STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515133	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansted Center	96 Tyree Street Ansted, WV 25812

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review and staff interview, the facility failed to ensure the menu was followed as posted in the facility and as printed on resident tray cards. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #15, #21, #25, #30, #37, and #54. Facility Census: 59. Findings included: a) The Lunch Menu posted for 03/23/2026 included: -Salisbury Steaks w/Gravy-Scalloped Potatoes-California Blend Vegetables-Dinner Roll-Brown Sugar Glazed Angel Food Cakeor-Kielbasa-Scalloped Potatoes-California Blend Vegetables-Dinner Roll On 03/23/26 at 12:00 PM, the posted menu, tray cards, and food service errors were reviewed with the Administrator and Director of Nursing (DON) viewed posted menu, tray card and food errors and the DON stated, I understand. Resident #37 received California Blend Vegetables, but the tray card stated [NAME] Peas - 1/2 Cup. Resident # 37 stated, They're never right. Nursing Assistant #31 confirmed resident #37's tray and stated, Let me go see about that. No further information was provided. Resident #54, #21, #30, #25 all received [NAME] Peas and the posted menu stated California Blend Vegetables. Resident #15 received sauerkraut which she wanted removed from her tray because the smell made her sick. Sauerkraut was not on the menu. Another state surveyor reported incident to this State Surveyor and the Director of Nursing. On 03/24/2026 at 11:20 AM, the state surveyor asked to temp the garnish (lettuce and tomato per the menu) and Account Manager #69 stated she was using parsley but would fix the lettuce and tomato per the menu. Lettuce and tomato were served with the fish sandwich this date per the menu following state surveyor intervention.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and staff interview, the facility failed to ensure food was stored in accordance with professional standards for food service safety and in a manner that prevents foodborne illness to the residents. This failed practice has the potential to affect more than a limited number of residents. FACILITY:FACILITY. Facility Census: 59. Findings included: a) On 03/23/2026 at 10:30 AM, an initial kitchen investigation was initiated with Account Manager #69. The following items were identified: Dry Storage -Yellow Cake Mix leaking out of a bag onto the shelf.-Hotdog and hamburger buns - no use by date.-Imperial pumpkin - dented can.-Gehls Mild Cheddar Cheese - dented can.-Lasagna Noodles - not labeled in a plastic zipper bag Freezer - -Bakers' Source Southern Style Biscuits - opened in the delivery, brown box, not sealed and no use by date.-Two (2) Angel Food Cakes - no use by date. b) On 03/24/2026 at 8:50 AM, the nourishment center in the main dining room was investigated. The following items were identified: - Sterile Water -opened and dated 1/22 - water was yellowish in the bottle.- Apples for Resident #64 with use by date of 03/04/2026. Account Manager #69 confirmed the items and stated the policy for food brought in by family to discard after seven (7) days. - Bread - open with use by date 03/23/2026- [NAME] crackers -in a zipper bag with a use by date of 03/20/26 Account Manager #69 confirmed the items at 9:01 AM. c) The facility's policy and procedures for Food Brought in for Patients/Residents stated, Food will be held in refrigerator for three (3) days following date on label and will be discarded by staff upon notification to resident. The facility's policy and procedure for Food Storage: Dry Goods stated, Storage areas will be neat, arranged for easy identification, and date marked as appropriate. The facility's policy and procedure for Food Storage: Cold Foods stated, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview the facility failed to dispose of garbage and refuse properly. The facility failed to maintain a clean and sanitary environment, creating potential health and safety risks for all residents of the facility. Facility census #59. Findings included: a) 03/24/26 at 1:20 PM during the tour of the exterior garbage dumpster area, loose trash was observed scattered around the dumpster. Items included multiple gloves, plastic spoons, plastic lids, plastic bags, Styrofoam bowls, a Pringles container, soda bottles, and loose tissue. This was confirmed with DON at 1:30 PM. 03/24/26.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review and staff interview the facility failed to ensure three (3) of six (6) residents received a written notification whenever their account reached within $200 of the asset level allowed for Medicaid. Resident identifiers: #55, #27, and #10. Facility census: 59. Findings included:a) A record review conducted on 03/25/26 identified the following balances in resident accounts: - Resident #55: $2,795.17- Resident #27: $2,835.00- Resident #10: $1,990.00 On 03/25/26 at 1:00 PM, Business Office Advisor (BOA) #82 stated that the required notices regarding assets being over or within $200 of the $2,000 Medicaid limit had not been sent. Admissions Director #52 confirmed this information on 03/26/26 at 1:30 PM.