STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515099	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roane General Hospital	200 Hospital Drive Spencer, WV 25276

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review reviews the facility failed to follow the grievance process making prompt efforts to resolve a grievance and to keep the resident notified of progress toward resolution. Resident identifiers: #23, #3, #123, #2, #101, #2, #19. Facility Census: 32 Findings Include: On 09/22/25 at 1:15 PM record review of Resident Council minutes for the last six (6) months found several complaints voiced to the Activity Director (AD) #14. According to the Director of Nursing (ADON) there have been no grievances for the year 2025. During sitting in on a current Resident Council meeting on 09/22/25 at 2:30 PM, there were complaints voiced. A review of the Resident Council Minutes for the last six (6) months found the following issues were identified relating to lost personal belongings, Certified Nurse Aide actions and attitudes, condition of rooms, safety issues, and furniture repairs. 03/20/25 Resident #19 missing clothing, Resident #19 - not getting ice, Resident #19, - not getting underwear back, not answering call lights fast enough, Televisions turn on/off with either remote in double rooms 04/21/25 Nurse Aides not putting stuff back where it belongs Nurse Aides getting an attitude with residentsNot having V8 juice Underwear not coming back,Drawers are not opening all the way,Television needs to be programed. 05/19/25 Stock piling briefs and wash cloths in dressers, not answering call lights in a timely manner, too loud at night, talking too loud at tray line, 06/23/25 Meat tough to eat,Television needs repaired in room [ROOM NUMBER] B, room [ROOM NUMBER] bed needs fixed, (name of resident) needs a new mattress. 07/28/25 room [ROOM NUMBER] needs painted, it is trashy, Mattress is bad. Flies in the dining room Resident #2 not getting blood sugar checked in AM. 08/28/25 Resident #2 wants wheelchair looked at.Resident #23 and #3 Water pitchers not being filled ot checked, Eye drops not done on time, takes too long to get help to bathroom, missing blankets small ones.Resident #123 Bed not risingroom [ROOM NUMBER] B Television needs to be worked on. 09/22/25 Resident #23, cannot safely get out the door in the dining room outside and had missing blankets.Resident #3 had missing blankets.It was confirmed in the Resident Council Meeting on 09/22/25 with the ten (10) residents present that not all items listed above have been addressed, especially missing items.On 09/23/25 at 1:15 PM it was confirmed with the Director of Nursing that the above instances above should have been filed as a grievance and addressed in a timely manner to ensure documentation was available at which time she agreed.

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review the facility failed to complete comprehensive assessment timely. This was true for two (2) of six (6) Resident reviewed during the Long-Term Survey Process. Resident Identifiers: #1 and #7. Facility Census: 32.Findings Included: a) Resident #1 On 09/23/25 during record review of Resident #1 MDS review of Quarterly Minimum Data Set (MDS) assessment dated [DATE], Completed Late: (assessment completion date) is more than 14 days after the (assessment reference date). The assessment was submitted 09/04/25. During an Interview on 09/24/25 at 1:55 PM the MDS Coordinator verified the submission date was past the 14-day assessment completion date. b) Resident #7 On 09/23/25 during record review of Resident #7 MDS review of Quarterly Minimum Data Set (MDS) assessment 08/08/25. Completed Late: (assessment completion date) is more than 14 days after the (assessment reference date). The assessment was submitted 09/04/25. During an Interview on 09/24/25 at 1:55 PM the MDS Coordinator verified the submission date was past the 14-day assessment completion date.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, and staff interview, the facility failed to ensure the physician documented the actions or rational if no action taken to monthly drug regimen reviews and GDR's and the pharmacist failed identified an irregularity in a prescription written by the physician. This was true for four (4) of five (5) reviewed for unnecessary medications. Resident identifiers: #3, #4, #18, and #27. Facility census: 32. Findings included: a) Resident #3 A record review for Resident #3 revealed a pharmacy recommendation dated 04/18/25. The recommendation stated the resident was due for a gradual dose reduction (GDR) assessment for Bupropion which was received for a diagnosis of Depression and Escitalopram