STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515102	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkersburg Center	1716 Gihon Road Parkersburg, WV 26101

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to provide a safe, clean, comfortable homelike environment. These failed practice findings were random acts of discovery. Room Identifiers: #225, #226, #229 and #222. Facility Census: #63Findings Include: a) Room # 225 On 12/07/25 at 11:40 AM upon the initial observations and interview the window blinds by Resident #60 were found to be broken and missing. b) room [ROOM NUMBER] On 12/07/25 at 11:45 AM upon the initial observations and interview the privacy curtain by Resident #1 was found to be dirty with a dark brown substance. c) room [ROOM NUMBER] On 12/07/25 at 12:05 PM upon the initial observations and interview the floor at the head of the bed (under the pole holding the tube feeding) for Resident #9 was dirty. There were sticky, dirty spots on the floor where the feeding appeared to have leaked or spilled and the entire floor was dirty and had a sticky substance on it. The above findings were confirmed with the Environmental Services Manager #78 on 12/07/25 at 12:08 PM and the Administrator on 12/07/25 at 3:10 PM at which time they both agreed the items listed above needed attention. d) Resident #36 On 12/07/2025 at 02:10 PM, during the initial resident interview, Resident #36 reported her floor was dirty and the wall was dirty behind her bed and needed painted. The resident also reported the there was no baseboard replaced in her bathroom and that the paint job was poor. The state surveyor observed the dirty walls, dirty floor and baseboard missing in the bathroom behind the toilet and around the vanity. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/08/2025 at 10:15 AM, the Regulatory Compliance Officer accompanied the state surveyor to the resident's room and verified the dirty wall, scuffmarks and missing paint on the wall. The resident's floor had been cleaned. The missing baseboard in the bathroom behind the toilet and around the vanity was verified at 12:40 PM. On 12/08/2025 at 10:45 PM, the facility reported they were looking for documentation the resident was in the toilet using her phone and they were unable to replace baseboard. A Facility Work Order created on 11/14/2025 was reviewed and it stated on 11/24: Baseboard applied.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on staff interviews, resident interviews, and record reviews, the facility failed to ensure residents were free from abuse and/or neglect by refusing to toilet/Change residents and treating a resident who had a fall that resulted an facture. This failed practice was found true during the long-term care survey process and had the potential to affect more than a minimal number of residents residing in the long-term care facility. Resident Identifier #21, #66, and #50. Facility Census: 63.Findings include: a) Resident #21 Record review completed on12/08/25 2:15 PM of a reported incident (FRI) was reviewed and found to be true according to the credible evidence provided by the facility. As written on the five (5) day follow up – The resident reported that she is able to get up and walk to the bathroom but CNA's tell her to just soil her brief. It was reported to APS, OHFLAC, and Ombudsman. Skin check was completed on 10/25/25. On October 23, 2025 (Facility name here) Care Center reported an allegation of neglect for Resident #21. (resident name here) alleges that Certified Nursing Assistant (CNA's) {as written} told her to soil her brief, even though she is capable of going to the toilet. (resident name here) was given a skin check with no new negative outcomes noted. Allegation of neglect was reported to OHFLAC, APS, and the Ombudsman. (Resident name here) is a long term care patient who was admitted to(Facility name here) Care Center on June 27 2023. She is alert and oriented but does not have capacity to make her own medical decisions; BIMS of 13. (Resident name here) has a diagnosis of aftercare following joint replacement surgery, right artificial knee joint, obesity, muscle weakness, type 2 diabetes, afib, repeated falls, cognitive communication deficit, polyneuropathy, Ogilvie syndrome, foot droop, difficulty in walking, anxiety disorder, major depressive disorder, irritable bowel syndrome, and age-related osteoporosis. She is a part assist of one using stand with pivot for transfers and a total assist of one or two for toileting. Certified Nursing Assistants were interviewed by Nursing Home Administrator/Designee regarding allegations with CNAs reporting they have not made those statements or head (as written) another CNA tell a resident to soil his/her brief. All residents within the facility with a BIMS of 8 or higher were interviewed with corrective action immediately upon discovery of any additional concerns. Skin checks were completed of all current residents with a BIMS of 7 or lower with no new skin concerns identified. When interviewed, (resident's name here Resident #21)stated that she can't recall when this happened who made the statement but knows it has happened in the past. (residents name here) has been referred to Dr. Office name here) Health for any emotional distress. