STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515100	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Sulphur Springs Center	345 Pocahontas Trail White Sulphur Spring, WV 24986

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record review, staff interview and observations, the facility failed to ensure residents were served food in the correct consistency according to the facility's diet description for puree consistency solids. It was determined that this failed practice placed all (5) five residents currently on a puree diet in an immediate jeopardy situation. Providing a resident with the wrong consistency of food could result in choking, and/or aspiration pneumonia which can lead to serious harm and/or death. This failed practice was found to be true for five (5) of five (5) residents reviewed for diet consistency during the Long-Term Care Survey Process. Resident Identifiers: #12, #21, #33, #38, and #53. Facility Census: 65.Findings Include: a) Puree diets A record review on 09/08/25 at 11:00 AM, revealed a diet order for Resident #38 that read as follows:Regular/Liberalized-Dys Puree. Thick Liquids-Nectar. Resident #38 had a diagnosis of Dysphagia, Oropharyngeal Phase. An observation of the lunch meal on 09/08/25 at 12:30 PM, revealed Resident #38 being served a tray that included puree bread, puree cinnamonapples, puree peas, and a puree chicken fillet that appeared to be ground instead of pureed. The Regulatory compliance advisor (RCA) confirmed that the breaded chicken fillet was in fact ground, and not pureed as the diet order indicated. During an interview and observation on 09/08/2025 at 12:45 PM, The Corporate Dietary Manager (CDM) scooped up a scoop of puree breaded chicken, onto a plate. The State Agency (SA) asked, Was this the right consistency? The CDM stated, No, it's supposed to be a pudding consistency. SA then asked, Was all residents on a pureed diet served the ground consistency meat today CDM stated, All of them were served out of this. I feel like the liquid dried up.Further review of the medical record revealed that Resident #38 did have an against medical advice (AMA) signed by his Medical Power of Attorney (MPOA). The following nurses note dated 08/21/25 was found in the medial record regarding the AMA: Care plan meeting completed with family at bedside today. Sister, MPOA, brought food for resident that goes against his current diet regiment (dysphagia pureed w/nectar thickened liquids). I and the entire management team explained to sister the risks of resident having any food that does not follow current diet orders. MPOA said that she did not care what recommendations are, she will give him whatever he wants and our staff may do the same if he asks. She verbalized understanding of the risk of aspiration and all other risks. She did sign informed refusal and Acknowledgement for Diet Regimen and verbalized the meaning of thatrefusal form. Provider is aware. Further review of the medical record showed that the facility had (5) five residents currently on a puree diet, Residents #12, #21, #33, #38, and #53. None ofthe other (4) four residents on Puree has an AMA for the diet texture and according to the Regional Dietary Manager all were served the chicken that was ground texture, rather than puree. The facilities diet description for puree consistency solids reads as follows: All pureed foods must be the consistency of moist mashed potatoes or pudding. During an interview on 09/08/25 at 3:46 PM, The Speech Therapist (ST) stated,When I had (Resident #38 name) on caseload, it took a while to get him in for a modified barium swallow. When he did have the test there were some pretty significant deficits and they recommended him to be NPO and put in a peg tube. The family said no. So the best I could do was the puree diet and thickened liquid. The ST further stated, Getting the wrong consistency of diet can lead to a lot of things like choking and aspiration pneumonia. The facility was (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	notified of the immeditate jeopardy on 09/08/25 at 4:00 PM. The facility's plan of correction was accepted on 09/08/25 at 5:00 PM. b) Facility Corrective Action Residents with a pureed diet did not receive proper consistency for pureed meats. The diet try was removed form the residents room and a fresh tray was provided with the correct texture. All residents on mechanically altered diets have the potential to be affected. The DON/designee conducted an audit on or before 09/08/25 for all residents to ensure diet orders are correct and accurate and attached to the Kardex with any corrective action immediately upon discovery. Re-education was provided by the DON/designee to all staff beginning on 09/08/25 to ensure diet orders are followed and the correct diet is being served with post-test