STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515105	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Center	8 Rose Street Grafton, WV 26354

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interviews, and policy review, the facility failed to report a resident allegation of verbal abuse within two (2) hours of facility staff being aware of the allegation. Additionally, the facility failed to complete and/or submit a 5-day follow-up for an allegation of abuse for Resident #77. This failed practice was found true for two (2) of two (2) residents reviewed for abuse during the Long-Term Care Survey Process. Resident identifier #3. Facility census: 67. Findings Included:A review of the policy titled, OPS300 Abuse Prohibition, revealed verbal abuse defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.Additionally, the policy directs, immediately upon identification of a concern, a report of suspected or alleged abuse, mistreatment, or neglect, the administrator or designee will report allegations involving abuse (physical, verbal, sexual, mental) no later than two (2) hours after the allegation is made. a) Resident #3During an interview on 03/22/26 at 1:15 PM, Resident #3 who had a Brief Interview for Mental Status (BIMS) of 15, stated, There are (2) two nurses that work Monday thru Thursday. They are always sleeping. I told the administration and I guess the (2) two nurses were mad at me. I have a recording of the one calling me a jerk. Resident #15 then let the State Agency (SA) listen to the recording, with a date of 03/11/26, which in fact revealed the voice of a staff member saying, You are a jerk. Resident #3 then asked, So, your calling me a jerk?. The staff member could be heard replying, Because you are a jerk. A BIMS score of 15 indicates Resident #3 was cognitively intact. Resident #15 identified the two (2) staff members as Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #2. The one speaking on the recording was identified as RN #1.Resident #15 further stated, I told (LPN #3's Name) and she reported it to (Registered Nurse, Infection Preventionist RNIP #4's Name).During a telephone interview, on 03/22/26 at 1:46 PM, RNIP #4 stated, I do not know entirely what went on. He has a conversation on his phone and in that conversation someone is calling him a jerk. I think it might have been brought up in a care plan meeting.During an interview on 03/22/26 at 2:00 PM, the Administrator said she was unaware of the entire situation. She immediately reported the incident and started an investigation.The investigation was ongoing at the end of survey.Audio evidence was attached to the survey in the iQUIES program.b) Resident #77A record review on 03/25/26 at 9:30 AM, revealed that Resident #77 was admitted on [DATE] and was discharged to the hospital on [DATE].A review of reportable #238789 led the state agency (SA) to review the facility's list of reportable incidents for (1) year. This review was completed on 03/25/26 at 10:00 AM.Resident #77 had a reportable incident of verbal abuse reported to the SA on 04/15/25. There was no evidence that a five-day follow-up report was sent.During an interview on 03/25/26 at 11:30 AM, the Administrator stated, We do not have a record of that reportable. There is no five-day follow-up.

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, resident interview, and staff interview, the facility failed to ensure a thorough investigation and ongoing documentation of an allegation of misappropriation of resident property for one (1) of one (1) resident reviewed (Resident #32). The facility failed to maintain sufficient documentation to determine the extent of the alleged financial exploitation and failed to follow up on the outcome of the investigation, potentially placing residents at risk for continued or unaddressed misappropriation of property. Resident Identifier: #32. Facility Census: 67.Findings Included:a) Record ReviewA record review was completed on 03/24/26. The record review revealed that on 09/10/25, Resident #32 reported unknown charges on her debit card. The facility initiated an investigation and reported the allegation to the Office of Health Facility Licensure and Certification (OHFLAC), Adult Protective Services (APS), the Ombudsman, and local law enforcement.Progress notes documented the following actions:-09/12/25: Law enforcement interviewed Resident #32 at the facility. The resident had cancelled her debit card and planned to obtain additional information from her bank.-09/15/25: Resident #32 was scheduled to go to the bank for further information, with plans to update law enforcement.-09/18/25: Resident #32 obtained bank statements; attempts were made to contact the investigating officer.-09/19/25: Law enforcement returned to the facility, obtained the resident's banking information, and asked additional questions.Review of the facility's 5-day investigation report indicated the Administrator and Director of Nursing reported the allegation as required. The facility assisted the resident in obtaining bank statements and reviewed charges with her. The report noted the alleged perpetrator was the resident's former roommate. The investigation was determined to be inconclusive, with law enforcement continuing the investigation. The residents were separated, and the resident's debit card was deactivated.Further review revealed a January 14, 2026, Grand [NAME] subpoena for Resident #32 related to the alleged fraudulent use of her debit card.However, at the time of survey, the facility was unable to provide any additional documentation or evidence of follow-up regarding the alleged misappropriation, including the total amount of funds involved, outcomes of the investigation, or ongoing tracking of the allegation, until requested by the State Agency.b) Resident and Staff InterviewsDuring an interview, on 03/23/26 at approximately 11:00 AM, Resident #32 stated her former roommate used her debit card without permission and estimated that approximately $800-$900 had been spent. The resident stated she had not received any updates regarding the situation.During an interview, on 03/25/26 at approximately 3:00 PM, the Business Office Manager (BOM) stated the facility did not have copies of the resident's bank statements, as they had been turned over to law enforcement. The BOM reported that law enforcement would not release information due to an ongoing investigation.In a follow-up interview, on 03/25/26 at approximately 3:45 PM, Resident #32 stated that no one from the facility had requested copies of her bank statements or attempted to review them, aside from law enforcement, until shortly before the interview when the BOM inquired. This indicated the facility did not maintain documentation necessary to determine the extent of the alleged misappropriation.On 03/25/26 at 4:00 PM, Staff #43 provided a written statement indicating they accompanied Resident #32 to a Grand [NAME] proceeding, on January 20, 2026, related to fraudulent use of the resident's debit card. The statement noted the prosecutor obtained an indictment without the resident's testimony.