

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER Marmet Center		STREET ADDRESS, CITY, STATE, ZIP CODE One Sutphin Drive Marmet, WV 25315	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on record review, and staff interviews the facility failed to document behavioral monitoring and the effectiveness of non-pharmacological interventions for Resident #69, who was receiving psychotropic medications. Additionally, the facility failed to ensure Resident #10 was not overly medicated, which caused drowsiness and restraint. This failed practice was found true for one (1) of five (5) residents reviewed for unnecessary medications during the Long-Term Care Survey Process. Resident identifier: #69. Facility Census: 88.</p> <p>a) Resident #69</p> <p>The facility's policy titled, Behaviors: Management of Symptoms, with effective date 08/01/99 and review date 09/15/25, stated as follows:</p> <ul style="list-style-type: none"> - Staff will observe and monitor for behavioral symptoms and document these symptoms in the medical records. - Individualized, person-centered, non-pharmacologic interventions would be implemented. <p>Review of Resident #69's physician's orders showed the resident had been receiving the antipsychotic medication Risperdal (risperidone) since 2023 for schizophrenia as evidenced by hallucinations and delusions.</p> <p>Resident #69's comprehensive care plan contained the following focus created and revised on 08/09/23: Resident/Patient exhibits or has the potential to demonstrate verbal behaviors related to: cognitive loss/dementia. Resident noted to have agitation, yelling, cursing, screaming, attempting to hit and kick staff. Increased hallucinations including seeing snakes and rats.</p> <p>The goal created on 08/09/23 and revised on 12/29/25 was as follows: Resident/Patient will have not more than 10 episodes of (type of behavior i.e. verbal aggression) by next review.</p> <p>The interventions were as follows:</p> <ul style="list-style-type: none"> - Monitor medications, especially new/changed/discontinued, for side-effect and resident's/patient's response contributing to verbal behaviors. - Evaluate the nature and circumstances (i.e. triggers of the [verbal behavior] with resident/patient and/or resident representative. - Evaluate need/provide for Psych/Behavioral Health consultation. <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Explain all care, including procedures (one step at a time), and the reason for performing the care before initiating. - Provide consistent, trusted caregiver and structured daily routine, when possible. - Remove resident/patient from environment, if needed. Gently guide the resident from the environment while speaking in a calm, reassuring voice. - Provide a calm, quiet, well-lit environment. <p>Resident #69's Medication Administration Record (MAR) contained the following order written on 10/15/24, Is the resident free from side effects of psychotherapeutic medications? (If no, document side-effects in PN [progress note]) every day and night shift for monitoring.</p> <p>Resident #69's MAR showed no documentation regarding behavioral monitoring or non-pharmaceutical interventions for behaviors. Review of the resident's other electronic medical records showed no evidence of behavioral monitoring or non-pharmaceutical interventions for behaviors.</p> <p>On 04/22/2026 at 9:54 AM, the Director of Nursing (DON) confirmed Resident #69's medical records contained no documentation of behavioral monitoring or non-pharmaceutical interventions for behaviors. She stated a performance improvement plan (PIP) regarding behavioral monitoring and non-pharmaceutical interventions had started in February. The DON stated the plan was for the physician to write orders for specific behavioral monitoring and non-pharmaceutical interventions for behaviors. These orders would be placed on residents' MARs for nurses' documentation.</p> <p>No further information was provided through the completion of the survey process.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure a resident received double entree portions as ordered by the facility. This was a random opportunity for discovery. Resident Identifier: #69. Facility Census: 88. Findings included:a) Resident #69 Review of Resident #69's physician's orders showed an order written on 12/15/24 for double entrees with meals. On 04/20/2026 at 1:02 PM, Resident #69 was observed eating in the dining room. Nurse Aide (NA) #5 was sitting with the resident and assisting him. The resident's tray ticket stated he was to receive double entree. However, the resident only received one (1) BBQ sandwich. NA #5 left the table to get a clean spoon for Resident #69's tablemate. Resident #69 picked up his BBQ sandwich and had eaten almost all of it by the time NA #5 returned to the table. There was some bun left. Resident #69 picked off some of the BBQ meat that had fallen onto his shirt and put that in his mouth. When NA #5 returned to the table, she began feeding Resident #59 some chopped marinated vegetable salad with a spoon. The surveyor pointed out that Resident #69's tray ticket stated he was to receive double entrees. NA #5 stated, I didn't know that. She stated she would get another BBQ sandwich for the resident. No further information was provided through the completion of the survey process.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interviews and staff interview. The facility failed to ensure meals were served in an appealing manner for residents to consume. This was found during the Annual Long Term Care survey. (Resident indicators # 2,16, 24,and47) (Facility census 88)Findings include A)On 04/19/2026 at around 12:30 PM. During a resident interview with (Resident #47). This resident reports the food is not real good most of the time, I usually ask for what is on the always available menu-On 04/19/2026 at around 1:30PM. During observation of meal service on the unit. In (room [ROOM NUMBER]B) meal that was served, chicken cacciatore, rice and capri vegetable blend, with a dinner roll. The dinner roll was placed on the plate and had become soggy from the tomato juices. (Resident #2,16 and 47) reports they do this all the time, I wish they would bag the bread. Dietary manager (#82) verified plating with dinner roll on the plate and was soggy, reports I will educate them to ensure the dinner roll is bagged. -On 04/19/2026 at around 2:50 PM. During resident interview,(Resident #24) reports the food is not good here, I usually have my daughter bring me something B) On 04/20/2026 at around 1:50 PM. During observation in the dining room (x4) residents did not receive desserts, they had left before nursing assistants offered. Residents affected,(#77,39,30,and18). -Nursing assistant (#5) verified these residents left before dessert was offered and reported We should have served the dessert with the meal. -Puree meal plate presentation: BBQ in firm round form, baked beans smooth however running on plate, puree bread firm stiff difficult to smash with fork. Nursing assistant (#5) verified the puree plate presentation reporting the vegetables and bread are always like this, Dietary manager (#82) verified the dessert was missed for the residents in the dining room and the puree plate presentation for the baked beans and bread were not appealing. Reporting I will work with the cook for puree diets and the aides to ensure all residents are offered a dessert while in the dining room.</p>		