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 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interview the facility failed to ensure residents who were ordered honey and nectar thickened liquids received liquids at a correct consistency. This was true for two (2) of four (4) residents reviewed for thickened liquids. Providing a resident with the wrong consistency of liquids could result in choking, aspiration pneumonia which can lead to serious harm and or death if not immediately corrected. This situation could occur again and have the likelihood of resulting in serious injury or death for any residents requiring thickened liquids.This failed practice was a random opportunity of discovery and the State Agency (SA) determined this to be an immediate jeopardy situation. Resident identifiers: #1 and #24 Facility Census: #63.Findings include: a) Resident #1On 12/08/25 at 12:10 PM an observation found that Resident #1 was ordered honey thickened liquids but had a bottle of water and a facility pitcher of thin water at bedside. She was eating her lunch meal and was able to reach and drink the liquids provided. Record review showed she had a medical diagnosis of oral phase dysphagia and pharyngeal phase dysphagia. There were current orders for a regular/liberalized diet dysphagia puree texture, thick liquids honey consistency, mashed potatoes with lunch and dinner. According to the Administrator it is unknown how long or who gave Resident #1 the water.The Speech Language Therapist (SLP) currently saw Resident #1 and the resident had therapy for a diagnosis of silent aspiration. She had a Modified Barium Swallow (MBS) on 11/11/25 at a local hospital. The resident was safest on honey thickened liquids. The SLP #72 had educated the staff, the resident and her MPOA (husband) concerning the need for thickened liquids. The resident's husband wishes her to remain on thickened liquids. He is present daily for lunch and dinner to assist her if needed. The SLP watches labs and vital signs for signs and symptoms of infection indicating aspiration pneumonia.b) Resident #24 On 12/08/25 at 12:30 PM an observation found that Resident #24 had a current order for Regular Liberalized Dysphagia Advance Texture with Thick Liquid-Nectar consistency two handled cup with inset lid. Further observation showed he had a facility pitcher of water at bedside containing thin liquids. Further record review of the facility's Food and Nutrition [NAME] Policies and Procedures showed thickened liquid modifications may be used in conjunction with any diet for individuals having difficulty swallowing thin liquids. Liquid modifications include Nectar like, Honey like and Spoon thick modifications. The Regulatory Compliance Advisor took the pitcher of water belonging to Resident #24 and bought it to the State Surveyor that is licensed as a Speech/Language Pathologist (SLP) to confirm by the spoon test that the water was not the correct consistency.On 12/08/25 at 3:25 PM during a telephone interview with SLP #72 she stated the purpose and risk of not receiving thickened liquids would be to avoid aspiration pneumonia. She stated the resident was evaluated at bedside and if signs or symptoms of choking were present. She said she would recommend a modified barium swallow (MBS) or a Fiberoptic Endoscopic Evaluation of Swallowing (FEES)SLP #72 has discharged Resident #24 due to noncompliance with his therapy exercise which she believed he was cognitively unable to do. He continued to aspirate liquids.The SLP stated, I expect staff to know exactly who is on thickened liquids as there are only four (4) out of sixty-three (63) residents that required thickened liquids. I have educated staff several (continued on next page)