to validate understanding any staff not available during this time frame will be provided re-education, including post-test during orientation by the DON/designee. Meal service will be audited to ensure correct consistency per diet order daily for 2 weeks including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 week then randomly thereafter. Results of monitors will be reported by the DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the QIC. c) Education Education provided to all staff reads as follows: If a resident is ordered a pureed diet, all food should be a pudding-like consistency. There should be no chunks throughout any of the food. If the food is found to be incorrect then the employee should immediately take the incorrect items back to the kitchen to be fixed. d) Follow-up of POC A review was completed of the signed education of all staff, to ensure all staff that are working has been provided the education. This correction has been completed. Post test for the education ask the following questions:Puree texture food should of a pudding type consistency. True of FalseIf a resident is served a diet that does not match their tray ticket what should you do?All post test were answered correctly. Staff interviews were conducted on O9/09/25 at approximately 10:30 PM. All staff interviewed answered the questions appropriately. Observation of the lunch meal pass on 09/09/25 beginning at 11:45 AM, revealed that all (5) five residents currently on a puree diet were served the correct consistency of diet. The IJ was abated on 09/09/25 at 12:30 PM.

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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 observation and staff interview, the facility failed to ensure it had a clean, comfortable, homelike environment. This deficient practice was a random opportunity for discovery. Resident identifiers: #18, #3, #32. Facility census: 65. Findings included: a) Resident's #18 and #3 On 09/03/25 at 2:27 PM found Resident #18's bathroom corner commode had a hole through the drywall to allow the toilet handle to function. The base of the commode was stained yellow and had a black substance around the base. An observation of the toilet room in Resident #3's room found a black substance around the base of the commode with a white caulking substance erratically applied over the black substance. On 09/10/25 at 11:30 AM an observation with the Nursing Home Administrator (NHA) of Resident's #18 and #3's toilet room confirmed Resident #18 and #3's toilet rooms were in disrepair. b) Laundry On 09/09/2025 2:45 PM an observation was conducted of the laundry with Regulatory Compliance Advisor (RCO) and the Laundry Director. A fan covered with a gray fuzzy substance was sitting on the floor on the clean side. It was not in use at this time. The RCO stated that he had asked staff to dispose of the fan yesterday. The Laundry Director #70 stated the fan was not in use and should have been removed. The vent in the clean laundry was darkened in color (gray) and LD #70 explained there was a washer fire (the washer had been replaced) and the gray ceiling and vent was from the smoke. He stated maintenance had attempted to clean the vent and ceiling, but it really needed to be painted. In the soiled laundry there were 3-4 bags of soiled laundry on the floor. [NAME] stated that he had put those there as they needed an empty barrel on the unit. There were broken and missing floor tiles in the clean laundry. The RCO confirmed all the findings. c) Resident #32 During the initial interview and observation on 09/02/25 at 3:10 PM, Resident #32 stated, It is really hard to see in my bathroom. I have told them, but nobody has fixed it. The observation revealed that there are 2 light bulbs over the sink, one of them is out and that the light over the stand-up shower is very dim. An observation on 09/09/25 at 3:56 PM, revealed that Resident #32's light over the bathroom sink is still out and the light over the stand-up shower is very dim. 09/09/2025 4:06 PM During an observation and interview with Licensed Practical Nurse (LPN) #37, the LPN turned on the light switch, one light bulb came on, after approximately 30 seconds the other light bulb blinked and then came on. The light bulb over the shower came on as well but was very dim. The LPN confirmed that the lights in Resident #32's bathroom were not working properly and stated, I will put in a work order for that.