STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515144	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lewisburg Healthcare Center	979 Rocky Hill Road Ronceverte, WV 24970

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to follow a physician order for a resident to receive nothing by mouth (NPO). Resident #95 was given a soft drink by a staff member which resulted in the resident immediately coughing. This failed practice had the potential for more than minimal harm to any resident with an (NPO) order for or an order for thickened liquids. Resident identifiers #95, #13, #33, #80, #87 and #51. Facility Census 90.The citation will be cited at past non-compliance. The immediate Jeopardy occurred on 05/01/25 and was corrected on 05/03/25. Findings Include:a) Resident #95A record review on 01/14/25 at 1:30 PM revealed Resident #95 was admitted to the facility on [DATE].Resident #95 was admitted with diagnoses that included Cerebral Palsy and Autism.Further record review revealed that Resident #95 had a Peg Tube and a physician's order to have nothing by mouth (NPO) dated 04/21/25. Additionally, Resident #95 was determined to be incapacitated on 04/21/25. A review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/24/25, Section C, revealed that Resident #95 had a Brief Interview for Mental Status Score (BIMS) of (9) nine, indicating moderate cognitive impairment.A nurses note dated 05/01/25 at 2:24 PM that read as follows: Resident during activities this afternoon was given cola by staff that was not familiar with Resident. Resident coughed one time and it scared her when another staff stated that she was NPO. Resident is in no distress but was scared that she would get into trouble. MD and POA aware.A nurses note dated 05/02/25 at 5:05 PM reads as follows: Interdisciplinary Team (IDT) met to review and discuss resident recent choking episode. Resident was noted to be in the dining room post-activity, before noon mealtime. She is alert and can make needs known to staff, denies any pain, harm, or neglect and was aware of her NPO status, but still requested a Cola from staff. After she asked for the cola, resident took a drink and got choked. Resident was noted to be on a NPO diet. Cola was immediately removed from resident after choking episode noted. Staff removed resident from dining room and brought her back to the nurse for assessment and to inform of episode. MD and POA were notified with new orders for monitoring vital signs and chest Xray.Further record review revealed that the following residents currently have orders for Nectar Thick Liquids: Resident #13, #33, #80, and #87. Resident #51 had an order for Honey Thick Liquids.During an interview on 01/14/25 at approximately 6:00 PM, The Certified Nursing Assistant Instructor/Staff Educator shared she had conducted a Nurse Staff Meeting in May of 2025. The Agenda and with signatures of staff members in attendance was provided. During the nurse staff meeting, the importance of looking at the Kardex to ensure residents are getting the right diets was discussed. On 01/14/25 at 4:12 PM, the DON reported that the CNA who provided the soft drink was provided re-education and an Employee Corrective Action form documented the incident. The corrective action reads as follows:CNA gave NPO resident a can of pop (Cola) without checking her Kardex and diet orders, resulting in the resident having a choking episode.Facility administration failed to ensure staff were implementing resident-directed care consistent with the resident's comprehensive assessment and care plan physician orders, and professional standards of practice, placing the residents on specialized liquids or on a NPO diet at risk for aspiration pneumonia which could lead to hospitalization and possible death.Education was done with staff on 05/03/25 that read (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	as follows: All foods and beverages requested by residents required verification of resident specific current diet orders and fluid consistencies. Do not provide residents with food or beverage until their diet order has been verified and the food or beverage is deemed appropriate per the physician order in the resident chart.The State Agency did an interview with staff on 01/15/26 at approximately 10:00 AM, that consisted of the following question: If a resident comes to you and requests something to eat or drink, what is the first thing you need to do?Dietary cook #107 replied, I would ask their name, verify the diet and inform nursing.Business Office Manager #80, replied, I would ask their name then inform them that I would let their nurse and or aide know the request.Nursing Assistant #90,replied, I would check the residents' Kardex for their dietary information.The Environmental Service Director replied, I would assist the person to a nurse or aide that could assist. The Activities Director replied, I would check the Kardex for proper diet and drink orders per resident.The Assistant Director of Nursing, replied, I would check the PCC order to the correct diet and liquid consistency before I give them anything,Therapy Staff #93, replied, Check the resident's food and drink orders before I give them anything.Maintenance Technician #37 replied, I'm not allowed to give the resident food or drinks. I would go to the CNA or nurse to have them get it for them.On 01/15/25 at 9:30 AM, The Administrator and DON presented SA with some Relias trainings that staff had completed for thickened liquids and for reading the meal tray ticket, however none of the documentation they supplied read to the fact of following the physician's order, and to check the order before given residents any food and/or liquid.