STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515146	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marmet Center	One Sutphin Drive Marmet, WV 25315

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and staff interview, the facility failed to designate a qualified Infection Preventionist. This deficient practice had the potential to affect all residents residing in the building. Facility Census: 88. Findings included:On 04/21/2026 at 1:36 PM, the Director of Nursing (DON) stated the facility's Infection Preventionist had resigned in February. Registered Nurse (RN) #12 provided her certificate of Infection Preventionist Training. RN #12 stated she was available for staff training in Infection Control as needed but was not involved in day-to-day Infection Preventionist activities due to her position as director of the dementia unit. On 04/22/26 at 9:26 AM, the DON stated an Infection Preventionist had been hired and had started yesterday. 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, resident interview, and staff interview. The facility failed to develop and implement a comprehensive care plan for activities. This was found during the Long Term Care Annual Survey process. (Facility census 88) (Resident indicators, #2, and #12.) c1) Resident #69 - AIMS The facility's policy titled, Behaviors: Management of Symptoms, with an effective date of 08/01/99 and a revision date of 09/15/25, stated the Abnormal Involuntary Movement Scale (AIMS) would be completed per nursing schedule for patients receiving antipsychotic medications. Review of Resident #69's comprehensive care plan showed the following focus, Resident is at risk for complications related to the use of psychotropic drugs for schizophrenia. Antipsychotic and antidepressant medications. The focus was initiated on 09/23/19 and revised on 01/11/24. Interventions included AIMS testing per protocol, initiated 12/05/25. Tardive dyskinesia, involuntary movements of the face and mouth, is a potential side effect of antipsychotic medications. Abnormal Involuntary Movement Scale (AIMS) assessments are used to assess the presence or progression of tardive dyskinesia. AIMS assessments were performed for Resident #69 on 01/04/24 and 07/03/24. Symptoms of tardive dyskinesia were not documented. On 04/09/25, the monthly consultant pharmacist's medication regimen review stated, Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. This resident is taking risperdal. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. On 06/07/25, the monthly consultant pharmacist's medication regimen review stated, REPEAT RECOMMENDATION FROM APRIL 2025. Risperidone 0.5 twice daily schizophrenia and Benztropine 1 mg two times daily drooling. Last AIMS in PCC from 07/03/24. Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. This resident is taking risperdal. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. On 08/21/25, the monthly consultant pharmacist's medication regimen review stated, REPEAT RECOMMENDATION FROM APRIL 2025. Risperidone 0.5 twice daily schizophrenia and Benztropine 1 mg two times daily drooling. Last AIMS in PCC from 07/03/24. Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. This resident is taking risperdal. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. On 10/29/25, the monthly consultant pharmacist's medication regimen review stated, Risperidone 0.5 twice daily schizophrenia and Benztropine 1 mg two times daily drooling. Last AIMS in PCC from 07/03/24. Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. This resident is taking risperdal. Recommend movement test, such as AIMS or DISCUS, be (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performed at least every six months while this resident continues on antipsychotic therapy. On 02/19/26, a Note to Attending Physician/Prescriber from the consultant pharmacist stated, Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. This resident continues on Risperdal. The last AIMS/DISCUS test located in the chart was dated 2024. An AIMS assessment was performed for Resident #69 on 03/02/26. Symptoms of tardive dyskinesia were not documented. Another AIMS assessment was performed for Resident #69 on 03/23/26. The following observations were made: The resident had minimal movements of muscles of facial expression The resident had minimal tongue movements On 04/21/2026 at 10:51 AM, the Director of Nursing (DON) confirmed Resident #69's care plan was not followed regarding AIMS testing. The DON stated she did not disagree with the pharmacist's statement that AIMS assessments should be performed at least every six (6) months for residents receiving antipsychotic medications. c2) Resident #69 - Behavior monitoring The facility's policy titled, Behaviors: Management of Symptoms, with effective date 08/01/99 and review date 09/15/25, stated as follows: - 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. Review