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allegation of neglect is substantiated. Residents' statements consistently remained the same. Residents were unable to recall details, and staff did not indicate any concerns, so they were unable to determine when and/or which staff member. On 12/09/25 at approximately 3:00 PM then Administrator stated this FRI was verified but could not pinpoint which staff said it due to residents not being able to recall what the staff member looked like or when they said it. b) Resident #66 Record review completed on 12/10/2025 at 9:38 AM of a facility reported incident (FRI) was reviewed and found to be true according to the credible evidence provided by the facility. As written on the five (5) day follow up – To whom it concerns: While conducting an investigation into an injury of unknown origin regarding the long-term care facility resident #66, a Certified Nursing Assistant (CNA) reported that she had previously been notified in report resident #66 had sustained a fall on 2/28/2024. Resident #66's roommate, who is alert and oriented, also confirmed that he had a fall on 2/28/24 and a nurse and CNA placed resident #66 back into his bed. Review of resident #66 medical record showed no documentation of a fall on 2/28/24, no neuro-checks, and no treatment or follow-up. His nurse on duty at the time, Registered Nurse (RN) #110, has since submitted and completed her resignation, and this allegation of neglect was reported to the [NAME] Virginia Board of Registered Nurses. She has declined to return phone calls when attempting to contact her for a statement. Resident #66 returned to (facility name her) care center on 3/14/24 with new Thoracic-Lumbar-Sacral Orthosis {a rigid spinal brace, often plastic, that supports the mid-back (thoracic) down to the lower back (sacral)} in place, as well as Vancomycin (antibiotic for infections) HCl Intravenous Solution 500 MG/100ML one time a day for left hip infection until 04/20/2024. He is to follow up with (Dr office name here) Orthopedics on 4/1/2024 and (Dr. name here), Hematologist, on 4/2/2024. Resident #66 lacks medical decision-making capacity related to Alzheimer's disease and dementia diagnoses. He was unable to recall to (hospital name here) Medical Center staff if he had a recent fall or injury. He also has diagnosis of osteoporosis. On 12/10/2025 at11:04 AM At 11:03 am this allegation of neglect was verified by the administrator. Who stated Yes, this reportable was verified. c) Policy Record review of the facilities Abuse Prohibition Policy and Procedure reads in part as follows. {as written in policy} (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Manual title: Center operations policies and procedures Policy Title: Abuse Prohibition Effective date: 02/23/21 Review Date: 02/23/21 Policy: HealthCare Centers prohibit abuse, mistreatment, neglect, misappropriation of residents property, and exploitation for all residents. This includes, but not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patients medical symptoms. The Center Executive Director, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, and involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property. The notified supervisor will report the suspected abuse immediately to the Center Executive Director (CED) or designee and other officials in accordance with state law. If the patient/resident sustains serious bodily injury, the employee who forms the suspicion ir witnesses the incident must report no later than two (2) hours after forming the suspicion. Whether abuse or neglect occurred and to what extent; Clinical examination for signs of injuries, if indicated; causative factors; and Interventions to prevent further injury. The investigation will be thoroughly documented. Ensure that the documentation if witnessed interviews included. Report findings of all completed investigations within five (5) working days to the Licensing District Office. During the Facility Reportable Incident (FRI) investigation dated 09/23/25 on 12/09/25, it was determined that the allegation of neglect based on a thorough investigation performed by the facility was verified for Resident #50. Interview on 12/09/25 at approximately 4:00 p.m. with the facility Administrator verified the finding of neglect related to the FRI for Resident #50.

