STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515131	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sistersville Center	201 Wood Street Sistersville, WV 26175

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on medical record review, observation, and staff interview, the facility failed to ensure Resident's received treatment and care in accordance with professional standards of practice. Specifically, physician's orders were not followed for Neurological checks (neuro checks) . This practice affected one (1) of one (1) residents reviewed, during the Long-Term Care Survey Process (LTCSP). Resident identifier #13. Facility census: 60. a) Resident #13 The facility's policy titled Falls Management, with effective date 09/15/01 and revision date 01/15/26, stated any resident who had a fall unwitnessed by staff would be observed for neurological abnormalities by performing neurological checks per policy. The facility's policy titled, Neurological Evaluation, with effective date 03/01/98 and revision date 01/15/26, stated when a resident has an unwitnessed fall, neurological evaluations would be performed every 15 minutes for two (2) hours, then every 30 minutes for two (2) hours, then every hour for four (4) hours, and then every eight (8) hours for at least 72 hours. Review of Resident #13's progress notes showed the resident had an unwitnessed fall on 12/26/25. A progress note written on 12/26/25 at 10:15 PM stated, This nurse heard resident yelling Help me from hallway. Upon entering room, resident was on her hands and knees beside of her bed. She stated, I was trying to get comfortable in the bed and somehow ended up in the floor. Assessed resident for injuries, no injuries observed. PERRLA [pupils equal, round, reactive to light and accommodation]. VSS [vital signs stable] and WNL [within normal limits]. Denies any pain or discomfort. No change in ROM [range of motion]. Resident able to move all extremities without difficulty. Resident denies hitting her head. Assisted resident back to bed x2 assist. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Neuro checks per facility protocol. Other than the initial neurological evaluation documented in the note above, no neurological evaluations were found in the medical record. On 04/02/2026 at 10:57 AM, Administrator #47 confirmed no neurological evaluations could be located for Resident #13's fall on 12/26/25. Administrator #47 also confirmed Resident #13's fall on 12/26/25 was unwitnessed by staff. No further information was provided through the completion of the survey process.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on staff interview and surveyor intervention, the facility failed to provide feeding of meals in a timely manner after serving the trays to residents with no drink or meal assistance. This was true for two (2) of two (2) residents in the care area of Resident Rights/Exercise of Rights. Resident Identifiers: Resident #55 and Resident # 57. Facility census: 60. Findings include: a) Resident # 55 Review of Resident # 55's records show Regular/Liberalized Puree Thick liquids- Honey with 240 ml of cranberry juice with all meals. On 03/31/26 at 12:39 PM, Resident # 55 was served lunch tray with no drink or utensils. Utensils include large maroon spoon. The meals were sitting, uncovered, in trays for eleven (11) minutes before a staff member came over to check what drinks were needed and to start assisting resident with feeding. At 12:53 PM, Registered Nurse Clinical Lead Staff # 45 was asked if it is common for residents to have to wait to be fed or assisted with dining room meals for over ten minutes to which her reply was, absolutely not! This is not a practice we like to see. b) Resident # 57 Review of Resident # 57's records show Regular/Liberalized Puree diet with 2 % milk (eight ounces) and assorted beverage (eight ounces). The pureed food in tray was served at 12:39 PM on 03/31/26 in the dining room and resident was in reclined position by table until Staff #45 came over at 12:53 PM to start with feeding. Staff member was asked if waiting ten minutes was common for residents to start being fed after the uncovered trays have been sitting at table and the reply was Absolutely not! This is not a practice we like to see. The Nursing Home Administrator was not working on this day to discuss this item so the corporate staff member was the main contact for this discussion.