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to ensure a homelike environment for the residents. There were issues with caulking around the base of the toilets, and with base moulding as well as an issue with a bug zapper in the hallway. Room identifiers: #212, #215, Facility census: 59. a) room [ROOM NUMBER]Observation revealed missing or disrepaired caulking around the base of toilets in room [ROOM NUMBER].b) room [ROOM NUMBER]The floor molding near the sink was torn and in disrepair.The surveyor reviewed and confirmed these findings with the facility Administrator at approximately 3:20 PM.Further observation during the facility walkthrough revealed that insect control devices (bug lights) in the 100 and 200 hallways contained multiple dead insects adhered to visible sticky paper, indicating a lack of routine maintenance. The condition of these devices was inconsistent with a clean and homelike environment. The surveyor observed this on 3/24/26 at approximately 12:45 PM and confirmed it with the facility Administrator at 1:05 PM.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 notify the resident or the resident's representative(s) of the transfer or discharge and the reasons for the move in writing; send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman; and provide the resident and the resident representative written notice which specified the duration of the bed-hold policy. This was found to be true for two (2) of four (4) residents reviewed during the long term care survey process. Resident identifiers: #64, #10. Facility census: 59. Findings included:a) Resident #64 Resident #64 had the capacity to make their own medical decisions. Resident #64 had an emergency transfer to an acute care facility on 03/13/26, following a fall at the facility. The resident returned to the facility on [DATE] following surgery for a left femur fracture resulting from the fall. The facility provided an electronic eInteract Communication Form with resident medical information to the hospital. However, the facility failed to issue a transfer/discharge notice to the resident or to the Office of the State Long Term Care Ombudsman. A Bed Hold Notice was located in the electronic medical record. The facility had obtained verbal consent from the resident's next of kin due to the emergency situation. However, the facility failed to obtain a written signature or have a second person witness the verbal consent. When the forms were reviewed with the Director of Nursing (DON) on 03/24/2026 at 4:01 PM, she acknowledged the errors and the lack of a transfer notice. b) Resident #10 Resident #10 did not have the capacity to make their own medical decisions. Resident #10 was transferred to an acute care facility on 10/11/25. The resident returned to the facility on [DATE].The facility provided an electronic eInteract Communication Form with resident medical information to the hospital. However, the facility failed to issue a transfer/discharge notice to the resident's representative or to the Office of the State Long Term Care Ombudsman. A Bed Hold Notice was located in the electronic medical record. The facility had initiated a Bed Hold Notice of Policy and Authorization, however, it was not signed by the facility or by the resident's representative. When the forms were reviewed with the Director of Nursing (DON) on 03/24/2026 at 4:01 PM, she acknowledged the errors and the lack of a transfer notice.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interviews, the facility failed to ensure the accuracy of the Pre-admission Screening and Resident Review (PASARR) of residents upon admission to the facility. This was found to be true for three (3) of seven (7) residents reviewed during the long term care survey process. Resident identifiers: #18, #8, and #64. Facility census: 59. Findings included: a) Resident #8 On 03/23/2026 at 12:43 PM, record review for Resident #8 included a review of the resident's diagnoses. The resident was admitted on [DATE] with a diagnosis of schizophrenia. Upon further review, the Pre-admission Screening (PAS) dated 02/20/26 did not include the diagnosis of schizophrenia. On 03/25/2026 at 2:30 PM, the Director of Nursing (DON) confirmed the PAS dated 02/20/26 was incorrect. Also, the DON stated, We are aware of the issues with the PASARR. b) Resident #18 On 3/23/2026 at 2:32 PM a review of the latest Pre-admission Screening and Resident Review (PASSR) for Resident #18 (dated 2/1/24), provided by the facility states under Section 30, Current Diagnosis a) None. However the medical diagnosis and medication indications reflect differently. A Review of Resident #18's Medical Diagnosis show the following: a. BiPolar Disorder Mild or Moderate Severity b) Anxiety Disorder Resident #18 has the following current medication orders by the Physician 1) Buspirone HCL Oral Tablet 10 milligrams (MG). Give 2 tablets by mouth three times a day for targeted behaviors: cursing, yelling and combativeness for anxiety. 