STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515103	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenville Health & Rehab	111 Fairground Road Glenville, WV 26351

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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 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 on record review and staff interview, the facility failed to enusre they referred a resident with a newly evident mental disorder to the appropriate state-designated authority for review. This was found to be true for three (3) of eight (8) residents sampled during the long term care survey process. Resident identifiers: #3, #5, #12. Facility census: 63 Findings included: a) Resident #3 Resident #3 was admitted to the facility on [DATE].The resident had the following diagnoses on admission: -PARKINSON'S DISEASE WITHOUT DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS 07/25/25 Principal Diagnosis admission POST-TRAUMATIC STRESS DISORDER, CHRONIC Medical Management 07/25/25 History During the stay at the facility, the resident had a new diagnosis of: -MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE 11/5/25 During Stay The MDS dated [DATE], had a primary diagnosis of Parkinson's. Other diagnoses of Post Traumatic Stress Disorder, and depression were indicated on the MDS. The PASARR for the resident is dated 07/23/25, and was completed by an acute care facility. The PASARR has no diagnoses for mental illness or intellectual disabilities. b) Resident #5 This resident was first admitted to the facility on [DATE], with a re-admission date of 07/17/24. Upon admission, the resident had these diagnoses: -ALZHEIMER'S DISEASE, UNSPECIFIED 3/4/2021 Principal Diagnosis admission -UNSPECIFIED CONVULSIONS 03/3/21 admission -MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED 03/03/21 admission During the resident's stay at the facility, additional diagnoses were made, including: -Dementia in other diseases classified elsewhere, unspecified severity, without behavioral, psychotic, mood, or anxiety disturbance 6/21/21 During Stay -ANXIETY DISORDER, UNSPECIFIED 03/10/21 During Stay -DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, MODERATE, WITH MOOD DISTURBANCE 01/30/2026 During Stay -MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED 01/30/2026 During Stay The MDS for the resident was last updated on 03/04/26, and contained all of the above diagnoses. The PASARR was completed on 03/01/21 at an acute care facility. The PASARR did not contain any of those diagnoses. It was marked none for current diagnoses. c) Resident #12 Resident #12 was admitted to the facility on [DATE]. The resident had diagnoses which included: - Bipolar Disorder, Unspecified -Generalized Anxiety Disorder -Depression, Unspecified The most recent MDS was completed on 02/27/26, and had a primary diagnosis of Type II Diabetes. The MDS contained all of the above diagnoses. The current PASARR was completed on 05/07/25 by another long term care facility. The PASARR had diagnoses of bipolar and anxiety disorder, but no diagnosis for depression. The findings of Resident #3, #5, and #12 were reviewed with the Nursing Home Administrator and the Director of Nursing on 04/14/26 at approximately 3:30 PM. The NHA acknowledged the discrepancies.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that the resident's Pre-admission Screening (PAS) reflected pre-admission diagnoses for four (2) of eight (8) resident reviewed for the category of PASARR, during the long-term care survey. Resident identifiers: #4, and #5, Facility Census: 63. a) Resident #5 This resident was first admitted to the facility on [DATE], with a re-admission date of 07/17/24. Upon admission, the resident had these diagnoses: -ALZHEIMER'S DISEASE, UNSPECIFIED 3/4/2021 Principal Diagnosis admission -UNSPECIFIED CONVULSIONS 03/3/2021 admission -MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED 03/03/2021 admission The PASARR was completed on 03/01/21 in an acute care facility. The PASARR did not contain any of the above diagnoses. It is marked 'none' for current diagnoses. In summary, the PASARR should have been updated when the resident was admitted to the facility. This was reviewed with the Nursing Home Administrator (NHA) and the Director of Nursing on 04/14/26 at approximately 3:30 PM. The NHA acknowledged this discrepancy. b) Resident #4 A review of Resident #4's PASARR revealed that bipolar disorder was not marked as a current diagnosis. Further, 'delusional' is not marked under the clinical and psychological data section. Resident #4 had listed under diagnoses: Bipolar disorder with an onset date of admission and Delusional disorders with an onset of admission. During an interview on 04/14/26 at 11:33 AM it was confirmed with the Administrator that bipolar disorder and delusions were not indicated on the PASARR and should have been.