STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based upon observation and staff interviews. the facility failed to maintain a safe, clean homelike environment for residents. This was found to be true for three (3) of 26 residents reviewed during the long-term care survey process. Resident identifiers: #3, #13, #25. Facility census: 65.Findings include: a) Resident #3 During the initial visit with Resident #3 on 03/16/26 at approximately 10:00 AM, an observation was made of the air vent filters in the air conditioner/heating unit. A dust film of approximately one quarter of an inch in thickness could be seen attached to the vent filter. This was reviewed with the Nursing Home Administrator (NHA) on 03/16/26 at approximately 10:45 AM. The Nursing Home Administrator said she would get maintenance to clean this as soon as possible. b) Resident #13 During the initial visit with Resident #13 on 03/16/26 at approximately 10:20 AM, an observation was made of the air vent filters in the air conditioner/heating unit. A dust film of approximately one quarter of an inch in thickness could be seen attached to the vent filter. This was reviewed with the NHA on 03/16/26 at approximately 10:45 AM. The NHA said she would get maintenance to clean this as soon as possible. c) Resident #25 During the initial interview process initiated on 03/16/26, Resident #25's closet door was observed to be opened with a plastic bag with items hanging out and would not close. On 03/18/26 at 10:07 AM, the resident's closet door was still opened with items hanging out. At 10:10 AM, the Director of Nursing (DON) confirmed the door would not close and items were hanging out in a plastic bag and stated, I will clean it out. The DON asked the resident permission to straighten her closet and the resident stated, Yes, please.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review and staff interview, the facility failed to meet the nutritional needs of the residents in accordance with established national guidelines, due to not following the menu, recipes, and prepping in advance. This had the potential to affect more than a limited number of residents who received their meals from the kitchen. Resident #11, #30, #63, and a sample tray sent to the survey team. Facility census: 65. Findings include: a) Policy Review The Healthcare Services Group (HCSG) policy 004 titled Menus, states: Menus will be planned in advance to meet the nutritional needs of the residents in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. Menu cycles will include standardized recipes. A menu substitution log will be maintained on file. b) Resident #11 On 03/16/26 at 12:50 PM, Resident #11 had a piece of plain unfrosted angel food cake setting on top of what appeared to be finely chopped and grated fresh carrots . He was supposed to have received carrot cake per the menu, and his tray ticket. Employee #9 was in the room and did verify that the cake did not look like a traditional carrot cake. On 03/17/26 at 12:40 PM, Resident #11 did not receive wheat bread for his egg salad sandwich as per the menu, recipe and his tray ticket. Employee #9 was in his room and did verify that he had white bread instead of the wheat bread that was on his tray ticket. On 03/18/2026 at 11:06 AM, the HCSG District Manager (DM) brought this surveyor a copy of the menu substitution log and the carrot cake recipe. The recipe did not match what the residents received. The menu substitution log did not have the cake substitution on 03/16/26 or the bread substitution for the egg salad sandwich on 03/17/26. c) Resident #30 and Resident #63 On 03/19/26 at 12:10 PM, Resident #30 and #63 received a pureed diet and did not receive the key lime pie that was on the menu for lunch. They received vanilla pudding instead. On 03/19/26 at 12:15 PM, the administrator accompanied me to the kitchen to ask for a serving of the purred key lime pie, that was on the menu today. The HSCG DM gave us a bowl of vanilla pudding and said we served the pureed diets vanilla pudding today instead of pureed key lime pie. The tray ticket also stated key lime pie.

