STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515116	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tygart Valley Health & Rehabilitation	216 Samaritan Circle Belington, WV 26250

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interview, the facility failed to allow Resident #46 to have a dignified dining experience. This finding was related to the facility failing to serve his meal with the other residents at his table before serving other tables. This failed practice was a random opportunity for discovery. Resident identifier: #46. Facility Census: 54.Findings Included:a) Resident #46 On 11/17/25 at 12:46 PM, during a dining room observation, It was observed that Resident #46 was not served his lunch tray with the rest of his tablemates before staff began serving other tables. In an interview with Certified Nurse Assistant(CNA) employee identifier # on 11/17/20250 at 1:14 PM, she acknowledged Resident #46 was not served correctly with the other resident at his table.During an interview on 11/19/2025, at approximately 2:45 PM, the facility Director of Nursing stated she was made aware that Resident #46 was not served his lunch with his tablemates in the dining room on 11/17/25.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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, and staff interview, the facility failed to properly store food in accordance with professional standards. This is true for the kitchen walk in cooler and utensil storage.This had the potential to affect all residents in the facility. Facility census: 54.Findings included:a) On 11/17/2525 at 12:27PM, during Initial Brief Tour of Kitchen with the facility Kitchen Manager, who acknowledged the following in the walk-in cooler, an opened plastic bag of lettuce with no label or dates and in the utensil drawer, the utensils were incorrectly placed in different directions. On 11/18/25 at 1:30 PM, the Cooperate Kitchen Manager (CKM) acknowledged the bag of lettuce in the walk-in cooler without a dated label 9/25 and the utensils were not stored correctly in the utensil drawer. On 11/19/25 at 2:25PM, during an interview with the Director of Nursing, she stated she was aware of the unlabeled lettuce in the walk-in cooler and the incorrectly stored utensils.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and record review the facility failed to ensure it had a complete and accurate medical record related to dental status. This failed practice was found true for (1) one of (3) three residents reviewed for dental during the Long-Term Care Survey Process. Resident identifier #54. Facility census: 54. Findings Include: a) Resident #54 An observation on 11/17/25 at 3:15 PM revealed Resident #54 sitting in the hallway in her wheelchair. She had several teeth missing and some were decayed and broken off at the gums.A record review on 11/18/25 at 12:30 PM, revealed that Resident #54 had seen an in-house dentistry on 02/06/25. The dental consult showed the following:Teeth numbers 11, 21, 22, and 6 are decayed. Teeth numbers 1-3, 13-20, 31 and 32 are missing. Teeth numbers 7-10 and 25-30 are retained root.The summary of the dental consult read as follows: Limited tolerance with treatment will attempt to complete extractions on 29 and 30 next time. PC/SC left with facility to have them next time. Will see how patient tolerates with them to determine future treatment. She may need to be referred out to have other things completedFurther record review revealed that Resident #54 was also seen by in-house dentistry on 08/15/25. Summary of the dental consult read as follows:States she does want to start with removing teeth, will start still with LR side 29/30 area, if tolerant with us, papers left with facility again for extractions. Next visit plan: extractions.A review of Resident #54's last annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/25 section L, question 2 is marked Good for oral cavity/teeth condition. Question 4 indicates that no natural teeth are missing, A review of Resident #54's last Nutritional Risk assessment dated [DATE], question #4 indicated that the resident has her own teeth with no issues noted. During an interview on 11/20/25 at 9:17 AM, with the Administrator and the Regional Risk Management Director (RRMD), both confirmed Resident #54's MDS and nutritional assessment did not match her current dental status.A continuous observation of Resident #54 on 11/19/25 revealed the resident was eating her lunch meal. The meal consisted of beef stew, carrots, and a biscuit. Resident #54 finished eating her lunch at approximately 1:10 PM. Left on the tray was about seven (7) carrots, the entire bowl of beef stew and about 1/2 of a biscuit. The amount eaten was 25% to 50%. The Activity Director (AD) confirmed what was left on the lunch tray for Resident #54. A record review on 11/19/25 at 1:30 PM, showed that the recorded amount in the chart was 75% to 100%, and it was documented at 12:45 PM, before the resident finished eating. During an interview, on 11/20/25 at 9:17 AM, the Regional Risk Management Director (RRMD) confirmed that the meal percentage entered for Resident #54 was incorrect.