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on observation and staff interview, the facility failed to ensure it notified the Ombudsman of discharges/transfers. This was true for three (3) of seven (7) residents.Resident Identifiers: #72, #71,and #68. Facility Census: 65. a) Resident #72 09/10/2025 8:54 AM record review revealed Resident #72 was discharged to another skilled nursing facility on 08/02/24. The review of this discharge revealed no evidence that the Ombudsman was not notified of Resident #72's discharge. This was discussed with Employee #89. b) Resident #71 On 09/09/25 at 9:10 PM Resident #71 a review of the discharge record found no evidence that the Ombudsman had been notified of the discharge. c) Resident #68 A review of the discharge record on 09/04/25 at 11:21 AM found Resident #68 had been transferred to a local hospital and was discharged from the facility on 08/04/25. The family requested the discharge so that Resident #68 could be closer to family. There was no evidence that the Ombudsman had been notified. An interview with the Nursing Home Administrator (NHA) and the Social Worker (SW) on 09/04/25 at 12:12 PM, revealed they were not aware that the Ombudsman was to be notified of discharges/transfers. The Ombudsman had not been notified of any discharges/transfers. The facility was now going to send a monthly list to the Ombudsman.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed follow the menus by not serving the correct serving sizes per the dietary guide sheet, not serving the residents large portions as ordered by the physician and serving items listed on the tray card not to serve. Resident Identifiers: #36, #61, #53, #4 and #21. Facility Census: 65. Findings included: a) On 09/03/2025 at 11:50 AM, [NAME] #59 was serving/plating the lunch meal. The menu consisted of Chicken and Cheese Quesadillas, Gelatin Cubes, Cilantro [NAME] 1/2 cup and Fiesta Corn 1/2 cup. Mashed Potatoes and Fajita Vegetable Miz - 1/2 cup were confirmed by Dining Director # 67. The following items were served with less than full scoops and then were not emptied all the way onto the plate. Serving sizes were less than stated on facility's Diet Guide Sheet for meal service for corn, mashed potatoes, rice and fajita mix. Whole scoops were not utilized, which was confirmed by the Regulatory Compliance Officer and Administrator # 90. The Regulatory Compliance Officer instructed the staff to make sure scoops are filled all the way and emptied all the way. Further observation during the dining service process revealed, pureed rice and pureed meat scoops were not filled. No consistent scoop size with -1//2 scoops or two (2) scoops used at times. At 12:02 PM, the state surveyor consulted with Administrator #90 and the Regulatory Compliance Officer and confirmed the inconsistent scoops sizes and stated , She's still not filling them. At 12:14 PM , Administer #90 attempted to re-direct/educate [NAME] #59 [NAME] to make sure the scoops were filled to the top prior to serving. b) Resident #36 On 9/20 2025, during the initial interview process, Resident #36 was observed receiving his dinner tray. permission was given to review the resident's tray card. The resident's tray card listed the following items: Large Portions Herb Roasted chicken 2 each Dinner Roll - 2 each Banana pudding w/ Whipped Topping Squash Medley - 3/4 cup 2% milk - 8 Oz The resident received the following items: One (1) piece of Herb Roasted Chicken (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One (1) Dinner Roll No whipped topping on banana pudding Three half pieces of squash medley No milk on tray On 09/02/2025 at 05:35 PM, Nursing Assistant (NA) #12 confirmed the resident did not receive large portions and stated, I'll let the kitchen know he didn't get double portions. Resident #36's diet order stated, Regular/Liberalized diet Regular Texture, Standard Thin Liquids consistency, large portions all meals. On 09/08/2025, the following residents were ordered to have large portions and their tray cards stated Large Portions : Residents # 61, #53 and #4. c) Resident #61 Resident #61 did not receive 1 and 1/2 chicken sandwiches on a bun per tray card. Registered Nurse (RN) #9 confirmed the resident did not receive his large portion and stated, We noticed that. and we are getting him a second one. d) Resident #4 Resident #4 did not receive 1 and 1/2 chicken sandwiches on a bun per tray card. RN #9 confirmed the resident did not receive his large portion. e) Resident #53 Resident #53's tray card stated, Large Portions, x2 mash, L&D (lunch and dinner). The resident did not receive 1 and 1/2 chicken sandwiches or two (2) portions of mashed potatoes which was confirmed by Nursing Assistant (NA) #41. f) Resident #21 An observation on 09/02/2025 at 12:40 PM, revealed Resident #21 eating lunch in the dining area. Resident had an empty carton of milk sitting in front of her. Resident had a meal ticket that read, No Milk in bold letters at the top. During an interview 09/02/25 at12:42 PM, Nursing Assistant (NA) #28 confirmed that Resident #21 had drank the carton of milk and that the meal ticket read, No milk. NA #28 further stated, She likes it, she always drinks it all. A record review on 09/02/25 at 2:40 PM, revealed a diet order for Resident #21 that reads as follows: Regular/Liberalized-puree, No Milk.