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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. The facility failed to honor resident choices regarding the things that are important in her life in regards to getting out of bed before lunch. This is true for two (2) of two (2) residents reviewed for choices. Resident identifier: #54. Facility census: 60. Findings Included: a) Resident #54 During an interview with Resident #4 on 03/30/26 at 11:32 AM, the resident expressed frustration regarding a delay in assistance with getting out of bed. She stated that she had been waiting for approximately one (1) hour and noted that her aide had previously mentioned they would return with help but had not yet done so. She stated she must get them early or she don't get up in time. During an interview on 03/30/26 at 11:45 AM with Registered Nurse #30 she stated she would get Resident #54's aide to get her out of bed for lunch. An observation at 12:10 PM found Resident #54 still in bed. A second observation at 12:50 PM found Resident #54 still in bed eating lunch. On 03/30/26 at 12:55 PM during an interview, Clinical Lead #62 stated that she would investigate the situation and follow up. On 03/30/26 at 1:05 PM during an interview Clinical Lead #62 subsequently stated that Resident #54 would be assisted out of bed after she finished eating.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and staff interview, the facility failed to implement their abuse prohibition policy regarding the reporting of allegations of potential verbal abuse. This was true for one (1) of four (4) residents reviewed for the care area of abuse. Additionally, a random opportunity for discovery showed other allegations of potential verbal abuse had not been reported. Resident Identifier: #7. Facility Census: 60. Findings included: a) Policy Review The facility's policy titled, Abuse Prohibition, with effective date 07/01/13 and revision date 11/14/25, stated allegations involving abuse with no serious bodily injury would be reported immediately but no later than 24 hours after forming the suspicion of abuse. b) Resident #7 On 03/16/26, an allegation of potential verbal abuse was reported to the Office of Health Facility Licensure and Certification. The incident occurred on 02/13/26 at 7:45 PM. The initial reporting of allegations stated, Resident thought she heard the CNA [certified nursing assistant] calling her a mumbled word that sounded like bitch. Resident told her father and he asked the CNA if it was true .The resident's father asked the CNA not to report it, so no immediate steps were taken. According to the initial reporting of allegations, the incident was discovered during the investigation of an unrelated concern on 03/16/26 and was reported to all required entities at that time. Following this, an investigation was conducted. The five (5) day follow-up, which unsubstantiated the allegation, was submitted on 03/20/26. According to a typed statement on 03/16/26 by Nurse Aide (NA) #1, who was involved in the allegation, the incident had been reported to former Director of Nursing (DON) #88 and former Administrator #89 at the time of the incident. The former DON and Administrator stated the incident did not need reported because it was a muttered word. On 04/01/26 at 1:00 PM, Administrator #47 confirmed the incident involving an allegation of potential verbal abuse that occurred on 02/13/26 was not reported until 03/16/26. No further information was reported through the completion of the survey. c) NA #57 and NA #1 On 04/01/26, the surveyor asked to review the investigation for the allegation of potential verbal abuse described above. In the file was a typed statement. The statement indicated it was from google.com mail and was sent from an iPhone. However, there was no information regarding the writer of the statement. The statement read as follows: I have worked with [Nurse Aide (NA) #53] in this facility for almost three years. She does come in and do her job, and does not call off ever. Our job is far more than just showing up though. I have seen residents trying to talk to her, and her just walk off. Many residents have told me they know she's mad at them. I have heard her call a certain resident pissy pants, and told him he needed to start using a urinal. That was reported by a nurse at one time also. She has also made the comment about it stinking in there while she was changing him. I know that resident was afraid to use his call light at one point because he didn't want her coming in to change him. Multiple residents have told me she's mean and calls them names. I know she has a nickname for everyone she doesn't like. Working with her got so tense, and hostile You never know what kind of mood she's going to be in, and she doesn't just take it out on her coworkers it is with the residents also. I would work with a resident on one side of the curtain, and [NA #53] on the other side with the other resident. There was multiple times residents would yell out and tell her to be easy, and she would say well roll. I would finish up and go help her so I know what was going on. I never witnessed her physically hurting anyone, but she is mean, and always in a horrible mood. She's shut call lights off without answering them multiple times. I also know that she has reported us to state before. She's the one that went online and reported sexual activitu on red hall. She has told many people about doing it. [NA #1] has told so many lies to so many there. She is as mean as [NA #53]. She's always complaining about having to do her job. Complaining about her coworkers, and how no one ever does their jobs. I've heard her calling the residents nicknames also. She does it at the nurses station talking to other coworkers. I don't hang around and listen to her much. I don't have too much interaction with her. I have had a few residents call her the mean one. I know they are talking about her because they say it's the pregnant one. On 04/01/26 at 1:00 PM, Administrator #47 was asked if (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the allegations of abuse contained in this statement had been reported and investigated. She was unaware of the source of this statement. On 04/01/26 at 1:27 PM, Administrator #47 stated the allegations of abuse contained in this statement had not been previously reported and investigated. However, the matter had just been reported to the required entities. Additionally, the NAs involved had just been suspended pending investigation. No further information was provided through the completion of the survey process.