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

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	times. The plan of correction (POC) for the immediate jeopardy (IJ) was as follows: Resident (#1) and (#24) was served a liquid that did not match the ordered consistency on 12/8/2025. MD notified at 16:49 (4:49 PM) on 12/8/2025. All thickener packets were removed from the floors and placed in the medication room. Pre-Thickened liquids only will be used at this time, unless a resident requires a manually thickened drink, per orders. All residents of the facility have the potential to be affected. The Director of Nursing (DON)/designee conducted an audit on 12/8/2025 of all residents with diet orders specifying thickened liquids (nectar/mildly thick, honey/moderately thick, pudding/extremely thick) to ensure:Liquid consistency orders are current, accurate, and clearly listed in the medical record.Correct consistency is reflected on the electronic health record.All cups, pitchers, and beverage containers delivered to residents match the ordered consistency. Nursing staff who hand beverages to residents are using the correct consistency. Any discrepancies identified were immediately corrected, and all impacted diet slips and kardex entries were updated.Re-education was provided by the DON/designee/Speech-Language Pathologist (SLP) or Dietary Manager starting on 12/8/2025 to all staff, including nursing assistants, licensed nurses, and tray passers. Education included:Review of the standardized liquid consistency levels (e.g., nectar/mildly thick honey/moderately thick, pudding/extremely thick).Following manufacturer's directions on manually thickening liquids, if required.How to verify consistency before serving.The importance of cross-checking diet orders, tray tickets, and posted consistency lists.A post-test and return demonstration of preparing each consistency level were completed to validate understanding. Any staff not present during this timeframe will receive re-education, including post-test and competency validation, prior to their next scheduled shift. All new dietary and nursing staff will receive this training during orientation. Annual in-servicing will include liquid consistency preparation, dysphagia safety, and safe feeding practices.The Dietary Manager and Unit Managers (UM)/designee will conduct observations starting on 12/9/2025 to ensure correct liquid consistencies are prepared and served. Observations will include:Tray line checks for accuracy of liquid consistency.Verification that nursing staff are serving beverages correctly.Checking nourishment rooms, hydration carts, and bedside beverages for compliance.Observations will be completed:Daily across all shifts for two weeks (including weekends and holidays),Then five times per week for four weeks,Then three times per week for four weeks,Then randomly thereafter.Results of audits will be reported monthly by the DON/designee to the Quality Improvement Committee (QIC) for review, follow-up, and/or additional in-servicing until the issue is fully resolved and sustained. Random monitoring will continue thereafter as determined by the QIC.During the abatement procedure the following questions were asked of all staff members present at the time: Were you educated on thickened liquids for residents? (Yes)Which is thicker, nectar thick or honey thick? (honey)Who can thicken liquids at this time? (Two different RN names provided)How do you know the amount of packaged thickener to use? (manufacturer's directions on the back of the packet) Where are thickener packets stored at this time? (Locked in the medication room) Once all staff members interviewed and correctly answered the above questions the IJ was abated.IJ was given to the facility on [DATE] at 4:46 PMIJ was accepted by the facility on 12/08/25 at 4:49 PMThe Plan of Correction (POC) was accepted by the state survey team on 12/08/25 at 6:38 PMThe IJ was abated by the state survey team on 12/09/25 at 4:12 PM.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, staff interview and resident interview, the facility failed to ensure the menus were followed and met the nutritional needs of the residents. 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 Menus stated menus will be planned in advance to meet the resident's nutritional needs. Menus will be served as written unless a substitution is provided in response to preference, unavailability of an item, or a special need. Menus will be posted. On 12/07/2025, the posted menu in the dining included: Turkey, Cornbread, Dressing, Broccoli, Rolls, Pumpkin Pie and Whipped Topping. The Week at a Glance Menu stated the following items were to be served: Maple Sage Turkey,, Dinner Roll, Homemade Pumpkin Pie w/Whipped Topping, Seasoned Peas and Cornbread Dressing. The lunch meal that was served included: Turkey, Cauliflower, Pumpkin Cake, and Cornbread. On 12/07/2025 at 01:20 PM in the Dining Room, Recreation Assistant #6 confirmed rolls, peas and broccoli were not served cauliflower and stated, If they can't prepare it, they change the menu. Recreation Assistant #6 confirmed cornbread, cauliflower and cake were served.c) Residents that did not receive the posted lunch menu items included: Residents #11, #56, #24, #35, and #58 as observed by the state surveyor.On 12/07/2025 at 12:47 PM, Resident #58 received broccoli and stated, I like broccoli if it's done right. Resident received cake, not pie and cauliflower, not peas or broccoli on the served lunch tray.On 12/07/2025 at12:50 PM, Resident #16 stated, Looks like cake. The resident did not receive peas or broccoli which was confirmed by Nursing Assistant #42.On 12/02/2025 at 02:10 PM, Resident #36 reported lunch was awful and all she received was bits of turkey, cauliflower, and cornbread. The resident reported she did not receive pumpkin pie.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and resident interview, the facility failed to ensure the food served to the residents was palatable, attractive and prepared by methods that conserved the nutritive value, flavor, and appearance of the food. Resident Identifiers: #36, #14, and #40. Facility Census: 63. Findings included: a) On 12/08/2025 at 11:55 AM, the state survey team tested a lunch tray for palatability. It was determined the scalloped potatoes had chewy edges and were not soft. they had an inconsistent consistency. The Salisbury steak was judged to be tough, hard to cut and had crunchy edges. The vegetables were judged to be too soft, especially the broccoli, and have no seasoning. These findings were confirmed by the Regulatory Compliance Officer at 12:05 PM. b) On 12/07/2025 at 2:10 PM, Resident #36 reported the food was awful and the food was never hot .always lukewarm. On 12/08/2025 at 03:50PM, when the resident was asked about today's lunch, Oh, I can't eat that. The potatoes were okay and the roll. That's all I ate. On 12/08/25 at 06:15 PM, another state surveyor observed that Resident #14 did not eat dinner due to the sandwich being excessively toasted. The sandwich was burned to a black color, and the resident reported that it was too hard and tasted unpleasant. c) On 12/07/2025 at 12:05 p.m resident #40 stated Food doesn't taste good at times. A food tray was tested on [DATE] that contained Scalloped Potatoes that had chewy edges and not soft - inconsistent consistency, Salisbury steak was hard to cut tough, crunchy edges - crunchy, tough steak, and vegetables were too soft especially broccoli, no seasoning. Interview with employee #107 on 12/08/25 at approximately 12:05 p.m., informed of the surveyor's findings.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure effective administrative oversight related to freedom from neglect and abuse, quality of care, staffing, infection control, dietary services, investigation and reporting of incidents, staff training, and an immediate jeopardy situation that affected multiple residents. Facility Census: 63Findings include:During the survey conducted from 12/07/25 through 12/10/25, the following concerns were identified:a) Failure to Investigate and Report Facility Reportable Incidents (FRIs):Review of facility records revealed the facility failed to ensure reportable incidents were thoroughly investigated and that the results were reported to the State Agency within five (5) working days, with appropriate corrective actions taken. This was found to be true for eight (8) of nine (9) residents reviewed.b) Resident #15 Review of the FRI dated 11/03/25 for Resident #15 revealed no documentation of staff interviews and no documentation demonstrating a five (5) day follow-up report was submitted to the State Agency.c) Resident #39Review of the FRI dated 10/23/25 for Resident #39 revealed no documentation of staff or resident interviews conducted during the investigation.d) Resident #67Review of the FRI dated 07/27/23 for Resident #67 revealed no documentation that staff received education related to proper handling of emergency situations.These findings were verified with the Administrator on 12/09/25 at approximately 12:30 PM and again during the exit conference on 12/10/25. The Administrator acknowledged responsibility for self-reporting, investigations, follow-up, and staff re-education related to reportable incidents. Failure to Ensure Residents Were Free From Abuse and Neglect:Administrative oversight failed to ensure residents were free from neglect and/or abuse, including refusal to toilet or change residents and failure to appropriately treat a resident who sustained a fall resulting in a fracture.Failure to Ensure Adequate Staffing:The facility failed to:Provide the services of a registered nurse for at least eight (8) hours per day, seven (7) days per week.Post accurate daily staffing information, including facility name, date, nursing hours worked by staff category, and resident census. This was found to be true for two (2) of thirteen (13) days reviewed.Failure to Ensure Required Nurse Aide Training:The facility failed to ensure nurse aides completed at least twelve (12) hours of annual in-service education, including dementia management training and resident abuse prevention training. This was found to be true for three (3) of five (5) nurse aides reviewed.Failure to Ensure Resident Hygiene and Dignity:Observation on 12/09/25 at approximately 2:00 PM revealed a resident with uncombed hair and visible facial hair.On 12/10/25 at approximately 2:30 PM, Resident #56 approached a surveyor visibly distressed and crying and reported she could not recall the last time she received a shower and was only receiving bed baths.The Administrator stated the resident could not fit through the shower room doors. Interviews with Occupational Therapy and the Physical Therapy Assistant confirmed the resident exceeded the weight limit of the available shower chair and therefore could not receive a shower at the facility. The facility failed to ensure alternative accommodation was provided to meet the resident's hygiene needs.Failure to Ensure Timely and Appropriate Care:d) Resident #66The facility failed to treat a fall for Resident #66.e) Resident #9The facility failed to administer medications as ordered by the physician in a timely manner for Resident #9.Failure to Ensure Dietary Safety and Services:Administrative oversight failed to ensure:Food was stored and served in accordance with professional standards.Residents ordered honey-thick and nectar-thick liquids received the correct consistency. This was found to be true for two (2) of four (4) residents reviewed and was determined by the State Agency to constitute Immediate Jeopardy.Kitchen equipment, specifically the freezer, was maintained in safe operating condition.h)Failure to Maintain Effective Infection Control Program:The facility failed to maintain an effective infection control program as evidenced by staff not wearing masks during a COVID outbreak and ice scoops being left in ice containers. These were (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	identified as random opportunities for discovery.i)Failure to Maintain Safe Environmental Conditions:The facility failed to ensure hot water temperatures did not exceed 110 degrees Fahrenheit, placing residents at risk for injury.Failure to Provide an Ongoing Activity Program: The facility failed to provide an ongoing activity program designed to meet residents' interests and support physical, mental, and psychosocial well-being.in conclusion, the nature of these deficient practices demonstrates a systemic failure of administrative oversight. The facility failed to identify, investigate, correct, and prevent deficient practices despite being aware or having the means to be aware through daily reports and routine operations.