2) Cymbalta Oral Capsule Delayed Release Particles 60 MG. Give 1 capsule by mouth once a day for Targeted behaviors of cursing, yelling for depression. 3) Lamictal Oral Tablet 100 MG. Give 1 tablet by mouth one time a day for Bi Polar disorder. Document behaviors: agitation, restlessness. 4) Latuda Oral Tablet 80 MG. Give 80 MG by mouth one time a day for Bi Polar disorder. Targeted behaviors: cursing, yelling, combative towards others. 5) Trazodone HCL Oral Tablet. Give 200 MG by mouth at bedtime for depression. Document behaviors: Restlessness, wandering, NPI: offer food/drink, redirect. Document side effects such as headache, hallucinations. (continued on next page)

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	515133	A. Building B. Wing	03/26/2026

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18 was admitted to the facility on [DATE] According to an interview with Unit Manager #10 and the Administrator on 3/26/26 at 10:49 AM Resident #18 had the previously mentioned medical diagnoses upon admission to the facility. They also agreed the PASSR should reflect the following medical diagnoses: Bipolar, Depression, and Anxiety c) Resident #64 Resident #64 was initially admitted to the facility on [DATE], with a re-admission on [DATE]. At admission, the resident had the following diagnoses related to mental/intellectual diabilities: -Depression -Mental disorder, not otherwise specified A Pre-admission Screening and Resident Review (PASARR) was completed on 01/21/26 at another facility. Under Section III Question 30 of the PASARR for current diagnosis, mood disorder - stable, managed with medications was the only diagnosis marked. The PASARR did not contain a diagnosis of depression or mental disorder, unspecified. A review of the resident's Minimum Data Set (MDS) dated [DATE] includes the following diagnoses : -Depression -Mental disorder, not otherwise specified. Therefore, the PASARR was incorrect for the resident upon admission to the facility. This was reviewed with the Director of Nursing (DON) on 03/24/26 mid afternoon. She stated she identified PASARRs as an issue on 03/21/26 and had put a plan in place to get these corrected.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and policy review the facility failed to provide nail care to dependent residents to ensure nails were short, and smooth to avoid injury. Resident identifiers: #53. Facility census: 59.a) Resident #2 On 03/24/26 at 9:53 AM observation revealed Resident #2 had long, jagged unkept fingernails. The resident said she would like to have the nails shorter. On 03/24/26 at 2:00 PM Registered Nurse #4 was told what the residen [NAME] said regarding her fingernails. b) Resident #39 On 03/25/26 at 12:49 PM an observation of Resident #39 revealed this residen [NAME] long, jagged unkept fingernails. He said he would like to have them trimmed but was not sure who would do it. c) Resident #42 On 03/24/26 during the lunch meal observation revealed Resident #42 had long, jagged unkept fingernails. He said he would like to have them shorter. d) Resident #57 On 03/25/26 at 9:00 AM observation revealed this resident had long, jagged unkept fingernails. He said he would like to have them trimmed. He said he had clippers in his drawer but would need help trimming his nails. A policy review titled NSG222 Nail Care dated 05/01/25 stated Patient nails will be kept short and smooth to avoid skin injury. Routine cleaning and inspection of nails will be provided during activities of daily living (ADL) care on an ongoing basis. On 03/26/26 at 11:45 AM during an interview with the Director of Nursing the above findings were relayed to her. No futher comments were provided regarding the lack of nail care for these residents. e) Resident #53 During the survey conducted on 3/25/26 in the afternoon different surveyors observed an offensive odor permeating into the hallway from Resident #53's room. Interview with the Director of Nursing (DON) on 03/25/26 at approximatley 3:15 PM revealed the odor was most likley associated with Resident #53 and challenges related to a yeast infection. Record review indicated the resident had received a shower on 03/25/26 after the surveyor brought the issue up to the nursing staff. The care plan review did not reflect a history of shower refusals. A review of the resident's physiciain's orders revealed orders for Diflucan Oral Tablet 150 MG (Fluconazole) which was prescribed on 03/25/26 at 5:59 PM. Nystatin External Powder 100000 UNIT/GM (Nystatin (Topical) apply to abdominal fold typically three (3) times a day for Yeast for 30 days. This order was dated 02/06/25 Apply to Abdominal Fold (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	topically three times a day for Yeast for 30 Days Another order dated 01/05/26 was for Nystop External Powder 100000 Unit/GM (Nystatin (Topical) apply to under breast topically every day and night shift for yeast infection for 14 days.