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on resident interview, record review, and staff interview the facility failed to ensure residents knew the location of the state inspection resultsThis was a random opportunity for discovery. Facility Census: 90.Findings Included:a) Resident Council Meeting: During the resident council meeting held on 01/13/26 at 2:00 PM Resident #16, #17, #30, #11, and #75 were in attendance and all had BIMS of 14 or higher. When the residents were asked if they knew the location of the survey results, the resident council president stated he was never told where they were located and all others were in agreement of that statement. On 01/13/26 at 3:20PM, During an interview with the activities coordinator, she stated she knows the State Survey Results book and location are discussed upon admission but she had not discussed the location of the state survey results book, but would make sure to add that to their council meetings.During an interview on 01/14/26 with the Social Worker, She stated she had not discussed the location of the state survey results with the residents.c)During record review of Resident Council Meeting Minutes, discussions of the state survey results book and location were not found.

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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 provide a safe, clean, comfortable, and homelike environment for resident's bathrooms and also for not resolving a grievance for missing clothing for a resident. This was a random opportunity for discovery. Rooms: #112, #204, #205, #207. Resident identifiers: #57, #21, #81, #12 and #5 Facility census: 90. a) Resident bathroom [ROOM NUMBER]: Upon facility entrance observation and walkthrough on 01/12/26 at 11:35AM, Resident #57's bathroom did not appear to have been cleaned and was observed to have dried brown spots on the floor around the base of the toilet and on the toilet seat. b) Resident bathroom [ROOM NUMBER]:On 01/12/26 at 12:05PM, during an interview with Resident # 21, in room [ROOM NUMBER], it was observed the bathroom did not appear to have been cleaned with yellow and brown spots on toilet seat. c) Resident Bathroom [ROOM NUMBER]:On 01/12/26 at 12:25PM, during an interview with Resident #81, in room [ROOM NUMBER], it was observed the bathroom did not appear to have been cleaned with dried brown liquid spots splattered on the wall above the light switch and some dried brown spots on the floor around the toilet. d) Resident Bathroom [ROOM NUMBER]:On 01/12/26 at approximately 12:40PM, during an interview with Resident #12, in room [ROOM NUMBER], it was observed bathroom did not appear to have been cleaned with a built up of residue on the back of the toilet tank and multiple pieces of torn tissue paper scattered in a large area around the bathroom floor. Some with brown substance smears and some were yellow and were wet and brown spots on the toilet seat. Facility Walk throughs: During a facility walk through on 01/13/26 at 1:40PM, Resident bathroom conditions in room [ROOM NUMBER], #204, #205, and #207 still had not changed. During a facility walk through on 01/12/26 at 3:55PM, Resident bathrooms in room [ROOM NUMBER], #204, #205, and #207 still had not been cleaned. During an interview with Employee #27, on 01/12/26 at 11:55 AM, she acknowledged the unclean bathrooms in room [ROOM NUMBER], #205, and #207. She stated she did not know the cleaning schedule for resident rooms. During a facility walk through with the Infection Control Preventionist on 01/13/26 at 1:45 PM, She acknowledged the bathrooms in room [ROOM NUMBER], #204, #205, and #207 that have not been cleaned over a 24-hour period and did not know the cleaning schedule for the residents' rooms. 01/13/26 at 2:45pm, during an interview with Housekeeping Manager, related to the cleaning schedule for room [ROOM NUMBER], #204, #205, #207. He acknowledged those rooms had not been cleaned. In a follow-up interview with the Housekeeping Manager, on 01/14/26 at 3:55 PM, he stated that there were three (3) housekeeping employees in the facility daily to clean all resident rooms and bathrooms but could not explain why those bathrooms were not cleaned on 01/12/26 or 01/13/26.