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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 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. 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. Allegation of neglect is substantiated. Residents' statements consistently remained the same. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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} Manual title: Center operations policies and procedures (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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 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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	515102	A. Building B. Wing	12/10/2025

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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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	515102	A. Building B. Wing	12/10/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program when a new mental health diagnosis or change in condition is presented. This was found to be true for four (4) of five (5) residents during the long term care survey process. Resident identifiers: #44, #56, #59, and #5. Facility census: 63Findings included: a) Resident #56 The resident's PASARR was completed on 08/19/24 at another facility. Diagnoses on this PASRR included Bipolar disorder and depression, unspecified. Upon review of the medical record, the resident had the following diagnoses related to mental health upon admission to the nursing home facility: BIPOLAR DISORDER, CURRENT EPISODE MANIC WITHOUT PSYCHOTIC FEATURES, UNSPECIFIED 8/9/2024 Upon Admission/Readmission The PASARR was completed as a Level I, with no Level II required. During the resident's stay at the facility, she received a new diagnosis of: MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD 07/15/25 The facility failed to initiate a new PASRR to notify the state-designated mental health or intellectual disability authority promptly with the resident's new diagnosis of major depressive disorder. An interview was conducted with the facility's Director of Social Services on12/09/25 at1:20 PM. The Director was asked if a resident in this facility initially had a diagnosis upon admission of depression, unspecified, and later received a new diagnosis of major depressive disorder, mild and recurrent, would the facility normally do a new PASRR for this change. The social worker said yes. b) Resident #59 The resident's PASRR was last completed on 08/21/24 at this facility. It did not require a Level II screening. This PASARR contained the following mental health diagnoses: Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety A review of the medical diagnoses, documented the following mental health disorders for the resident: Mood Disturbance, and Anxiety 06/10/24 Admission Major Depressive Disorder, Recurrent Mild 08/16/25 (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility last completed a Medical Diagnostic Screening (MDS) assessment on the resident on 11/16/25. The MDS had the following mental health diagnoses: Depression Comparing the diagnoses on the MDS to the [NAME], the diagnosis for Major Depressive Disorder could not be found. The facility failed to initiate a new PASRR to notify the state-designated mental health or intellectual disability authority promptly with the resident's new diagnosis of major depressive disorder. c) Resident #44 The resident's PASRR was completed on 04/27/25 at an acute care facility. It was evaluated for and approved as Level I. Level 2 was not required. On the PASARR, the resident only had one mental health disorder, Schizophrenic Disorder. A review of the resident's medical record shows the following mental health diagnoses: Schizophrenia, Unspecified 04/28/22 Admitting Anxiety Disorder, 04/28/25 Admission/Readmission Auditory Hallucinations 04/28/22 Admission/Readmission Visual Hallucinations 04/28/22 Admission/Readmission Major Depressive Disorder, Single Episode 06/11/25 During Stay Generalized Anxiety Disorder 09/04/24 During Stay Disturbance, Mood Disturbance, and Anxiety 06/20/34 During Stay The MDS was last updated on the resident on 10/27/25. Diagnoses for mental health conditions documented on this MDS were: Schizophrenia, Unspecified Anxiety Disorder Depression Schizophrenia Auditory Hallucinations Verbal Hallucinations Comparing the diagnoses on the MDS to the PASRR, the diagnosis for Major Depressive Disorder (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could not be found. The facility failed to initiate a new PASRR to notify the state-designated mental health or intellectual disability authority promptly with the resident's new diagnosis of major depressive disorder. Resident #44 and #59 PASRR findings were reviewed with the Regional Compliance Advisor for the facility on 12/09/25 at approximately 4:20 PM. d) Resident #5 A record review of Resident #5 Diagnoses was completed and found the following diagnoses; As written in medical chart- MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD Medical Management 10/08/25 10/23/25 SCHIZOAFFECTIVE DISORDER, UNSPECIFIED Medical Management 5/8/2025 Admission/readmission [DATE] Further record review of the Preadmission Screening and Resident Review (PASRR) reviled Major Depressive Disorder and Schizoaffective Disorder was not marked on the PASRR as an active diagnosis. An interview with Administrator on 12/07/25 at approximately 1:30 PM confirmed that PASRR was not coded correctly.