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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. Based on record review and staff interview, the facility failed to report allegations of potential verbal abuse within a timely manner. This was true for one (1) of four (4) residents reviewed for the care area of abuse. Additionally, a random opportunity for discovery showed other allegations of potential verbal abuse had not been reported. Resident Identifier: #7. Facility Census: 60. Findings included:a) Policy Review The facility's policy titled, Abuse Prohibition, with effective date 07/01/13 and revision date 11/14/25, stated allegations involving abuse with no serious bodily injury would be reported immediately but no later than 24 hours after forming the suspicion of abuse. b) Resident #7 On 03/16/26, an allegation of potential verbal abuse was reported to the Office of Health Facility Licensure and Certification. The incident occurred on 02/13/26 at 7:45 PM. The initial reporting of allegations stated, Resident thought she heard the CNA [certified nursing assistant] calling her a mumbled word that sounded like bitch. Resident told her father and he asked the CNA if it was true .The resident's father asked the CNA not to report it, so no immediate steps were taken. According to the initial reporting of allegations, the incident was discovered during the investigation of an unrelated concern on 03/16/26 and was reported to all required entities at that time. Following this, an investigation was conducted. The five (5) day follow-up, which unsubstantiated the allegation, was submitted on 03/20/26. According to a typed statement on 03/16/26 by Nurse Aide (NA) #1, who was involved in the allegation, the incident had been reported to former Director of Nursing (DON) #88 and former Administrator #89 at the time of the incident. The former DON and Administrator stated the incident did not need reported because it was a muttered word. On 04/01/26 at 1:00 PM, Administrator #47 confirmed the incident involving an allegation of potential verbal abuse that occurred on 02/13/26 was not reported until 03/16/26. No further information was reported through the completion of the survey. c) NA #57 and NA #1 On 04/01/26, the surveyor asked to review the investigation for the allegation of potential verbal abuse described above. In the file was a typed statement. The statement indicated it was from google.com mail and was sent from an iPhone. However, there was no information regarding the writer of the statement. The statement read as follows: I have worked with [Nurse Aide (NA) #53] in this facility for almost three years. She does come in and do her job, and does not call off ever. Our job is far more than just showing up though. I have seen residents trying to talk to her, and her just walk off. Many residents have told me they know she's mad at them. I have heard her call a certain resident pissy pants, and told him he needed to start using a urinal. That was reported by a nurse at one time also. She has also made the comment about it stinking in there while she was changing him. I know that resident was afraid to use his call light at one point because he didn't want her coming in to change him. Multiple residents have told me she's mean and calls them names. I know she has a nickname for everyone she doesn't like. Working with her got so tense, and hostile You never know what kind of mood she's going to be in, and she doesn't just take it out on her coworkers it is with the residents also. I would work with a resident on one side of the curtain, and [NA #53] on the other side with the other resident. There was multiple times residents would yell out and tell her to be easy, and she would say well roll. I would finish up and go help her so I know what was going on. I never witnessed her physically hurting anyone, but she is mean, and always in a horrible mood. She's shut call lights off without answering them multiple times. I also know that she has reported us to state before. She's the one that went online and reported sexual activitu on red hall. She has told many people about doing it. [NA #1] has told so many lies to so many there. She is as mean as [NA #53]. She's always complaining about having to do her job. Complaining about her coworkers, and how no one ever does their jobs. I've heard her calling the residents nicknames also. She does it at the nurses station talking to other coworkers. I don't hang around and listen to her much. I don't have too much interaction with her. I have had a few residents call her the mean one. I know they are talking about her because they say (continued on next page)

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	515131	A. Building B. Wing	04/02/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it's the pregnant one. On 04/01/26 at 1:00 PM, Administrator #47 was asked if the allegations of abuse contained in this statement had been reported and investigated. She was unaware of the source of this statement. On 04/01/26 at 1:27 PM, Administrator #47 stated the allegations of abuse contained in this statement had not been previously reported and investigated. However, the matter had just been reported to the required entities. Additionally, the NAs involved had just been suspended pending investigation. No further information was provided through the completion of the survey process.