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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. Based on observation, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections during meal service in the dining room. This failed practice was a random opportunity for discovery during the Long Term Care Facility Annual Survey. Resident identifier: #81, #58, and #61. Facility Census: 90.a) Resident #61 On 01/12/2026 1:15 PM During tray delivery and meal set up in Resident #61's room, It was observed that CNA #77 touched resident's brownie and his cornbread with her bare hands and also removed the straw from the package, touching both the end and the middle with her bare hands and placed it into the resident's drink. In an Interview with CNA # 77 on 01/12/26 at 1:25P M, when asked about touching the food with her bare hands, she stated, that's how I have always done it. How should I have done it? She then stated Maybe I should have been wearing gloves. b) Resident #81 During the entrance interview with Resident #81, on 01/12/26 at 11:45 AM, it was observed a wheelchair in her room had cracked edges with tears in the plastic cover on the right arm rest, exposing the inner padding. Resident #81 stated the wheelchair was hers and used it everyday. During an interview with Resident #81 on 01/12/26 at 12:25 PM It was observed cracked edges on the right arm rest of her wheelchair. c) Resident #58 During an interview with Resident # 58 on 01/12/26 at 12:10PM, it was observed on the wheelchair she was sitting in had cracks and tears across the back rest with exposed inner padding. In an interview with the Infection Preventionist on 01/12/26 at 1:45 PM, she acknowledged the wheel-chair had cracked edges and a tear in the plastic right arm pad and agreed the chair had exposed padding and could not be cleaned to prevent infection. During observation in the main dining room, Activity assistant (AA) #83 was assisting a resident with a meal set up, touched the brownie and corn bread with bare hand while removing from the baggie, this surveyor questioned policy, and actions. AA #83 informed this surveyor, Usually we don't touch the items but use utensils, it is ok. This surveyor informed her that she was observed handling the brownie and cornbread piece with her bare hands, she replied, Oh man, I must have not thought about it. The surveyor also observed Nursing Assistant (NA) #78 removing the cornbread with his bare hand. This surveyor questioned him and he informed this surveyor, I was not thinking, we're supposed to open the wax bags and use utensils. During a staff interview with the Dining Service Manager (DSM) the DSM said, Everyone that serves a meal is to not touch the ready to eat foods with bare hands. Resident Hand Hygiene on 600 Hall (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 01/12/26, of the lunch time meal being passed on hall 600, revealed trays passed to (6) residents. During an interview on 1/12/26 at 12:48 PM, Nursing Assistant (NA) #36 stated, We are supposed to, but no I did not do it today.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure a resident's dignity was protected when leaving the building for outside appointments.The resident was transported in a hospital gown. This was a random opportunity for discovery. Resident identifier: #5. Facility census: 90. Findings included: a) Resident #5 An interview on 01/12/26 at 2:21 PM, Resident #5 reported he has not had clothes since he was admitted to this facility. He had his clothes cut off of him at the hospital prior to his admission. He reported he ordered clothes from Amazon:(3) three shirts (2) two pairs of pants. He was told he had to send items to the laundry to get his name labeled on them and when he did, they did not return to him. He reported this and Activities staff replaced two (2) shirts that were delivered 10/1/25. Resident #5 reported he also ordered a large quilt, blue with the same issue. Activities were supposed to replace. but he has not seen that either. Resident #5 was observed wearing a hospital gown on 01/12/26, 01/13/26 and 01/14/26. Reviewed grievance log and reportable log with none filed for Resident #5. Resident was admitted to the facility on [DATE].Resident goes out of the facility for dialysis for three days per week, Monday, Wednesday, Friday. Interview with Activities Director 1/13/26 at 2:25 PM, she reported she was given a form notifying her that the resident had missing items and it is her job to order them. She reported that she ordered the resident a pack of shirts and two (2) pairs of pants. She was told the shirts had arrived but she was not aware of the pants. She would look for the receipt from where the clothing