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	515102	A. Building B. Wing	12/10/2025

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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 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! (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on record review resident interviews and staff interview the facility failed to provide an ongoing activity program to support residents in their choice of activities, through facility-sponsored group activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, This found practice has the potential to affect more than a minimal number of resident residing in the long term care facility. Facility Census: 63.Findings include:a) ObservationAn observation on 12/08/25 at 11:00 AM of the large Monthly Activity Program Calendar posted near the facilities nurses stated to have the same activities each week other than a few volunteer days, and showed Monday through Friday the last activity was at 4:30 PM and was a Movie. On Saturday and Sunday, the last activity was at 5:00 PM which was Dinner and Movie that would interrupt for some a dignified dining experience.Further observation revealed there were no locations on the calendar where these activities would be held.b) Record review A review completed on 12/09/25 of the facilities Monthly Activity Program calendar for the months of August, September and October revealed the same activities for each day of the week repeated every week unless volunteer or holiday event . Further review revealed a movie was the only thing occurring as an evening activity and this was at 4:30 PM Monday through Friday and at dinner time 5:00 PM on weekends. Further record review of Resident Council meetings revealed the following; 06/25/25- Activity assistant does nothing entertaining and wants more evening activities 08/11/25 more volleyball, horseshoes badminton, comedians, and get Elvis to come 09/01/25 Weekends are boring, no crafting when scheduled, the Activity Assistant states the Activity Director does not tell her what crafts to do. 10/13/25 Weekends are bad11/04/25 states activities are ok except on weekends12/02/25 stated Activity assistant is not doing activitiesc) Resident concerns during Resident Council During resident council meeting completed on 12/09/25 at 11:30 AM residents that attended all agreed to each other's concerns regarding activities and those concerns were as follows:Not everyone enjoys watching movies of the eveningsWe need more craftsWe would like to play the golf game more We go to bed early on weekends because there is nothing else offered to doThe activity assistant does not do the stuff we are supposed to do, the activity director does it all here. The Activity Director does hold her assistant countable for her jobWe do not say this to the activity director, we like her, she does a lot, she cannot do it all and we do not want to hurt her feelings. An interview with the Activity Director was completed on 12/09/25 who stated she only has one other assistant and evening activities were movies because it was easier that way. The AD said someone can just run back and start the movies and set everything up and continued to say this was not the first time she had concerns about her assistant, however, could not provide education regarding not completing activity duties confirming evening activities not being completed correctly and evening and weekend activities.

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	515102	A. Building B. Wing	12/10/2025

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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 upon record review and staff interview, the facility failed to review and take action on the consultant pharmacist's recommendations on irregularities found in residents' drug regimen reviews. This was found to be true for three (3) of five (5) residents reviewed during the long term care survey process. Resident identifiers: #44, #59, #14. Facility census: 63Findings included: A) Resident #44A review of Resident #44's medical record documents the resident had the following diagnoses as it relates to psychosocial health: SCHIZOPHRENIA, UNSPECIFIED 4/28/2022 Upon admissionANXIETY DISORDER, UNSPECIFIED 4/28/2022 Upon Admission/ReadmissionAUDITORY HALLUCINATIONS 4/28/2022 Upon Admission/ReadmissionVISUAL HALLUCINATIONS 4/28/2022 Upon Admission/ReadmissionMAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD 6/11/2025 During Stay GENERALIZED ANXIETY DISORDER 9/4/2024 During StayUNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY 6/20/2023 During StayThe resident had the following physician orders as it related to the above diagnoses: DULoxetine HCl Capsule Delayed Release Particles 20 MGGive 1 capsule by mouth one time a day for Depression aeb social with draw monitor for side effects; sedation, dry mouth, nausea, dizziness, insomnia, apathy, constipation, diarrhea, akinesia, muscle rigidity, extra pyramidal reactions, Parkinson's-like symptoms, tremor, drooling from mouth, photo sensitivityPharmacy Active 11/22/2025 Mirtazapine Oral Tablet 15 MG (Mirtazapine)Give 1 tablet by mouth at bedtime for Depression aeb poor po intake monitor for side effects; sedation, dry mouth, nausea, dizziness, insomnia, apathy, constipation, diarrhea, akinesia, muscle rigidity, extra pyramidal reactions, Parkinson's-like symptoms, tremor, drooling from mouth, photo sensitivityPharmacy Active 11/21/2025 Loxapine Succinate Oral Capsule 10 MG (Loxapine Succinate)Give 10 mg by mouth three times a day for Schizophrenia AEB Hallucinations and delusions for blurred vision, sedation, dry mouth, drowsiness, insomnia, apathy, constipation, diarrhea, akinesia, muscle rigidity, extra pyramidal reactions, Parkinson's like symptoms, tremor, drooling from mouth, photosensitivity, weight gain, edemaPharmacy Active 11/21/2025 BusPIRone HCl Tablet 5 MGGive 1 tablet by mouth two times a day for anxiety aeb hallucinations and delusions Monitor for SE of AA; Common SE:Sedation, drowsiness, ataxia, dizziness, nausea, confusion, nasal congestion; Less common SE: vomiting, skin rash, falls, agitation. Rare SE: hypotension, blurred vision, ataxia, mood swings. Notify provider if presentPharmacy Active 4/21/2025 CBC, BMP, TSH, A1C every 6 months (May/Nov) A1C is for antipsychotic therapy) one time a day every 182 day(s)Laboratory Active 5/7/2025 A review of the consultant pharmacist's monthly medication regimen review assessments documented irregularities on 12/22/24. 09/21/25, 10/14/25, 11/12/25. The surveyor requested on 12/08/2025 at 2:25 PM to see the pharmacist's reports of what the irregularities were on these dates and what actions were taken on the recommendations. On 12/09/2025 at 11:54 AM upon asking for these a second time, the NHA stated they could not find these. B) Resident #59 A review of the resident's medical record for physician orders documented the following medications: Eliquis Oral Tablet 2.5 MG (Apixaban)Give 1 tablet by mouth two times a day for history of transient ischemic attackPharmacyActive 08/20/2025 Anticoagulant Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, shortness of breath, nose bleeds, document in supplemental documentation if any of the above was observed and any findings in a progress note.every shiftOther Active 08/14/2025 A review of the consultant pharmacist's monthly medication regimen review assessment reports documented irregularities found on 09/23/24, 12/22/24, 01/20/25, and 04/14/25. The surveyor requested these irregularities and action taken by the facility on 12/09/2025 at 9:58 AM. During a discussion with the NHA on 12/09/2025 at 11:54 AM, she stated they could not find these. C) Resident #14 This resident has the following diagnosis: TYPE 2 (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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED 05/14/2024 Admitting For this illness, the physician ordered: LANTUS SOLOSTAR 100UNIT/1ML INSULN PENInject 30 unit subcutaneously every morning and at bedtime Pharmacy Active 06/26/2024A review of the consultant pharmacist's monthly medication regimen review assessment reports documented irregularities found on 10/08/25, 04/12/25, 01/18/25, 11/16/24. The surveyor requested these irregularities and action taken by the facility on 12/08/25 at 1:17 PM. During a discussion with the Regional Compliance Advisor on 12/08/2025 at 2:15 PM, he stated they could not find these.