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 upon record review and staff interviews, the facility failed to revise residents care plan in a timely manner, following significant change in condition. This was found to be true for four (4) of 23 residents reviewed during the long term care survey process. Resident identifiers: #25, #9, #5, #50. Facility census: 63. Findings Include: a) Resident # 25 Resident #25, is [AGE] years old who has capacity to make own medical decisions. The resident was admitted to the facility on [DATE]. A trauma screening was performed on 01/14/26 by the Director of Social Services. To the question, Was care plan updated to reflect the resident's experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization. A response of yes was marked. From the care plan: the resident reported trauma during their trauma screening related to childhood abuse, domestic violence, PTSD, substance abuse and rape. Goal was the residents past traumatic experiences will not cause the distress thru the review period Date Initiated: 01/13/2026 Target Date: 07/14/2026 The interventions were: attempt to determine any triggers that the resident may have related to their pasttrauma and work with staff to avoid those when possibleDate Initiated: 01/13/2026SW refer to psych services as indicatedDate Initiated: 01/13/2026LPNRNSW schedule familiar staff to the resident as possibleDate Initiated: 01/13/2026LPNRNSW trauma screen as indicatedDate Initiated: 01/13/2026 There was nothing in the medical record to suggest the facility attempted to find out triggers for the PTSD. The Director of Social Services offered resident MindCare Services, a psychiatric counseling service, which was accepted by the resident on 01/13/26. The progess notes from the initial Mind Care visit on 01/16/26 stated: Non-Pharmacological Interventions: Dementia: Agitated/ Resistant with Care-- The person may push, grab, or strike out as the caregiver attempts to provide care.-- This may be a way for a patient with difficulty expressing themselves verbally, to tell caregivers they are uncomfortable and/or unwilling to cooperate. Caregivers must listen to the behavior to understand what the problem may be.-- Patient can be anxious because he or she misinterprets the event, or because he or she is cold or hot, or because of modesty concerns, or because the movement of joints causes pain-- Interventions:--- Staff reassurance--- Staff training in how to appropriately approach and calm an anxious patient--- (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Same-sex attendant--- Slow down, communicate clearly, cue: Slowing down, making eye contact, and explaining step-by-step Instructions on care being provided can be helpful to reduce agitation. Encourage the person to do as much as she/he can by providing cues and limited assistance.--- Adjust routines to fit long-standing habits: Plan care around patterns that are familiar to the person or align with their routine. More flexible bathing methods and schedule (e.g., towel bath)--- Use alternative approaches during bathing: Bathing introduces a number of potential threats that the person with dementia may Resist. Both physical (cold, pain on movement, water in face) and psychological (embarrassed by nudity, frightened by spraying water) discomforts contribute. Adjust the bathroom decor to more inviting, homelike and comfortable. Effective comfort include room and water temperature, soft covers when not being washed, and distractions such pleasant aromas, preferred music, having a snack and singing with the person.Recommendations: Recommendations are provided as a reference for patient-identified behaviors. Please see the EHR/patient chart at thefacility for Patient-specific Care Planning/Documentation. (These are not orders)Non-Pharmacological Interventions: New residentFor the resident who has recently moved-in: welcoming activities and/or orientation activities; Provide support and encouragement during transition to new facility; Encourage socialization and participation in activities;Recommendations: Recommendations are provided as a reference for patient identified behaviors. Please see the EHR/patient chart at the facility for Patient specific Care Planning/Documentation. (These are not orders)Non-Pharmacological Interventions: AnxietyOffer a calm environment, offer own support as well as from family and peers, reassurance during panic attacks, music therapy, pet therapy, massage, art therapy or other relaxing activities, relaxation training, breathing exercises to encourage relaxation, guided imagery, exercise, outdoor walks, and aromatherapy.Non-pharmacological Interventions: DepressionEncourage resident to participate in activities; encourage adequate sleep, nutrition, and exercise; good sleep-hygiene; social interaction; Touch and sensory activities such as massage or aromatherapy; psychotherapy as indicatedNon-Pharmacological Interventions: Dementia: BPSDFor the resident with Behavioral and Psychological Symptoms of Dementia-- Mild to Moderate BPSD: Careful documentation of behaviors and identification of target symptoms, a search for potential triggers or precipitants, recording of the consequences of the behavior,an evaluation to rule out treatable or contributory causes, and consideration of the safety of the patient, their caregiver (including nursing staff), and others in their environment.-- Severe BPSD: The management of BPSD should begin with appropriate assessments, diagnosis, and identification of target symptoms and consideration of safety of the patient, their caregiver/nursing staff and others in their environment. Behavioral management for depression, and education programs for caregivers and staff to teach them how to recognize behavioral problems and to teach them behavior-modification techniques. Music therapy and controlled multi-sensory stimulation. Medications are used when appropriate as a last resort. Examples include but not limited to, those with severe depression, psychosis, or aggression. -- Adjusting caregiver approaches: simplify tasks and communication, use the persons history as a guide, and avoid confronting the person with what they are unable to remember. Breaking tasks and instructions into doable steps, using physical and verbal cues, and accepting misbeliefs as real to the person (using validation vs. reality orientation). Staff training to use multi-component dementia care management approaches.