccurate pertaining to amount of house supplement consumed. Resident Identifiers: #101, #117, #10, and #11. Facility Census: 115. Findings included: a) Resident #117 An observation of Resident #117 in her room beginning at appx 10:30 am on 06/22/26 found the resident was resting quietly with her eye closed. Her house supplement was on her bedside table, and the resident had not drunk it. A review of her Medication Administration Record at this time found the percentage drunk had not been documented. At approximately 10:57 am the MAR was again reviewed and showed the nurse had documented the resident had drunk 100 percent of her house supplement. The house supplement was still sitting on the resident's bedside table. An interview with the Licensed Practical Nurse (LPN) assigned to Resident #117 at 11:00 am on 06/22/26 when asked if the brown liquid in the cup on the residents bedside table was her house supplement she stated, I think that was left over from breakfast. When the LPN was asked why she documented 100 percent when none had been drunk from the cup she stated, Well what I do is I'll go back later and get it and change it if I need to. b) Resident #101 An observation of Resident #101 sitting in her room in her wheelchair with her house supplement on her bed side table. The DON had assisted the resident in drinking her supplement but at least 25 percent of the supplement remained in the cup. In her room beginning at approx. 10:30 am on 06/22/26 the resident was found resting quietly with her eyes closed. Her house supplement was on her bedside table and was not drunk. Her house supplement was on her bedside table and was not drunk. A review of her Medication Administration Record at this time found the percentage drunk had not been documented. At approximately 10:57 am the MAR was again reviewed and showed the nurse had documented the resident had drunk 100 percent of her house supplement. The house supplement was still sitting on the resident's bedside table. During interview with the Licensed Practical Nurse (LPN) assigned to Resident #101 at 11:00 am on 06/22/26 when asked if the brown liquid in the cup on the residents bedside table was her house (continued on next page)		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplement she stated, I think that was left over from breakfast. When the LPN was asked why she documented 100 percent when none had been drunk from the cup she stated, Well what I do is I'll go back later and get it and change it if I need to. d). Resident #11. Facility failed to ensure Resident # 11's accuracy of records and provision of care related to left arm supporting cushion to wheelchair and accurate care and documentation of left arm trough. Survey observation on 06/16/26 at 10:30 am revealed no left arm trough present on the wheelchair. Review of treatment record for Resident # 11 states to monitor left arm trough for placement and skin check to ensure patient safety every shift. Treatment record review revealed it was signed every shift by a licensed nurse from 06/01/26 through 06/22/26. An Interview with the DON confirmed that no trough was present on Resident #11's wheelchair and confirms the nurses initials are present on the treatment records. c) Resident #10 Resident #10 had a diagnosis code of M24.571, which was a contracture of the right ankle. Resident #10 had orders that stated: Medex boots to Bilateral Lower Extremity (BLE) licensed nurse to remove and assess skin integrity every shift. It was observed on 06/18/2026 at 12:05 PM no boots were on Resident #10. The Treatment Administration Record (TAR) was reviewed for the month of June 2026, and it revealed the the assessment was done and boots removed at the following times: 1:17 AM, 10:40 AM and 7:05 PM. This was signed off by employee # 67. Resident #10's tasks were also reviewed for 06/18/26. Preventative skin care (protectors heel/elbow) were documented at 10:40 AM and 7:05 PM by Employee #102 that these items were completed. It was observed during the 10:40 AM time that Resident #10 was not wearing anything on either foot. Then on 06/22/26 at 10:30 AM, it was observed Resident #10 was not wearing Medex boots on either lower extremity. In observation with Nursing Home Administrator (NHA), on 06/22/26 at 11:45 AM, this was confirmed. In speaking with NHA, the Medex boots could not be found to put on the resident. Employee #114 noted the boots were applied to resident at 11:04 AM, but this was observed to not be true. When speaking with Director of Nursing on 06/22/2026 at 12:37 PM, it was discussed that she will (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have discussion with Medical Director to discontinue this order because Resident #10 was non compliant.