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, review of clinical records, facility documentation, and staff interviews, it was determined that the facility failed to establish and maintain an infection prevention program to help prevent the development and transmission of communicable diseases, to help prevent cross-contamination and infections including Covid-19 in regard to, follow CDC (Centers for Disease Control) guidelines for use of PPE (Personal Protective Equipment) and ensure staff donned appropriate personal protective equipment (PPE) prior to wound care for a resident on (Enhanced Barrier Precautions). The facility also failed to ensure a barrier was maintained in the laundry area and failed to repair unhygienic wheelchair surfaces. These failed practices had the potential to affect every resident currently residing in the facility. Resident identifiers: #4, #24, #8, #46, and #50. Facility census: 54. Findings included: a) Resident #8 A record review revealed Resident #8 was in Enhanced Barrier Precautions (EBP) due to wound care. On 11/19/25 at 2:00 PM, Licensed Practical Nurse (LPN) #66 was observed providing wound care on Resident #8's pressure Ulcer without proper Personal Protective Equipment (PPE). She was only wearing gloves. Continued observation found that LPN #66 removed packaging from wound supplies and placed them in the trash receptacle and pushed the packaging down with her gloved hand. Without changing her gloves, she continued to prepare wound supplies. Subsequent observation found LPN #66 using her wound scissors to cut negative pressure wound therapy (NPWT) drape after it was affixed to Residents wound area, she did not clean the scissors after and continued to use the scissors to cut additional supplies. Observation of a sign on the wall above Resident #8's bed read: Enhanced Barrier Precautions -Attention: Caregivers, Staff, and Visitors --Wear Gown and Gloves prior to these activities: During high contact resident care activities. - Dressing, bathing/ showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (i.e. central line, urinary catheters, feeding tube, tracheotomies, ventilators), and wound care: any skin opening requiring a dressing. - Face protection may also be needed if performing activity with risk of splash or spray. -See the care plan for additional information. During an Interview with LPN #66 on 11/19/25 at 2:35 PM she stated that she should have had a gown on during wound care. During an interview with the administrator on 11/19/25 at approximately 3:25 PM she stated that LPN #66 was reeducated on EBP, and the facility was starting whole house reeducation at this time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to the end of the survey on 11/20/25. b) Laundry Services An observation during the laundry tour on 11/19/25 at approximately 12:30 PM found the window open in the dirty laundry room breaking the negative air pressure, preventing the system from containing contaminants to the dirty area. Laundry was being processed in the dirty area, and clean area, the clean laundry was out on the folding table at this time. During an interview on 11/19/25 at 12:30 PM the Maintenance Director (MD) the MD verified that the air was pulling from the dirty area to the clean area. He closed the window in the dirty laundry area to reestablish the negative area flow at this time. a) Resident #50 During the entrance interview with Resident #50, on 11/17/25 at 3:34 PM, it was observed that a wheelchair in his room had tears in the plastic cover on both arm rests. Resident # 50 stated he used that wheelchair when going out to activities, dining room, and to activities. During a facility walk through on with the DON on 11/18/25 at 3:20 PM, it was observed that wheelchairs belonging to Resident #4, #24, and #46 were sitting in the hallway in the 200 hall with tears in the arm rests exposing inner padding. In an interview with the Director of Nursing, on 11/18/25 at 11:05 AM, she acknowledged the wheelchairs had tears in the plastic arm pads and agreed the above-mentioned chairs could not be cleaned to prevent infection.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based upon Record Review and Interviews, the facility failed to promote Resident #7's self determination through choices for her shower preference and time. This was true for one (1) out of four (4) residents reviewed. Resident identifier: #7. Census: 54. Findings include:a) Resident #7 Record review on 11/18/25 showed the care plan reflected showers three (3) times a week, but no preferences noted. The shower tracking sheet confirmed that showers were given on 11/18/25 and on 11/11/25. Task record on system showed shower/bathe self-Monday, Wednesday and Friday nights and PRN (as needed).During an interview, on 11/18/25 at 9:09 AM, with Resident #7, she stated they do not get many showers due to being scheduled on the same days as their dialysis (M-W-F) nights.Resident #7 said she had previously requested the staff move it because she was so exhausted from the treatments. I have not gotten a shower in lord knows how long. The facility is ok with me wanting three showers a week, but that's very hard with my treatments.During an interview with the Director of Nursing #20 (DON) she confirmed that Resident #7 was on the bathing schedule for three (3) nights a week (M-W-F). She said the resident got a shower on 11/18/2025 and 11/11/2025, as well and some bed baths between. She was not aware of any requests made to have the shower days moved or what times they were done but would talk to the shower scheduler and have that addressed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview the facility failed to coordinate with the appropriate State-designated authority,to ensure that individuals with a mental disorder, intellectual disability or a related condition received care and services in the most integrated setting appropriate to their needs when completing/revising a Pre-admission Screening and Resident Review (PASSR). Resident identifier #34. Facility Census: 54Findings Included:a) Resident # 34Review of the PASSR dated 11/18/24 found the following medical diagnosis was not identified on the Pre admission Screening and Resident Review.Major Depressive Disorder onset 04/29/25,Schizophrenic Disorder onset 12/03/24The above information was confirmed with the Director Of Nursing (DON) on 11/18/25 at 2:20 PM. The DON agreed that the additional medical diagnosis should be on the PASSR.