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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on record review and interviews, the facility failed to employ a qualified social worker to provide and oversee social services from 10/14/25 through the time of survey, resulting in a failure to ensure appropriate follow-up, documentation, and resident support related to an allegation of misappropriation of property, abuse, neglect, reporting, and investigation. Resident identifiers: #54, #36, #32, #30, #3. Facility census: 67. Findings Include: a) Resident #32 Record review and staff interview revealed the facility did not employ a qualified social worker from 10/14/25 through the time of survey. During an interview on 03/25/26, facility administration confirmed there had been no qualified social worker employed during this time period. Record review of an allegation of misappropriation involving Resident #32 revealed the facility failed to ensure ongoing social service follow-up and oversight. On 09/10/25, Resident #32 reported unauthorized use of her debit card. Although the allegation was reported and initially investigated, the facility failed to maintain documentation of the resident's bank records, determine the total amount of funds misappropriated, or track the outcome of the investigation. Further review revealed a Grand [NAME] subpoena dated 01/14/26 related to the incident; however, the facility was unable to provide additional follow-up documentation at the time of survey. During an interview on 03/23/26 at 3:45 PM , Resident #32 stated she had not received updates regarding the situation. During interviews on 03/25/26, at 3:30 PM the Business Office Manager confirmed the facility did not maintain copies of the resident's financial records. Resident #32 confirmed the facility had not requested or reviewed her bank statements until the time of survey An interview completed on 03/25/26 at approximately 4:15 PM with the facility administrator who stated they have not had a full time social worker at the facility since 10/14/25. The Administrator also stated we did have a contract Social Worker who would come twice a week. Confirming the (continued on next page)