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview and record review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 65. Findings included: a) The facility's policy and procedure for dry food storage stated, 2.3 Food stock is dated on the day of receipt. Items that are removed from the original box are individually dated. 2.6 Open packages are stored in closed containers, tightly secured with ties or in a food quality storage bags and include the use by date. The facility's policy and procedure for Refrigerated/Frozen Storage stated, 1.4 All foods are labeled with the name of the product and the date received and use by date once opened. Manufacturer use by dates are used until opened. 1.5 Prepared foods are labeled and dated with the name of the product, date opened, and use by date. Dining District Manager #74 stated for food storage, Typically seven (7) days. Drinks on the floor - three (3) days. Sandwiches - three (3) days. The kitchen investigation was initiated on 09/02/2025 at 11:15 AM. The following items were found: 1. Tortilla Strips - opened and not dated. Dining District Manager #74 stated, I'll go ahead and get rid of those.2. A carton of United whole milk - not dated.3. Hard boiled eggs - opened not labeled. On 09/03/2025 at 03:30 PM, the Nourishment Center for 100-300 Halls was investigated with the following items found: 1. Gold 'N Sweet whipped spread - No open date and no use by date - four (4) individual containers in a plastic cup.2 Thirty-six (36) [NAME] individual cups/containers of apple juice - No open or use by dates. These items were confirmed by Nurse Practice Educator (NPE) #33 at 03:40 PM. NPE #33 stated, I don't know why they're in here. - referring to the plastic cup of butter. On 09/03/2025 at 03:42 PM, the Nourishment Center for 200-400 Halls was investigated with the following items found: 1. Loaf of bread - opened, not sealed and not labeled.2. Eighteen (18) individual cups/containers of apple juice - No open or use by date. These items were confirmed by Licensed Practical Nurse (LPN) #329 at 03:46 PM. On 09/03/2025 at 11:25 AM, Dining Director #72 was preparing/cooking quesadillas for the lunch meal with no beard covering. Dining District Manager #74 confirmed Dining Director #72 did not have a beard covering on and instructed the staff member to put one on. Dining Director #72 wore a mask for the rest of the cooking, preparation and meal service.

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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, staff interview and record review the facility failed to maintain an infection prevention program to provide a safe, sanitary and comfortable environment to help prevent the transmission of infections. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Resident identifier #43. Facility Census 65.a) Laundry On 09/09/25 at 2:45 PM a tour of the facility laundry was conducted with the Regulatory Compliance Advisor (RCO) and the Laundry Supervisor. A basket full of clean socks was found stored on the floor in the clean laundry. The Laundry Supervisor was asked if the clean socks were stored to prevent contamination, he responded No. In the soiled laundry, there were three (3) open bags of soiled laundry on the floor. The Laundry Supervisor stated he had put those there as they needed an empty barrel on the unit. When asked if the bags were stored properly, he stated No. b) Resident #43 An observation on 09/09/25 at 12:08 PM, revealed a sign on Resident #43's door for contact precautions that stated the resident could not come out of the room. The sign also stated the following: Wash hands with soap and water before and after patient contact, contact with environment and after removal of PPE. Wear gloves upon entering this room; remove prior to exiting and discard. Wear gowns upon entering this room; remove prior to exiting and bag before leaving this room. Please do not remove dedicated or single use disposable equipment from this room. When dedicated equipment is not possible, disinfect shared patient equipment with EPA approved sporicidal. Further observation showed A Nursing Assistant (NA) delivering Resident #43 his lunch tray. The NA went into the room and set up residents tray without putting on Personal Protective Equipment (PPE). During an interview 09/09/25 at 12:09 PM, The Director of Nursing (DON) stated, He is on contact precautions for C-Diff. The DON confirmed that Resident #43 is on Contact Precautions for Clostridium Difficile (C-Diff) and that the NA went into his room without following the precautions. A record review on 09/09/25 at 1:45 PM, confirmed the C- DIFF diagnosis and the Contact Precautions for Resident #43.