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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 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, resident interviews and staff interview, the facility failed to serve food to residents that was attractive, palatable and at a safe and appetizing temperature to prevent foodborne illness. The facility failed to ensure cold foods were served cold. This failed practice was true for one (1) of one (1) meal tray tested for food temperatures throughout the survey process but had the potential to effect more than an isolated number of residents. Residents identified: #11, 15, 53, 48, 49, 1 and 69. Facility census: 65. Findings include: a) Policy Review Healthcare Services Group (HCSG) policy 016 titled Food Preparation states: All foods are prepared in accordance with the FDA Food Code. All foods will be cooked, held and served at the appropriate temperature. The Healthcare Services Group (HCSG) policy 004 titled Menus states: Menus will be planned in advance to meet the nutritional needs of the residents in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. Menu cycles will include standardized recipes. b) Test Tray On 03/17/2026 at 12:30 PM, this surveyor asked the Healthcare Services Group (HCSG) District Manager (DM) for a regular consistency test tray to temp and another surveyor asked for an advanced consistency test tray to taste. The HCSG DM brought a new freshly made tray to the dining room, and he took the temperatures of the following food items: Egg Salad Sandwich - 50 degrees Fahrenheit (F) Baked Potato Soup - 157 degrees F Pasta Salad - 57 degrees F Sliced Peaches - 40 degrees F The Pasta Salad did not meet the point of service maximum temperature regulation for cold foods of 50 degrees F. The HCSG DM also gave the other surveyor an advanced consistency diet for the survey team to taste due to residents complaints. The baked potato soup was bland and was also thick and chunky without a soup like consistency. The pasta salad was visually not appealing, and looked to be pasta only. It smelled like white vinegar and tasted like white vinegar only. The egg salad sandwich was supposed to be on wheat bread, per the menu, and was on white bread instead. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The HCSG DM stated that the pasta salad was cooked today, and was chilled for forty five minutes. The recipe states to cook the pasta and chill it until it reaches 41 degrees F and then add the vegetables and dressing, and chill for another two - three (2 - 3) hours before serving. He also stated that no one received wheat bread today, because Genesis wants them to order the frozen bread from Sysco, and the residents do not like the frozen wheat bread, so we do not buy it. On 03/17/26 at 12:45 PM, the HCSG DM brought another plate of pasta salad to the room where the survey team was located. He took the temperature in front of all of us, and it was 64 degrees F. On 03/17/26 at 1:10 PM, the HCSG DM and the Administrator came to the room where the survey team was located and stated we did not have enough green onions to complete the Baked Potato Soup recipe, but we used some. He also stated we made our own Italian dressing. The recipe calls for bulk Italian dressing. He also stated we did not have the fresh parsley for the Pasta salad as per the recipe. On 3/17/26 at 12:40 PM it was confirmed with both the District Manager and Administrator that the food had no flavor, that it was not palatable nor attractive. c) Resident Interviews On 03/16/26 at 11:55 AM, Resident #15 stated the food is bad. On 03/16/26 at 11:56 AM, Resident #53 stated the food is all bad. On 03/16/26 at 11:00 AM, Resident #49 stated sometimes the food is good and sometimes not so much. On 03/16/26 at 12:09 PM, Resident #48 stated the food is awful. I do like their meatloaf though. On 03/16/26 at 11:15 AM, during the initial interview process, Resident #1 reported she had lost weight and the food was awful. Resident #1 reported when she was sick and couldn't eat, she would drink cokes. The resident stated they will bring a substitute if they have it , but most of the time they don't have it. On 03/17/26, the state surveyor asked Resident #1 about the potato soup. Resident #1 looked at her tray and asked, Where's the potato soup? while she was eating her lunch tray. On 3/16/26 during the interview process of the initial long term survey process, when ask if the food was good, Resident #69 states, Well, I'm not going to lie about that, it sucks. She went on to state the food is bland, there are missing items that is suppose to be in the item.

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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 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: 65. Findings include: a) Policy Review Healthcare Services Group policy #019 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. All residents personal food brought in from the outside, will have a date put on when received, when opened, and will be given a seven (7) day use by date, unless the manufacturers use by date is before the seven (7) days. HCSG policy #27 titled Equipment, states the following: All food service equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. All staff members will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after every use. All non-food contact equipment will be clean and free of debris. b) Initial walkthrough of the kitchen. On 03/16/26 10:00 AM an initial walkthrough of the kitchen was performed and the following issues were identified: One (1) container of rice with no label or date in the storage room.One (1) container of maraschino cherries expired on 03/03/26.One (1) opened package of brussels sprouts not dated in the freezer.The floor in the freezer had debris and needed to be swept.The walk- in refrigerator had water pooling in the floor.Two (2) convection ovens had debris and needed to be cleaned.Two (2) knife racks were dusty.The inside top of the microwave had food splatter that needed to be cleaned.The toaster crumb tray needed to be cleaned.Clean cups and bowls were not stored upside down above the coffee maker.The food scoop holding racks had debris and dust.There were four (4) spices not closed tightly.The refrigerator located in the nourishment room had one (1) bottle of balsamic dressing without an open or use by date.There were seven (7) bowls of applesauce in the nourishment room refrigerator that was outdated with a use by dates of 3/10/26 and 3/15/26.The Director of Dining Services said we will fix these concerns today. On 03/17/26 at 9:17 AM during a second visit to the kitchen the following issues were identified: he bottom of the reach in refrigerator was soiled and needed to be cleaned.The floor behind and underneath of the milk cooler, stove, steamer and oven was soiled and needed to be cleaned.The District Manager (DM) for Healthcare Services Group (HCSG) stated we will get these concerns taken care of as soon as possible.