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	515102	A. Building B. Wing	12/10/2025

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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 record review, staff interview and observation, the facility failed to ensure food was stored 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: 63.Findings included: a) The facility's policy and procedures for Food Storage: Cold Foods stated, all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The facility's policy and procedure for Food Storage: Dry Goods stated, all food would be stored according to the Food and Drug Administration) (FDA) Food Code. and that the food storage areas would be neat, arranged for easy identification and the date marked as appropriate. b) On 12/07/2025 at 11:35 AM, the kitchen investigation was initiated. The following items were found and verified by [NAME] #62: Dry Storage - Beverage cart was sitting in the dry food storage area for lunch. The cart contained milk that was not labeled or dated., a carafe of hot water that was not labeled or dated and an ice scoop in a serving container with a small amount of water. Dietary Aide #76 confirmed the cart was in the storage area and stated, It goes out first to the dining room. Additional items found in the dry storage included ripple potato chips - opened, not dated and not sealed, House Recipe Saltines with stored date 10/23 and no use by date and bananas which were not labeled with a received or use by date. The items were verified by [NAME] #63 at 12:00 PM and she reported We just got that Friday. Cold Storage - The following items were found during the initial kitchen tour: Four (4) pitchers of tea - not labeled or dated.Three (3) gallons of United brand mild - opened with no open or use by date.Sysco Imperial Mayonnaise with use by date 12/02/25.French's mustard - mustard dripping and dried on the outside of the container.House Fancy Ketchup - ketchup dripping and dried on the outside of the container.Raw hamburger patties - dated 12/02/25-12/06/25.Gold 'N Sweet Margarine - opened and no use by date.Reliance Italian Dressing - opened date 08/02/25 and us by date 12/02/25.Large container of fruit punch - not labeled and not dated.Bowl of Cheerios - not labeled or datedAngel food cake not labeled and dated 3/10-4/10.Salami dated 4/12-5/17.Box of frozen biscuits - not sealed and not dated. On 12/09/2025 at 09:15 AM, the facility's Nourishment Center was investigated. A bottle of [NAME] Creamy French Dressing was found opened with manufacturer expiration date of 10/07/2024. On 12/09/25 at 9:20 AM, Environmental Service Staff #78 confirmed and removed the item from the refrigerator. On 12/09/25, during a follow-up visit to the kitchen, serving utensils were found not stored with the handles in the same direction in two (2) investigated drawers. This was confirmed by the Dietary Manager and the Corporate Dietary Manager.

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	515102	A. Building B. Wing	12/10/2025

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, and staff interview the facility failed to ensure garbage and refuse disposed of properly by blocking trash cans This had the potential to affect more than an isolated number of residents. Facility census: 63. Findings included:a) According to the facility's policy and procedure, garbage and refuse will be disposed of in a safe and efficient manner. The policy and procedure indicated the Dining Service Director (DSD) would ensure lined containers wiould be available within the food service area and garbage and refuse would be removed routinely from the kitchen area during the day and at the end of the workday.b) On 12/07/2025 at 11:35 AM, during the initial kitchen observation, five (5) empty and opened boxes were under the handwashing sink on the floor covering the trash can. A plunger was under the boxes. The boxes had to be moved to dispose of paper towels when the state surveyor's hands were washed. Dietary [NAME] #62 confirmed the boxes on the floor and difficulty disposing of paper towels after hand hygiene was completed.

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	515102	A. Building B. Wing	12/10/2025

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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, document review, and staff interviews, the facility failed to maintain an effective infection control program by staff not wearing masks during COVID outbreak and staff leaving ice scoops in ice containers. These were random opportunities for discovery during the survey process. Facility census 63. Findings included: a) On 12/07/25 at approximately 11:30 a.m., upon initial entry observed that the facility was under COVID outbreak and observed Employee #18 and Employee #42 sitting at the nurse's station not wearing any masks. Reviewed the facility's COVID outbreak policy and policy requires all staff to wear masks during outbreak. Interview on 12/07/25 at approximately 11:38 AM with Employee #20 verified that during a COVID outbreak all staff were required to wear masks inside of the facility. b) On 12/07/25 at 12:00 PM, the state surveyor observed no separate container for the ice scoop as drinks were passed on the 200 Hall. The ice scoops were placed in the ice bucket. Nurse Aide (NA) #24 confirmed the scoop was in the ice container during the drink pass and stated, No, there's not. (a separate container). On 12/07/2025 at 12:45 PM, the state surveyor observed no separate container for the ice scoop as drinks were passed on the 100 Hall. NA #9 confirmed the scoop was in the ice container during the drink pass. On 12/08/25 and 12/09/25, ice scoops remained in the ice containers on both halls during the drink passes. The observation was reviewed and verified with the Regulatory Compliance Officer on 12/09/25.