of Resident #69's comprehensive care plan showed the following focus, Resident is at risk for complications related to the use of psychotropic drugs for schizophrenia. Antipsychotic and antidepressant medications. The focus was initiated on 09/23/19 and revised on 01/11/24. Interventions included Complete behavior monitoring flow sheet, initiated 12/05/25. Resident #69's MAR showed no documentation regarding behavioral monitoring. Review of the resident's other electronic medical records showed no evidence of behavioral monitoring. On 04/22/2026 at 9:54 AM, the Director of Nursing (DON) confirmed Resident #69's medical records contained no documentation the resident's care plan was followed to monitor behaviors. She stated a performance improvement plan (PIP) regarding behavioral monitoring and non-pharmaceutical interventions had been started in February. The DON stated the plan was for the physician to write orders for specific behavioral monitoring. These orders would be placed on residents' MARs for nurses' documentation. No further information was provided through the completion of the survey process. Findings include (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-04/19/2026 2:30PM Interview with (Resident #2), she reports I don't go to activities much, I'd prefer to stay in my room, They only ask if I want to go play bingo nothing else -4/19/26 2:15PM Resident interview regarding activities, resident reports, I usually don't go to any they seem pointless. Usually someone comes in here every day or so to talk with me, I like that. -04/20/2026 4:00PM(Resident #2, Resident #12) record review, no care plan for activities was observed for the above stated residents. At around 4:15PM I held a staff interview with the Administrator. Questioned the Administrator regarding not being able to locate the care plan in the records. The Administrator reports These are not in the record, our activities director has been doing audits to ensure all aspects of care plans assessments etcetera(etc.) are in the system and she is now on leave and is not available. The assistant can do all questions of the assessments but not input anything, our MDS person does that.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to provide care and services within accepted standards of practice. Timely and consistent Abnormal Involuntary Movement scale (AIMS) assessments were not completed, and they failed to monitor peripheral intravenous (IV) access. This deficient practice applied to five (5) four of (5) five residents reviewed for unnecessary medication and (1) one of (1) one residents for antibiotic usage during the Long-Term Care Survey Process. Resident identifiers: #76, #69, #56. Facility Census: 88. Findings Include: a) Resident #76 A record review on 04/21/26 at 10:41 AM, showed Resident #76 was prescribed Zyprexa from 07/10/23 to 09/20/25. Further record review found that the only AIMS assessment completed for Resident #76 was on 01/10/24. During an interview on 04/21/26 at 10:52 AM, the Director of Nursing (DON) confirmed that the AIMS assessment should be completed every 6 months for residents on psychotropic medications. b) Resident #69 Tardive dyskinesia, involuntary movements of the face and mouth, is a potential side effect of antipsychotic medications. Abnormal Involuntary Movement Scale (AIMS) assessments are used to assess the presence or progression of tardive dyskinesia. Dyskinesia Identification System: Condensed User Scale (DISCUS) is another assessment that can identify tardive dyskinesia symptoms. 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. AIMS assessments were performed for Resident #69 on 01/04/24 and 07/03/24. Symptoms of tardive dyskinesia were not documented. On 04/09/25, the monthly consultant pharmacist's medication regimen review stated, Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. This resident is taking risperdal. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. On 06/07/25, the monthly consultant pharmacist's medication regimen review stated, REPEAT RECOMMENDATION FROM APRIL 2025. Risperidone 0.5 twice daily schizophrenia and Benztropine 1 mg two times daily drooling. Last AIMS in PCC from 07/03/24. Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. This resident is taking risperdal. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/25, the monthly consultant pharmacist's medication regimen review stated, REPEAT RECOMMENDATION FROM APRIL 2025. Risperidone 0.5 twice daily schizophrenia and Benztropine 1 mg two times daily drooling. Last AIMS in PCC from 07/03/24. Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. This resident is taking risperdal. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. On 10/29/25, the monthly consultant pharmacist's medication regimen review stated, Risperidone 0.5 twice daily schizophrenia and Benztropine 1 mg two times daily drooling. Last AIMS in PCC from 07/03/24. Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. This resident is taking risperdal. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. On 02/19/26, a Note to Attending Physician/Prescriber from the consultant pharmacist stated, Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. Recommend movement test, such as AIMS or DISCUS, be performed at least every six months while this resident continues on antipsychotic therapy. This resident continues on Risperdal. The last AIMS/DISCUS test located in the chart was dated 2024. An AIMS assessment was performed for Resident #69 on 03/02/26. Symptoms of tardive dyskinesia were not documented. An AIMS assessment was performed for Resident #69 on 03/23/26. The following observations were made: The resident had minimal movements of muscles of facial expression The resident had minimal tongue movements On 04/21/2026 at 10:51 AM, the Director of Nursing (DON) confirmed Resident #69 did not have AIMS assessments performed between 07/03/24 and 03/02/26. The DON stated she did not disagree with the pharmacist's statement on the monthly reports that AIMS assessments should be performed at least every six (6) months for residents receiving antipsychotic medications. AIMS policy The facility's policy titled, Behaviors: Management of Symptoms, with effective date 08/01/99 and revision date 09/15/25, stated Abnormal Involuntary Movement Scale (AIMS) would be completed per nursing schedule for patients receiving antipsychotic medications. c) Resident #56 The facility's policy titled Infusion Therapy Policy and Procedure Manual, dated October 2024, stated that transparent, semi-permeable membrane dressing for intravenous (IV) access devices would be changed a minimum of every seven (7) days. During observation on 04/19/26 at 3:06 PM, Resident #56 was noted to have a pump for administration of intravenous medications or fluids. She had an ace wrap on her right antecubital area which appeared to have Kling wrap under it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #56 had been admitted to the facility on [DATE] from the hospital with orders to continue intravenous antibiotics through an existing peripheral intravenous access. Review of Resident #56's physician's orders showed an order written on 04/13/26 for cefazolin sodium, an antibiotic, intravenously every eight (8) hours. The resident had no orders for observation or care of her peripheral intravenous access. The resident's Treatment Administration Record (TAR), Medication Administration Record (MAR), and progress notes contained no documentation regarding observation or care of the resident's peripheral intravenous access. On 04/21/2026 at 11:08 AM, the Director of Nursing (DON) was asked to remove the ace bandage and Kling wrap from Resident #56's right antecubital area. The resident had peripheral intravenous access in her right antecubital area. The access was covered with a transparent dressing. The dressing was not dated to indicate when it had been applied. The DON stated she did not know if the intravenous access dressing had been changed since the resident had been admitted to the facility on [DATE]. She stated she would have the dressing changed immediately. On 04/21/26, the following order was written, IV: Change Catheter Site Transparent Dressing. Indicate external catheter length and upper arm circumference (10 cm above antecubital). Notify practitioner if the external length has changed since last measurement every day shift every 7 day(s) weekly and as needed. No further information was provided prior to the completion of the survey process. d) Resident #6 On 04/21/2026 at around 11:00 AM Record review for Resident #6 revealed that the Abnormal Involuntary Movement Scale (AIMS) assessment was not completed upon admission or at six-month intervals while on antipsychotic medication. Resident #6 received Olanzapine oral tablets (5mg) once daily at bedtime as an antipsychotic agent from 11/03/25 through 02/24/26. Then reduced to (2.5mg) one (1) time a day at bedtime for mood disorder began 10/02//26 and discontinued 03/10/26. Diagnosis on record: bipolar disorder, anxiety and mood (affective) disorder. On 04/21/26 at around 11:30AM.An interview with Director of Nursing, verified this was not completed upon admission. e) Resident #10 On 04/21/2026 at around 10:20 AM, Record review for (Resident #10) for the (AIMS) assessment revealed one was not completed upon admission,06/05/2025. (Resident #10) was receiving Zyprexa (2.5mg) one (1) time a day for target behaviors: aggression and agitation. An (AIMS) assessment was completed on 11/03/25. Diagnosis on record: unspecified dementia severe with psychotic disturbance, unspecified dementia moderate with agitation and anxiety disorder. On 04/21/26 at around 11:30 AM, an interview with the Director of Nursing verified this was not completed upon admission.