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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 ensure all alleged violations involving verbal abuse are reported immediately, but not later than 2 hours after the allegation is made. This failed practice has the potential to affect more than a minimal number of residents residing in the long-term care facility. Resident identifier: #35 Facility census: 63. Findings include:Review on 12/10/25 of a Facility Reported Incident (FRI) revealed the Initial Reporting of Allegations for verbal abuse which should be reported immediately or within two (2) hours had a date and time of 12/18/25 12:00 AM.Further record review of the FRI revealed there no fax or email confirmation of when the incident was reported.Continued record review on 12/10/25 revealed the incident happened on 11/18/25 according to some immediately witness statements taken, however no time of incident was noted in that statement. Other witness statements taken were on 11/25/25 and 11/26/25 which were 6 days after the allegation of verbal abuse was made.During an interview on 12/10/25 at 4:24 PM with the Regulatory Compliance Advisor (RCA) the RCA confirmed there was no fax or email confirmation of date and time the FRI was sent.Further information and email/fax confirmation were requested from the facility administrator on 12/10/25 at approximately 4:30 PM, and no other information was provided to this surveyor.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on observations, interviews, and document reviews, the facility failed to thoroughly investigate reportable incidents and report the results of those investigations to the State Agency within five (5) working days of the incident and if the alleged violation was verified include the appropriate corrective action taken. This was found to be true for eight (8) of nine (9) residents reviewed during the long term care survey process. Resident identifiers: #6, #14, #15, #24, #35, #39, #56, #57, and #68. Facility census: 63. a) Resident #15 During the survey process between 12/07/25 through 12/10/25, reviewed the facility reported incident (FRI) documents from 11/03/25 regarding Resident #15. There were no documentation readily available of staff interviews conducted during the investigation. There were no documentation readily available to demonstrated that the facility submitted a five (5) day follow up investigation report to the State Agency. These findings were verified with the facility Administrator on 12/09/25 at approximately 12:30 p.m. b) Resident #39 During the survey process between 12/07/25 through 12/10/25, reviewed the facility reported incident (FRI) documents from 10/23/25 regarding Resident #39. There were no documentation readily available of staff and resident interviews conducted during the investigation. This finding were verified with the facility Administrator on 12/09/25 at approximately 12:30 p.m. c) Resident #67 During the survey process between 12/07/25 through 12/10/25, reviewed the facility reported incident (FRI) documents from 0727/23 regarding Resident #67. There were no documentation readily available of where staff completed education on how to properly handle emergency situations. This finding was verified with the facility Administrator on 12/09/25 at approximately 12:30 p.m. d) Resident #35 On 12/10/2025 at 2:58 PM, a review of Resident #35 facility's incident investigation records revealed residents were asked the following questions: Have you ever heard a resident use derogatory terms toward you? Have you ever received threats of harm from a resident? Have you ever had a resident yell at you? Further record review indicated Resident #56 answered Yes to the question, Have you ever had a resident yell at you? stating, Happens all the time from (residents name here). e) Resident #3 Continued record review revealed Resident #3 also answered Yes to the question, Have you ever received threats of harm from a resident? stating, Once a long time ago from (resident name here). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation to demonstrate that these responses were investigated or that any follow-up actions were taken. An interview with the Regulatory Compliance Advisor on 12/10/25 at around 4:25 PM who confirmed there were no documentation showing further investigating were completed for Resident #3 and #56 for answering Yes on the questioner. The administrator was asked to provide the email or fax for the five day follow up on 12/10/2025 at approximately 4:30 PM. No other information provided. f) Resident #24 The facility self reported an incident of resident to resident abuse involving Resident #24 and Resident #74 on 10/19/24. The incident involved Resident #24 rolling in his wheelchair into the dining room where he pulled up to sit next to Resident #74. Resident #24 then proceeded to grab the breast of Resident #74. g) Resident #74 Resident #74 told him to stop, and then smacked his hand away. Shortly afterwards, she reported the incident to facility staff. The residents were immediately separated. Resident #24 was taken back to his room and placed on 1:1 supervision. Staff performed a skin assessment on Resident #74, and found no findings of bruising or skin issues. Witness statements were obtained from all the parties involved, as well as other residents who were sitting in the dining room at the time of the incident. The incident was reported to the WV Office of Health Facility and Licensure (OHFLAC), the WV Office of the Ombudsman, and Adult Protective Services on 10/19/24. Upon review of the facility reported incident, no five day follow up report was submitted to the above offices as required, outlining their investigation, findings, and any action taken on the concern. During an interview with the interim Director of Nursing (DoN) when asked to see the five day follow-up report, she stated on 12/08/25 at approximately 1:38 PM, the five day follow-up report could not be found

