STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515089	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charleston Healthcare Center	3819 Chesterfield Avenue Charleston, WV 25304

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review, observation, staff interview and resident interview, the facility failed to ensure a resident's call light was within reach. This failed practice had the potential to affect a limited number of residents. Resident Identifiers: #129 and #146. Facility Census: 145.Findings included: The facility's policy and procedure for Resident Rights stated, c. To have a method to communicate needs to staff. i. Call light or bell access will be within reach of the resident as one method to communicate needs to staff. a) Resident #129 - On 03/31/2026 at 11:10 AM, during the initial interview process, Resident #129's call light was observed on the floor. The resident was lying in bed. Nurse Aide #138 confirmed the call light was out of reach and on the floor and stated, I'll fix it and let their CNA know. Resident #129's care plan stated, Place call bell within reach, remind resident to call for assistance.b) Resident #146 On 03/31/2026 at 11:15 AM, during the initial interview process, Resident #146 reported his only problem was he wanted to get back in bed and that he had been sitting here a long time. The resident was observed sitting in his wheelchair beside the bed with his call light under his wheelchair. The resident was unable to reach his call light to obtain assistance. Nursing Aide #138 confirmed the call light was out of reach and stated, I'll take care of it and let their CNA know. Resident #146's care plan stated, Place call light within reach. Remind resident to call for assistance if cognitively intact.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based upon record review and staff interview, the facility failed to notify the resident's representative in writing of the reason for transfer/discharge and provide a copy of the bed hold notice. This was found to be true for one (1) of four (4) resident reviewed during the long term care survey process. Resident identifier: #19. Facility census: 145. Findings included: a) Resident #19 Record review revealed Resident #19 had three (3) acute transfers in the last 120 days. These included: 01/29/26 - 02/03/26, 02/22/26 - 03/01/26, and 03/04/26 - 03/10/26. During the first two acute transfers, the resident had the capacity to make their own medical decisions. The resident was provided a notice of transfer and bed hold notice. The resident lost her capacity to make her own medical decisions on 03/02/26. On 03/04/26, the resident sustained a fall at the facility and was transferred to the hospital. The resident was provided a transfer notice and bed hold notice. However, since the resident's capacity had changed two days earlier and the resident no longer had the capacity to make medical decisions, the resident's designated representative or Power of Attorney should have been informed. This was reviewed with the Director of Nursing on 04/02/26 at approximately 10:40 AM.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview, the facility failed to ensure an updated Preadmission Screening and Resident Review (PASRR) was completed for a resident with a bipolar diagnosis identified after admission. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #153. Facility census: 145. Findings included: Resident #153 a) On 04/01/26 at 9:26 AM, Resident #153's medical chart was reviewed. A diagnosis of Bipolar II Disorder was listed after the resident's admission to the facility in 08/2024. The diagnosis of Bipolar II Disorder was added on 04/04/2025 to the resident's diagnosis list in the medical chart. The resident's most recent Preadmission Screening and Resident Review (PASRR) dated 11/21/2024 did not have Bipolar Disorder listed or checked under Section 30 of the PASARR. On 04/01/26 at 3:30 PM, the PASSAR and diagnosis list with bipolar diagnosis date were reviewed with the Director of Nursing (DON). The DON confirmed the Bipolar II Disorder diagnosis was not listed or marked on the most recent PASARR.

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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 update the comprehensive care plan in a timely manner following a significant change in the resident's mental capacity. This was found to be true for one (1) of three (3) residents reviewed during the long term care survey process. Resident identifier: #19. Facility census: 145.Findings included: a) Resident #19 Resident #19 had a change in her capacity to make own medical decisions on 03/02/26. Upon initial review of the resident's medical record on day one of the long-term care survey process (03/31/26), the resident's comprehensive care plan stated the resident had capacity to make her own medical decisions. Surveyor requested a copy of the care plan late afternoon on 04/01/26. Upon the surveyor's arrival at the facility the next morning, the care plan was provided. A review of the care plan documented that it had been updated on 04/01/26 to show the resident no longer has capacity. The surveyor reviewed the care plan documentation change with the Director of Nursing (DON) on 04/02/26 at 10:50 AM, showing the DON the change was made only after the surveyor requested the care plan. The DON stated, I guess there is not much I can say to defend us on this one.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to ensure the resident's orders and care plan matched for a resident ordered Nothing By Mouth (NPO) by the physician. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #56. Facility Census: 145. Findings included:Resident #56 a) On 03/31/2026 at 3:13 PM, Resident #56's medical chart was reviewed. The resident's care plan stated, NPO diet order. and Administer medications per physician orders and flush before/after medication administration per order. The residents diet order stated, NPO diet NPO texture, NPO consistency. A medication order for Norvasc Tablet was stated, Norvasc Tablet (amLODIPine Besylate) Give 5 mg by mouth one time a day for HTN. On 04/01/2026 at 1:40 PM, the Administrator confirmed the order for Nothing by Mouth (NPO), the medication ordered by mouth and the care plan for NPO. The Administrator stated, We will get that taken care of.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based upon Observation, staff interviews and policy, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections by not dating IV lines for Resident #108 and #60. This was discovered during the normal Long Term Survey Process and has the ability to affect more than a limited number of residents. Resident identifiers #108, #60. Census: 145.Findings included: a) During the resident interview process performed on 03/31/26 at approximately 1:30 PM it was observed that Resident #108's IV line was not dated and was in use. The Director of Nursing and Unit manager confirmed that there was no date on the IV line. Secondary observation on 03/31/2026 at approximately 2:00PM, Resident #60 had medication running and the IV line was not labeled with date and time when two surveyors went into the room, before they (surveyors) were able to get a staff member to confirm , the nurse took down the set because the medication had finished. Interview with DON at 2:00 PM revaled the DON said I'll go look at it and get it fixed Policy named Changing IV administration Set dated 02-2009 Revision 02-2019; states that IV tubing must be changed every 24 hours. It also states Label IV tubing indicating the date and time and initials.