

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/02/2026
NAME OF PROVIDER OR SUPPLIER  Pendleton Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  68 Good Samaritan Drive Franklin, WV 26807	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based upon observations, staff interviews and record reviews, the facility failed to ensure that it remained free from accident hazards in resident accessible areas. There were multiple areas with accident hazards or hazardous products that could be reached by residents while under the care and control of the facility. This was discovered during the normal Long Term Survey Process and has the ability to affect more than a limited number of residents. Census 84.a) At 9:50 AM, an observation of the 500 hall nourishment room and resident dining area revealed that residents had access to the mini-kitchen. Under the sink, a can of Scrubbing Bubbles and a gallon of white vinegar were found. Additionally, a manual can opener with sharp edges was left on the stovetop. In the dining area, a cart containing two uncovered metal cans filled with food waste was left unattended for approximately 20 minutes while residents were present.</p> <p>At 10:00 AM, Employee #125 acknowledged the unattended waste carts and the can opener. She confirmed the carts are used for leftover food, stated the can opener should not have been left out, and removed it. At 10:15 AM, the Facility Administrator acknowledged the unattended waste carts. While she did not believe the can edges were sharp, she committed to finding a solution to prevent resident access to open food waste.</p> <p>At 1:50 PM, during a walkthrough with the Dietary Manager, two (2) unattended waste carts with uncovered lunch waste were observed in the 200 hallway, an area actively used by residents.</p> <p>The Dietary Manager acknowledged the presence of the waste carts and immediately instructed staff to remove them from the hallway.</p> <p>b) At approximately 11:50 AM, two single resident oxygen tanks were observed stored in a cubby area in the 100 hall. The tanks lacked regulators and were not labeled as full or empty. Storing tanks in non-designated areas poses a fire and explosion hazard. LPN #31 confirmed the tanks were improperly stored. During a follow-up at 12:29 PM, administration and maintenance confirmed the facility currently lacks a compliant indoor area for oxygen storage and stated they would contact the OHFLAC office to discuss necessary adjustments for compliance.</p> <p>At approximately 11:45 AM an observation on the 400 Hall revealed Sani-Wipes (purple top) unattended on a treatment cart near the 400 hall nurses' station. These wipes are poisonous if ingested and posed a chemical burn risk. The Registered Nurse confirmed these should not be accessible to residents and moved them to secure storage.</p> <p>At approximately 12:02 PM, an observation on 500 Hall revealed a linen cart with a side pouch containing zinc skin tubes, moisturizer, and calamine lotion packets. Additionally, a large wooden storage cabinet in the 500 hall living area was found unlocked and labeled only staff only. The cabinet (continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>contained linens, soap, incontinence briefs, hand sanitizer, alcohol wipes, and skin prep pads. RN #109 confirmed the contents and committed to removing the supplies from the cart and securing or clearing the cabinet.</p> <p>c) On 02/25/26, at approximately 1:50 PM during the initial resident interview process, the surveyor found the shower room door open and unattended. The following items were found on a table, easily accessible to residents:</p> <ol style="list-style-type: none"> <li>1. A sharps container overflowing with three blue razors.</li> <li>2. An opened can of Scrubbing Bubbles.</li> <li>3. An opened container of whirlpool disinfectant.</li> </ol> <p>Activity Director #152 confirmed that the door was open and that these items were left unsecured. These findings were reported to the administrator at 2:00 PM on the same day.</p>		