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on record review and staff interview, the facility failed to document the percentage of a house supplement a resident consumed when that resident was experiencing weight loss. This deficient practice had the potential to affect one (1) of seven (7) residents reviewed for the care area of nutrition. Resident Identifier: #29. Facility Census: 88. Findings included: a) Resident #29 On 10/14/2025, Resident #29 weighed 106 pounds. On 04/06/2026, the resident weighed 86 lbs. This was an 18 percent weight loss in six (6) months. On 03/25/26, Resident #29 was ordered a house supplement one (1) time a day for weight loss. The amount of supplement the resident consumed was recorded on the medication administration record (MAR). On 04/02/26, the order for the house supplement changed to two (2) times a day. The resident's supplement consumption was no longer recorded on the MAR. A quarterly nutrition note written on 04/13/26 by the Registered Dietician (RD) stated, No new losses since house supplements BID [twice a day] in place. On 04/20/26 at 2:24 PM, the Director of Nursing confirmed Resident #29's supplement consumption had not been recorded since 04/02/26. On 04/20/26 at 3:16 PM, the Registered Dietician agreed it would be important to know how much supplement Resident #29 was consuming. No further information was provided through the completion of the survey process.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and staff interview, the facility failed to store and label medications within accepted standards of care. A multi-use vial of Purified protein derivative (PPD) was not dated when accessed. Multi-use insulin pens were not discarded when they expired and were not dated when they were first opened. These deficient practices were discovered during investigation for the medication storage and labeling facility task. Resident Identifiers: #59, #44, #32, and #6. Facility census: 88. Findings included:a) Policy reviews The facility's policy titled, Insulin Pens, with effective date 10/01/12 and review date 05/01/25, stated as follows:- Insulin pens would be clearly labeled with the date used- Manufacturer recommendations would be followed for product expiration The facility's policy titled, Medications and Medication Labels, dated January 2025, stated nursing staff should document the date opened on multi-dose vials.b) Medication RoomOn 04/20/2026 at 7:48 am, inspection was made of the medication room serving A, B, C, and D hallways. Registered Nurse (RN) #43 was in attendance. In the refrigerator, there was a multi-use vial of Tubersol purified protein derivative (PPD) that had not been dated when first opened. There was no label on the vial packaging showing when the vial had been delivered from the pharmacy to the facility. PPD is injected under the skin to determine if a person is infected with tuberculosis (TB).RN #43 confirmed the multi-use vial of Tubersol PPD had not been dated when first accessed and there would be no way to determine when the vial had been in use for 30 days. The package insert for Tubersol PPD, available on-line on the Food and Drug Administration Website stated, A vial of Tubersol which has been entered and in use for 30 days should be discarded.Also in the refrigerator was a Lispro insulin multi-dose pen for Resident #59 dated with an opening date of 03/15/26. The pen had a label stating to discard the pen 28 days after opening. RN #43 confirmed the Lispro insulin pen for Resident #59 had been in use for longer than 28 days. Review of Resident #59's physician's orders showed the resident was currently prescribed Lispro insulin as coverage for elevated fingerstick blood glucose checks. The package insert for Lispro insulin, available on-line on the Food and Drug Administration Website, stated the pen must be used within 28 days or be discarded.c) Medication Cart - D Hallway On 04/20/2026 at 8:41 AM, inspection was made of the D hallway medication cart with RN #43 in attendance. A Novolog insulin pen labeled for Resident #44 was labeled as being opened on 03/15/26. The pen had a label to discard within 28 days. Review of Resident #44's physician's orders showed the resident was currently prescribed Novolog insulin as coverage for elevated fingerstick blood glucose checks. The package insert for Novolog insulin pen, available on-line on the Food and Drug Administration Website, stated to dispose of the pen after 28 days of use. Also, the following insulin pens located in the D hallway medication cart were not dated to indicate when they were first opened: Lispro insulin pen for Resident #44 Lantus insulin pen for Resident #32Two (2) Humalog insulin pens for Resident #32Lantus insulin pen for Resident #6 All pens were labeled to be discarded within 28 days. The package inserts for these insulins, available on-line on the Food and Drug Administration Website, stated to discard the pens after 28 days of use. RN #43 confirmed these insulin pens had not been dated when first accessed and there would be no way to determine when the pens had been in use for 28 days. No further information was provided through the completion of the survey process.