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	515102	A. Building B. Wing	12/10/2025

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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.

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	515102	A. Building B. Wing	12/10/2025

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based upon record review and staff interview, the facility failed to ensure twelve hours of in-service education for nurse aides, which includes dementia management training and resident abuse prevention training. This was found to be true for three (3) of five (5) nurse aide personnel reviewed during the long term care recertification process. Staff identifiers: #24, #9, #54, #43, #21. Census: 63 Findings included: A) Nurse Aide (NA) #9 Nurse Aide #9 only had sixteen (16) minutes of dementia management training during the twelve-month period from 12/01/24 to 11/30/25. This falls short of the two hours minimum required annually. B) Nurse Aide (NA) #43 Nurse Aide #43 had a hire date of 09/17/25. She only had twenty-four (24) minutes of dementia management training during the period from 09/17/25 through 11/30/25. This fails to comply with WV regulations of receiving two hours of education within her first 30 days or at next orientation. She also had not been educated on resident abuse prevention, or resident rights. The Nurse Aide had no competencies completed prior to assuming direct care of residents, following her date of hire. C) Nurse Aide (NA) #21 Nurse Aide #21 had a hire date of 10/08/25. She had no education on dementia management training during the period from 10/08/25 through 11/30/25. The Nurse Aide had no competencies completed prior to assuming direct care of residents, following her date of hire. During an interview with the facility's Regional Compliance Advisor on 12/09/25 mid-morning, this was reviewed with him. He had no comments.

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	515102	A. Building B. Wing	12/10/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based upon record review, resident interviews, staff interview and observation, the facility failed to honor resident's preferences for showers.This was found to be true for two (2) of eleven (11) residents reviewed during the long term care survey process. Resident identifiers: #6, and #56. Facility census: 63. Findings included: A) Resident #6 During an interview with the resident on 12/07/25 at approximately noon, the resident stated he would like to get a shower. He stated, All they do is give me a bed bath. Resident's hair appeared oily, and hair did not look like it had been combed. He had facial beard growth of a few days length. A review of the resident's current care plan, developed on 03/10/25, documents, It is important to me to shower. The facility's shower/bathing schedule showed Resident #6 was scheduled showers for Wednesdays and Saturdays on day shift. A review of the ADL tasks for showering for the last three (3) months documents the following: 9/9/25 through 9/16/25 no bath or showers documented 9/17/25, Wednesday 1:18 PM shower provided 09/18/25-09/20/25 no bath or showers documented 9/21/25, Sunday 11:25 AM bed bath/sponge was given 9/22/25 - 10/02/25 no bath or showers documented 10/03/25 Friday 10:58 AM bed bath/sponge was given 10/04/25 - 11/12/25 no bath or showers documented 11/13/25 Thursday 1:02 PM bed bath/sponge provided 11/14/25 - 11/19/25 no bath or showers documented 11/20/25 Thursday @11:36 AM bed bath/sponge provided 11/21/25 - 12/1/25 no bath or showers documented 12/02/25 Tuesday @10:48 AM tub bath provided 12/03/25 - 12/08/25 no bath or showers documented (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility census documents the resident was not on leave during last 90 days. B) Policy The facility's policy on Activities of Daily Living (ADLs) of 05.01.23, reads: Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living (ADL) abilities are maintained and improved and do not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable. Activities of daily living include:Hygiene - bathing, dressing, grooming, and oral care Purpose: To ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and the patient's choices and preferences. C) Resident #56 A review of the resident's care plan documents revealed the resident required an assist of one to two staff for bathing, and requires the assistance of two for mechanical lift. Under interventions, the care plan reads, 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 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! An observation of the resident found hair uncombed, female facial hair appeared on mustache line and at chin level. Facial hair was approximately 1/4 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 11:59 AM bed bath/sponge provided 10/2/25 - 10/09/25 no bath or showers documented (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/10/25 Friday 2:59 PM bed bath/sponge provided 10/11/25-10/13/25 no bath or showers documented 10/14/25 Tuesday 11:17 AM shower provided 10/15/25 - 10/31/25 no bath or showers documented 11/01/25 Saturday 12:59 PM bed bath/sponge provided 11/02/25 no bath or shower documented 11/03/25 Monday 2:59 PM bed bath/sponge provided 11/04/25 Tuesday 10:20 AM bed bath/sponge provided 11/05/25 - 11/06/25 no bath or shower documented 11/07/25 Friday 10:56 AM bed bath/sponge provided 11/08/25 - 11/24/25 no bath or shower documented 11/25/25 Tuesday 10:40 AM bed bath/sponge provided 11/26/25 Wednesday 10:46 AM bed bath/sponge provided 11/27/25 Thursday 10:36 AM bed bath/sponge provided 11/28/25 - 11/29/25 no bath or showers documented 11/30/25 Sunday 12:57 PM bed bath/sponge provided 12/01/25 - 12/08/25 no bath or showers documented 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. During an interview with employee # 27 on 12/09/25 at approximately 4:00 p.m., stated that the facility was going to expand the entry way into the 100 Hallway shower room to allow Resident #56 to have entry into the area. Asked Employee #27 why the need to expand the doorway? Employee #27 replied To allow Resident #56 to get in the shower room safely and with dignity.