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record reviews, staff interviews, resident interviews, and observations, the facility failed to ensure Activities of Daily Living (ADLs) and care were provided to dependent residents for showers, oral care and grooming. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Resident identifiers: #28, #56, #23. Facility Census: 63.Findings included: a) Resident #28 The facility's policy and procedure for Oral Health stated, Oral hygiene will be performed, at a minimum, two (2) times per day (morning and night - after dinner, if possible). The facility's policy and procedure for Activities of Daily Living (ADLs) stated a patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. Resident #28 had a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side. The resident's care plan interventions started to provide resident with dependent assist of one (1) to two (2) for bathing and to provide assist of one (1) for personal hygiene (grooming). The resident had a history of refusal of having her teeth and hair brushed by staff per the care plan focus. Review of the Oral Care Task for the past thirty (30) days documentation revealed oral care had not been provided for Resident #28 two (2) times a day per the policy and procedure on the following dates: 11/11/2025, 11/13/2025, 11/17/2025, 11/20/2025, 11/21/2025, 11/25/2025, 11/29/2025, 11/30/2025, and 12/01/2025 (refusal x2 days 11/17/2025 and 11/21/2025). The resident's shower schedule was for Tuesday on Night Shift and Friday' on Day Shift. The resident had received no showers for the past thirty (30) days. No refusals of bd baths or showers were documented. Review of the resident's showers and bed bath task documentation: for the past thirty (30) days revealed the following: No showers or bed baths on the following scheduled shower days - 11/18/2025 11/21/2025 12/05/2025 12/09/2025 On 12/10/25 at 10:35 AM, the task documentation for Resident #28's showers and oral care were reviewed and verified by the Regulatory Compliance Officer. b) Resident # 56 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the resident on 12/07/25 at approximately 1:20 PM, the resident stated, I am tired of always getting a bed or sponge bath. I want to shower! A review of the resident's care plan documents revealed the resident required assistance of one (1) to two (2) staff for bathing and required the assistance of two (2) staff for mechanical lift. Under interventions, the care plan read It is important for me to choose between a tub bath, shower, bed bath or sponge bath. I prefer showers. Date initiated: 09/29/25 An observation of the resident found hair on head to be uncombed, significant facial hair appeared on her upper lip line and at chin level. Facial hair was approximately 1/4 - 1/2 inch. During the interview with the resident, she was questioned about her preference for her facial hair. She responded that she wanted it removed, but that staff did not bother to help her. The resident's current Medical Diagnostic Screening (MDS) assessment documents the following response to this question: How important is it to you to choose between a tub bath, shower, bed bath or sponge bath?Response was : Very important. A review of the facility's shower schedule documents resident is supposed to receive a shower on Mondays and Thursdays on day shift. The documentation in the medical record for showers was requested from the facility for the past two (2) months of showering. The results were: 10/1/25 Wednesday at 11:59 AM bed bath/sponge provided10/2/25 - 10/09/25 no bath or showers documented (one week span)10/10/25 Friday at 2:59 PM bed bath/sponge provided10/11/25-10/13/25 no bath or showers documented10/14/25 Tuesday at 11:17 AM shower provided10/15/25 - 10/31/25 no bath or showers documented11/01/25 Saturday at 12:59 PM bed bath/sponge provided11/02/25 no bath or shower documented11/03/25 Monday at 2:59 PM bed bath/sponge provided11/04/25 Tuesday at 10:20 AM bed bath/sponge provided11/05/25 - 11/06/25 no bath or shower documented11/07/25 Friday at 10:56 AM bed bath/sponge provided11/08/25 - 11/24/25 no bath or shower documented (> two week span)11/25/25 Tuesday at 10:40 AM bed bath/sponge provided11/26/25 Wednesday at 10:46 AM bed bath/sponge provided11/27/25 Thursday at 10:36 AM bed bath/sponge provided11/28/25 - 11/29/25 no bath or showers documented11/30/25 Sunday at 12:57 PM bed bath/sponge provided12/01/25 - 12/08/25 no bath or showers documented (> one week span)12/09/25 Tuesday @ 2:59 PM bed bath/sponge provided The facility's Regional Compliance Advisor was asked about why residents' choices were not being