also for a diagnosis of Depression. The pharmacist suggested a GDR or documentation of clinical contraindication. The record review revealed the physician had not considered a GDR and did not document the clinical rationale as to why this was not considered. b) Resident #18 Record review for Resident #18 revealed a pharmacy recommendation dated 11/28/25. The recommendation stated the resident was due for a GDR assessment for Duloxetine. This was the first of two recommended GDR assessments within the first year of the order for this medication. The physician had not accepted the recommendation or provided a rationale as to why the GDR was not done. c) Resident #4 Record review for Resident #4 revealed a pharmacy recommendation dated 05/25/25. The pharmacist had recommended a GDR assessment for Citalopram which the resident received for Anxiety and Depression. The physician declined this recommendation but did not provide a clinical rationale for this decision. During an interview on 09/25/25 at 2:30 PM the Director of Nursing (DON) said she agreed the physician had not signed or provided documentation of clinical contraindications for the Resident #18, #4, and #3. d) Resident #27 Record review of Resident #27's medications on 09/24/25 at 9:10 AM revealed that the resident was prescribed Buspirone 7.5 Mg PO BID on 03/22/25.The order specified that the resident was to be administered 0.25 tablet of a 30 MG tablet of Buspirone. During a review of Resident #27's medications on 09/24/25 at 1:25 PM, Licensed Practical Nurse (LPN) #31 produced a bubble pack labeled with Resident #27's name, containing single tablets in each pouch labeled Buspirone 7.5 MG. LPN #31 stated that Resident #27 was dispensed a single tablet during the morning medication pass.At approximately 2:50 PM on 09/24/25, [NAME] President of Nursing Service (VPNS) #79 reviewed the order and inspected the medication cart together with LPN #31. VPNS #79 confirmed that there was an irregularity in the medication order and that the order would need to be revised to reflect the medication being dispensed accurately.

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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 and staff interview the facility failed to establish and maintain an infection prevention program to help prevent the development and transmission of communicable diseases and infections. Enhanced Barrier Precautions were not being followed, a nurse was giving medications without gloves and without a barrier and issues with the tile were found in the shower room. In addition ventilation issues were found in the soiled laundry room. Resident Identifiers: #7 and #10. Facility Census: 32 Findings Include: a) Food and drink at the nurses' station On 09/22/25 at 10:30 AM upon arrival to the Nurses station there were three (3) nurses with personal drinks at the nurses' station. There was also a Nurse eating at the station. According to the Facility Infection Control Policy there was to be no food/drink at the nurses' station. On 09/24/25 at 9:00AM the above findings were confirmed with Director of Nursing who agreed the nurses were not to have food or drink at the station. b) Resident #7 On 09/22/25 at 10:45 AM it was observed this Resident's' room had a Enhanced Barrier Precaution (EBP) sign on the door. It was, however, covered with a large pumpkin decoration causing the sign to be blocked by the decoration. According to the facility EBP Polity the Procedure for EBP is: Residents who require EBP should have proper signage placed on their door and/or overbed space if in a shared room. On 09/24/25 at 9:00 AM the above findings were confirmed with Director of Nursing who agreed the precaution signs should be visible to anyone coming into the room. c) Resident #110 On 09/24/25 at 8:40 AM Licensed Practical Nurse was being observed passing medications. When removing the pills from the bubble pack for Resident #110, the nurse removed the pills into her ungloved hand. She then placed the pills in the medication cup. She was also observed missing the medication cup and a pill fell on the medication cart which did not have a barrier in place. She then picked up the pill, ungloved, and placed it in the medication cup. On 09/24/25 at 9:00AM the above findings were confirmed with Director of Nursing who agreed the nurse should have a barrier and/or gloves in place. d) Soiled Laundry Room On 09/24/25, at approximately 9:05 AM, an inspection of the laundry room was conducted in the presence of Housekeeping Manager #16. It was observed that the venting system in the soiled laundry room was non-functional. A fan was observed in use. The fan was directed toward the door of the clean