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, and staff interviews. The facility failed to ensure meals were served in a sanitary manner to prevent potential foodborne illness, and that equipment was kept clean. This was found during the Annual Long Term Care Survey and had the potentail to affect all residents who received nutrition from the kitchen. Facility Census: 88.Findings include:a) Review of Policy for EnvironmentPolicy statement: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.Procedure reads in part:2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing all food service equipment and surfaces.B) Observations in the main dining room on 04/19/26 around 12:15 PM revealed that Server/Dietary Aide (SDA) #84 lacked sufficient utensils for service. SDA #84 used gloved hands to obtain dinner rolls instead of tongs. SDA #84 used a fork for the chicken. SDA #84 touched all surfaces with the gloved hands then placed the dinner roll on the plate. Lead cook (#88) verified and corrected.Observations made around 9:10 AM on 04/20/26 in the dining room revealed that the steam wells in the kitchenette contained moderate amounts of food debris-egg and oatmeal-floating in the water. Meal service had ended at 7:40 AM. On 04/20/26 at around 10:45 AM, a follow-up observation of the dining room steam wells showed that the wells still contained moderate amounts of food debris-egg and oatmeal-floating in the water. The Dietary Manager (#82) verified, reporting should have been cleaned after breakfast.On 04/20/26 at around 12:20 PM during an observation in the dining room for meal service Server/Cook (SC) #83 did not wash hands after coming from the kitchen to the serving area. She then placed gloves back on, then proceeded to begin meal service. Dietary district manager in training (DDMIT) #99 stopped SC #83 and instructed the server to wash her hands, then re-glove. During the meal service, SC #83 would use tongs to get a hamburger bun but then use gloved hands to open the bun, she did not change gloves or wash hands unless instructed. DDMIT #99 verified this practice and reported, I will educate her.On 04/20/26, around 12:50 PM, during the observation of meal service in the kitchen. [NAME] #88, using gloved hands left her serving area, obtained extra plates and bases, then returned to the area. She did not change her gloves or wash her hands before proceeding to continue on the tray line. Meal served for puree- beans ran on the plate, and the puree bread was very firm and thick in appearance. Dietary Manager DM #82 verified that [NAME] #88 did not use proper gloves or handwashing techniques, and the pureed meal was not appealing for the prescribed diets. DM #82 said, I will educate her on correct glove use, and proper plating of meals.

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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 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, record review, and staff interview, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. The facility failed to perform appropriate infection surveillance, which had the potential to affect more than a limited number of residents. Also, the facility failed to ensure enhanced barrier precautions were followed during one (1) of one (1) dressing change observations. Additionally, the facility failed to store bedpans appropriately. This was a random opportunity for discovery. Resident Identifiers: #42 and #30. Facility Census: 88. Findings included: a) Infection Control Surveillance The facility's policy titled, Infection Control Outcome and Process Surveillance and Reporting, with effective date 09/01/04 and revision date 03/20/26 stated as follows: The Infection Preventionist will conduct regular outcome surveillance which consists of collecting/documenting data on individual cases and comparing the collective data to standard, written definitions of infections. Review of the facility's Infection Surveillance Reports for May 2025 through April 2026 showed no infections documented in February, March, and April 2026. On 04/21/2026 at 1:36 PM, the Director of Nursing (DON) stated the facility's Infection Preventionist had resigned in February, and no one had been available to perform infection surveillance since that time. On 04/22/26 at 9:26 AM, the DON stated an Infection Preventionist had been hired and started yesterday. No further information was provided through the completion of the survey process. b) Resident #42 The facility's policy titled Enhanced Barrier Precautions, with an effective date of 01/06/20 and a review date of 11/14/25, stated that a gown and gloves would be used during high-contact patient activities demonstrated to result in the transfer of MDROs [multidrug-resistant organisms] to healthcare personnel's hands and clothing. Resident #42 had an order for Enhanced Barrier Precautions (EBP) dated 02/04/26. He had pressure ulcers on his left foot requiring dressings. On the door to Resident #42's room was a sign stating, Enhanced Barrier Precautions Staff: Wear . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Gown and gloves when providing high-contact direct care for resident Change PPE [personal protective equipment] before caring for another patient Additional PPE as needed: Examples of high-contact direct care Changing linens Dressing Bathing/Showering Providing Hygiene Transferring/Repositioning Changing briefs or assisting with toileting Device care or use: urinary catheter, feeding tube, tracheostomy, etc. Wound Care: any chronic skin opening requiring a dressing On 04/21/26 at 12:04 PM, Registered Nurse (RN) #64 was observed changing the dressings on Resident #42's left foot. RN #64 was assisted by Nurse Aide (NA) #36 and visiting Administrator #100. RN #64 and visiting Administrator #100 wore gowns and gloves. NA #36 only wore gloves. NA #36 was standing on the right side of the bed. She leaned over the bed to assist the resident in elevating his left leg and foot so RN #64 could change the dressings. NA #36's scrub top and pants were observed to contact the resident's bed linens. NA #36's bare arms were observed to rest on the resident's bare legs. On 04/21/26 at 12:15 PM, the Director of Nursing (DON) confirmed NA #36 should have worn a gown to assist with positioning the resident during his dressing changes. No further information was provided through the completion of the survey process. c) Resident rooms C24 and C26 The initial observation on 04/19/26 at 12:02 PM, revealed (2) two bedpans in the bathroom between rooms C24 and C26. One bed pad was sitting on the commode and one was sitting on the handrail. Neither bedpan was in a bag. During an interview on 04/19/26 at 12:15 PM, the Regional Resource Registered Nurse (RRRN) confirmed that the bedpans were in the bathroom, unlabeled and not in a bag and stated, I will get someone to get it.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on record review, resident interviews, and staff interviews, the facility failed to ensure residents had a choice in room assignments and that they were notified of the room change in a timely manner. This failed practice was found true for (1) one of (4) four residents reviewed for choices during the Long-Term Care Survey Process. Resident identifier #63. Facility Census: 88.Findings Include:a) Resident #63A review on 04/23/25 at 10:00 AM, of the facilities room moves for the last month, revealed that (8) eight residents had room changes indicated as clinical need.Further record review showed that Resident #63 who has a Brief Interview for Mental Status (BIMS) of 14, was moved from room A3 B to room D32 A.During an interview on 04/22/26 at 11:20 AM, Resident #63 stated, I was not told the reason my room was changed. If I had my choice, I would of stayed in my old room becasue I like that hallway better. I went to my room one day and another lady was on my bed. I told the staff that someone was in my bed and she informed me that I was in a different room now.During an interview on 04/22/26 at 1:15 PM, the admission Director (AD) said that room changes are part of his responsibility. The AD stated, I told her of her room change that morning. Sometimes we have to change rooms to make sure we are putting MDRO'S together and stuff like that. The State Agency (SA) asked, Was Resident #63 agreeable to the room change? The AD replied, I think so. The AD further confirmed that a little more notice would be a good idea.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 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. a) Resident #69 The facility's policy titled, Behaviors: Management of Symptoms, with effective date 08/01/99 and review date 09/15/25, stated as follows: - 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. 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. 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. 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. The interventions were as follows: - 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. - 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. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Provide a calm, quiet, well-lit environment. 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. 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. 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. No further information was provided through the completion of the survey process.