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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 record review and staff interview, the facility failed to ensure medical records were accurate and complete. This was true for three (3) of five (5) residents reviewed under the care area of unnecessary medications. One relating to a Physicians Order for Scope of Treatment (POST) form, one for a vaccination witness and one for medical diagnoses. Resident Identifiers: #8, #18 and #64. Facility Census: #59.Findings included: a) Resident #8 On 03/23/2026 at 3:59 PM, a record review was completed for Resident #8. The review found the informed consents for the COVID-19 vaccination and for the chicken pox, shingles, respiratory syncytial virus, measles, mumps, rubella, varicella, tetanus, diptheria and pertussis vaccinations were signed by the resident. However, there were no witness signatures by staff on the document. On 03/23/26 at 4:10 PM, the Director of Nursing (DON) was notified and confirmed both consents did not have witness signatures. b) Resident #64 Upon initial review of the resident's medical record on 03/23/26 at approximately 1:10 PM, the resident's WV Post Form dated 01/23/26, was marked with the selection for full code. The resident has capacity to make own medical decisions. Conversely, the electronic health record and the resident's care plan showed the resident to be DNR (Do Not Resusitate). This surveyor asked another member on the survey team to review the discrepancy with me. We agreed there was a discrepancy in the medical record. The surveyor submitted a request to the facility on [DATE] at approximately 2:00 PM to see any Post forms for residents which were not yet uploaded into the medical record. At 4:45 PM, when surveyor asked again about the Post forms, the Director of Nursing responded that all post forms had already been uploaded. Upon arrival to the facility the next morning on 03/24/26 at aproximately 9:00 AM, an additional review of the resident's medical record was conducted. The electronic medical record included a new Post form dated 03/20/26. The resident had on 03/20/26 elected to be DNR. An interview was held with the Social Services staff #50 on 03/24/26 at 2:25 PM with the medical record pulled up. Surveyor pointed out the change in the Post form from Full Code to DNR. Surveyor asked about their process for when a change like this occurs, how do they void the older version of the Post form in the medical record. The medical record had two entries Post form 01/23/26, and Post form 03/20/26. Social Service staff #50 stated the new Post is uploaded and staff know to go by the most recent (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date. When asked what about new staff? #50 did not answer. When asked if a new Post form is sent to the WV Registry, she stated if the resident requests it. The guidance provided on the WV Post Form states: .voiding a POST form:If a patient or MPOA representative/surrogate (for patients lacking capacity) wants to void the form: destroy paper form and contact patient's health care provider and the WV e-Directive Registry to void orders in patient's medical record and the Registry.For health care providers: destroy copy (if possible), note in patient record form is voided and notify the WV e-Directive Registry When asked if the facility had a policy addressing voiding of Post forms, staff member #50 stated no. By failing to adhere to the guidelines surrounding voiding the previous WV Post form, it could create the potential for confusion of the desires of the resident in regards to life saving measures. New staff coming into the facility may not know to look for the most recent date of the form. c) Resident #18 On 3/23/2026 at 2:32 PM a review of Resident #18's medical diagnoses reflects Bi Polar and Anxiety disorder. However Resident #18 has the following current medication orders by the Physician 1) Buspirone HCL Oral Tablet 10 milligrams (MG) Give 2 tablets by mouth three times a day for Targeted behaviors, cursing, yelling and combativeness for anxiety. 2) Cymbalta Oral Capsule Delayed Release Particles 60 MG. Give 1 capsule by mouth one times a day for Targeted behaviors of cursing, yelling for depression. 3) Lamictal Oral Tablet 100 MG Give 1 tablet by mouth one time a day for Bi Polar disorder. Document Behaviors, agitation, restlessness. 4) Latuda Oral Tablet 80 MG Give 80 MG by mouth one time a day for Bi Polar disorder. Targeted Behaviors of cursing, yelling, combative towards others. 5) Trazodone HCL oral Tablet Give 200 MG by mouth at bedtime for depression. Document behaviors of Restlessness, wandering, NPI: offer food/drink, redirect. Document side effects such as headache, hallucinations. Resident #18 was admitted to the facility on [DATE] and according to an interview with the Unit Manager #10 and the Administrator on 3/26/26 at 10:49 AM Resident #18 had the previous mentioned medical diagnoses upon admission to the facility. They also agreed the following medical diagnoses should be reflected on the Diagnosis Report which should list all diagnoses: Bi Polar, Depression, and Anxiety