laundry room. Housekeeping Manager #16 confirmed that the venting system was not operational and remarked, It gets very hot in here! (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clean laundry room is located across from the soiled laundry room, separated by a closed door. When the door is opened, air from the soiled laundry room is blown into the clean laundry room. HM #16 stated that she would notify maintenance that the venting system was not working. e) Back Shower Room During an inspection of the back shower room on 09/24/25 at approximately 9:35 AM, accompanied by the Director of Nursing (DON) and the [NAME] President of Nursing Services (VPNS) #79, several concerns were identified. The shower room with cracked tiles on the floors, and the water pipes next to the commode were covered with material that could not be cleaned or disinfected. DON and VPNS #79 confirmed the findings and stated that the shower room was scheduled for complete renovation in October of 2025.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interview, the facility failed to report alleged violation related to, neglect, or abuse, and report the results of all investigation to the proper authorities within prescribe time frame. This was a random opportunity for discovery. Resident identifier: #21. Facility census: 32. Findings include:a) Resident 21During a Facility Reported Incident investigation for Resident #21 found a complaint/concern on 04/26/25. The complaint/concern stated, Resident #21 assisted to the wheelchair without the physician ordered Hoyer lift.Subsequent review of the medical record revealed the complaint/concern on 04/26/25 for Resident #21 was investigated but not reported to the appropriate services within the allotted time limits During an interview with DON on 09/24/25 at 3:30 PM she verified the complaint/concern on 04/26/25 for Resident #21 was not reported timely. She stated the incident happened over a weekend and did not get reported. She stated that concerns and grievances about neglect in Resident care should be reported to the appropriate services, Adult Protective services (APS), Office of Health Facility Licensure & Certification (OHFLAC) and State or regional Long-Term Care Ombudsman within 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to conduct a thorough investigation into a Facility Reported Incident (FRI) as required. Additionally, the facility failed to interview and assess all dependent residents to confirm that they had not suffered any harm or injury. Resident Identifier #38. Facility Census: 32. Findings include: a) Resident #38During an investigation of a Facility Reported Incident (FRI) on 09/24/25, at approximately 1:13 PM, it was discovered that on June 16, 2024, at 9:17 PM, Licensed Practical Nurse (LPN) #25 reported that Resident #38 had visible bruising on the left underarm and left upper arm.Review of the facility investigation on 09/24/25 at approximately 10:30 AM revealed the following documents and statements:Investigative document by Director of Nursing (DON) on 06/17/25 [Typed as Written] Bruise - Purple in color, appears new, no fading noted to edges or center of bruise.Bruise is located at the mid-clavicular left chest and extends to the proximal upper left arm and distally towards the elbow. ROM is normal for resident. Physician notified and no new orders.Skin assessment on last shower day reports no bruising and only refers to the resident's skin tear to the right forearm, which is healing well.Staff Interviews for Caregivers Working 6/14/24 - 6/16/24.06/17/24: Spoke with Nursing Assistant (NA) #153, who was the caregiver for [Resident] on 6/14 7a-3p shift, and she denies that there were any bruised areas during this time. She reports that she did change [Resident's] top and no skin alterations were noted.i06/17/24: Spoke with NA #151 caregiver for [Resident] on 6/13/24 3p-11p shift and she does not recall a bruised area. Stated that all she recalls is the skin tear area to her right arm. 06/18/24: Spoke with NA #152, caregiver for [Resident] on 6/15/24 and 06/16/24, she denies seeing bruising to DW on these days during personal care.NA #151 reports that CNA students were on unit Sunday 6/16/24 and performed multiple transfers without employee assistance.