STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515124	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pendleton Manor	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)
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 record review, observation and staff interview, the facility failed to ensure the resident's environment maintained or enhanced dignity and respect during the dining experience. The failed practice had the potential to affect a limited number of residents. Facility Census: 84. Findings included: a) The facility's policy and procedure for The Dining Experience: Staff and Responsibilities stated, Staff should provide service that will help to make dining a special event that individual patients/residents look forward to and that will create lasting memories. On 02/25/26 at 12:25 PM in the Day Room/Sitting Room, four (4) of five (5) residents were served their lunch meal without their food being removed from their plastic trays. Licensed Practical Nurse (LPN) #32 confirmed the residents were served their lunch meal on a plastic tray.

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 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 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. 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. 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. The Dietary Manager acknowledged the presence of the waste carts and immediately instructed staff to remove them from the hallway. 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. 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. 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 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. 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: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. A sharps container overflowing with three blue razors. 2. An opened can of Scrubbing Bubbles. 3. An opened container of whirlpool disinfectant. 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.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and staff interviews the facility failed to provide food at a safe appetizing temperature. This failed practice had the potential to affect all residents in the facility. Resident identifiers #'s 79 and 38 Facility census: 87 a) During facility walkthrough and resident interviews, Resident #79 stated that food was a sore point; the food is terrible. Whoever cooks it .ruins it. and it has been cold. In an interview with Resident # 38 on 02/26.26, at 2:15 PM, she stated The food is ok but sometimes its too cold when it gets here. During an observation on 02/27/26 at 1:15 PM of the 400 hall meals being passed without a heated cart and only 2 staff members delivering all trays to residents on that hall. The dietary manager took the temperature of the food, at time of service. The food temperatures were as follows: Lasagna 57 degrees Fahrenheit.Vegetables 53 degrees Fahrenheit. During an interview with the Dietary Manager on 02/27/26 at approximately 1:25 PM, she temp-tested the last tray and confirmed that the food was not served at 120 degrees Fahrenheit at time of service. She stated there are not enough heated carts for the entire facility. The 400 hall was the only hall without a heated cart on that date.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and policy review the facility failed to properly store food in accordance with professional standards. This is true for the facility kitchen and nourishment pantries. This had the potential to affect all residents in the facility. Facility census: 87Findings included:a) On 02/25/2026 12:36 PM During the initial kitchen visit and walk through with the Dietary Manager, who acknowledged the following:Freezer :-one box of opened frozen hamburger patties stored in an opened box with the inside plastic wrap left open to air-one box of opened frozen fish filets stored in an opened box with the inside plastic wrap left open to air-one box of sugar cookie dough stored in an opened box with the inside plastic wrap left open to air Pantry:-Tea bags not sealed and left open to air-Plastic bags of All Bran, [NAME] Wheats, and Creme of Wheats cereals unsealed and left open to air Utensil drawers -utensils were found stored in different directions,- plastic box holding utensils taken directly out of the dishwasher stored in different directions b) 500 Hall Nourishment Room and Dining Area:-On 02/26/2026 at 9:00 AM, during an observation of the 500 Hall nourishment room and dining area found the following:-Freezer:Klondike Ice Cream Bar w/out label or date-Fridge: lunchmeat left open to air -Right top cabinet found an unopened sleeve of Ritz crackers w/out date or label Staff Interviews: During an interview with Nurse Aide Employee #125, she acknowledged the lunchmeat was left open to air in the refrigerator and removed it. at 10:15 AM in a later interview with the Administrator, she stated the ham should have been stored inside a sealed bag with a label and date. c) During an observation of the 300 Hall Nourishment Room on 02/26/2026 at 9:00 AM, it was observed:-Upper Cabinet an opened sleeve of Ritz crackers without a dated label staff interviews:In an interview on 02/26/26 at 10:15AM with The Administrator, she acknowledged the sleeve of Ritz crackers and stated they should have had a dated label then sent staff to remove the crackers from the cabinet shelf d) Dining Room Storage Cabinets:On 02/26/26 at 10:15AM, during a walk through and observations of the dining room storage cabinets with the Facility Administrator who acknowledged the following: Counter and Bottom Cabinet:-One box of All Bran Cereal left out on the counter opened with unsealed inner package left open to air-three plastic packages of cereal, Corn Flakes, Toasted Oats, and Raisin Bran were left open to air in the cabinet beneath the counter e) 300 Hall Nourishment