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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 and staff interview, the facility failed to investigate allegations of potential abuse. This was a random opportunity for discovery. Facility Census: 60. Findings included:c) NA #57 and NA #1esOn 04/01/26, the surveyor asked to review the investigation for the allegation of potential verbal abuse toward Resident #7 that had been reported to the Office of Health Facility Licensure and Certification (OHFLAC) on 03/16/26. The allegation of verbal abuse toward Resident #7 had been investigated and was determined to be unsubstantiated. In the finvestigation file was a typed statement. The statement indicated it was from google.com mail and was sent from an iPhone. However, there was no information regarding the writer of the statement. The statement read as follows: I have worked with [Nurse Aide (NA) #53] in this facility for almost three years. She does come in and do her job, and does not call off ever. Our job is far more than just showing up though. I have seen residents trying to talk to her, and her just walk off. Many residents have told me they know she's mad at them. I have heard her call a certain resident pissy pants, and told him he needed to start using a urinal. That was reported by a nurse at one time also. She has also made the comment about it stinking in there while she was changing him. I know that resident was afraid to use his call light at one point because he didn't want her coming in to change him. Multiple residents have told me she's mean and calls them names. I know she has a nickname for everyone she doesn't like. Working with her got so tense, and hostile You never know what kind of mood she's going to be in, and she doesn't just take it out on her coworkers it is with the residents also. I would work with a resident on one side of the curtain, and [NA #53] on the other side with the other resident. There was multiple times residents would yell out and tell her to be easy, and she would say well roll. I would finish up and go help her so I know what was going on. I never witnessed her physically hurting anyone, but she is mean, and always in a horrible mood. She's shut call lights off without answering them multiple times. I also know that she has reported us to state before. She's the one that went online and reported sexual activitu on red hall. She has told many people about doing it. [NA #1] has told so many lies to so many there. She is as mean as [NA #53]. She's always complaining about having to do her job. Complaining about her coworkers, and how no one ever does their jobs. I've heard her calling the residents nicknames also. She does it at the nurses station talking to other coworkers. I don't hang around and listen to her much. I don't have too much interaction with her. I have had a few residents call her the mean one. I know they are talking about her because they say it's the pregnant one. On 04/01/26 at 1:27 PM, Administrator #47 stated the allegations of abuse contained in this statement had not been previously investigated. She stated the matter would be investigated. No further information was provided through the completion of the survey process.

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Sistersville Center	201 Wood Street Sistersville, WV 26175

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and staff interview, the facility failed to complete a yearly performance appraisal for direct care staff. This is true for one of five nurse aide performance appraisal's reviewed during this survey. Nurse Aide #52. Facility Census: 60Findings included: a) On 04/01/26 at approximately 4:00 PM, Administrator #47 was asked for Nurse Aide (NA) #52's Performance Appraisal for this year and she reported it is not in the chart. The surveyor asked if they could have the most recent one completed. The performance review delivered to the surveyor was dated 09/16/24. On 4/01/26 at 4:02 PM, a reviewed of Employee Performance Appraisal Form for NA #52 who was hired on 12/14/15 revealed her last performance review was completed on 09/16/24. Review of facility title, HR616 Performance Appraisal states: Managers will meet with their regular full-time, regular part-time, and casual employees at least annually to conduct a performance appraisal or have a performance based conversation. In-service education will be provided based on the outcome of these reviews.