[Resident's] roommate is incapacitated and unable to provide any insight to injury.At this time, it is inconclusive as to who or how bruising was caused/occurred to [Resident]. After multiple staff interviews it was discovered that there are multiple reports of improper transfer techniques. [Resident] should always transferred utilizing a full body lift. Staff report that it is easier to transfer her by pivoting from chair to bed or bed to chair.Discussed with staff safety and injury concerns with transfer practices and will initiate mandatory competency regarding transfers, lift use, hand off report regarding transfer orders and where to locate transfer order directions in the electronic medical record.A memo sent by DON to all staff dated 06/17/25 at 3:22 PM, which stated [Typed as Written]: Good afternoon, it has come to my attention that some staff are electing not to use the appropriate care planned or ordered transfer devices for residents. This is not an option. Transfer/lift status is determined by staff input as well as therapy evaluation for resident safety utilizing the least restrictive device that maintains resident functionality and safety of the resident as well as the staff. Lifts are to be utilized for residents as ordered in their care plan. If a lift is not being used and is ordered this is grounds for neglect/abuse especially if/when it results in resident injury. I will be scheduling mandatory competencies and evaluations on lift use as well as determining where to find the resident lift orders/status. Please feel free to see me if you have any questions or concerns regarding this policy.Another memo from the DON to staff dated 07/16/24 (approximately a month later) at 2:51 PM, which stated [Typed as Written]: Lift competencies will be held tomorrow, 07/17/25, and Thursday, 07/18/25. You will be required to operate the lift with supervision from physical therapy or the DON as well as verbalize where to find information regarding resident lift status. Competency evaluations will be for full body and sit to stand lifts. I realize not everyone will be able to make a session tomorrow. I will be scheduling a make-up time as well.Wednesday 07/17/2410:30, 10:45, 11:00, 11:15Thursday 07/18/2413:00, 13:15, 13:30, 13:45, 15:30.Record review on 09/24/25 at 12:11 PM revealed in-service information and a sign-in sheet that documented staff in-services as having been completed.Further review of records on 09/24/25, at approximately 2:00 PM, revealed that the incident had been reported to the Director of Nursing (DON) on 06/16/24, at 9:58 PM. The Initial Report was submitted (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and received by the Office of Health Facility Licensure and Certification (OHFLAC) on 06/17/24 at 12:29 PM by SW #150.The five-day follow up submitted to OHFLAC on 06/20/24 at 10:54 AM, by Social Worker #150, and the result of the investigation was noted to be inconclusive.However, the facility stated that the DON would be implementing mandatory competencies regarding transfers, lift use, hand-off reports regarding transfer orders, and where to locate transfer order directions in the electronic medical record.Further investigation on 09/24/25 at 2:45 PM revealed that:NA #151 and #152 were no longer employed at the facility. SW #150 was also no longer at the facility.LPN #25 worked the night shift and was unavailable for interview, and NA #153 (now an RN) worked night shifts at the hospital and was also unavailable for interview. During an interview with the DON on 09/24/25 at approximately 3:00 PM, the DON was asked about the investigation, and confirmed that while staff members had been questioned about the care of Resident #38, no other dependent residents had been interviewed or assessed for injury soon after the incident was reported.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and staff interview the facility failed to submit the correct admitting diagnosis on a Preadmission Screeing and Resident Review for one (1) of one (1) PASARRs reviewed. Resident Identifier: #4 Facility Census: #32. Findings Include:a) Resident #4On 09/23/25 at 01:15 PM a review of Residents #4's medical diagnoses found the following listed:Generalized anxiety disorder Major Depressive disorderChronic paranoid schizophreniaBipolar Review of the latest PASARR dated 05/18/21 submitted by the MDS Coordinator shows the following conditions: Schizophrenia DisorderHallucinationsDelusionalDisorientedSeriously impaired judgmentDementiaThe PASARR did not reflect Anxiety, Major Depressive Disorder, or Bipolar.The care plan had the following reflected on it: Anxiety, Major Depressive Disorder, and Schizophrenia. Dementia and Bipolar were not care planned.Resident #4 was also ordered the following medications: Xanax 05.mg three times a day for Anxiety disorder, Lamotrigine (Lamictal) 100mg twice a day for Schizophrenia, Citalopram 20 mg daily, Rexuit for schizophrenia, Zyprexa 5 mg for Schizophrenia. During an interview with the MDS Coordinator on 09/23/25 at 1:45 PM she stated she did not know why the two documents did not match and agreed they should.