-- Changing the physical and social environment. Reducing the risk of problem behaviors often relies on changing the environment in which persons with dementia live. Simplify the world around the person with dementia.-- Select and individualize non-pharmacological interventions: Selectone or more intervention that fits the problem behavior identified, and then tailor that intervention to the individualized needs of the person. Use the information about the persons cognitive level; physical function; long-standing traits, habits, and interests; preferred routines; and resources to individualize the selected activity.Non-Pharmacological Interventions: Dementia: General Interventions-- Provide opportunities for the resident to engage in structured, meaningful activities throughout theday-- Assure the person exercises which can reduce (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety, agitation, and restlessness.-- Ensure all basic needs are met including toileting, nutrition, and thirst-- Involve the person in daily activities-- Sensory stimulation or cognitive therapy (e.g., touch/visual/auditory stimulation, reminiscence, or validation therapy) such as special stimulus rooms or equipment; alerting/upbeat music and using alerting aromas or providing fabrics or other materials of varying textures;-- Social engagement (e.g., directed conversation, initiating a resident to resident conversation, pleasure walk or coffee visit);-- Spiritual support, nurturing (e.g., daily devotion, Bible reading, or prayer with or for resident per religious requests/desires);-- Creative, task-oriented activities (e.g., music or pet activities/therapy, letter writing, word puzzles); or Support of self-directed activity (e.g., delivering of library books, craft material to rooms, setting up talking book service).-- Arranging staffing to optimize familiarity with the resident (e.g., consistent caregiver assignment);-- Identifying, to the extent possible, factors that may underlie the residents expressions of distress, as well as applying knowledge of lifelong patterns, preferences, and interests for daily activities to enhance quality of life and individualize routine care.-- Understanding that the resident with dementia may be responding predictably given the situation or surroundings. For example, being awakened at night in his/her bedroom by staff and not recognizing the staff could elicit an aggressive response;-- Matching activities for a resident with dementia to his/her individual cognitive and other abilities and the specific behaviors in that individual based on the assessment. None of these suggestions from Mind Care were included in the resident's care plan. During an interview with the Director of Social Services on 04/16/16 at noon, the surveyor asked about the suggestions provided by MindCare and why were they not implemented in the resident's care plan? The Director of Social Services first statement was it would be up to the Doctor to include that. The Director further stated we did have some of that in the behavior section of the care plan. When surveyor asked what did the facility try to do to identify the resident's triggers for PTSD, the Director of Social Services said let me go get the Administrator. The Surveyor waited ten minutes and Director and Administrator did not come back to provide any answers. Approximately twenty minutes later, the Nursing Home Administrator (NHA) and Social Services Director came to discuss this further. The surveyor asked again, what did the facility do to try to determine triggers and what are things you implemented for trauma informed care? No specific information was provided, but NHA did state she felt the facility could benefit from their corporate office providing some guidance on things they could do to improve trauma informed care. b) Resident #9 Resident #9 was admitted to the facility on [DATE]. This resident does not have capacity to make own medical decisions. The resident is age [AGE]. Upon admission to the facility, the resident weighed 228.6 lbs. On 04/01/2026, the resident weighed 186.4 lbs which is a -18.46% weight loss. His orders pertaining to diet were: -Regular diet, *Regular texture, *Regular/Thin consistencyfortified food at lunch Diet Active 1/27/2026 -Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ Minerals)Give 1 tablet by mouth one time a (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	day for wound healingPharmacy Active 01/31/2026 -Vitamin D3 Ultra Potency Oral Tablet 1250 MCG (Cholecalciferol)Give 1 tablet by mouth one time a day every Thu for supplementPharmacy Active 01/29/2026 A Nutritional at Risk Assessment was completed by the facility on 01/30/26. The resident scored 12, which is categorized as normal nutritional status. The Assessment documented resident's BMI as 32.8. The summary stated, Resident receives regular diet, regular textures, thin liquids with excellent meal intakes (majority of meals > 75% consumed). Can eat independently with tray set up, BMI obese for age, gradual loss would be beneficuak if occurs .Will monitor weights, PO intakes, hydration status, labs, and skin integrity. The resident's care plan stated, -Focus: Resident is at risk for malnutrition, related to advanced age, limited mobility, edema, obesity, chronic diseases, sig weight loss. -Goal: Will have gradual weight loss towards BMI WNL (within normal limits) through the review period. Will consume >/= 75% of trays through the review period. The resident will have optimal nutrition and hydration status thru review period. Resident will maintain or improve nutritional status, with no new or worsening signs and symptoms of malnutrition through the review date. -Interventions: Assess for s/s (signs and symptoms) of malnutrition, including PO intake, labs, wts (weights) per facility protocol, skin integrity, and s/s dehydration, Encourage to eat. RD (Registered Dietitician) consult as needed. Record meal % intake. Review dietary preferences with the resident as needed. Therapeutic diet as ordered. Weights as ordered. On 02/24/26, the resident's weight was recorded as 206.8, representing a -9.5% weight loss in one month. A progress note from Dietician #90 on 02/27/26, stated Resident with significant weight loss of -22 lbs (-9.6%) x 1 month since admission. Loss is considered clinically significant and desirable at this time given elevated BMI (29.7, overweight range). Weight change likely multifactorial, including history of wounds with prior Pro-Stat BID use, variable PO intake (50-100%, and overall clinical status Continue to monitor intake, weight trends, wound history, and fluid status closely. MD aware. On 03/10/26, resident's weight was recorded as 191.6, representing a weight loss of -16.18% since admission. A progress note from a different dietician on 03/13/26 stated, Resident with significant weight loss x 1 and 2 months. Loss is considered clinically significant and desirable at this time given elevated BMI. Weight change likely multifactorial, including history of wounds with prior Pro-Stat BID use, variable PO intake (50-100%, and overall clinical status Continue to monitor intake, weight trends, wound history, and fluid status closely. MD aware. A progress note on 04/09/26, stated Resident triggered for unplanned significant weight loss. Rt recently fell and gradual decline in cognition noted last month. Bilateral lower extremity edema noted by RD last month- loss could also be r/t fluid. RD recommended fortified food qd at lunch (4/9/26) .IDT/MD aware. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's section of the medical record for significant change in condition assessments, the surveyor found no significant change assessment pertaining to weight loss in the medical record. A discussion was initiated with the Nursing Home Administrator (NHA) on 04/15/2026 at 3:33 PM. Surveyor referred to the care plan, which stated the resident was at risk for malnutrition, yet a goal was set to gradually have weight loss. This seemed contradictory to me, and the NHA agreed. The NHA further stated the resident and his family wanted him to lose weight. They thought it would enable him to be able to walk better. As we walked through the pieces of the resident's medical record, the surveyor said to the NHA, I did not see documented anywhere of the resident wanting to lose weight. If this was true, shouldn't the care plan have stated this? Also asked the NHA, shouldn't the care plan been updated to reflect the significant change in weight? c) Resident #5 This Resident had an unwitnessed fall on 02/18/26. The resident struck head, resulting in a bruise to the forehead. Neurochecks were implemented per the facility's policy. The resident's care plan for falls stated: RISK FOR FALLS: the resident is at riskfor falls related to: cognitive impairment.Has a hx of putting self in floor when upset.Date Initiated: 01/13/2025Revision on: 01/13/2025 Goal: the resident will not have a fallthru the review periodDate Initiated: 08/14/2025Revision on: 12/15/2025Target Date: 06/02/2026 Interventions: Bed locked and in low positionDate Initiated: 01/13/2025Revision on: 06/12/2025 Bedside table/items within reachDate Initiated: 01/13/2025 Encourage resident to go to activities after visiting with daughter to decreaseanxietyDate Initiated: 01/13/2025 non-skid socks while out of bedDate Initiated: 01/13/2025 Place call light within reach while in bed or close proximity to the bed.Date Initiated: 01/13/2025 remind the resident to use their call light to ask for assistance with ADLSDate Initiated: 01/13/2025 Therapy referral for fall on 10/27/2025 and 12/16/25Date Initiated: 10/28/2025 The resident's care plan was not updated with any interventions for falls prevention following fall on 02/18/26. D) Resident #50 An order placed on 02/11/26 reads, Regular diet, puree texture, regular/thin consistency. Resident #50's care plan with a revision date of 02/13/26 reads as follows: - therapeutic diet as ordered: regular; puree/honey thick (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident is at risk for malnutrition [related to] r/t advanced age, [history] hx of significant weight changes, need for mechanically altered diet texture, need for thickened liquids -[Resident] Res will tolerate mechanically altered diet and thickened liquids without aspiration. An interview with Dietary Manager and Director of Rehab at approximately 12:00PM on 04/15/26 confirm Resident #50 should have thin liquids. An interview with Director of Nursing (DON) at approximately 2:00PM confirms the care plan was not revised when the order was changed to thin liquids.