was ordered. She is not aware of the blue blanket. Interview with Social Worker on 01/13/26 at 2:35 PM who reported that she did not do a grievance for resident resident's missing clothing items. She reported they were trying to handle it in house. When asked, she probably should have filed a grievance and they used to fill out missing item forms but she just sent the Activities Director an email notifying her of what was missing so that she could reorder for Resident #5. She said she would ask her to make a copy of that email. She reported she remembered the clothing coming in and being sent to laundry for labeling. She was not sure of the blue blanket, if it was dark blue or light blue, they are still looking for it. She reported she has never seen him wear anything other than a hospital gown and to her knowledge he wears this gown when going out to dialysis. Review of documentation on 01/13/26 given to Surveyor by Activities Director at approximately 3:00 PM: Grievance Form for (Resident #5) dated received 11/03/25Resolved 11/05/25 Patient sent bag of clothing items to be tagged. Bag was lost and never tagged.Clothing replaced 11/5/25 signed Social Worker and Administrator. Review of email 11/11/25 from Social Worker to Activities Director that stated as follows: He ordered 2 pair of black size 50X30, 1 packet of shirts size 6x. Review of bank statement dated 12/18/24 FBB*Kingsize Tel order Indianapolis, IN $59.82. 0n 01/14/26 at 11:00 AM an Interview with Laundry Staff #120 who reported that Resident #5 has recently had some new shirts come through the laundry that she has marked with his name and then she had never seen them again. The only items she washes for him are gowns, socks and underwear. Interview on 11/14/26 at 11:25 AM with Nurse Aide #26 who reported resident came with very little, he ordered clothes that were lost so the facility ordered more clothes for him and she does not know what happened to them. She reported he wears hospital gowns when he walks down the hall or leaves the facility. She stated his family does not live close and have only been able to visit him a couple of times. Interview with Administrator 01/14/26 at 1:00 PM who reported that the Resident was wearing pants the previous day. He looked in Point Click Care at the picture and stated that he was 100% sure it was Resident #5 that he saw on 01/13/26 wearing pants. I stated that this Resident reported to this surveyor that he had no pants and only 2 (two) shirts and that his staff reported to me he only wore gowns. Administrator reported that he was unsure why the grievance had not been added to the log and the social worker had some help hired on this date. He was not aware that the resident was also missing a blanket. He reviewed an invoice with this surveyor that showed 2 shirts and one pair of (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	women's pants were ordered. I explained the resident had 3 shirts and 2 pairs of pants missing and the Administrator reported that there were no further orders pending. He reported they would replace it if there were more items missing. Interview with Resident on 01/14/26 at 2:34 PM who reported that he did not wear pants the previous day because he does not have any. He stated that he would just replace them himself if the facility would reimburse his money. He stated that he would prefer to go to dialysis wearing clothes that is why he ordered them. Observed inside of resident's closet 2:35 PM 2 (two) hanging tee shirts with tags.During an interview on 01/14/26 at 2:15 PM, Resident #5 reported that he would prefer to wear clothes to dialysis and outside of his room. If I am just laying around here, I don't care to wear a gown but that's why I bought clothes to wear to dialysis.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and staff interview, the facility failed to secure and keep confidential residents personal and medical information. The facility failed to safeguard private information that was on display on a laptop on top of a medication cart and private information that was on display on a wall-mounted tablet on the 600 hallway. These were random opportunities for discovery. Resident identifier: #67. Facility census: 90. Findings included:a) Resident #67 On 01/13/26 at 11:45 AM, a random opportunity for discovery found an unlocked and unattended laptop placed on a medication cart by the nurse's station. Resident #67's prescribed medications were visible to any passerby. LPN #72 confirmed the medication cart and laptop were assigned to her and she had erroneously walked away without locking the computer to ensure privacy. On 01/13/26 at 3:40 PM, a random opportunity for discovery found