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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 and staff interview, the facility failed to store and dispose of garbage and refuse properly. This was a random opportunity for discovery that has the potential to affect more than a limited number of the residents currently residing at the facility. Facility census: 65. Findings include: a) Policy Review The Healthcare Services Group Policy #30 titled Dispose of Garbage and Refuse states: All garbage and refuse will be collected and disposed of in a safe and efficient manner. The Dining Services Director will ensure that there are appropriately lined containers available within the food service area for disposal of garbage or other refuse. Appropriate lids are provided for all containers. b) Initial Walkthrough of the kitchen On 03/16/2026 at 10:00 AM during the initial walkthrough of the kitchen the following was identified: Two (2) trash cans not in constant use, were without a lid in the kitchen. The trash can in the dish room was not in constant use and did not have a lid on it. The trash can located by the hand washing sink was soiled on the outside. c) Second visit to the kitchen. On 03/17/26 at 9:17 AM during the second visit to the kitchen the following was identified: The trash can in the kitchen was not in constant use, and the lid was off. The outside of the trash can beside the hand washing sink still needed to be cleaned. There was no liner in that trash can, with debris / trash inside of it.

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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 record review, observation and staff interviews, the facility failed to ensure a safe and sanitary environment was provided to prevent the development and transmission of communicable diseases and infections. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #33, #50, #58 and #40. Facility Census: 65.Findings include: a) During the Dining Room initial observation conducted on 03/16/26, the ice scoop remained in the ice storage container while the residents were served. On 03/16/26 at 11:53 AM, the ice scoop, not being placed in a holder after each use, was confirmed by Licensed Practical Nurse (LPN) #24. The ice scoop on B Hall was not placed in a separate container , but remained in the ice storage container during meal service. At 12:10 PM. the Administrator confirmed the ice scoop was in the ice storage container and stated, They have a cup .they should have moved it over. At 12:11 PM, the ice scoop wad observed in the ice storage container on A Hall. The Admissions Director confirmed the ice scoop was in the ice storage container and stated, Okay. b) On 03/16/2026 at 11:20 AM, the dining room observation was initiated. Three residents were observed not to receive hand hygiene before the meal. LPN #24 reported all residents received hand hygiene prior to the lunch meal by the activities department. No resident hand hygiene was observed or provided in the dining room after the state surveyor entered at 11:20 AM. When asked about residents that come later after initial hand hygiene was complete by the activities department or leave and come back into the dining room, LPN #24 stated, I don't know. The following residents were not provided hand hygiene during the dining room observation: 1) Resident #50 was brought into the dining room after 11:20 AM. No hand hygiene was observed by any staff member prior to giving the resident her drinks and meal. 2) Resident #58 walked out of the dining room and later returned. No hand hygiene was performed upon their return. 3) Resident #40 rolled her wheelchair throughout the dining room and down the hallway before returning to the dining room for the lunch meal. No hand hygiene was performed after her return to the dining room. c) Resident #33 On 3/16/26 at 12:15 PM, Resident #33was observed in room [ROOM NUMBER]-B and was in contact precautions due to Clostridioides Difficile Infection (C-diff). There was a Contact Precaution sign on the door indicating the resident was in contact precautions. There was Personal Protective Equipment (PPE) by the doorway to room [ROOM NUMBER]-B. The sign indicated the resident could not come out of the room. That families, visitors, and staff please report to the nurse before entering and ask the Nurse or Infection Preventionist if you have any questions. Clean hands before entering the room and before leaving. Staff to wear gown and gloves, required to use dedicated equipment to the patient and do not remove it from the room, clean and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disinfect ay shared equipment before using with next patient. The resident did have an