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

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility with a census above 60 did not obtain a social worker full time. b) Resident #3 During an interview on 03/22/26 at 1:15 PM, Resident #3 who has 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) listened to recording with a date of 3-11-26, which in fact revealed the voice of a staff member say, You are a jerk Resident #3 says, So, your calling me a jerk staff member says because you are a jerk. Resident #15 identified the (2) two staff members as Registered Nurse (RN) # 1, and Licensed Practical Nurse (LPN) #2. The one speaking on the phone is RN #1. Resident #15 further stated, I told (LPN #3 named) and she reported it to (Registered Nurse, Infection Preventionist RNIP #4 named) 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. Video evidence is attached During an interview on 03/24/26 at 11:00 AM, The State Agency (SA) asked the Administrator, What did you find out with the reportable? The Administrator replied, During my resident interviews, I found a few more things and now have three (3) more reportables. c) Facilities interview with residents A review of the above investigation revealed the following (5) five questions asked to residents: Have you eve heard or seen (Licensed Practical Nurse (LPN) #2 name) or (Registered Nurse (RN) #1 name) (Monday-Thursday Night Shift Nurses) sleep during work hours or while not on break? Have you ever heard or seen (Licensed Practical Nurse (LPN) #2 name) or (Registered Nurse (RN) #1 name) (Monday-Thursday Night Shift Nurses) be loud with or speak inappropriately to another staff member? Have you ever heard or seen (Licensed Practical Nurse (LPN) #2 name) or (Registered Nurse (RN) #1 name) (Monday-Thursday Night Shift Nurses) be loud with or speak inappropriately to a resident? Do you have any concerns with any staff member in the facility sleeping or speaking inappropriately to a resident or another staff member? Do you feel comfortable reporting concerns to administration (Administrator or Director of Nursing (DON)? (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #36 reported yes to question #4 and named Nursing Assistant (NA) #14. The administrator started an investigation. Resident #54 answered yes to question #4 and named NA #14. The administrator started an investigation. Resident #30 answered yes to question #4 and named NA#14. The administrator stared an investigation. During an interview on 03/25/26 at 10:00 AM, The State Agency (SA) asked Resident #36 who has a Brief interview for Mental Status (BIMS) of 15, Do you feel if you had a social worker, that these allegations would of been easier to report? Resident #36 replied I feel like I would be able to tell someone, yes. During an interview on 03/25/26 at 10:05 AM, The SA asked Resident #30 who has a BIMS of 10, Do you feel if you had a social worker, that these allegations would of been easier to report? Resident #30 replied, Yes. During an interview on 03/25/26 at 11:00 AM, The SA asked Resident #3 who has a BIMS of 15, Do you feel if you had a social worker, that these allegation would of been easier to report? Resident #3 replied, Yes, I think it would of already been taken care of. d) Director of Social Services Job Description A review of the Job Description on 03/25/26 at 3:00 PM under (ADVOCACY) reads as follows: Works with Social Services staff, interprofessional team, and administration to promote and protect patient/resident rights and psychosocial well-being of all patients/residents. Prevents, addresses, and reports patient/resident abuse as mandated by law and professional licensure. Active contributor in Center's grievance/concern investigation and resolution process. Identifies and monitors community changes and opportunities such a legislation, regulations, and programs that impact nursing home patients/residents. Works with patients/residents, families, and significant others to provide support and information for taking a more proactive role in self-advocacy to improve the quality of life/care for individual patients/residents Responds to issues identified by patient/resident and families to determine satisfaction with services. With the above allegations that would not have been discovered without Surveyor intervention, combined with the Advocacy role of a Social Worker the State Agency determined that this had the potential to effect all 67 residents currently residing in the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interview, the facility failed to ensure that medications were disposed of in accordance with professional standards of practice for one (1) of one (1) medication storage rooms observed. The facility failed to remove and properly dispose of 11 discontinued medications that remained in the storage room in various random drawers. This failure created a potential for medication errors or unauthorized access to medications. Facility Census: 67 Findings include:The facility's policy titled Medication Storage Storage of Medications, revised 01/26, indicated that discontinued medications must be removed from the active storage area immediately and documented for disposal to prevent accidental administration.On 03/24/26 at 9:30 AM, during a review of the medication storage room, 11 different medications were found stored in random drawers rather than being sequestered for destruction or returned to the pharmacy. The following medications were observed:-Carvedilol 3.125 MG -Tamsulosin HCL 0,4-Clopidogrel 75 MG-Dapagliflozin 10 MG-Prednisolone 20 MG-6 vials of Haloperidol lactate 5MG with expiration date of October 2025 In an interview, on 03/24/26 at 10:00 AM, the Director of Nursing (DON) confirmed that these medications were no longer in use. The DON stated that the medications should have been pulled and processed for disposal according to facility policy but were left in the drawers.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections with regards to the resident's personal products. This failed practice was a random opportunity for discovery. Resident identifiers: #12, #7, #39, and #68. Facility Census: 68.Findings Included:a) Resident #12During an interview with Resident #12, on 03/22/26 at 12:08 PM, a wheelchair near the resident's bed had rips and holes in the plastic cover on the left side of the head rest, and both of the arm rests covering and plastic trim, exposing the inner padding. b) Resident #17During entrance interview, on 03/22/26 at approximately 12:25 PM, it was observed that resident #17's Geri-chair had cracks and tears down the right of the back rest and on both arm rests exposing the inner padding.c) Resident #39An observation of Resident #39's wheel chair, on 03/22/26 at 2:45 PM, found cracks and tears in both armrests and tears on the front and back edges on the corner of his foot pad, with exposed inner padding. d) Resident #68During an interview with Resident #68, on 03/23/26 at 3:18 PM, it was observed her wheel chair's plastic covering was worn off from the edge halfway up the right armrest with exposed inner padding.e) 100 hall wheel chair outside room [ROOM NUMBER]An observation of a wheel chair sitting outside room [ROOM NUMBER], on 03/23/26 at 12:45 PM, found tears in both arm rests and open broken zipper in the leg padding, with exposed inner padding.f) Staff InterviewDuring a facility walk through and interview with the Director of Nursing, on 03/23/2026 at 3:23 PM, she acknowledged the above listed Resident wheelchairs and one Geri-chair had areas with exposed inner padding and stated they would be reported to the maintenance department for repairs or replacement.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on resident interview, staff interview, and policy review, the facility failed to ensure residents were free of verbal abuse from staff. This failed practice was true for (1) one of (2) two 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 #3 During 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, you're 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 phone 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 iQIES program.

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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. **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.