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review and staff interviews, 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 regarding resident ambulatory equipment and the screening for tuberculosis. This failed practice was a random opportunity for discovery. Resident identifiers: #102, #126, #37, #110, #36 and #98. Facility Census: 115 Findings included: a) Resident #102 Resident wheelchair, Geri-chair and rollator/walker: During an interview with Resident #102 on 06/16/2026 at 3:33 PM, it was found that Resident #102's wheel chair (w/c) had rips and tears across the front edges of the seat exposing the inner padding. In an interview with the Director of Nursing (DON) on 06/16/2026 at 3:45 PM, she confirmed the exposed padding of Resident # 102's w/c she removed the chair and stated she would order her a new one. b) Resident #36 During a facility walk through on 06/17/26 at 10:35 AM, with the facility administrator found and confirmed, Resident #36's Rollator/walker seat with exposed inner padding due to a tear in the right side of the plastic seat covering. c) Resident #98 During a facility walk through on 06/17/26 at 10:35 AM with the facility administrator it was observed that Resident # 98's Geri-chair had tears down both sides of the back rest, also exposing the inner padding. The issues above create porous surfaces that cannot be cleaned effectively, fostering an environment for bacteria growth. d) Resident #126 Resident #126 was admitted on [DATE]. Review of the immunization tab revealed no documentation of the administration of the TB Two Step skin test. e) Resident #37 Resident #37 was admitted on [DATE]. Review of the immunization tab revealed no documentation of the administration of the TB Two Step skin test. f) Resident #110 Resident #110 was admitted on [DATE]. Review of the immunization tab revealed no documentation of the administration of the TB Two Step skin test. Interview with DON 06/23/26 at 11:00 am confirmed that NO TB Two Step PPD skin tests were administered at the time of admission per the facility TB policy. Genesis policy states: All patients will be screened for tuberculosis (TB) on admission to the Center, according to Centers for CDC and local /state Health Department regulations, and recommendations. Policy IC 500 Effective Date: 09/01/04. Revision date: 09/15/25. CDC guidance indicates .Skin tests should be administered to all new residents and employees as soon as their residency or employment begins unless they have documentation of a previous positive reaction. A two-step procedure is advisable for the initial testing of residents and employees in order to establish a reliable baseline		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on record review and staff interview the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health. This was true for Two (2) of Two (2) residents reviewed related to foot health. Resident Identifiers: Resident #27 and #22. Facility Census: 115. Findings include: a) Resident #27 06/16/2026 8:56 AM Interview with Resident #27. He stated I need to see a podiatrist. His feet look bad. 06/17/26 9:31 AM I asked the DON to go and speak to Resident #27 with me and for her to look as his feet. After speaking to Resident #27 and looking at his feet, she agreed that the facility is not following the Physicians orders, or the care plan for Residents #27 Activities of Daily Living (ADL) care of his feet. She stated I will get him an appointment scheduled with a podiatrist today. Resident #27 has a physician order for: Podiatry obtain consult as needed / indicated and treatment for patient for health and comfort. Resident #27 care plan states: Focus: Resident requires assistance / is dependent for ADL care. Date Initiated: 07/18/25 Current: other skin issues to left Dorsum 1st Digit, Redness to left great toe. Date Initiated: 07/18/25 Goal: Residents ADL care needs will be anticipated and met throughout the next review period. Date Initiated: 07/18/25 Interventions: Provide resident with max assist of 1 staff for personal hygiene (grooming). Date Initiated: 07/25/25 Observe skin condition daily with ADL care and report abnormalities. Date Initiated: 07/18/25 Off load / float heels while in bed. Date Initiated: 07/18/25 Provide wound treatment as ordered. Date Initiated: 10/24/25 b) Resident #22 06/17/26 at 11:05 AM I asked the DON to go and speak to Resident #22 with me and for her to look at her feet. After speaking to Resident #22 and looking at her feet, she agreed that the facility is not following the Physicians orders or the care plan for Residents #22 ADL care of her feet. She stated I will get her toenails clipped. 06/18/26 at 10:55 AM The DON stated we will get Resident #22 toenails clipped today.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, taking into consideration each resident's preferences and physician's orders. Resident identifier: #22. Facility census: 115 Findings include: a) Resident #22 On 06/16/26 at 1:13 PM the south short meal cart arrived for lunch, and at 1:15 PM, Resident #22's meal tray was served without the additional sandwich and additional serving of fruit per the physician's orders dated 05/19/26. Resident #22's meal tray was served without the additional sandwich and additional serving of fruit per the physician's orders dated 05/19/26. This order was put in place due to Resident #22 having significant weight loss. Resident #22 was admitted on [DATE] at 106 pounds. Her last documented weight was on 06/10/26 and she weighed 86.2 pounds. She had lost a total of 19.8 pounds, which is 18.7% of her total body weight since admission. The most recent care plan also showed this intervention for weight loss. When this surveyor brought this to the Nursing staff's attention, Unit Manager #18 went to the kitchen to get the missing food items. When I asked Unit Manager #18 what the kitchen staff said she stated, They said they were unaware of this order. Unit Manager #18 then said, I will write a new communication slip, and send it to them now. The quarterly nutritional assessment was completed this morning (06/16/26) at 11:50 AM by the Dietetic Tech, and it showed that Resident #22 was underweight, had a current significant weight loss and had an order for an assorted sandwich and assorted fruit with every lunch and dinner meal.		