active order dated 3/10/26 for Contact Precautions. She also was on Vancomycin HCL Suspension 50 MG/ ML Give 150 mg by mouth four times a day for suspected C-diff for 10 days (3/10/26 through 3/20/26). On 3/16/26 at 12:15 PM it was observed the Director of Nursing (DON) exiting Resident #33's room and use hand sanitizer. According to the Center for Disease Control and Prevention (CDC) Clostridioides difficile (C. diff) is a common cause of antibiotic-associated diarrhea (AAD). They also state In addition it is recommended not to use hand sanitizer as it does not kill C. diff. It is recommended by the CDC to perform hand hygiene by using antibacterial soap and water to eliminate C. diff spores. At the time the DON exited the room (3/16/26 at 12:15 PM) she was approached by the Surveyor and ask if she was to use hand sanitizer or soap and water for this room. There was no response, and the Surveyor informed her that for C Diff residents, soap and water must be used. It was also confirmed with the Administrator, as she was in the hallway, at which time she agreed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based upon record review and staff interview, the facility failed to accurately record a diagnosis of bipolar on a resident's Minimum Data Set (MDS). This was found to be true for one (1) of 26 residents reviewed during the long term care survey process. Resident identifier: #12. Facility census: 65.Findings include: a) Resident #12 Resident #12's medical record was reviewed and found their active diagnoses included: - Schizoaffective disorder, Bipolar type , with an onset date of 05/17/24. The resident's most recent MDS was conducted on 12/31/25. Section I for Active Diagnoses was reviewed and found Bipolar Disorder was not marked for this resident. A review of the MDS completed on 09/22/25, found Section I, was not marked for bipolar disorder, and the MDS completed on 07/23/25 was also not marked for bipolar disorder. This discrepancy was reviewed with the Nursing Home Administrator on 03/19/26 at 12:10 PM. She acknowledged the error on all three MDSs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and staff interview the facility failed to implement a personalized care plan to provide adaptative equipment (plate guard) for Resident #26. This was a random opportunity for discovery and was only true for Resident #26. Resident Identifiers: Resident #26. Facility Census: 65 Findings Include: a) Resident #26 On 3/16/26 at 12:20 PM an observation found Resident 26 did not have a plate guard provided with her noon time meal. Resident #26 has a medical diagnosis which includes hemiplegia, affecting the left non dominant side as well as legal blindness. Resident #26 has an order for a regular/liberalized diet, regular texture, standard thin liquids consistent. Plate guard and built up utensils with meals, no salt packet, sugar sub.(Substitute) A plate guard is an assistive dining device designed to foster independence for individuals with limited dexterity, tremors, or one-handed capability (e.g., due to stroke, Parkinson's, or cerebral palsy). Its primary purpose is to prevent food spills by offering a high, curved, or straight edge (often 1-1.5 inches high). This allows users to push food onto their utensils without pushing it off the plate, reducing mess and simplifying the feeding process. The diet ticket which was in place on her noon meal on the date of the observation (3/16/26) read: Built up foam utensils and plate guard. The plate guard was not on her tray. Upon review, her care plan read: Focus: Resident is at nutritional risk: Severe Protein-energy malnutrition, history of Osteomyelitis sacrum, hypertension, MS, diabetes Type 2, hypokalemia, Goal: Resident will consume 75% of at least 3 meals every day over the next review.She will maintain adequate nutritional status as evidenced by maintaining weight with no significant changes, promote wound healing and or skin integrity, no s/s of malnutrition, aspiration, or dehydration and consuming at least 50-100% of most meals daily through next review.Interventions: including but not limited to: Provide Regular/liberalized diet, regular texture, standard thin liquids consistency, plate guard and built up utensils with meals, no salt packet, sugar sub as ordered.Observe for changes in nutritional status (changes in intake ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated. On 03/26/26 at 12:23 PM it was confirmed with the Administrator this resident was to have a plate guard, it was on her meal ticket but missing from her tray. The Administrator agreed the plate guard was not provided in order to help the resident with her ability to obtain food on her utensils as necessary. On 03/26/26 at 1:10 PM it