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review, resident interview and staff interview the facility failed to provide Activities of Daily Living (ADL) care to dependent residents. This failed practice was found true for (1) one of (4) four residents reviewed for ADL care during the Long-Term Care Survey Process. Resident identifier: #54. Facility census: 54. Findings Include:a) Resident #54 An observation on 11/17/25 at 3:15 PM, revealed Resident #54 sitting in the hallway, she had several hair stubbles on her chin and her mustache area. During an interview on 11/17/25 at 3:15 PM, Resident #54 stated, I would like for them to shave them off every time, but they don't.During an interview on 11/17/25 at 3:20 PM, The Director of Nursing (DON) stated, Her shower day is today. The system shows she had her shower today already. I will get it taken care of. A review on 11/17/25 at 3:30 PM, revealed an ADL care plan for Resident #54 with a focus that reads as follows:(Resident #54 name) is a long-term care resident and requires assistance with their ADL's related to chronic health conditions, congestive heart failure, dementia , muscle weakness The care plan includes an intervention that read as follows Substantial or maximal assistance with bathing-may require more assistance at times.The DON further confirmed that Resident #54 had not been shaven.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based upon Record review and interviews, the facility failed to provide one on one activities fo one (1) of four 4) residents that were unable to participate in group activities. Residents identifier: #7. Census: 54. Findings included:a) Resident #7Record review on 11/18/25 at 9:20 AM revealed Resident #7 was receiving dialysis on Monday, Wednesday and Friday. This had an impact on how the resident was able to participate in activities due to the energy level after dialysis. Resident #7 was not listed on any 1:1 activity sheets or the sunshine visit list. The residents on the sunshine visit list get morning visits or non-group activities provided.During an interview with Resident #7 on 11/18/25 at 9:20 AM the resident stated, No one comes into my room for activities. I don't do well in group activities because I am always tired. I don't have a lot of chances to talk with people. My roommate doesn't talk so I don't even get the chance to talk to them. I don't have the energy to go out and participate most days.The Activities Director (AD), was interviewed on 11/19/25 at 12:13 PM, and stated that she knew the resident was unable to participate in group activities due to her medical conditions and being tired from treatment. She knew that the resident enjoyed going to devotionals and could not really participate in them any longer. Activities director (AD) stated she will go later and have a talk with the resident to see what she would like to do in her room for activities. The AD stated, She shouldn't just have to lay there.

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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 observation, record review, and staff interview, the facility failed to provide care and services in accordance with professional standards of practice by not following physician orders related to insulin and weights. This failed practice was found true for (2) two of 25 residents reviewed for physician order accuracy during the long term care survey process. Resident identifiers: #11 and #4. Facility census: 54.Findings included: a) Resident #4 Record review of the facility's policy titled, Weight Assessment and Intervention, with a date 10/01/21 showed: Any weight (wt.) change of 5% or more since last weight will be retaken for confirmation. If the weight is verified, nursing will immediately notify the physician/practitioner and dietary team. Medical record review on 11/20/25, showed a 14.12 % weight increase for Resident #4, 11/17/25 at 4:02 PM 187.5 lbs. 10/01/25 1:55 PM 185.1 lbs. 09/05/25 5:11 PM 164.8 lbs. 09/02/25 7:15 PM 162.2 lbs. During an interview on 11/20/22 at 2:45 PM the Director of Nursing (DON) verified a reweight was not completed and the physician/practitioner and dietary team were not notified of a significant weight change. b) Resident # 11 A record review on 11/19/25 at 10:30 am, revealed a physician order for Resident #11 that read as follows: Inject 40 units subcutaneously before meals for DM II related to Type 2 Diabetes Mellites with Hyperglycemia. Hold if Blood Glucose Level (BGL) less than 180. Further record review of the Medication Administration Record (MAR) for 09/25, 10/25, and 11/25 noted that in Residents #11's BGL was less than 180, 38 times and insulin was not held as ordered. During an interview on 11/19/25 at 11:02 AM, the Director of Nursing (DON), confirmed that Resident #11 was given insulin, when the BGL was below 180, not as the Physician ordered.