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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 a review of Centers for Disease Control and Prevention (CDC) guidance, medical records, and staff interviews, the facility failed to follow established disease control and prevention protocols. The following issues were identified: A staff member was observed carrying linens against their clothing. A staff member failed to wear a gown while providing incontinence care to a resident on enhanced barrier precautions.Signage on a resident's door failed to identify which specific bed required enhanced barrier precautions. Resident identifier: #4. Facility census: 59. b) Resident #4 On 03/24/26 at approximately 9:45 AM, it was observed that Nurse Aide (NA) #46 was providing incontinence care to Resident #4 behind a closed divider curtain. NA #46 was subsequently seen exiting the curtained area with bagged linens and incontinence products while not wearing a gown. According to the Centers for Disease Control and Prevention (CDC) staff members providing care to residents should gown and glove during during high contact tasks. A review of Resident #4's records indicates a history of carbapenem-resistant Enterobacteriaceae (CRE), requiring enhanced barrier precautions. The precautions sign posted on the resident's door explicitly states that a gown must be worn when performing high-contact care. The Director of Nursing was informed of these findings during interviews conducted on 03/24/26 and on 03/26/26 at 11:45 AM. c) On 03/23/2026 3:49 PM, during the initial survey interview process on the 100 Hall, Central Supply Staff #51 was observed by the state surveyor carrying a stack of clean linen (towels and sheets) down the hallway to the linen closet against his shirt. Central Supply Staff #51 confirmed the linen was not being carried away from his clothes and it was not in a bag and stated, Oh, okay. The staff member later asked, Has it always been like that? On 03/25/2026at 9:45 AM, another state surveyor observed Account Manager #64 carrying a blanket against his clothing on the 200 Hall. d) On 03/23/2026 at 11:30 AM, an enhanced barrier precautions (EBP) sign outside the door of room [ROOM NUMBER] was observed to have no bed marked or labeled to identify the residents(s) on precautions for staff. Corporate Registered Nurse #81 confirmed a bed(s) was not identified on the signage for EBP. The Director of Nursing confirmed neither resident in the room were on EBP. According to the Centers for Disease Control and Prevention (CDC) staff members providing care to residents should gown and glove during during high contact tasks. e) Resident #30 On 03/26/2026 at 9:55 AM, an observation of wound care for Resident #30 was completed. The wound care was provided by Registered Nurse (RN) #24 and RN #39. The resident is noted with an unstageable (UN) wound to the coccyx and moisture-associated skin damage (MASD) to the left and right buttock. There was no signage at the door of Resident #30's room to indicate the resident was on enhanced-barrier precautions. Neither RN #24 nor RN #39 donned personal protective equipment (PPE) upon entering the resident's room and providing wound care. (continued on next page)

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	515133	A. Building B. Wing	03/26/2026

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Ansted Center	96 Tyree Street Ansted, WV 25812

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was held with RN #39 regarding the enhanced-barrier precautions and the PPE. RN #39 stated, there was no sign hanging at her door. On 03/26/2026 at 11:10 AM, the Director of Nursing (DON) confirmed the resident does have a chronic wound and should be on enhanced-barrier precautions and the nurses should have worn PPE. Facility Policy On 03/26/26 at 11:00 AM, the DON provided the facility policy entitled, Enhanced Barrier Precautions. Under the heading of definitions, Chronic wounds were listed and states, refers to a wound that is not healing as expected or that has been present for more than 30 days.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on resident interview and staff interview the facility failed to provide reasonable accommodations of needs for Resident #39. This was found true for one (1) of 29 residents reviewed. Resident identifier: #39. Facility census: 59. Findings included:a) Resident #39. During an interview with Resident #39 on 03/27/26 at 10:45 AM, the resident reported that his reclining chair, in which he slept, did not function properly. Observation and interview revealed the leg/foot rest of the recliner did not deploy. The resident stated he elevates his legs in a wheelchair at night due to the malfunctioning recliner.This concern was brought to the attention of the Director of Nursing (DON). Documentation provided by the on 03/23/26 at 3:55 PM. DON confirmed that a new reclining chair was ordered for the resident following surveyor intervention.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and staff interview the facility failed to ensure two (2) of two (2) residents were provided quarterly statements. Resident identifiers: #41, and #24. Facility census: 59.Findings included: a) Resident #41 On 03/23/26 at 2:00 PM during an interview with Resident #41 and the resident's daughter they mentioned they had not received a quarterly statement to show the amount in the resident's account. During an interview with Business Office Advisor (BOA) #82 on 03/25/26 at 11:00 AM the BOA said the former business office manager had left the job and she did not think she could verify the quarterly statements had been provided. On 03/26/26 at 1:00 PM a letter dated 07/23/25 was provided to the surveyor by Admissions Director (AD) #52. The letter verified that a quarterly statement was provided for the quarter ending June 2025. No additional statements could be provided. b) Resident #24 During an interview with Resident #24 on 03/23/26 at 11:15 AM the resident stated she had not received a quarterly statement to show the amount of money in her account. During an interview on 03/24/26 at 11:00 AM with the BOA she said she could not provide any quarterly statement verifications and that the facility's BOM had recently left the position. On 03/26/26 at 1:00 PM AD #52 provided a letter dated 07/23/25 which reflected that Resident #24 had received a letter indicating what her account balance was for the quarter ending June 2025. No additional statement verifications were able to be provided before the end of the survey on 03/26/26 at 2:15 PM. No additional statemeent verifications were able to be provided before the end of the survey on 03/26/26 at 2:15 PM.