Room/Dining Area:On 02/26/26 at 10:20AM During a walk through of the 300 Hall Nourishment Room/Dining Area with the Facility Administrator who acknowledged the following: Freezer:-pint size carton of Ben and Jerrys Ice cream w/out label or date -Frozen toaster pastries w/out label or date left open to air- One box of Banquet sausage gravy/biscuits w/out label or date-Tostitos Pizza Rolls w/out label or date unsealed, left open to air -Individual Ice Cream bars w/out label or dates Upper Cabinet:-Honey Nut Cheerios Bars w/out label or date on the middle shelf-Loaf of bread with green mold on the middle shelf -One lone stick of gum on bottom shelf no package F) Facility Food Storage Policies:On 02/25/26 at 4:30PM a review of the Facility Food Storage Policy Statement number 5-a. stated Non -perishable foods are stored in re-sealable containers with tightly fitting lids and 5-b stated perishable foods are stored in resealable containers with tightly fitting lids in a refrigerator, Containers are labeled with name and date, the item, and the use by date

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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 interview, the facility failed to ensure an infection prevention and control program per professional standards was maintained and followed. This failed practice had the potential to affect more than a limited number of residents. Resident #'s 17 and 58 Facility Census: 84. Resident #17 During an interview with Resident #17 on 02/25/25 at 3:50 PM, observation revealed the wheelchair she was sitting in, had cracks and tears, exposing padding on both armrests. Resident #38 During resident observation and interviews on 02/25/26 4:08 PM, it was observed Resident #38's wheelchair had a tear with exposed padding on the back rest . In an interview with the infection preventionist on 02/25/2026 at 2:30 PM, she acknowledged the two (2) wheelchairs for Resident #'s 38 and #17 had exposed padding causing an infection control issue. She stated she would have them taken care of immediately. During the routine walk-through of the facility on 02/26/2026, at approximately 11:30 AM on the 400 resident hall it was noted that there was an Enhanced Barrier Protection (EBP) sign on the door of room [ROOM NUMBER]. The sign had no markings or indications as to which resident the precautions (EBP) were for. RN #149 confirmed there was no markings on that sign to indicate what resident it would pertain to. They (chuckled), It figures you found the one sign without a mark on it right as you entered the building. The facility's policy and procedure for Infection Prevention and Control Program stated, the program was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility's policy and procedure for The Dining Experience: Staff Responsibilities stated, 6. Individuals will be provided with proper hand hygiene prior to each meal or snack, prepared for the meal by the nursing staff (i.e. hearing aids in place, dentures in, hair combed, dressed properly, and eyeglasses on), and assisted to the dining area as needed. On 02/25/2026 at 11:45 AM, in the main dining room, no hand hygiene was observed to be completed prior to the lunch dining experience for the residents. Six (6) ambulatory residents utilizing an assistive device and five (5) residents propelling their wheelchairs were observed entering the dining room with no hand hygiene completed upon being seated at the table for the lunch meal At 2:06 PM, Nursing Aide #120, confirmed no hand hygiene was completed for the residents in the dining room and stated, They should be taking residents and washing their hands.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and staff interview, the facility failed to notify the physician of a change in condition for a resident's admission to hospice services. Resident Identifier: #47. Facility Census: 84.Findings included: a) Resident #47 The facility's policy stated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).On 09/24/25, a progress note for Resident #47 documented a decline with nursing reporting a significant change. No documentation was found for physician notification of the decline/significant change. A nursing progress note dated 10/14/25, documented admission to hospice services with family in attendance. On 10/29/25, a progress note documenting the care conference documented, Nursing Significant Change due to hospice placement.On 02/26/26, the Administrator verified there was no documentation for the resident's change of condition for hospice, including physician notification, in the progress notes. A change in condition Minimum Data Set (MDS) was initiated on 10/15/2025. On 03/02/2026, the state surveyor requested documentation of physician inclusion in hospice decision making process and notification of change of condition No additional information was obtained.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to send a copy of the Notice of Transfer/Discharge form to the Long-Term Care Ombudsman when a resident was discharge to an acute care setting. Resident Identifier: #7. Facility Census: 84. Findings included: a) Resident #7 An electronic medical record review was completed on 03/01/2026 at 12:08 PM. Resident #7 was transferred to the hospital on [DATE]. There was no evidence in resident's medical record to reflect the Long-Term Care Ombudsman had received a copy of the Notice of Transfer/Discharge paperwork or had been made aware of the hospitalization. The Administrator was asked if the facility could produce evidence staff had shared the appropriate notice of transfer/discharge with the ombudsman. During an interview, on 03/02/26 at 10:40 AM, the Social Worker confirmed the Notice of Transfer/Discharge paperwork had not been shared with the Long-Term Care Ombudsman prior to Surveyor intervention. It was noted that it had been accidentally overlooked.