the wall-mounted tablet located on the 600 hall was left unlocked and unattended. In the top left-hand corner it read, Welcome, [CNA #5's First Name] [CNA #5's Last Name]. Thirteen (13) resident names and pictures were visible to any passerby. It was also possible to click on any resident's name and enter a screen where more information was visible. This observation was confirmed by RN #20 who stated that staff are trained to always lock/ log off the device prior to walking away. Review of the facility's Confidentiality of the Clinical Records policy found the following expectations noted as a means to protect all health information records from unauthorized use:-The clinical record record is a legal document and its contents are confidential. -Confidentiality must be maintained in all areas of health information, whether oral, written or electronic. -Procedure for electronic record the application must be closed when leaving the computer unattended.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews and staff interviews the facility failed to ensure residents were informed of the right to file grievances anonymously and to know the location of where to file it, if they so choose. This was a random opportunity for discovery. This was true for Resident #16, #17, #30, #11, #71,#5, and #75. Facility Census: 90 Findings Included:a) Resident Council Meeting: b) Residential Council Meeting discussion:During Residential Council Meeting held on 01/13/26, at 2:00PM, Resident #'s 16, 17, 30, 11, 71, and 75 were in attendance with BIMS of 14 and higher. When asked if they knew they could file a grievance anonymously, they all stated they did not know that. They also stated they did not know where to file it if they had wanted to. b)Staff interviews:On 01/13/26 at 3:20PM, During an interview with the activities coordinator, she stated, during resident rights discussions she did discuss the subject of grievances but she had not discussed filing it anonymously nor discussed the location of the drop-off box outside the Social Worker's office door.During an interview on 01/14/26 with the Social Worker, She stated she had not discussed filing a grievance anonymously with the residents and stated that is usually done during resident council meetings.c) Record Review:During a record reviews of Resident Council Meeting Minutes for the past year, on 01/13/26 at 1:45PM, there weren't any discussions on how to file a grievance anonymously.b) Resident #5 An interview on 01/12/26 at 2:21 PM, Resident #5 reported he has not had clothes since he was admitted to this facility. He had his clothes cut off of him at the hospital prior to his admission. He reported he ordered clothes from Amazon:(3) three shirts (2) two pairs of pants. He was told he had to send items to the laundry to get his name labeled on them and when he did, they did not return to him. He reported this and Activities staff replaced two (2) shirts that were delivered 10/1/25. Resident #5 reported he also ordered a large quilt, blue with the same issue. Activities were supposed to replace. but he has not seen that either. Resident #5 was observed wearing a hospital gown on 01/12/26, 01/13/26 and 01/14/26. Reviewed grievance log and reportable log with none filed for Resident #5. Resident was admitted to the facility on [DATE].Resident goes out of the facility for dialysis for three days per week, Monday, Wednesday, Friday. Interview with Activities Director 1/13/26 at 2:25 PM, she reported she was given a form notifying her that the resident had missing items and it is her job to order them. She reported that she ordered the resident a pack of shirts and two (2) pairs of pants. She was told the shirts had arrived but she was not aware of the pants. She would look for the receipt from where the clothing was ordered. She is not aware of the blue blanket. Interview with Social Worker on 01/13/26 at 2:35 PM who reported that she did not do a grievance for resident resident's missing clothing items. She reported they were trying to handle it in house. When asked, she probably should have filed a grievance and they used to fill out missing item forms but she just sent the Activities Director an email notifying her of what was missing so that she could reorder for Resident #5. She said she would ask her to make a copy of that email. She reported she remembered the clothing coming in and being sent to laundry for labeling. She was not sure of the blue blanket, if it was dark blue or light blue, they are still looking for it. She reported she has never seen him wear anything other than a hospital gown and to her knowledge he wears this gown when going out to dialysis. Review of documentation on 01/13/26 given to Surveyor by Activities Director at approximately 3:00 PM: Grievance Form for [NAME] Church dated received 11/03/25Resolved 11/05/25 Patient sent bag of clothing items to be tagged. Bag was lost and never tagged.Clothing replaced 11/5/25 signed Social Worker and Administrator. Review of email 11/11/25 from Social Worker to Activities Director that stated as follows: He ordered 2 pair of black size 50X30, 1 packet of shirts size 6x. Review of bank statement dated 12/18/24 FBB*Kingsize Tel order Indianapolis, IN $59.82. 