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interviews, the facility failed to ensure the resident environment over which they had control was as free from accident hazards as possible in regards to bed safety and unsecured medication. This was random opportunity for discovery. Resident # 9, #52 and #6 . Facility census: 63. a)Resident #52 During an initial tour of the facility an observation completed on 04/13/26 at 12:16 PM, revealed Resident #6's bed had an approximate 12-inch gap between the mattress and head board. b) Resident #9 During an initial tour of the facility an observation completed on 04/13/26 at 12:30 PM, revealed Resident #9 was lying in bed with an approximate 12-inch gap between the mattress and head board. c) Resident #6 The observation noted Resident #52's bed. The bed had a large gap between the foot board and mattress. During an interview and tour on 04/13/26 at 1:10 PM, the Director of Nursing and Administrator verified the gaps between the mattress and the bed frame. They stated they would fix them immediately. A policy titled, Storage of Medication reads: Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration.The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. On 04/15/2026 at 11:10 AM, the state surveyor observed Aspercreme with lidocaine sitting on top of the treatment cart with no staff nearby. An interview with Healing Partners NP#91 confirmed this was left on the cart without supervision. The Material Safety Data Sheet indicates to keep it out of reach of children. If ingested, induce vomiting and seek immediate medical attention or contact Poison Control Center.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and staff interview, the facility failed to ensure qualified dietary staff carried out the functions of food and nutrition services. This had the potential to affect all of the residents receiving nutrition from the kitchen. Census: 63Findings include: An interview with Dietician #90 on 04/14/26 at 2:30pm confirmed that she works remotely as a consultant and does not come to the facility in person. A review of current credentials revealed the Dietary Manager was not certified as a manager for dietary services. An interview with Regional Dietary Manager and Administrator on 04/14/26 at approximately 3:00PM confirms there is not a Certified Dietary Manager overseeing food and nutrition services at this time and that the Dietician works remotely.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review and staff interviews, the facility failed to ensure the menu met the residents' daily nutrition requirements. This had the potential to affect a majority of the residents getting nutrition from the kitchen. Census: 63. Findings included:A policy titled Director of Food and Nutrition Services Responsibilities states that food served will be attractive, palatable and meet the dietary needs of the individuals being served. The lunch menu for 04/13/26 consisted of homemade cream of potato soup, cornbread, jello, choice of milk and beverage of choice. The dietary guidelines provided by the Dietary Manager for 04/13/26 are as follows: Carbohydrates: Required: 16; Total for day: 12 Fruits and Vegetables: Required: 5; Total for day: 2.5 Meats and Proteins: Required: 6;Total for day: 5 In an interview with Dietician #90 on 04/14/26 at approximately 2:30 PM, she confirmed that the menu for 04/13/26 did not match the regional menu that ensures all nutritional requirements are met. An interview with the Regional Dietary Manager and Administrator at approximately 3:00 PM confirmed that the daily nutritional requirements for 04/13/26 were not met.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenville Health & Rehab	111 Fairground Road Glenville, WV 26351

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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. Based on observation, policy and staff interviews, the facility failed to ensure food was prepared and stored under sanitary conditions and that dishes were stored under sanitary conditions. This had the potential to affect a majority of residents receiving nutrition from the kitchen. Census: 63Findings include: a)A policy titled, Food Storage, contains the following: all foods should be covered, labeled and dated and routinely monitored to ensure they will be consumed by their use by dates. A policy titled, Cleaning Instructions: Microwave Oven, reads that the microwave oven interior should be cleaned after each use as needed. In the procedure section states to remove any food particles from the microwave oven interior with a clean, wet cloth and wipe the interior, including the ceiling, with hot sudsy water. A policy titled, General Food Preparation and Handling, states that all food service equipment should be cleaned, sanitized, air-dried and reassembled after each use. During the initial kitchen tour at 11:15 AM on 04/13/26, small ziploc bags of cheese in the walk in refrigerator were not dated or labeled. There was a bag of chopped lettuce with a use by date of 04/10/26 in the walk in refrigerator and two (2) packages of cupcakes in the stand up freezer with a use by date of 03/12/26. These findings were confirmed by the Dietary Manager at 11:20 AM on 04/13/26. During a second kitchen tour on 04/15/26 at 11:00AM, wet nesting (the practice of stacking wet dishes that does not allow for air flow and encourages bacterial growth) was identified in the metal serving dishes. Food particles and a yellow greasy substance were also stuck to the top of the microwave. These findings were confirmed by Regional Dietary Manager confirmed these findings at 11:04 AM.