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	515133	A. Building B. Wing	03/26/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to ensure a new Pre admission Screening and Resident Review (PASARR) was completed when three (3) of seven (7) residents developed a new mental disorder. Resident identifiers: #7, #22, #53. Facility census: 59.Findings included: a) Resident #53 The most recent PASARR was completed at an acute care facility on 12/17/24. Under Section III, Question 30, Current Diagnosis (Check all that apply). (a) none was checked, and (n) Other related conditions (Specify below) bipolar disorder was typed in. Question 37 is Diagnosis - Other medical conditions requiring services. Included in the typed list are altered mental status, visual hallucinations, bipolar illness, Dementia with behavioral problem. Question 47: The individual has a primary diagnosis of: Dementia was checked. Resident #53 was admiitted to the facility on [DATE]. The resident does not have capacity to make own medical decisions. The resident had the following diagnoses related to mental illnesses: Depression - Primary Diagnosis 01/16/2025 Bipoloar Disorder, - 12/20/2024 Admission/readmission Anxiety Disorder - 01/16/2025 Adjustment Disorder with mixed anxiety and depressed mood - 09/26/25 For these conditions, the resident had the following physician orders: SEROquel XR Oral Tablet Extended Release 24 Hour 300 Milligram (Quetiapine Fumarate)Give 1 tablet by mouth at bedtime for Target Behaviors: agitation, halluccinations, delusions dx: Bipolar DisorderPharmacy Active 03/06/2026 busPIRone HCl Oral Tablet 10 MG (Buspirone HCl)Give 10 mg by mouth two times a day for Targeted behaviors: AgitationPharmacy Active 12/7/2025 Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium)Give 2 tablet by mouth two times a day for Targeted behaviors Delusions, hallucinations.Pharmacy Active 12/7/2025 The medical record also included a completed Provider Attestation for Schizophrenia, Schizoaffective or Schizophreniform Diagnosis form. This form was dated on 01/16/26 and has comments patient exhibits signs and symptoms of schizoaffective disorder. The form was signed by the physician/practitioner with an acknowledgement that this resident meets the diagnostic criteria as set by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as outlines in the reference table below for the current psychiatric listed above. The PASARR was reviewed with the Director of Nursing (DON) on 03/24/26 mid afternoon. The DON stated they were already in the process of identiying incorrect PASARRs and showed me the facility plan she had put together just a few days prior. b) Resident #22 Resident #22 was admitted into the facility on [DATE]. This resident did not have capacity to make their own medical decisions. Upon admission, the resident had the following diagnosis related to mental illness: - Bipoloar Disorder During the stay at the facility, the resident subsequently was diagnosed with the following mental illness: -Depression Date of Diagnosis- 3/17/2025 For the above conditions, the resident had the following orders: -Lamictal Oral Tablet 100 MG (Lamotrigine)Give 1 tablet by mouth one time a day for depressionPharmacy Active 02/17/2026 -Cymbalta Oral Capsule Delayed Release Particles 60 MG (Duloxetine HCl)Give 1 capsule by mouth one time a day for Bipolar Disorder document behaviors: yelling out, restlessness. Non-Pharmalogic Intervention (NPI): re-direct, re-approach.Monitor for side effects: nausea, dry mouthPharmacy Active 01/01/2026 -Buspirone HCl Oral Tablet 7.5 MG (Buspirone HCl)Give 1 tablet by mouth two times a day for Bipolar disorderPharmacy Active 05/08/2025 The Preadmission Screening and Resident Review (PASARR) was completed on 06/20/24 by the facility. Section III, Question 30 Current Diagnosis (Check all that Apply): only (n) was checked for Other related conditions, where bipolar disorder was inserted. A review of the most recent Minimum Data Set (MDS) completed on 03/10/26, contained the following diagnoses related to mental illness: - Bipolar Disorder- Depresssion The facility's policy entitled Pre-admission Screening for Mental Disorders andor Intellectual Disability Patients, was effective on 06/01/01, and most recently revised on 02/16/24. Under the Practice Standards revealed the following: Social Services (continued on next page)