was confirmed with the Administrator the care plan was not implemented in this case, at which time she agreed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed ensure a care plan was revised and updated when a nutritional supplement was discontinued. This was true for one (1) of 26 sampled residents reviewed during the long term care survey process. Resident Identifier: #2. Facility Census: 65.Findings include: a) Resident #2 A Nutrition assessment dated [DATE] was reviewed and stated, Sig (Significant) change and wt. (weight) review. Average po (by mouth) intake 65% meeting around 90% est. (established) needs. Sig wt. loss x 30 and 180 days; resident desires wt. loss w/ (with) goal wt. of 150#; hx (history) ozempic not currently ordered; diuretic recently reordered and wt. fluctuations may occur; hx sig wt. loss and sig wt. gain. BMI indicates obesity. Therapeutic diet d/t (due to) modular protein tid (three times a day); refusing most of modular protein. Rec. (recommend) d/c (discontinue) modular protein d/t refusals. Will f/u (follow up) prn (as needed). Resident #2's care plan was reviewed and found the following: Protein supplement as ordered Date Initiated: 05/19/25 Created on: 05/19/25.Resident #2's order stated, Protein Liquid two times a day give 1oz Supplement Discontinued7/26/25.On 03/17/26 at 3:17 PM, the Director of Nursing (DON) confirmed the resident's care plan with ordered supplement was not revised and stated, I will look into that,On 03/17/26 at 3:39 PM, the DON reported the supplement had been resolved under skin breakdown on the resident's care plan, but the nutritional part was missed.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, record review and staff interview the facility failed to provide adaptative equipment (plate guard) for Resident #26 as ordered. This was a random opportunity of discovery and was true for only Resident #26. Facility Census: 65Findings Include: a) Resident #26 On 3/16/26 at 12:20 PM an observation found Resident #26 did not have a plate guard provided with her noon meal. Resident #26 has medical diagnoses which includes hemiplegia, affecting the left non dominant side as well as legal blindness. Resident #26 has an order for a regular/liberalized diet, regular texture, standard thin liquids consistent. Plate guard and built up utensils with meals, no salt packet, sugar sub (substitute). A plate guard is an assistive dining device designed to foster independence for individuals with limited dexterity, tremors, or one-handed capability (e.g., due to stroke, Parkinson's, or cerebral palsy). Its primary purpose is to prevent food spills by offering a high, curved, or straight edge (often 1-1.5 inches high). This allows users to push food onto their utensils without pushing it off the plate, reducing mess and simplifying the feeding process. The diet ticket which was in place on her noon meal on the date of the observation (3/16/26) read: Built up foam utensils and plate guard. The plate guard was not on her tray. On 03/26/26 at 12:23 PM it was confirmed with the Administrator this resident was to have a plate guard, it was on her meal ticket but missing from her tray. The Administrator agreed the plate guard was not provided in order to help the resident with her ability to obtain food on her utensils as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515088	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Center	1631 Ritter Drive Daniels, WV 25832

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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to ensure a resident's Physician Orders for Scope of Treatment (POST) form was signed by the resident's Power of Attorney (POA). This was true for one (1) of three (3) residents reviewed for the care area of advance directives during the long term care survey process. Resident Identifier: #39. Facility Census: 65. Findings include: On 03/16/26 at 2:12 PM, during Resident's #39's electronic medical record review, the POST form was reviewed. A verbal consent was obtained by the POA on 01/19/26. A signed POST form was not in the electronic medical record. The state surveyor requested documentation or records to indicate the POST form had been mailed for the signature to be obtained. No documentation or records to indicate the form had been mailed to be signed or follow-up was attempted for signature until state surveyor intervention. On 03/16/26 at 3:20 PM, the Social Worker confirmed there was no signature on Resident #39's POST form. The Social Worker stated, I did follow-up and she said she would mail it. She has the admission paperwork. A copy of the progress note documenting the follow-up was given to the state surveyor dated 03/16/26 at 2:21 pm.