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and staff interview, the facility failed to follow their grievance policy as related to an investigation of neglect for Resident #36. This failed practice has the potential to affect more than a limited number of residents. Resident identifier: #36. Census: 63.Findings include: a) Resident #36 A policy titled Grievances/Complaints reads, The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. The grievance report for Resident #36 stated, Resident reported on 01/11/26 he had peed in the bed about 9:00bPM and did not get cleaned up until 3:00 AM and had call light on and reported staff turned off the light and left. In an interview with Administrator and Director of Nursing at approximately 12:00PM on 04/16/26, it was confirmed that this was an allegation of neglect and it was not reported to the appropriate state agencies as per their grievance policy.

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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 interviews, the facility failed to identify a grievance as neglect and report that to the appropriate state agencies. This failed practice has the potential to affect more than a minimal number of residents. Census: 63Findings include: A policy titled Grievances/Complaints reads, The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. The grievance report for Resident #36 stated, Resident reported on 01/11/26 he had peed in the bed about 9:00 PM and did not get cleaned up until 3:00 AM and had call light on and reported staff turned off the light and left. In an interview with Administrator and Director of Nursing at approximately 12:00PM on 04/16/26, it was confirmed that this was an allegation of neglect and it was not reported to the appropriate state agencies as per their grievance policy.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to thoroughly investigate a complaint of neglect for Resident #36. Resident identifier: #36. Facility Census: 63.Findings include: a) Resident #36 A policy titled Grievances/Complaints reads, The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. The grievance policy also states, The Grievance Officer, Administrator and Staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated.The Federal regulation 483.12(c)(1)-(4) require facilities to report allegations of abuse, neglect, exploitation or mistreatment, including injuries ofunknown origin/source and misappropriation of resident property, are reported immediately.The grievance report for Resident #36 stated, Resident reported on 01/11/26 that he had peed in the bed about 9:00 PM and did not get cleaned up until 3:00 AM, and that he had the call light on and reported staff turned off the light and left. The summary of the investigation reads as follows: At this time, there is no conclusive evidence into the investigation to determine an appropriate outcome. The investigation consisted of statements from three (3) nurse aides typed and signed by the Director of Nursing dated 01/12/26 and a skin assessment dated [DATE]. The grievance report states the incident was reported on 01/16/26.In an interview with Administrator and Director of Nursing at approximately 12:00PM on 04/16/26, it was confirmed that this was an allegation of neglect and it was not reported to the appropriate state agencies as per their grievance policy. It was also confirmed that there are no handwritten statements signed by the nurse aides providing care that day.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to perform a comprehensive assessment following significant change in a resident with weight loss of over 18% in less than three (3) months. This was found to be true for one (1) of one (1) residents reviewed during the long term care survey process. Resident identifier: #9. Facility census: 63. Findings included: a) Resident #9 Resident #9 was admitted to the facility on [DATE]. This resident does not have capacity to make own medical decisions. The resident is age [AGE]. Upon admission to the facility, the resident weighed 228.6 lbs. On 04/01/2026, the resident weighed 186.4 lbs which is a -18.46% weight loss. Resident #9's orders pertaining to diet were: -Regular diet, *Regular texture, *Regular/Thin consistencyfortified food at lunch Diet Active 1/27/2026 -Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ Minerals)Give 1 tablet by mouth one time a day for wound healingPharmacy Active 01/31/2026-Vitamin D3 Ultra Potency Oral Tablet 1250 MCG (Cholecalciferol)Give 1 tablet by mouth one time a day every Thu for supplementPharmacy Active 01/29/2026A Nutritional at Risk Assessment was completed by the facility on 01/30/26. The resident scored 12, which was categorized as normal nutritional status. The Assessment documented resident's BMI as 32.8. The summary stated, Resident receives regular diet, regular textures, thin liquids with excellent meal intakes (majority of meals > 75% consumed). Can eat independently