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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 medical record review and staff interview, the facility failed to ensure Resident #7 received medications as ordered by the physician. Insulin aspart [NovoLog] (a medication used to control blood sugar in people with diabetes mellitus) was not administered and documented in accordance with professional standards of practice. This affected one (1) of five (5) residents reviewed for unnecessary medications during the long-term care survey process. Resident identifier: #7. Facility census: 84.Findings included: a) Physician Order for Resident #7 An electronic medical record review, completed on 03/01/2026 at 10:10 AM, revealed the following physician order:Insulin Aspart Injection Solution (Insulin Aspart)Inject 10 units subcutaneously three times a day related to TYPE 1 DIABETES MELLITUS WITH HYPERGLYCEMIA (E10.65) Give insulin immediately after each meal, EXCEPT when blood sugar is >400, then administer the full 10 units, regardless of amount eaten. If >50% of meal is eaten, give full dose. If <=50% of meal is eaten, give half dose. b) Review of Medication Administration RecordsA subsequent review of the Medication Administration Records (MAR) revealed the following dates and times that Resident #7 received a dose of Insulin aspart but the percentage of the meal consumed and the number of units administered had not been recorded on the MAR:-08/05/25 Breakfast Meal-08/05/25 Lunch Meal-08/05/25 Dinner Meal-08/13/25 Breakfast Meal-08/13/25 Lunch Meal-08/13/25 Dinner Meal-08/18/25 Breakfast Meal-08/18/25 Lunch Meal-08/18/25 Dinner Meal -08/19/25 Lunch Meal-08/19/25 Dinner Meal-08/21/25 Lunch Meal-09/01/25 Breakfast Meal-09/01/25 Lunch Meal-09/01/25 Dinner Meal-09/02/25 Lunch Meal-09/02/25 Dinner Meal-09/10/25 Breakfast Meal-09/10/25 Lunch Meal-09/10/25 Dinner Meal-09/11/25 Lunch Meal-09/11/25 Dinner Meal-09/15/25 Breakfast Meal-09/15/25 Lunch Meal-09/15/25 Dinner Meal-09/16/25 Lunch Meal-09/16/25 Dinner Meal-09/17/25 Lunch Meal-09/17/25 Dinner Meal-10/22/25 Lunch Meal-10/22/25 Dinner Meal-10/23/25 Breakfast Meal-10/23/25 Lunch Meal-10/23/25 Dinner Meal-10/27/25 Breakfast Meal-10/27/25 Lunch Meal-10/27/25 Dinner Meal-10/28/25 Breakfast Meal-11/10/25 Breakfast Meal-11/10/25 Lunch Meal-11/10/25 Dinner Meal-11/11/25 Dinner Meal-11/19/25 Breakfast Meal-11/19/25 Lunch Meal-11/19/25 Dinner Meal-11/20/25 Lunch Meal-11/20/25 Dinner Meal-11/25/25 Breakfast Meal-11/25/25 Lunch Meal-11/25/25 Dinner Meal-12/03/25 Breakfast Meal-12/03/25 Dinner Meal-12/08/25 Breakfast Meal-12/08/25 Lunch Meal-12/08/25 Dinner Meal-12/09/25 Breakfast Meal-12/09/25 Lunch Meal-12/09/25 Dinner Meal-12/17/25 Lunch Meal-12/17/25 Dinner Meal-12/18/25 Lunch Meal-12/18/25 Dinner Meal-12/31/25 Breakfast Meal-12/31/25 Lunch Meal-12/31/25 Dinner Meal-01/01/25 Breakfast Meal-01/01/25 Lunch Meal-01/01/25 Dinner Meal-01/02/25 Lunch Meal-01/02/25 Dinner Meal-01/10/25 Breakfast Meal-01/10/25 Lunch Meal-01/10/25 Dinner Meal-01/11/25 Breakfast Meal-01/11/25 Lunch Meal-01/11/25 Dinner Meal -01/19/25 Breakfast Meal-01/19/25 Lunch Meal-01/19/25 Dinner Meal-01/20/25 Breakfast Meal-01/20/25 Lunch Meal-01/20/25 Dinner Meal-01/24/25 Breakfast Meal-01/24/25 Lunch Meal-01/24/25 Dinner Meal-01/25/25 Breakfast Meal-01/25/25 Lunch Meal-01/25/25 Dinner Meal-01/28/25 Breakfast Meal-01/28/25 Lunch Meal-01/28/25 Dinner Meal-01/29/25 Breakfast Meal-01/29/25 Lunch Meal-01/29/25 Dinner Meal-02/02/25 Breakfast Meal-02/02/25 Lunch Meal-02/02/25 Dinner Meal-02/03/25 Breakfast Meal-02/03/25 Lunch Meal-02/03/25 Dinner Meal-02/04/25 Lunch Meal-02/07/25 Breakfast Meal-02/07/25 Lunch Meal-02/07/25 Dinner Meal-02/08/25 Breakfast Meal-02/08/25 Lunch Meal-02/08/25 Dinner Mealc) Interview with DONDuring an interview on 03/02/26 at 10:20 AM, the Director of Nursing confirmed that MARs on the above-mentioned dates and times did not have the percentage of the meal consumed and the number of units administered recorded.