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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 observation and staff interview, the facility failed to ensure a updated Pre-admission Screening and Resident Review (PASARR) was completed for a resident with a new diagnosis of Bipolar Disorder. Resident Identifier: #11. Facility Census: 65. Findings included: On 09/03/2025 at 12:41 PM, Resident #11's PASARR was reviewed. The resident's PASRR was completed on 02/19/2025 and did not include Bipolar Disorder. The diagnosis of Bipolar Disorder was added to the resident's diagnosis list on 03/12/2025. The resident's PASARR was not updated to reflect the new diagnosis. On 09/09/2025 at 01:26 PM, the Director of Nursing (DON) confirmed their was no diagnosis of Bipolar Disorder on the resident's PASARR and and stated, I will get a new one started.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, resident interview and staff interview, the facility failed to ensure a resident with limited Activities of Daily Living (ADL) ability was provided the necessary services to maintain grooming by assisting with facial hair removal. This was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident identifier: #36. Facility Census: 65. a) Resident #36On 09/02/25 at 5:42 PM, the state surveyor observed facial hair on Resident # 36 during the initial survey interview process. The patient reported he did not want the facial hair and stated, I want it shaved. and They need to do it. Nursing Assistant #12 confirmed the resident's facial hair growth and stated she would get it shaved.09/09/25 at 8:45 AM, the resident was observed to still have facial hair. The state surveyor asked the resident if they had shaved him and the resident replied, A long time ago. and You can see it. Licensed Practical Nurse #37 confirmed the resident's facial hair.

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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 observation, record review, and staff interview the facility failed to provide care and services in accordance with professional standards of practice by not putting in physician orders timely related to skin issues. This failed practice was found true for (1) one (3) residents reviewed for general skin issues during the Long-Term Care Survey Process. Resident identifier #8. Facility Census 65. Findings include: a) Resident #8The initial observation on 09/02/25 at 2:00 PM, revealed a bandage to Resident #8's right arm dated 09/01.Further observation on 09/03/25 at 2:00 PM, revealed a bandage to Resident #8's right arm dated 09/01.An observation on 09/04/25 at 10:00 AM, revealed a bandage to Resident #8's right arm dated 09/01.A record review on 09/04/25 at 10:30 AM, found no mention of the bandage to right arm in the medical record for Resident #8. During an interview, on 09/04/2025 at 10:40 AM, the Director of Nursing (DON) stated, So the nurse on Monday discovered skin tears. I just talked to him, and he said that he got a skin tear from scratching his arm on the bed. He called the doctor and got an order but forgot to put it in. We are getting it assessed right now and getting pictures.A record review on 09/04/25 at 11:00 AM, revealed a nurse's note dated 09/04/25 at 10:45 AM that reads as follows:Reviewed with nurse for 9/1. Resident had scratched himself on his right forearm and obtained an order to cleanse an apply an Opti foam dressing for one time only. Nurse failed order entry. SHTL in for revaluation. Verified with Provider. Wife present at facility and aware.