honored as it related to bathing and hygiene on 12/09/25 during the afternoon. He responded by saying I do not really know. Another observation was made of the resident on 12/09/2025 @ 2:00 PM, and the resident's hair had not been combed. Her facial hair was still present. On 12/10/25 at approximately 2:30 PM, a surveyor was approached by this resident, who appeared visibly distressed and was crying. The resident stated that she could not recall the last time she had received a shower and reported that she was only receiving bed baths. The resident further expressed concern that her hygiene needs were not being fully met and stated she required more thorough washing than what she had been receiving. This concern was reported immediately to the Administrator. During an interview, the Administrator stated that the resident was unable to fit through the shower room doors. Interviews with Occupational Therapy (OT) and the Physical Therapy Assistant (PTA) revealed that the resident exceeded the weight limit for the available shower chair and, as a result, could not receive a shower at the facility. The resident was subsequently transported to a nearby facility, where she received a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Staff #27 on 12/09/25 at approximately 4:00 PM, Staff #27 stated the facility was going to expand the entry way into the 100 Hallway shower room to allow Resident #56 to enter the area. Staff #27 was asked why they need to expand the doorway. Staff #27 replied To allow Resident #56 to get in the shower room safely and with dignity. c) Resident #23 On 12/07/25 at 12:40 AM during the initial interview process Resident #23 stated he does not get his shower/baths as scheduled. He states he prefers a bed bath. According to the shower/bath schedule reviewed on 12/08/25 at 2:10 PM which was provided by the facility, Resident #23 is scheduled for a shower/bath Sunday and Wednesday on day shift. Review of the care plan shows the resident requires assistance for ADL care in bathing, grooming, personal hygiene, dressing and eating. It also states an intervention is to provide resident with extensive assist of 1 for bathing. The care plan states the resident has vision impairment related to: Diagnosed blindness in both eyes. According to the task for the last 30 days for bathing Resident #23 received a bath/shower four (4) out of nine (9) scheduled baths/showers. Resident #23 was scheduled and received baths on the following dates during the last 30 days: due received 11/9/25 yes 11/12/25 no 11/16/25 no 11/19/25 yes 11/23/25 no 11/26/25 yes 11/30/25 no 12/3/25 no 12/7/25 no but did on 6tth The above information was confirmed with the Administrator on 12/08/25 at 3:20 PM, at which time she agreed the showers/baths were not sufficient.

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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 observations, record review and interview the facility failed to treat a fall for Resident #66 and failed to administer medications in a timely manner as ordered by the physician for Resident #9. These failed practices were random opportunities for discovery during the long term care survey process and had the potential to affect more than a minimal number of residents residing in the long term care facility. Resident identifier #66 and #9 Facility census: 63 Findings include: a) Resident #66 Record review completed on 12/10/25 at 9:38 AM of a facility reported incident (FRI) revealed the facility substantiated that a resident was neglected. As written on the five (5) day follow up – To whom it concerns: While conducting an investigation into an injury of unknown origin regarding the long-term care facility Resident #66, a Certified Nursing Assistant (CNA) reported that she had previously been notified in report resident #66 had sustained a fall on 2/28/2024. Resident #66's roommate, who is alert and oriented, also confirmed that he had a fall on 2/28/24 and a nurse and CNA placed Resident #66 back into his bed. Review of Resident #66's medical record showed no documentation of a fall on 02/28/24, no neuro-checks, and no treatment or follow-up. His nurse on duty at the time, Registered Nurse (RN) #110, has since submitted and completed her resignation, and this allegation of neglect was reported to the [NAME] Virginia Board of Registered Nurses. She has declined to return phone calls when attempting to contact her for a statement. Resident #66 returned to care center on 3/14/24 with new Thoracic-Lumbar-Sacral Orthosis {a rigid spinal brace, often plastic, that supports the mid-back (thoracic) down to the lower back (sacral)} in place, as well as Vancomycin (antibiotic for infections) HCl Intravenous Solution 500 MG/100ML one time a day for left hip infection until 04/20/2024. He is to follow up with (Dr office name here) Orthopedics on 4/1/2024 and (Dr. name here), Hematologist, on 4/2/2024. Resident #66 lacks medical decision-making capacity related to Alzheimer's disease and dementia diagnoses. He was unable to recall to (hospital name here) Medical Center staff if he had a recent fall or injury. He also has diagnosis of osteoporosis. On 12/10/2025 at11:04 AM At 11:03 am the administrator confirmed the fall was not treated at the time the fall occurred. b) Resident #9 On 12/09/25 at 3:01 PM record review shows the following orders were missed during November and December 2025 up to this date according to the Medication Administration Audit Report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515102	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkersburg Center	1716 Gihon Road Parkersburg, WV 26101