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	515102	A. Building B. Wing	12/10/2025

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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 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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	515102	A. Building B. Wing	12/10/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interview the facility failed to provide the appropriate documentation when a resident was transferred out of the facility to the hospital. This was true for one (1) of one (1) resident reviewed for hospitalizations. Resident Identifier: #9. Facility Census: #63. Findings Include: a) Resident #9On 12/09/25 at 1:15 PM record review of hospitalizations for Resident #9 shows she was transferred to the hospital on the following days.08/20/25 no bed hold documentation available09/15/25 no transfer documentation available09/22/25 no bed hold documentation availableAccording to the Policy OPS404 Discharge and Transfer for a resident being transferred to a hospital includes but is not limited to the following:5.1 For unplanned, acute transfers, the patients must be permitted to return to the Center. Prior to the transfer, the patient and patient representative will be notified verbally followed by written notification using the Notice of Hospital Transfer or state specific transfer form. 5.3 For any hospital transfers, the following will be sent to the hospital with the patient. 5.3.1 State specific transfer form (e.g. Universal Transfer Form) if required by the state or 5.3.2 E-Interact Nursing Home to Hospital Transfer Form in states where no state specific form is required and 5.3.3 Medication list and 5.3.4 Patient's advance directives and 5.3.5 POLST, MOLST, POST, etc.5.4 A copy of the E-interact Form will be placed in the patient's medical record.5,5 The Bed Hold Notice of Policy & Authorization form will be provided per the Accounts Receivable Policies and Procedures. The above findings were confirmed with the Regional Compliance Advisor #107 at which time it was confirmed the missing documentation was not available for these transfers.

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	515102	A. Building B. Wing	12/10/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to ensure the resident's comprehensive care plan was revised relating to a resident using a straw, tube feeding orders, a urinary (Foley) catheter, an actual pressure ulcer and a Peripherally Inserted Central Catheter (PICC) line in place. These were random opportunities of discovery. Resident Identifiers: #9 and #11. Facility Census: #63Findings Include: a) Resident #9 On 12/08/25 at 11:55 AM record review shows that Resident #9 has orders for Enteral Feed Order every shift. Osmolite 1.5 Cal. 60 ml/hr. Runs for 22 hours/day with downtime from 1100-1300 (11:00 AM to 1:00 PM). 25ml H20 flushes every 4 hours. There are no current orders for a Peripherally Inserted Central Catheter (PICC) line, urinary foley catheter or pressure ulcer treatment. Review of the care plan states: Resident at risk for skin breakdown related to actual pressure ulcer, decreased activity, frail fragile skin, impaired sensation, incontinence, Foley catheter in place, tracheostomy in place, g tube in place and PICC line in place. The care plan also states under interventions for the focus of Resident has an enteral feeding tube to meet nutritional needs related to status post right cranioplasty and NPO status that the tube feeding is to be off between 1000-1400 (10 AM until 2:00 PM) daily when the order is for 11:00 AM until 1:00 PM daily. At this time it was confirmed by Licensed Practical Nurse #102 that Resident #9 does not have an actual pressure ulcer, a urinary catheter nor a PICC line at this time. She also confirmed that the down time for the tube feeding is actually 11:00 AM until 1:00 PM. b) Resident #11 On 12/07/2025, a dining room observation was initiated. Resident #52 had a straw in a [NAME] Cup in her wheelchair cup holder in the dining room during the lunch meal and a straw in her water pitcher in her room at bedside. At 01:35 PM, NA #52 verified the resident's tray card for 2 Handled cup w/no lid, Food in mugs, [NAME] Cup, and NO STRAWS The resident and Nursing Assistant (NA) #52 the resident has been using straws in the dining room and her room. At 01:35 PM, NA #52 verified the resident's tray card for 2 Handled cup w/no lid, Food in mugs, [NAME] Cup, and NO STRAWS. Resident #11's diet order stated, Regular/Liberalized Dysphagia Puree texture, Standard Thin Liquids consistency, no bread, may have regular cottage cheese, cheeseballs, and Reese's mini cups, food in coffee cups, Kennedy cup for beverages no straws. Resident #11 care plan report stated, Provide regular, dysphagia puree diet as ordered. No bread, may have regular cottage cheese, food in coffee cups 2 handled cup no straws. The resident's care plan also stated, Divided scoop plate pureed solids, thin liquids, use straws and handled cups. On 12/07/2025, the two differences in the care plan for straw utilization were verified by the Regulatory Compliance Officer. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/2025, a staff message from the Speech-Language Pathologist (SLP) stated the resident was to use straws.

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	515102	A. Building B. Wing	12/10/2025

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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)

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	515102	A. Building B. Wing	12/10/2025

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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. Encourage/Assist resident to turn and reposition frequently while in bed as resident will allow every (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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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 11/15/25 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. 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 (continued on next page)

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	515102	A. Building B. Wing	12/10/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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	515102	A. Building B. Wing	12/10/2025

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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. 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 (continued on next page)

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	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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	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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review and staff interview the facility failed to provide nutritional and hydration care and services to a resident that is dependent on tube feed for nutritional and hydration. This was true for one (1) of one (1) resident reviewed for tube feeding. Resident Identifier: #9. Facility Census: 63. Findings Include: a) Resident #9 On 12/07/25 at 2:45 PM it was observed Resident #9 had no tube feeding or water infusing. Upon checking the current orders it was found that Resident #9 was ordered: Enteral Feed Order: every shift Osmolite 1.5 CAL 60 ml/hr. Runs for 22 hours/day with downtime from 1100-1300 and 25 ml of H20 flushes every 4 hours. Order also stated 25 ml of H20 flushes every 4 hours. Hanging on the tube feed pole was Y-tubing which allows simultaneous or separate administration of feedings (formula/nutrition) and water (flushing/hydration) through different ports on the same connection. Upon approaching the Licensed Practical Nurse (LPN) #102 the surveyor asked LPN #102 to check the order for the tube feeding to see when it was to begin. She stated the feeding starts at 1:00 PM. (One hour and 45 minutes ago). The surveyor ask her if she knew why it had not been started. She responded, I will get it started immediately. This was also confirmed with the Administrator on 12/07/25 at 3:30 PM at which time she confirmed the feeding was late being started.