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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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, resident interview, and staff interview the facility failed to implement a care plan related to oral hygiene. This failed practice was found true for (1) one of (1) one residents reviewed under the dental pathway during the Long-Term Care Survey Process. Resident identifier: #70. Facility census: 67.Findings Included: a) Resident #70 The initial observation, on 03/22/26 at 12:15 PM, revealed Resident #70 in the dining room, waiting for her lunch tray. Resident #70's teeth were covered in debris and had a thick white substance around her gum lines. An observation, on 03/24/25 at 2:30 PM, revealed Resident #70 in her bed. Resident's teeth were covered in debris and had a thick white substance around her gum lines. A record review, completed on 03/24/25 at 2:40 PM, revealed an oral health care plan that included the following intervention, revised 03/19/25: Provide oral hygiene/mouth care twice per day and as needed. During an interview on 03/24/25 at 3:45 PM, the Director of Nursing (DON) confirmed that Resident #70 did not appear to have had oral hygiene completed. No further information was given prior to facility exit.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on record review, surveyor observation and intervention, as well as resident and staff interviews, the facility failed to provide necessary care and services to maintain or improve resident's ability to perform activities of daily living (ADL), such as mobility for one (1) of one (1) residents reviewed (Resident #60). The facility failed to follow up on the outcome of the resident receiving new custom made Hip Knee Ankle Foot Orthosis to resume Physical Therapy, placing resident at risk for continued decline in mobility. Resident Identifier: #60. Facility Census: 67.Findings include: a) Observation and Resident Interview During an initial tour of Resident #60's room, it was observed there was a brand new custom Hip Knee Ankle Foot Orthosis (HKAFO) against the wall by the bed. When resident was asked how long he had the device, he stated, A few weeks now. When asked if the resident went to Physical Therapy (PT), the answer was, Not anymore. This conversation took place on 03/23/2026 at 10:10 AM in resident's room. b) Record Review Record review, completed on 03/24/2026, showed Resident # 60 was discharged from Physical Therapy (PT) on 11/10/2025 with the intentions of picking resident back up for Physical Therapy once his new Hip Knee Ankle Foot Orthosis (HKAFO) arrived. Record review indicated that the resident was at risk for decreased ability to perform ADL(s) due to decreased mobility and increased weakness related to paraplegia and spina bifida. No documentation existed in PT showing when the resident went to be measured/casted for his HKAFO. In Resident #60's PT Discharge Summary, a note stated, awaiting arrival of new orthotics (arriving in 2 days). In the Patient Progress section of the Discharge Summary, it is quoted, Will address therapy services again when new orthotics arrive. A Patient Document Receipt from [Name and location of the company which supplied the HKAFO] showed the HKAFO was received on 02/24/2026 at the resident's appointment at 8:30 AM. Resident was discharged from PT on 11/10/2025 with the goal of picking resident back up on PT when the new orthotics arrived. The new orthotic was received on 2/24/2026 but as of 3/24/26 the resident has not been picked back up for therapy services b) Interviews with Resident and Staff An interview with the Director of Rehab, on 03/24/26 at 8:55 AM, revealed the therapy department was not aware Resident #60 had received the new HKAFO, nor had they followed up with resident to see if new item had been received. This situation was also discussed with the Nursing Home Administrator (NHA) on 03/24/2026 at 9:35 AM. It was acknowledged that a month had transpired from the time Resident #60 had received the new HKAFO and Surveyor intervention.

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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 record review and staff interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. Physician orders related to medications changes and instructions for Atorvastatin, Digoxin, and Lidocaine patches were not found in the electronic record. This was a random opportunity for discovery. Resident Identifier: #4. Facility Census: 67.Findings Included: a)Resident #4's Record Review Atorvastatin:On 03/24/2026 at 12:29 PM, during Resident #4's record review, the Medical Regimen Review, dated 07/25/25, recommended Atorvastatin 40mg HS to be discontinued. The physician agreed and signed off on the discontinuation. On 03/24/2026, it was found this order still active in the electronic record. Digoxin:On 03/24/2026 at 12:29 PM, during Resident #4's record review, the Medical Regimen Review, dated 12/30/25, recommended ordering daily apical pulse readings prior to Digoxin administration along with hold parameters if pulse is less that 60, to monitor for rhythm and rate. The physician agreed and signed off on the recommendation. On 03/24/2026, it was found the instructions for Digoxin had not been added in the electronic physician orders. Lidocaine Patch:On 03/24/2026 at 12:29 PM, during Resident #4's record review, the Medical Regimen Review, dated 02/25/26, found Pharmacist recommended instructions for resident #4's Lidocaine Patch. The physician agreed and signed off on the recommendation noting, Lidocaine patch to shoulders - Please add removal time of 2200 to med order. On 03/24/2026, it was found the recommended Lidocaine patch instructions had not been added in the electronic physician orders record. b) Staff interview: During an interview, 03/24/2026 at 2:33 PM, the Administrator verified the physician order for discontinuing Atorvastatin and the recommended instructions for Digoxin and the Lidocaine Patches were not added to Resident #4's electronic record and stated she could not explain why they were overlooked.

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

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on record review and staff interview the facility failed to ensure the daily Nurse Staff Posting had the correct date. This failed practice was a random opportunity for discovery and the potential to effect more than a limited number of residents during the Long-Term Care Survey Process. Facility Census 67.Findings Included:a) Nurse staff posting:Upon facility entrance, on 03/22/26 at 11:30 AM, a review of the Nurse Staff Posting found the posting had the incorrect date of 03/20/26, revealing it had not been updated for two (2) days.During an interview on 03/22/26 at 11:39 AM, The Nurse Manager on staff stated, Yes, we had a call off and I haven't gotten to that yet.