0n 01/14/26 at 11:00 AM an Interview with Laundry Staff #120 who reported that Resident #5 has recently had some new shirts come through the laundry that she has marked with his name and (continued on next page)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then she had never seen them again. The only items she washes for him are gowns, socks and underwear. Interview on 11/14/26 at 11:25 AM with Nurse Aide #26 who reported resident came with very little, he ordered clothes that were lost so the facility ordered more clothes for him and she does not know what happened to them. She reported he wears hospital gowns when he walks down the hall or leaves the facility. She stated his family does not live close and have only been able to visit him a couple of times. Interview with Administrator 01/14/26 at 1:00 PM who reported that the Resident was wearing pants the previous day. He looked in Point Click Care at the picture and stated that he was 100% sure it was Resident #5 that he saw on 01/13/26 wearing pants. I stated that this Resident reported to this surveyor that he had no pants and only 2 (two) shirts and that his staff reported to me he only wore gowns. Administrator reported that he was unsure why the grievance had not been added to the log and the social worker had some help hired on this date. He was not aware that the resident was also missing a blanket. He reviewed an invoice with this surveyor that showed 2 shirts and one pair of women's pants were ordered. I explained the resident had 3 shirts and 2 pairs of pants missing and the Administrator reported that there were no further orders pending. He reported they would replace it if there were more items missing. Interview with Resident on 01/14/26 at 2:34 PM who reported that he did not wear pants the previous day because he does not have any. He stated that he would just replace them himself if the facility would reimburse his money. He stated that he would prefer to go to dialysis wearing clothes that is why he ordered them. Observed inside of resident's closet 2:35 PM 2 (two) hanging tee shirts with tags.During an interview on 01/14/26 at 2:15 PM, Resident #5 reported that he would prefer to wear clothes to dialysis and outside of his room. If I am just laying around here, I don't care to wear a gown but that's why I bought clothes to wear to dialysis.

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	515144	A. Building B. Wing	01/15/2026

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, document review, and staff interviews, the facility failed to ensure that residents receive proper assistive devices to maintain their hearing abilities. This failed practice was found true for (1) one out of (1) one residents reviewed for hearing. Resident identifier #76. Facility Census 90.a) Resident #76On 01/12/26 at 1205 PM it was noted that Resident #76 had difficulty hearing and was care planned as having hearing deficits. On 01/14/26 at 11:20 a.m., during an observation of Resident #76 with Employee #31 and Employee #32 that Resident #76 did not have their hearing aid in their right ear as ordered by the physician. Employee #32 asked the resident when was the last time they had worn their hearing aid and the resident replied that it had been a long time. Interviews with Employee #31 and #32 verified this observation at the time of discovery. Also, the observation was verified and acknowledged with the facility's Director of Nursing on 01/14/26 at 11:25 a.m. Employee #72 later found the resident's hearing aid in the medication room.