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	515133	A. Building B. Wing	03/26/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if it is learned after admission that the Pre-admission screening and Resident Review (PASARR) was not completed or is incorrect; or there is a significant change in status that results in new evidence of possible mental disorder, intellectual disability or a related condition. Social Services will review PASARR to determine appropriate care needs and incorporate recommendations into the patient's assessment, care planning, and transition of care. The discrepancy in the PASARR and the MDS was reviewed with the Director of Nursing (DON) on 03/24/26 mid afternoon. The DON stated the facility had already identified PASARRs as an issue and she just put a plan in place to correct these on Friday. c) Resident #7 On 03/23/26 at 11:00 AM, a record review was completed for Resident #7. The review found the Pre-admission Screening and Record Review (PASARR) dated 06/27/25 did not include the diagnosis of Post-Traumatic Stress Disorder (PTSD). On 03/23/2026 at 2:50 PM, the Director of Nursing (DON) confirmed the PAS dated 06/27/25 was incorrect. For Resident #7 a record review indicated PTSD had an active diagnosis with the date of 07/09/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, resident interview and record review, the facility failed to ensure oxygen therapy was provided at the correct setting per the physician's order and the resident's care plan. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #37. Facility Census: 59. Findings include: a) Resident #37On 03/23/2026, during the initial interview process, Resident #37's oxygen concentrator setting was on two (2) liters. The resident reported she was on four (4) liters of oxygen. Resident #37 reported difficulty breathing. At 11:27 AM, Corporate Registered Nurse #81 reported the oxygen concentrator was set between two (2) and three (3) liters. Corporate Registered Nurse #81 reported the resident's order stated three (3) liters, confirmed the oxygen setting was between two (2) to three (3) liters, and stated they were giving the unit to maintenance to fix. At 11:27 AM, Unit Manager #10 reported the concentrator would not go above two and a half liters so they were replacing it and giving the unit to maintenance to fix. Resident #37's orders stated, Oxygen at 3 L/min via Nasal Cannula, continuously. The resident's care plan stated, Administer Oxygen via n/c as ordered/indicated. A progress note dated 03/23/2026 at 12:02 PM stated: Nursing observations, evaluation, and recommendations: Resident reports feeling SOB. Upon checking to ensure the oxygen concentrator was working, it was noted that it was malfunctioning. The concentrator was replaced, and the resident was assessed. She states she is no longer SOB. Pulse ox is 93% via Nasal Cannula.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to follow the Bed Safety Evaluation and Bed Safety Evaluation Follow-up for bed rails in order to avoid risks including entrapment due to the use of bed rails. This was true for one (1) of two (2) assessments for bed rails. Resident Identifier: #44. Facility Census: #59a) Resident #44 On 03/23/26 at 3:11 PM, Resident #44 was observed with bilateral bed rails in use. A subsequent review of the bed safety evaluation dated 01/25/26 indicated that bed rails should not be used for this resident. According to the evaluation's Step 2 guidance, if a No was recorded for any of the eight mobility questions, staff were instructed to attempt alternatives. The assessment dated [DATE] recorded No for all seven mobility questions. The Bed Safety Evaluation Follow-up dated 01/26/26 noted that alternatives, including elevating the head of the bed and a PT/OT screen, were attempted. The results confirmed these alternatives were successful, concluding that bed rails should not be used for this resident. During an interview on 03/24/26 at 11:25 AM, the Director of Nursing reviewed these evaluations and confirmed that Resident #44 should not have bed rails.