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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 interview the facility failed to ensure emergency dental services were provided to Medicaid funded residents in a timely manner. This failed practice was found true for (2) two of (3) three residents reviewed for dental services during the Long-Term Care Survey Process. Resident identifiers: #54 and #20. Facility census: 54. a) Resident #20 On 11/17/2025 at 2:55 PM, during interview and observation with Resident #20, it was observed that the resident had some missing, and decayed teeth. Resident #20 stated, I have asked to have some pulled and a plate put in a while back and nothing has been done. She pointed to one tooth that had been cracked and stated that had happened about a week ago. Record review on 11/18/25 at 12:30 PM, revealed that Resident #20 had seen an in-house dentist on 08/15/25. The dental consult showed the following: Teeth numbers 1-16, 17-19, 24, 25, 29-32, are missing. Teeth number 28 retained root. The summary of the dental consult reads as follows: Pt. wants to have remaining lower teeth extracted and the after healing time can make dentures, requested. Next visit plan: Extractions. On 11/17/25 a record review of Resident #20's progress notes, dated 11/13/25, revealed a note stating Resident broke a tooth and asked me to make her an appointment to the dentist. She asked me to call Dr (name) to schedule. I called and had to leave a voicemail because they were closed at 3 pm and on Fridays. I let (Resident name) know I left a voicemail and I would call them again on Monday and follow up with her after. On 11/18/25 at 5:00PM a further record review of Resident # 20's progress noted revealed a note dated 11/18/25 at 2:18 PM stating social services spoke with 360 care following a report from the resident that she had a chipped tooth. The note stated (Name) stated they were awaiting the surgical consent form. Upon review of the chart, the family surgical consent was not found scanned into the record. The physician consent form was scanned and signed and was emailed 11/18/25. The note revealed that a call was placed to Resident's MPOA to follow up on obtaining the consent form at 360 Care. The note also revealed that it was confirmed that the resident was able to sign her own consent since she had capacity. The note went on to state that a new consent form would be sent to the resident directly to sign and that an appointment was scheduled with the dentist in January 2026. On 11/19/25 at 2:30PM, During an interview with the Administrator, she stated the social worker had made calls in the community working on getting Resident #20's tooth taken care of. The administrator said she would check with the social worker. During an interview, on 11/20/25 at 9:17 AM, with the administrator and the Regional Risk Management Director (RRMD), both confirmed that the resident's teeth were not in the best shape, (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the RRMD stated, We are not sure what happened with the paperwork. It seems like it was a miscommunication between the dental service and the facility on who was going to get the consent. b) Resident #54 An observation on 11/17/25 at 3:15 PM, revealed Resident #54 sitting in the hallway, she had several teeth missing, and some that appeared broken off and decayed. A record review on 11/18/25 at 12:30 PM, revealed that Resident #54 had seen an in-house dentistry on 02/06/25. The dental consult showed the following: Teeth numbers 11, 21, 22, and 6 are decayed. Teeth numbers 1-3, 13-20, 31 and 32 are missing. Teeth numbers 7-10 and 25-30 are retained root. The summary of the dental consult reads as follows: Limited tolerance with treatment will attempt to complete extractions on 29 and 30 next time. PC/SC left with facility to have them next time. Will see how patient tolerates with them to determine future treatment. She may need to be referred out to have other things completed Further record review revealed that Resident #54 was also seen by in-house dentistry on 08/15/25. Summary of the dental consult reads as follows: States she does want to start with removing teeth, will start still with LR side 29/30 area, if tolerant with us, papers left with facility again for extractions. Next visit plan: extractions. During an interview on 11/20/25 at 9:17 AM, with the Administrator and the Regional Risk Management Director (RRMD), both confirmed that Resident #54's teeth were not in the best shape, and the RRMD stated, We are not sure what happened with the paperwork. It seems like it was a miscommunication between the dental service and the facility on who was going to get the consent.