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and staff interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible regarding an unidentified creamy substance sitting in a medicine cup in the resident's bathroom. This failed practice was a random opportunity for discovery. Resident identifier: # 21. Facility Census: 90.Based on observation and staff interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible regarding an unidentified creamy substance sitting in a medicine cup in the resident's bathroom. This failed practice was a random opportunity for discovery. Resident identifier: # 21. Facility Census: 90.Findings included: a) Resident #21On 01/12/26 at approximately 12:00PM, upon initial walk through a small medicine cup with a pink creamy ointment was observed in the bathroom on the back of the sink. Resident #21 said she did not know what was in the cup. During an interview with Licensed Practical Nurse (LPN) #36, on 01/12/26 at 12:10 PM, she acknowledged the medicine cup and stated it looked like barrier cream and that it should not be there. LPN #36 then removed it from the resident's room.On 1/13/26 at 11:30 am, the DON was interviewed. She stated she was aware and she would look into it to see if she could find out what the cream was. At 3:00PM the DON provided a barrier cream that was completely white but It was not the same cream found in resident #21's bathroom. She stated she would check again. On 1/14/26 at approximately 4:35PM, The DON stated she was unable to identify the pink creamy substance found in Resident' #21's bathroom.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on record review and staff interview the facility failed to ensure the daily Nurse Staff Posting included the total number of hours worked. This failed practice was a random opportunity for discovery and the potential to effect more than a limited number of residents during the Long-Term Care Survey Process. Facility Census 90. Findings Include: a) Nurse staff posting A review on 01/14/26 at 12:10 PM, of the Nurse staff posting on 01/14/26 at 12:10 PM revealed the postings for the following dates did not include the total number of hours worked: 11/27/25,11/28/25, 12/13/25, 12/14/25, 12/24/25, 12/25/25,01/02/26 and 01/03/26. During an interview on 01/14/26 at 12:49 PM, The Administrator stated, We switched to those forms sometime in September. The Administrator further confirmed that the new forms did not include total number of hours.

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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 records review and staff interviews, the facility failed to ensure a complete and accurate medical records. This failed practice was found true for three (3) two out of three (3) residents reviewed. Resident identifiers: #96, #76 and #1. Facility Census: 90. Findings included: a) Resident #96 A medical record review, completed, found a Portable Orders for Scope of Treatment form for Resident #96. The POST form indicated that Resident #96 chose to be a Do Not Resuscitate (DNR) and wanted limited interventions. The POST form was signed and dated by Resident #96's legal representative on 01/07/26. The POST form was not signed and dated by Resident #96's physician. The directions for completing the POST form, compiled by the [NAME] Virginia Center for End-of-Life, state the physician must sign and date the form. The guidance further clarifies that the signature is mandatory and a form lacking the signature is NOT valid. On 01/13/26 at 1:55 PM, the Director of Nursing acknowledged the POST form was not signed and dated by Resident #96's physician, thereby making the form invalid. b) Resident #1 Resident #1 was admitted to the facility on [DATE] A record review on 01/13/26 at 3:16 PM, of orders for Resident #1 showed that she was to receive Oxycodone-Acetaminophen oral tablet 5-325 Milligrams (MG), 1 tablet by mouth every 6 hours. Further record review of the Medication Administration Audit Report (MAAR), and the Individual Residents Controlled Substance Administration Record from admission to present revealed that Resident #1 was given the Oxycodone-Acetaminophen on time. On at least 12 occasions it was not documented that it was administered for (2) two to (4) four hours after administration. During an interview on 01/13/26 at 3:16 PM, The Director of Nursing (DON), confirmed that the medication had not been documented timely. A review of the policy titled {Medication Administration} on 01/13/26 at 3:30 PM, under General Procedures, dd, reads as follows: Medications will be charted when given. c) Resident #76 On 01/14/26 at approximately 3:50 p.m., while reviewing the medical record for Resident #76 it was discovered that Employee #123 documented they had placed Resident #76's hearing aid in the resident's right ear on 01/14/26 at 6:55 a.m. There was an observation made and verified that Resident #76 did not have their hearing aid in their right ear and the hearing aid was located in the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication room. Employee #32 verirfied the hearing aid belonging to Resident #76 was in the medication room. During an interview with the Director of Nursing on 01/14/26 at 3:55 p.m., the Director of Nursing (DON) verified and acknowledged the inaccuracy of the medical record.