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Missed orders for November 2025: 11/12/25 6:00 PM: Nasal Spray Solution (oxymetazoline HCL) 2 spray alternating nostrils two times a day for nasal congestion Urea Oral Packet 15 grams (urea Dietary Management) Give 15 grams via PEG tube two times (2) a day for hyponatremia Famotidine Oral Tablet 20 MG (Famotidine) Give 1 tablet via PEG tube two times a day for Gerd Levetiracetam Oral Solution 500 mg/5ml (Levetiracetam) Give 2.5 ml via PEG tube every 12 hours for seizures Flush g-tube with 75 ML of water every 6 hours related to decreased sodium, this provides an additional 300 ml of water every 6 hours 11/24/25 7:00 AM Cleanse buttocks with soap and water, apply Z-guard every shift and as needed every day and night shift. Tracheostomy care every day and night shift Apply skin prep to bilateral medical/lateral ankles every day and night shift for prevention Continuous Humidification per compressor while in bed, change humidification as needed every day and night shift Encourage/assist resident to float heels while in bed as resident will allow every day and night shift Encourage/Assist resident to turn and reposition frequently while in bed as resident will allow every day and night shift Low air loss Mattress. Check placement and function every shift every day and night shift. 11/28/25 7:00 AM Low air loss Mattress. Check placement and function every shift every day and night shift. Keep head of bed elevated at 30-45 degrees at all times while tube feed is running. Pause tube feeding while performing ADL care and wound care as needed every day and night shift. Enteral Feed: Check for gastric residual volume (GRV) every shift and as needed every day and night shift if 500 ml or over, hold feeding for one hour and recheck. If residual is 250 ml or over (upon recheck) hold feeding, notify Physician and document amount in ml. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encourage/Assist resident to turn and reposition frequently while in bed as resident will allow every day and night shift Encourage/assist resident to float heels while in bed as resident will allow every day and night shift Ask resident if they are having pain. Document pain level and new onset Y/N in supplementary documentation and document location of pain in emar every day and night shift. If new onset complete E-interact Change in Condition and Pain Evaluation. If not new initiate non-pharmalogical interventions and document interventions and effectiveness. Does the patient need to have the head of bed elevated to avoid shortness of breath while lying flat? Every day and night shift. Mouth Care to be performed every shift and as needed every day and night shift Placement and tube length in CM baseline length 44 CM every day and night shift. Check tube for proper placement prior to each feeding, flush, or medication administration by measuring the length of the tube No brief in bed every day and night shift Continuous Humidification per compressor while in bed, change humidification as needed every day and night shift Cleanse buttocks with soap and water, apply Z-guard every shift and as needed every day and night shift. Tracheostomy care every day and night shift Apply skin prep to bilateral medical/lateral ankles every day and night shift for prevention Total Nutrients: Osmolite 1.5 at 65 ml/hr X 20 hours. Provides 1300 ml volume, 1949 Kcals, 82 g PRO and 990 ml free fluid. Flush with 75 ml of water every 6 hours to provide additional 300 ml of water. Total free fluid 1290 ml. Down time between 1000-1400 daily every shift. 11/28/25 11:00 AM Prosource TF oral liquid (Nutritional Supplement) Give 45 ml via PEG tube four times a day for protein. 11/28/25 11:30 AM Check BP QID four times a day for follow up 11/28/25 12:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Flush g-tube with 75 ML of water every 6 hours related to decreased sodium, this provides an additional 300 ml of water every 6 hours 11/28/25 2:00 PM Sodium Chloride Oral Tablet 1 GM (Sodium Chloride) Give 1 tablet via G-tube three times a day for supplement Glycopyrrolate Oral Tablet 1 MG Give 1 tablet via PEG tube three times a day for interstitial pulmonary disease Baclofen oral Tablet 10 MG Give 1 tablet via PEG tube three times a day for muscle spasms. 11/28/25 3:00 PM Total Nutrients: Osmolite 1.5 at 65 ml/hr X 20 hours. Provides 1300 ml volume, 1949 Kcals, 82 g PRO and 990 ml free fluid. Flush with 75 ml of water every 6 hours to provide additional 300 ml of water. Total free fluid 1290 ml. Down time between 1000-1400 daily every shift. 