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and staff interview, the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments. This deficient practice had the potential to affect one (1) of three (3) residents reviewed for the care area of resident assessment and one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident Identifiers: #7 and #69. Facility census: 88. Findings included:a) Resident #7 Resident #7's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 03/18/26 coded the resident had a wound infection. However, the resident's medical records did not show the resident had a wound infection in the seven (7) day look-back period. On 04/20/26 at 11:00 AM Licensed Practical Nurse (LPN) Clinical Reimbursement #15 confirmed the MDS was incorrect and Resident #7 did not have a wound infection during the look-back period. She stated the diagnosis pulled from an old MDS that correctly coded a wound infection. LPN #15 stated she would modify and correct the MDS. b) Resident #69 Resident #69's quarterly MDS with ARD 03/02/26 indicated the resident had a hip fracture and other fracture. No evidence of hip fracture and other fracture was seen in the resident's medical records during the seven (7) day look-back period. On 04/21/26 at 10:10 AM, the Administrator confirmed Resident #69's MDS was incorrect and the resident did not have fractures within the look back period. She stated the diagnoses of fractures had pulled from a previous MDS that correctly coded hip fracture and other fracture. The Administrator stated the MDS had just been modified and corrected. No further information was provided through the completion of the survey process.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and staff interview the facility failed to ensure that the administration of enteral nutrition is consistent with and follows physician orders. This failed practice was found true for (1) one of (2) residents reviewed for the care area of tube feeding during the Long-Term Care Survey Process. Resident identifier #59. Facility Census: 88. a) Resident #59A record review on 04/19/26 at 11:30 PM, revealed an order for Resident #59 that read as follows:One time a day Isosource 1.5 @60ml/hr X18 hrs. Volume 1080ml.Instructions for the 18-hour tube feeding were to start at 12:00 PM, and end at 6:00 AM.An observation on 04/19/26 at 12:10 PM, found Resident #59 asleep in bed. No tube feeding was being administered.Further observations at 12:30 PM, 1:00 PM, and 1:45 PM found no tube feeding being administeredDuring an interview on 04/19/26 at 1:55 PM, The Director of Nursing confirmed that the tube feeding for Resident #56 was not hanging and should have started at 12:00 PM.During an interview on 04/19/26 at 1:55 PM, Licensed Practical Nurse (LPN) #68 stated, I forgot, I missed my one hour window. LPN confirmed that she had already signed, as if she had administered the tube feeding.To deliver the correct nutrition over 18 hours, the tube feeding would now have to run until 8:00 AM on 04/20/26 rather than 6:00 AM.An observation on 04/20/26 at 7:45 AM, revealed no tube feed hanging for Resident #59. LPN #7 confirmed the tube feeding was not hanging and stated, I already stopped it for the day.During an interview on 04/20/26 at 10:30 AM, the Corporate Resource Registered Nurse (CRRN) confirmed that the tube feeding did not appear to have hung for the ordered 18 hours and stated, It would have to run for 18 hours for her to get the 1080 ml that are ordered.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 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.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interview, the facility failed to administer COVID-19 vaccinations in accordance with professional standards of care. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of COVID-19 vaccination. Resident Identifier: #1. Facility Census: 88. Findings included:a) Resident #1 The facility's policy titled, COVID-19 Vaccination, with an effective date of 12/14/20 and a revision date of 12/16/24, stated COVID-19 vaccination would be administered with patient or patient representative consent. Review of Resident #1's medical records showed the resident lacked capacity to make medical decisions. On 02/24/26, Resident #1's representative verbally declined the 2025-2026 COVID-19 vaccination for the resident. The form stated, I do not give consent for the person named at the top of this form to be vaccinated with the COVID-19 vaccine. Resident #1's medication administration record (MAR) documented that the resident received the 2025-2026 COVID-19 vaccination on 03/02/26. On 04/20/26 at 12:07 PM, the Director of Nursing confirmed Resident #1 received the 2025-2026 COVID-19 vaccination despite the representative declining it. No further information was provided upon completion of the survey process.