STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515121	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rainelle Healthcare Center	276 Pennsylvania Avenue Rainelle, WV 25962

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Reference complaint# 2667227 Based on Record review and staff interview, the facility failed to ensure the safety and security of resident property; specifically medication. This was discovered during the normal Long Term Survey Process and has the ability to affect more than a limited number of residents. Resident Identifiers #1, 15, 39, 56, 64, 65. Census 55.Based on Record review and staff interview, the facility failed to ensure the safety and security of resident property; specifically, medication. This was discovered during the normal Long Term Survey Process and had the ability to affect more than a limited number of residents. This citation was issued at past noncompliance. Resident identifier: #64. Facility census: 55. Findings included: a) Resident #64 On 10/21/25 it was discovered that LPN #100 was not giving out as needed (PRN) medications to the residents assigned to them. There were multiple accounts of the medications being marked as given on the Medication administration Record (MAR), but when residents were asked about their PRN medication need or use, they stated they did not request those medications. This triggered an investigation to ensure no diversion was present. On 10/24/25 the facility went to Resident #64 and asked about the increase in PRN pain medication use, to ensure they were treated appropriately. During that time, it was discovered that LPN #100 was marking off PRN medications for this resident and others as given, but the residents were not needing nor getting those PRN medications. The PRN medications were controlled substances and as such monitored closely for use. The facility looked at both Resident #64's MAR and her overall pain assessments as well as performed a blood draw (with the resident permission) to test for medication levels in their system. The daily assessment of Resident #64 showed pain on average around Zero to One out of Ten for her daily pain. However, on the days LPN #100 the PRN pain scale that is needed to be submitted with the administration of a PRN pain med, showed Five to Seven out of Ten prior to the pain meds being administered. The follow up pain score reflected a Zero out of Ten after a one hour time period. The lab work also showed only trace amounts of pain medication in Resident #100's blood. This was not consistent with expected levels based upon the administration record. The facility performed a thorough investigation into this matter and found that there was sufficient evidence to support a diversion concern and took the necessary steps to protect the residents and their property. No harm was found to have come to any resident because of the LPN's actions. The residents did not miss any necessary medications, only had their PRN misappropriated by the nurse. Timeline of events Incident 10/21/25 Labs drawn and sent out 10/21/25 Facility filed reports and informed all necessary parties 10/24/25 LPN #100 placed on a temp suspension, pending investigation 10/24/25 Diversion forms filed and sent to appropriate offices 10/24 OIG informed 10/24/25 - Initial report APS informed 10/24/25 - Initial report Local police 10/24/25 - Initial report Audits performed 10/24 - 10/29 Investigations 10/24-10/29Labs in file all show trace levels only of the residents PRN pain medsInconsistent administration of PRN med versus pain assessments and resident requests. Other residents noted with similar concerns/missing PRN medication Resident's #1, #15, #39, #56, #64,#65. OIG 5 day follow up - 10/29/25 APS 5 day follow up - 10/29/25Staff education completed - 10/29/25LPN was terminated .- 10/29/25 Plan of correction The facility completed its investigation and put into place a Plan of Correction (POC) that was fully completed by 10/29/25. This POC included assessments of all residents, labs drawn and (continued on next page)

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	levels checked, PRN medications replaced, education of all staff about medication administration and storage. LPN #100's employment was terminated 10/29/25. The facility took all necessary steps in the investigation and correction of this issue prior to them having their yearly Long Term Survey Recertification completed.

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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 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, record review, and staff interview the facility failed to provide an environment free from accident hazards including, provide bed side floor mat for a resident that was in a care plan and ordered by physician and non-locking doors to general shower room and linen room. This was true for Resident #23 and has the potential affect a larger number of residents. Resident identifier: #23. Facility census: 55. Findings included: a) Resident #23 Review of Resident #23's physician orders on 05/19/26 revealed the following: Fall mat to patient's left side. Order date: 04/23/26. Review of the care plan on pages 19 and 20 revealed: Focus -Resident is at risk for falls related to, but not limited to history of falls, Parkinson's, Tremor etc Interventions- include fall mat to patients left side of bed when in bed. Date initiated 02/02/26 On 05/20/26 at 4:02 PM Resident #23 was observed lying in bed with eyes closed, call light within reach, bilateral bed bolsters but the fall mat was absent from the left side. On 05/20/26 at 4:04 PM the administrator was interviewed regarding the observation of Resident #23. The administrator acknowledged the mat was not in place. At 4:10 PM, the Administrator returned and reported the floor mat was behind the bed and had since been put into place. b) A hallway On 05/19/26 at approximately 11:30ˆAM during a routine walkthrough of the facility, two (2) doors in the A Hall of the residents' area were found unlocked. The General shower room and Clean utility room doors were unlocked and did not lock on three (3) attempts to allow the door to open and close under its own. Upon further inspection the doors were found to not function properly and would not lock even with assistance from a person to push them closed. These rooms contain multiple accident hazards and are to be secured at all times when not in use. On 05/19/26 at approximately 11:45ˆAM the Administrator (Admin) and Maintenance #11 were shown the two doors, both confirmed they were not locking. The Admin stated, I will have those looked at and fixed immediately. Maintenance #11 stated, Ill look into those right away and get them working for ya.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission by not ensuring Pre-admission screening and resident review (PASSR) reflected the medical diagnosis prior to admission to facility and updated the PASSR. This was found true for one (1) of four (4) reviewed during the Long Term Care Survey process. Resident identifier: #17. Facility census: 55. Findings Include: a) Resident #17 During record review completed on 05/20/26 at 11:00 Am found resident # 17 has a diagnoses of Major Depressive Disorder Recurrent unspecified on 11/17/23 resident was admitted to the facility on [DATE]. Further record review revealed the most recent Pre-admission screening and Resident Review (PASSR) created on 04/20/26 did not have the diagnosis of Major Depressive Disorder Recurrent unspecified. An interview with the facility's administrator was completed on 05/20/26 at 1:00 PM and confirmed the PASSR did not have the diagnosis when completed for admission. and no other updated PASSR was completed after admission.

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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 observation, staff interview and and record review, the Facility failed to implement a resident's care plan by failing to use a floor mat for Resident #23 with a a history of falls. Resident identifier: #23. Facility Census 55. a) Resident #23 A review of Resident #23's physician orders on 05/19/26 revealed the following: Fall mat to patients left side. Order date 04/23/26. A review of the care plan on pages 19 and 20 revealed: Focus -Resident is at risk for falls related but not limited to history of falls, Parkinson's, Tremor etc Interventions- include fall mat to patients left side of bed when in bed. Date initiated 02/02/26. On 05/20/26 at 4:02 PM Resident #23 was observed lying in bed with eyes closed, bulb call light in reach, bilateral bed bolsters but absence of fall mat to left side. On 05/20/26 at 4:04 PM interview with administrator who observed Resident #23, and acknowledged the mat was not in place. At 4:10 PM the Administrator returned and reported the floor mat was behind the bed but had since been put into place.

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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 interview, record review and observation the facility failed to ensure resident #10 was provided sunscreen prior to an outside activity. Resident identifier #10. Facility Census: 55. Findings Include: a) Resident #10 After observation of Resident #10 it was evident that the resident had a sunburn. Resident #10 stated that she had been outside for an activity and was not offered sunscreen prior to going outside, therefore Resident #10 suffered a sunburn. Resident #10 sunburn resulted in an order for aloe vera to be applied to affected areas. This deficient practice was verified by the Administrator on 5/20/26 at 2:39 PM.