11/28/25 4:00 PM Prosource TF oral liquid (Nutritional Supplement) Give 45 ml via PEG tube four times a day for protein 11/28/25 4:30 PM Check BP QID four times a day for follow up 11/28/25 6:00 PM Levetiracetam Oral Solution 500 mg/5ml (Levetiracetam) Give 2.5 ml via PEG tube every 12 hours for seizures Nasal Spray Solution (oxymetazoline HCL) 2 spray alternating nostrils two times a day for nasal congestion Urea Oral Packet 15 grams (urea Dietary Management) Give 15 grams via PEG tube two times a day for hyponatremia Famotidine Oral Tablet 20 MG (Famotidine) Give 1 tablet via PEG tube two times a day for gerd Flush g-tube with 75 ML of water every 6 hours related to decreased sodium, this provides an additional 300 ml of water every 6 hours Night 7:00 PM-7:00 AM Shift 11/03/25 9:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Check BP QID four times a day for follow up 11/03/25 10:00 PM Glycopyrrolate Oral Tablet 1 MG Give 1 tablet via PEG tube three times a day for interstitial pulmonary disease Baclofen oral Tablet 10 MG Give 1 tablet via PEG tube three times a day for muscle spasms. 11/05/25 7:00 PM Continuous Humidification per compressor while in bed, change humidification as needed every day and night shift Tracheostomy care every day and night shift Apply skin prep to bilateral medical/lateral ankles every day and night shift for prevention Enteral Feed: Cleanse site daily with soap and water and apply dry dressing daily every night shift. Cleanse buttocks with soap and water, apply Zguard every shift and as needed every day and night shift. Encourage/Assist resident to turn and reposition frequently while in bed as resident will allow every day and night shift Encourage/assist resident to float heels while in bed as resident will allow every day and night shift Low air loss Mattress. Check placement and function every shift every day and night shift. 11/09/25 7:00 PM Low air loss Mattress. Check placement and function every shift every day and night shift. Continuous Humidification per compressor while in bed, change humidification as needed every day and night shift Tracheostomy care every day and night shift Apply skin prep to bilateral medical/lateral ankles every day and night shift for prevention Enteral Feed: Cleanse site daily with soap and water and apply dry dressing daily every night shift. Cleanse buttocks with soap and water, apply Z-guard every shift and as needed every day and night shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encourage/Assist resident to turn and reposition frequently while in bed as resident will allow every day and night shift Encourage/assist resident to float heels while in bed as resident will allow every day and night shift 11/10/25 6:30 AM Check BP QID, four times a day for follow up 11/15/25 6:30 AM Check BP QID, four times a day for follow up 11/15/25 7:00 PM Encourage/Assist resident to turn and reposition frequently while in bed as resident will allow every day and night shift Encourage/assist resident to float heels while in bed as resident will allow every day and night shift Low air loss Mattress. Check placement and function every shift every day and night shift. Continuous Humidification per compressor while in bed, change humidification as needed every day and night shift Tracheostomy care every day and night shift Apply skin prep to bilateral medical/lateral ankles every day and night shift for prevention Enteral Feed: Cleanse site daily with soap and water and apply dry dressing daily every night shift. Cleanse buttocks with soap and water, apply Z-guard every shift and as needed every day and night shift. Missed orders for December 2025: 12/01/25 7:00 AM Encourage/Assist resident to turn and reposition frequently while in bed as resident will allow every day and night shift Encourage/assist resident to float heels while in bed as resident will allow every day and night shift Low air loss Mattress. Check placement and function every shift every day and night shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Apply skin prep to bilateral medical/lateral ankles every day and night shift for prevention Cleanse buttocks with soap and water, apply Z-guard every shift and as needed every day and night shift. Enteral Feed Order every shift Osmolite 1.5 CAL Administrator continuous via pump 60 ML per hour. 22 hours per day. Downtime 1100-1300. 12/02/25 7:00 AM Encourage/Assist resident to turn and reposition frequently while in bed as resident will allow every day and night shift Encourage/assist resident to float heels while in bed as resident will allow every day and night shift Low air loss Mattress. Check placement and function every shift every day and night shift. Apply skin prep to bilateral medical/lateral ankles every day and night shift for prevention Cleanse buttocks with soap and water, apply Z-guard every shift and as needed every day and night shift. Monitor scab to outside right knee every day and night shift Amino Acids-Protein Hydrolys Oral Liquid (Amino Acids-Protein Hydrolysate) Give 45 ml via G Tube four times a day for supplement. On 12/10/25 at 8:55 AM it was confirmed with the Administrator that the above orders had been missed according to Physicians orders at which time she agreed that not being completed was unacceptable.