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	515102	A. Building B. Wing	12/10/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to manage tube feeding care management as required. This was a random opportunity for discovery. Resident Identifier: #9. Facility Census: #63.Findings Include: a) Resident #9 On 12/07/25 at 2:45 PM it was observed that the tube feeding syringe used during administration did not have the current date on it as required. There was noo date on the syringe.According to the Procedure: Enteral Feeding: Administration by pump under 2) Gather supplies. 2.14 Clean bag or container for storing syringe and administration connector cover (to be changed every 24 hours) labeled with patient's name, date and start time.27. Rinse and dry syringe. Separately store syringe and barrel before storing in labeled and dated plastic bag or container. [NAME] can be used for up to 24 hours. It was confirmed on 12/07/25 at 2:48 PM with the Administrator that the syringe should have the current date on it and only used daily.

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	515102	A. Building B. Wing	12/10/2025

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based upon record review and staff interview, the facility failed to post accurate staffing information on 07/05//25, 07/06/25, and 12/07/25.This was found to be true for three (3) of thirteen days reviewed during the long term care survey process. Facility Census: 63 a) Upon entrance to the facility for the recertification survey on 12/07/25 at approximately 11:25 AM, the nursing schedule was posted in a prominent location, and contained the required data elements. However, the data which was posted was for the calendar day of 12/05/25. A review of the time detail report from the facility's timekeeping system documents the posted nurse staffing data hours were not consistent with the data from the time detail report. Discrepancies were as follows: Posted Daily Nurse Staffing Form for 07/05/25 Registered Nurse Hours totaled 24 hoursLicensed Practical Nurse Hours totaled 24 hoursCertified Nurse Aide Hours totaled 96.75 hours Time Detail Reports for 07/05/25 Registered Nurse Hours totaled 23.97 hoursLicensed Nurse Hours totaled 24.93 hoursCertified Nurse Hours totaled 98.97 hours Posted Daily Nurse Staffing Form for 07/06/25 Registered Nurse Hours totaled 24 hoursLicensed Practical Nurse Hours totaled 24 hoursCertified Nurse Aide Hours totaled 96 hours Time Detail Reports for 07/06/25 Registered Nurse Hours totaled 22.12 hoursLicensed Nurse Hours totaled 24.52 hoursCertified Nurse Hours totaled 101.13 hours The lack of current posted staffing data on 12/07/25 was reviewed with the Infection Control Registered Nurse (RN) upon entrance to the facility at approximately 11:25 AM on 12/07/25. The Infection Control RN was the designed RN in charge at the time of the entrance to the survey. She had no comment when this was reviewed with her for an incorrect date. Staffing was also reviewed with the Regional Compliance Advisor on 12/09/25 mid-morning. He also had no comments regarding staffing.

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 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.

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
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and resident interview, the facility failed to ensure an accurate physician order for thin liquids via straw. This was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident Identifier #11. Facility Census: 63. Findings included: Resident #11 a) On 12/07/2025, a dining room observation was initiated. Resident #52 had a straw in a [NAME] Cup in her wheelchair cup holder in the dining room during the lunch meal and a straw in her water pitcher in her room at bedside. At 1:35 PM, Nurse Aide (NA) #52 verified the resident's tray card for 2 Handled cup w/no lid, Food in mugs, [NAME] Cup, and NO STRAWS The resident and Nursing Aide (NA) #52 the resident had been using straws in the dining room and her room. At 1:35 PM, NA #52 verified the resident's tray card for 2 Handled cup w/no lid, Food in mugs, [NAME] Cup, and NO STRAWS. According to North Coast Medical and Rehabilitation Products, a [NAME] Cup is a Lightweight, easy-to-grip no spill cupUsed in either a reclined or seated position. Liquid is dispensed only as the client sucks on the straw. Resident #11's diet order stated, Regular/Liberalized Dysphagia Puree texture, Standard Thin Liquids consistency, no bread, may have regular cottage cheese, cheeseballs, and Reese's mini cups, food in coffee cups, Kennedy cup for beverages no straws. Resident #11 care plan report stated, Provide regular, dysphagia puree diet as ordered. No bread, may have regular cottage cheese, food in coffee cups 2 handled cup no straws. The resident's care plan also stated, Divided scoop plate pureed solids, thin liquids, use straws and handled cups. On 11/17/2025, a staff message from the Speech-Language Pathologist (SLP) stated the resident was to use straws. An SLP Evaluation dated 11/17/25 recommended thin liquids via straw.

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
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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based upon record review and staff interview, the facility failed to follow its policy for residents who choose to smoke or vape.This was found to be true for one (1) of one (1) resident reviewed during the long term care survey process. Resident identifier:#56 Census: 63 Findings included:A) Resident #56During the interview with this resident on 12/07/25 at 1:20 PM, the resident was complaining about the facility changing the designated smoking schedule, and having staff accompany her to smoke, as well as use of the smoking apron. A review of her care plan contained the following:Focus area:During my Preferences for Customary Routine Interview, there were daily routine preferences noted as important. The most important things for the center staff to know about my preferred daily routine are: smoking outside. Date initiated: 08/21/24. Surveyor explained to the resident the use of the smoking apron and having staff to accompany the residents outside were for the resident's own safety.A review of the resident's medical record documented a smoking assessment was last completed in August of 2025.A request was made to the facility to see if there was another smoking assessment completed after the August of 2025 date. Staff #108 responded to say one had not been done, and then handed me a smoking assessment which the facility had just completed with a date of 12/10/25 (today).B) Facility Policy The facility's policy entitled Smoking, created on 06/01/96, and revised on 02/24/25, stated: For Centers that allow smoking, smoking (including the use of e-cigarettes) will be permitted in designated areas only Patients/Residents (hereafter patient) will be assessed on admission, quarterly, and with change in condition for the ability to smoke safely and, if necessary, will be supervised Based upon the facility's Smoking Policy, the next quarterly assessment would have been due in November of 2025, and the facility failed to complete this until 12/10/25.