with tray set up, BMI obese for age, gradual loss would be beneficuak if occurs .Will monitor weights, PO intakes, hydration status, labs, and skin integrity. The resident's care plan stated, -Focus: Resident is at risk for malnutrition, related to advanced age, limited mobility, edema, obesity, chronic diseases, sig weight loss. -Goal: Will have gradual weight loss towards BMI WNL (within normal limits) through the review period. Will consume >/= 75% of trays through the review period. The resident will have optimal nutrition and hydration status thru review period. Resident will maintain or improve nutritional status, with no new or worsening signs and symptoms of malnutrition through the review date. -Interventions: Assess for s/s (signs and symptoms) of malnutrition, including PO intake, labs, wts (weights) per facility protocol, skin integrity, and s/s dehydration, Encourage to eat. RD (Registered Dietitician) consult as needed. Record meal % intake. Review dietary preferences with the resident as needed. Therapeutic diet as ordered. Weights as ordered. On 02/24/26, the resident's weight was recorded as 206.8, representing a -9.5% weight loss in one month. A progress note from Dietician #90 on 02/27/26, stated Resident with significant weight loss of -22 lbs (-9.6%) x 1 month since admission. Loss is considered clinically significant and desirable at this time given elevated BMI (29.7, overweight range). Weight change likely multifactorial, including history of wounds with prior Pro-Stat BID use, variable PO intake (50-100%, and overall clinical status Continue to monitor intake, weight trends, wound history, and fluid status closely. MD aware. On 03/10/26, resident's weight was recorded as 191.6, representing a weight loss of -16.18% since admission. A progress note from a different dietician on 03/13/26 stated, Resident with significant weight loss x 1 and 2 months. Loss is considered clinically significant and desirable at this time given elevated BMI. Weight change likely multifactorial, including history of wounds with prior Pro-Stat BID use, variable PO intake (50-100%, and overall clinical status Continue to monitor intake, weight trends, wound history, and fluid status closely. MD aware. A progress note on 04/09/26, stated Resident triggered for unplanned significant weight loss. Rt recently fell and gradual decline in cognition noted last month. Bilateral lower extremity edema noted by RD last month- loss could also be r/t fluid. RD recommended fortified food qd at lunch (4/9/26) .IDT/MD aware. A review of the resident's section of the medical record for significant change in condition assessments, the surveyor found no significant change assessment pertaining to weight loss in the medical record. A discussion was initiated with the Nursing Home Administrator (NHA) on 04/15/2026 at 3:33 PM. Surveyor referred to the care plan, which stated the resident was at risk for malnutrition, yet a goal was set to gradually have weight loss. This seemed contradictory to me, and the NHA agreed. The NHA further stated the resident and (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his family wanted him to lose weight. They thought it would enable him to be able to walk better. As we walked through the pieces of the resident's medical record, the surveyor said to the NHA, I did not see documented anywhere of the resident wanting to lose weight. If this was true, shouldn't the care plan have stated this? Further, advised NHA a weight loss of this significance should have triggered a change in condition assessment, but none were found.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) was accurate regarding toileting schedule for Resident #48. This was true for one (1) of seven (7) residents sampled for accidents during the Long-Term Care Survey Process. Resident identifier: #48. Facility census: 63. Findings include: a) Resident #48 Resident #48's care plan reads, Toileting schedule: toilet resident upon rising, before and after meals and at bedtime. The significant change Minimum Data Set (MDS) dated [DATE] marked 'no' for both the urinary toileting program and the bowel toileting program. An interview with MDS coordinator #61 and the Director of Nursing (DON) at 11:45 AM on 04/15/26 confirmed that the care plan stated Resident #48 had a toileting schedule, but the MDS was marked as having no schedule.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interview, the facility failed to ensure Resident #6 received Oxygen therapy as ordered by physician. This was true for one (1) of two (2) residents sampled for Oxygen during the Long-Term Care Survey Process. Census: 63 Resident identifier: #6 Findings include: a) Resident #6 On 04/14/2026 at 2:00 PM, state surveyors observed Resident #6 in the therapy gym without oxygen. At 2:41 PM, Resident #6 was still in the therapy gym without oxygen. According to Resident #6's orders and care plan, the resident was to receive five (5) liters/minute at 28% humidification via tracheostomy mask. An interview with the Director of Nursing (DON) and Director of Rehab at 2:41 PM confirmed the resident was without oxygen and had been without oxygen during therapy. An interview with the DON at 4:00 PM confirmed the resident should have oxygen per current documented orders.