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, staff interview and observation, the facility failed to ensure a safe environment for residents by transporting oxygen without a carrier and not documenting a fall that resulted in a fracture. These were failed practices were random opportunities for discovery and had the potential to affect more than a limited number of residents. Resident Identifier # 66. Facility Census: 63. Findings included: a) The facility's policy and procedure stated, the center staff will report, review and investigate all accidents/incidents which occurred, or allegedly occurred, on or off Center property involving, or allegedly involving, a patient who is receiving services. and the licensed nurse will Report accidents/incidents and assist with completion of a timely investigation to determine root cause. The facility's policy and procedure for Oxygen High Pressure Cylinders stated the cylinders must be properly secured to prevent accidental tipping of the tank and possible rupture causing high pressure release of gasses. and cylinders must be in a secured stand. Full oxygen cylinders are to be transported only after being secured to a self-supporting device. b) On 12/08/2025 at 12:30 PM, Nursing Assistant #3 was observed carrying a full oxygen tank down the hall in her hands. When asked if the tank was full, the NA confirmed it was full and stated she would go get a holder to transport the oxygen. The incident was reported and confirmed by the Regulatory Compliance Officer at 12:40 PM. b) Resident #66 Record review completed on 12/10/2025 at 9:38 AM of a facility reported incident (FRI) was reviewed and found to be true according to the credible evidence provided by the facility. As written on the five (5) day follow up – To whom it concerns: While conducting an investigation into an injury of unknown origin regarding the long-term care facility resident #66, a Certified Nursing Assistant (CNA) reported that she had previously been notified in report resident #66 had sustained a fall on 2/28/2024. Resident #66's roommate, who is alert and oriented, also confirmed that he had a fall on 2/28/24 and a nurse and CNA placed resident #66 back into his bed. Review of resident #66 medical record showed no documentation of a fall on 2/28/24, no neuro-checks, and no treatment or follow-up. His nurse on duty at the time, Registered Nurse (RN) #110, has since submitted and completed her resignation, and this allegation of neglect was reported to the [NAME] Virginia Board of Registered Nurses. She has declined to return phone calls when attempting to contact her for a statement. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #66 returned to (facility name her) care center on 3/14/24 with new Thoracic-Lumbar-Sacral Orthosis {a rigid spinal brace, often plastic, that supports the mid-back (thoracic) down to the lower back (sacral)} in place, as well as Vancomycin (antibiotic for infections) HCl Intravenous Solution 500 MG/100ML one time a day for left hip infection until 04/20/2024. He is to follow up with (Dr office name here) Orthopedics on 4/1/2024 and (Dr. name here), Hematologist, on 4/2/2024. Resident #66 lacks medical decision-making capacity related to Alzheimer's disease and dementia diagnoses. He was unable to recall to (hospital name here) Medical Center staff if he had a recent fall or injury. He also has diagnosis of osteoporosis. On 12/10/2025 at11:04 AM At 11:03 am the administrator confirmed the fall was not treated at the time the fall occurred.

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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 staff interview, record review and observation, the facility failed to provide an assistive device as ordered by the physician during the dinner meal. Theis was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident identifier: #17. Facility Census: 63. Findings included: a) Resident #17 The facility's policy and procedure for Assistive Devices stated assistive devices/utensils will be provided as identified on the individualized plan of care to maintain or improve a resident's/patient's ability to eat or drink independently. On 12/08/2025 at 06:2025 PM, Resident #17 was observed during the dinner meal. The resident's tray card stated in all capital letters two (2) times on the tray ticket with one in larger print and one in bold print, FOOD IN BOWLS. The resident did not receive his food in bowls for his entree or side, but did receive his dessert in a bowl. Nursing Assistant #9 confirmed the resident did not receive his food in bowls per his tray ticket. sand order. The resident's dietary order stated, regular diet, regular texture, standard thin liquids and food in bowls.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, record review and staff interview, the facility failed to ensure the kitchen equipment was maintained in safe operating condition. for the freezer. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 63.Findings included: a) The facility's policy and procedure for Safety as related to kitchen and associated equipment safety stated, the equipment will be properly maintained and the Dining Service Director Will ensure that all equipment is in proper working condition and equipped with safety guards, as appropriate. b) On 12/07/2025 at 12:10 PM, ice and significant frost was observed by the state surveyor on the right side of the freezer door during the initial kitchen inspection. Small ice drips were frozen on the freezer's fan, and a large block of ice was formed under the freezer fan. Dietary [NAME] #62 confirmed the finding and reported there was no frost this morning and that it must have been when the dietary aide was going in and out of the freezer.