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	515131	A. Building B. Wing	04/02/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure complete and accurate medical records. This deficient practice had the potential to affect two (2) of three (3) residents reviewed for the care area of advance directives. Resident Identifiers: #2 and #13. Facility Census: 60.Findings included:a) Resident #2 Review of Resident #2's medical records showed a Physician's Determination of Capacity form dated [DATE] that indicated the resident had capacity to make her own medical decisions. The medical records also showed a Physician Orders for Scope of Treatment (POST) form dated [DATE]. A POST form is a form a resident or their representative completes to specify end-of-life wishes. Resident #2's POST form indicated the resident wanted to receive cardio-pulmonary resuscitation (CPR) and full treatments. Resident #2's POST form had not been signed by the resident. The section stating Patient/Patient MPOA [Medical Power of Attorney representative]/surrogate signature (required) was marked with a small x. Review of Resident #2's admission documents revealed the resident was able to sign her name. According to the document titled, Using the POST form, Guidance for Health Care Professionals, available on-line, this section of the form must be signed to be legally valid. On [DATE] at 12:16 PM, Administrator #47 confirmed Resident #2's POST form had not been signed by the resident.No further information was provided through the completion of the survey process. b) Resident #13 Review of Resident #13's physician's orders showed an order written on [DATE] for No CPR [cardio-pulmonary resuscitation]- Do not attempt Resuscitation. Comfort focused treatment. Maximize comfort through symptom management, allowing natural death. Use oxygen suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or selective treatment unless consistent with comfort goals. Transfer to hospital only if comfort cannot be achieved in the current setting.Review of Resident #13's medical records showed the resident was determined to have the capacity to make her own medical decisions upon admission to the facility. The resident completed a POST form indicating she did not want CPR. She also wanted comfort-focused treatments. According to the form, Goal: Maximize comfort through symptom management; allow natural death. Use oxygen suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or selective treatment unless consistent with comfort goals. Transfer to hospital only if comfort cannot be achieved in the current setting. On the POST form, the resident authorized permission for her MPOA to make changes to the POST form if lost her decision-making capacity. On [DATE], the physician determined Resident #13 no longer had the capacity to make her own medical decisions. On [DATE], Resident #13's resident representative completed a new POST form, indicating the resident was to receive selective treatments instead of comfort-focused treatments. According to the form, Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation, and cardioversion.) May use non-invasive positive airway pressure, antibiotics and IV [intravenous] fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location. Another POST form was completed by Resident #13's resident representative on [DATE] to indicate the resident was to receive medically assisted nutrition if needed. This updated POST form continued to indicate no CPR and selective treatments. Resident #13's comprehensive care plan had a focus related to her end-of-life wishes. The focus had been updated [DATE] and stated, [Resident #13] has an established advanced directive: No CPR- Do not attempt Resuscitation. Selective Treatments. Attempt to restore function while avoiding intensive care if possible (e.g., ventilator, defibrillation).May use non-invasive positive airway pressure, antibiotics, and iv fluids as indicated. Transfer to hospital if treatment needs cannot be met in current location.On [DATE] at 10:24 AM, Senior Administrator #21 confirmed Resident #13's physician's orders for end-of-life treatment did not match the end-of-life treatment wishes indicated on her most recent POST form. No further information was provided through the completion of the survey process.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on staff interview and surveyor intervention, the facility failed to ensure pre meal hand hygiene was performed on one (1) of two (2) residents reviewed for the care area of infection prevention and control. Resident Identifier #55. Facility Census: 60. Findings included: a) During a dining room observation on 03/31/26 at 12:30 PM, it was noted that Resident #55 was not provided with pre-meal hand cleansing by staff. This was verified at 12:53 PM with Registered Nurse Clinical Lead staff #45, who confirmed that the hand wash was not performed. Upon review of the Infection Control Policies and Procedures for Patient Hand Hygiene provided by the Nursing Home Administrator, the policy states: Staff should assist patients/residents (hereafter 'patient') with hand hygiene after toileting and before meals as needed.