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on Interview, and record review the facility failed to ensure that a resident received the treatment and care in accordance with professional standards of practice in regard to monitoring pain levels. This was true for one (1) of five (5) residents reviewed for pain during the long-term survey process. Resident Identifier: #42. Facility census: 63.Findings included: a) Resident #42During an interview on 04/13/26, at 1:18 PM, Resident #42 reported experiencing constant pain. She stated that she was only provided with Tylenol, which she felt was ineffective most of the time. Additionally, she mentioned that she remained awake and wandered throughout the night due to the severity of her discomfort. Medical record review revealed Resident #42's Physician orders for pain management:-Tylenol 8-hour Arthritis Pain Oral Tablet Extended Release 650 MG (Acetaminophen): Give 650 MG by mouth 3 times a day for mild to moderate pain. With supplemental documentation for the pain level. The start date was 07/07/2025. -Monitor for pain every shift. Start date 09/03/2025.A continued review of Medication Administration Record (MAR) revealed:-03/13/26 at 6:00 PM pain level 8 - Acetaminophen 650 Mg tablet given.-03/21/26 at 6:00 PM pain level 7 - Acetaminophen 650 Mg tablet given.-03/22/26 at 6:00 PM pain level 8 - Acetaminophen 650 Mg tablet given.-03/23/26 at 6:00 AM pain level 7 - Acetaminophen 650 Mg tablet given.-03/30/26 at 6:00 PM pain level 7 - Acetaminophen 650 Mg tablet given.-04/02/26 at 12:00 PM pain level 7- Acetaminophen 650 Mg tablet given.-04/03/26 at 6:00 PM pain level 7- Acetaminophen 650 Mg tablet given.-04/04/26 at 6:00 PM pain level 7- Acetaminophen 650 Mg tablet given.-04/05/26 at 6:00 PM pain level 7- Acetaminophen 650 Mg tablet given.-04/06/26 at 6:00 PM pain level 7- Acetaminophen 650 Mg tablet given.-04/08/26 at 6:00 PM pain level 8- Acetaminophen 650 Mg tablet given.-04/09/26 at 6:00 PM pain level 7- Acetaminophen 650 Mg tablet given.-04/10/26 at 6:00 PM pain level 7- Acetaminophen 650 Mg tablet given.-04/11/26 at 6:00 PM pain level 7- Acetaminophen 650 Mg tablet given.-04/12/26 at 6:00 PM pain level 8- Acetaminophen 650 Mg tablet given.-04/13/26 at 6:00 PM pain level 8- Acetaminophen 650 Mg tablet given.-04/14/26 at 6:00 AM pain level 6- Acetaminophen 650 Mg tablet given.-04/03/26 at 6:00 AM pain level 6- Acetaminophen 650 Mg tablet given.Subsequent review found 15 other occurrences of pain levels 5 and below in the last 30 days.A medical record review found no documentation that the physician was notified of increased major pain levels.An interview on 04/16/26 at 11:42 AM with Director of Nursing (DON), confirmed that the physician was not notified of the reported increased pain levels until 04/15/26 after surveyor intervention. She stated that the Physician increased Resident #42's pain medication on 04/15/26.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to work to identify a resident's past history of trauma, and/or triggers which may cause re-traumatization. This was found to be true for one (1) of two (2) residents reviewed for PTSD during the long term care survey process. Resident identifier: #25. Facility census: 63. Findings included: a) Resident #25 This [AGE] year old resident has the capacity to make own medical decisions. Resident was admitted to the facility on [DATE]. This surveyor attempted three times to interview the resident, but each time the resident was asleep. A review of the resident's medical record documented a trauma screening was performed on 01/14/26 by the Director of Social Services. To the question, Was care plan updated to reflect the resident's experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization. A response of yes was marked. From the care plan:the resident reported drauma during their trauma screening related to childhood abuse, domestic violence, PTSD, substance abuse and rape. Goal was the residents past traumatic experiences will not cause the distress thru the review period Date Initiated: 01/13/2026 Target Date: 07/14/2026 Listed interventions were: attempt to determine any triggers that the resident may have related to their pasttrauma and work with staff to avoid those when possibleDate Initiated: 01/13/2026SW refer to psych services as indicatedDate Initiated: 01/13/2026LPNRNSW schedule familiar staff to the resident as possibleDate Initiated: 01/13/2026LPNRNSW trauma screen as indicatedDate Initiated: 01/13/2026 There is no documentation in the medical record that the care plan intervention for attempt to determine any triggers that the resident may have related to their pasttrauma and work with staff to avoid those when possible was implemented. The Director of Social Services offered resident MindCare Services, a psychiatry service, which was accepted by the resident on 01/13/26. This service did not identify any areas that would cause triggers for the resident. Nothing further was attempted. When asked what did the facility try to do to identify the resident's triggers for PTSD, the Director of Social Services said let me go get the Nursing Home Administrator (NHA). NHA and Social Director returned at 12:20 to the conference room to discuss further. The surveyor asked again what did the facility do to try to determine triggers and what are things they implemented for trauma informed care? Neither really had an answer. NHA did say she thought trauma informed care was something their corporate could work on to provide resources for their facilities across the country.