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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 record review and staff interview the facility failed to implement the care plan for the nutritional status regarding weights. This was a random opportunity for discovery. Resident Identifier: #1 Faility Census: 32 Findings include:a) Resident #1On 09/23/25 at 9:10 AM record review revealed an order for monthly weights. Review of the weights for this resident shows a weight gain of 14% on 05/10/25 and 11% on 05/14/25.According to the Director of Nursing (DON) on 09/23/25 at 1:00 PM there was no documentation to reflect that the Physician was notified of Resident #1 weight gain in either instance.According to the facility policy for Long Term Care Significant Weight Change the procedure states Physician and Medical Power of Attorney (MPOA) will be notified of the significant weight change.Review of Resident #1's care plan created 07/24/25 for Nutritional Status problems revealed the approach was for staff to monitor weights and report significant weight changes to the physician. On 09/23/25 at 1:10 PM it was confirmed with the DON that the facility did not implement their care plan as written 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. Based on record review and staff interview the facility failed to update the careplan to reflect current medications and diagnosis.This was true for five (5) of five (5) residents reviewed for unnecessary medications. Resident Identifier: #4 Facility Census: 32 Findings Include:a) Resident #4On 09/23/25 at 01:15 PM a review of Residents #4s medical diagnosis found the following listed:Generalized ansiety disorder - Major Depressive disorderChronic paranoid schizophreniaBipolar The careplan the following reflected on it: anxiety, major depressive disorder, schizophremia. Dementia or bipolar are not care planned.Resident #4 is also ordered the following medications: Xanax 05.mg three times a day for anxiety disorder, Lamotrigine (Lamictal) 100mg twice a day for schizophrenia, Citalopram 20 mg daily, Rexuit for schizophrenia, Zyprexa 5mg for schizophrenia. The care plan however, does not have the lamotrigine care planned.When confirmed with the MDS Coordinator on 09/23/25 at 01:45 PM that the care plan had not been revised she agreed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 policy to notify the physician in regards to weights. This was a random opportunity for discovery. Resident Identifier: #1 Facility Census: 32 Findings Include:a) Resident #1On 09/23/25 at 9:10 AM record review shows an order for monthly weights. Review of the weights for this resident shows a weight gain of 14% on 05/10/25 and 11% on 05/14/25. According to the Director of Nursing (DON) on 09/23/25 at 1:00 PM there was no documentation the Physician was notified of Resident #1's weight gain in either instance.According to the facility policy for Long Term Care Significant Weight Change the Physician and Medical Power of Attorney (MPOA) would be notified of the significant weight change.Resident #1's care plan created 07/24/25 for Nutritional Status problems the approach was for staff to monitor weights and report significant weight changes to physician. On 09/23/25 at 1:10 PM it was confirmed with the DON that the facility did not notify the Physician of either weight gain at which time she agreed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interview the facility failed to ensure that every resident's medication regimen is managed safely and effectively wth medical indications included. This is true for one (1) of five (5) residents reviewed for unnecessary medicaltions. Resident Identifier: #48 Facility Census: 32 Findings include:a) Resident #48On 09/24/25 at 10:48 AM during record review of unnecessary medications it was noted that two (2) currently ordered medication for Resident #48 did not have indications as to why the resident was prescribed the medications.The orders are as followsFurosemide 40mg Tablet (Lasix) daily, ordered 11/04/22 Citalopram hydrochloride (Celexa) 20 mg daily, ordered 09/12/23Neither order had a medical indication under problem to indicate the reason the resident is on these medications.It was confirmed with the Director of Nursing on 09/24/25 at 3:00 PM that the omission of indicators should have been caught during the pharmacy Medication Regimen Review at which time she agreed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515099	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roane General Hospital	200 Hospital Drive Spencer, WV 25276

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to ensure that a resident was offered the option to receive or decline the COVID vaccine. Furthermore, the resident was not provided with the appropriate education about the COVID vaccine. This was true for one (1) of eighteen (18) residents sampled. Resident Identifier: #10. Facility Census: 32.a) Resident #10Findings IncludeDuring a review of immunization records on 09/24/25 at approximately 3:00 PM, it was revealed that the facility had no records of COVID education, or a COVID vaccine being offered to Resident #10.During an interview with the Infection Preventionist (IP) on 09/24/25 at approximately 1:15 PM, IP stated that she did not have any records, consents, or declinations for the COVID vaccine for Resident #10.