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	515105	A. Building B. Wing	03/25/2026

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, record review, and staff interviews, the facility failed to ensure Medicaid residents receive routine dental services. This deficient practice was found for (1) one of (1) one residents reviewed for dental services during the Long-Term Care Survey Process. Resident identifier: #70. Facility census: 67. Findings Include: The facility policy titled, Dental Services, directs: Center will provide or obtain from an outside resource routine and emergency dental services, including 24-hour emergency dental care, to meet the needs of each patient. The policy defined routine dental services as follows: An annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures. a) Resident #70 The initial observation on 03/22/26 at 12:15 PM, revealed Resident #70 in the dining room, waiting for her lunch tray. Resident #70's teeth were covered in debris and had a thick white substance around her gum lines. An observation on 03/24/25 at 2:30 PM, revealed Resident #70 in her bed. Resident's teeth were covered in debris and had a thick white substance around her gum lines. A record review on 03/24/25 at 2:40 PM, revealed an oral health care plan that included the following intervention, revised 03/19/25:Provide oral hygiene/mouth care twice per day and as needed. Further record review had an admission date for Resident #70 for 2022. No dental consults could be found since admission. A general patient note dated for 01/09/26 read as follows:A dentist appt. was scheduled for 8:30 AM, however when she arrived she could not be seen because her MPOA was not present to sign the forms so this appt. needs to be reschedules at a convenient time for the MPOA to be present. The dental appointment was rescheduled for 03/26/26. During an interview on 03/24/25 at 3:45 PM, The Director of Nursing (DON) said that she could not find any dental consults in the medical record. The State Agency (SA) asked the DON, Is there no record since her admission in 2022 that any dental services had been provided? DON replied, You are correct.

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	515105	A. Building B. Wing	03/25/2026

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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. Based on record review and staff interviews, the facility failed to maintain a complete and accurate medical record related to intellectual disability. This failed practice was found true for one (1)of five (5) residents reviewed for unnecessary medications during the Long-Term Care Survey Process. Resident identifier: #8. Facility census: 67.Findings Include: a) Resident #8 A record review, on 03/23/26 at 2:25 PM, revealed Resident #8's most recent Pre-admission Screening and Resident Review (PASARR) dated 03/06/26, indicated Resident #8 has a diagnosis of Mental Retardation (intellectual disability). Further record review revealed a History and Physical (H&P), dated 01/28/26, under the History of Present illness section, the last sentence read, Patient has underlying mental retardation unable to communicate much. There was no diagnosis of Mental Retardation (intellectual disability) listed in Resident #8's medical record. During an interview on 03/23/25 at 3:35 PM, the Administrator confirmed that Mental Retardation (intellectual disability) was not listed on Resident #8's medical record as a diagnosis.

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	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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interview the facility failed to ensure staff was educated/ informed on the Covid Vaccine. The facility failed to provide education on the benefits, risks, and potential side effects of the COVID-19 vaccine to staff. This was true for one (1) of one (1) staff members selected. Census: 67. Findings include: a) Record Review Certified Nursing Assistant (CNA) #18 was randomly selected to verify if Covid-19 vaccine education/information was given as well as if the vaccine was offered. No record existed. b) Staff Interview Interview with Nursing Home Administrator (NHA), on 03/24/2026 2:25 PM, confirmed CNA #18 was not educated on the Covid-19 vaccine. No documentation existed showing any employee was offered or educated on Covid-19 vaccinations.

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	515105	A. Building B. Wing	03/25/2026

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, resident and staff interviews, the facility failed to ensure resident call lights were within reach. This was a random opportunity for discovery resident identifier: #27. Facility Census: 67. Findings Included: a) Resident #27 During an interview with Resident #27, on 03/23/2026 at 11:50 AM, he stated he couldn't find his call button. The staff forgot to put it back after my bed bath today. They usually clip it to my shirt. Surveyor pushed the roommate's call button. Employee #84 came into the room to answer the call light. She found the call bell behind the back of the bed and reclipped it to his shirt. b) Staff Interviews In an interview with Employee #84, on 03/23/26 at 12:02 PM, she acknowledged the call bell was not within resident's reach and clipped it to his shirt. During an interview on 03/23/26 at approximately 2:25 PM, the Director of Nursing stated she had been made aware of the call button not being within resident's reach.