STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515153	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayetteville Healthcare Center	100 Hresan Boulevard Fayetteville, WV 25840

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interview, the facility failed to provide a dignified experience during activities of daily living (ADL) care for Resident #55. This was a random opportunity for discovery. Resident Identifier: #55. Facility Census: 57. Findings Include: a) Resident #55 On 07/01/25 at 3:25 AM, an observation of Resident #55 sitting in a wheelchair with no shirt on and brief on in front of the bathroom with the door to the hallway was open. Nurse Aide (NA) #15 was emptying the urinary catheter bag. Resident #55 was interview at this time. The resident was asked, are you getting the assistance you need? The resident stated, she is getting my catheter emptied and getting ready to put me on the pot. On 07/01/25 at 3:40 AM, the Director of Nursing (DON) was advised of the observation. The DON confirmed the door to the hallway should have been closed.

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

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to complete discharge planning and permit Resident #58 to return to the facility after an acute care transfer. This was true for one (1) of one (1) residents reviewed under the care area of transfers/discharges. Resident identifier: #58. Facility census: 57.Based on record review and staff interview, the facility failed to complete discharge planning and permit Resident #58 to return to the facility after an acute care transfer. This was true for one (1) of one (1) residents reviewed under the care area of transfers/discharges. Resident Identifier: #58. Facility Census: 57. Findings Include: a) Resident #58 On 07/01/25 at 5:00 AM, a review of a facility-reported incident (FRI) dated 12/27/24 was completed. The review found Resident #58 had been admitted to the facility on [DATE]. The resident was noted with a Brief Interview for Mental Status (BIMS) score of 14 on 11/29/24. The score of 14 indicates the resident is cognitively intact. The resident was noted with capacity for medical-decisions on 09/06/24. The resident was listed with the following diagnoses: peripheral vascular disease, chronic obstructive pulmonary disease, chronic respiratory failure, history of falling, congestive heart failure, unspecified dementia, unspecified severity, with agitation and behavioral disturbance, difficulty in walking, atrial fibrillation, hyperlipidemia, hypertensive retinopathy, radiculopathy, lumbar region, unsteadiness on feet, major depressive disorder, unspecified, unspecified mood (affective) disorder, hypokalemia, constipation, cognitive communication deficit, abnormal posture, benign prostate hypertropy, age-related nuclear cataract, bilateral, presbytopia, insomnia, muscle (generalized) weakness, and essential (primary) hypertension. The review found the resident was noted with multiple instances of inappropriate sexual behaviors, as well as physical and verbal behaviors to staff members as well as other residents. The resident was noted with inappropriate sexual behavior on 12/27/24. The resident was sent to an acute care facility for this behavior. The resident did not have discharge planning in place and was not allowed to return to the facility. The facility had worked on transferring the resident to other facilities; however, no other facility would accept the resident or did not have a bed available. The referrals were sent out in 07/2024. No further indication of any other referrals were made after 07/2024. Although, the resident was medically cleared in the acute care facility, including a psychiatric evaluation, the resident was not allowed to return to the facility. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was held with the Director of Nursing (DON) on 07/01/25 at approximately 8:00 AM. The DON denied making any statements to the acute care facility regarding the resident being a dump. The DON stated, the resident had multiple incidents with other residents and staff members, including sexual inappropriate behaviors .we sent him out and the facility decided the resident could not return to the facility. The DON was then asked, why wasn't the resident allowed to return to the facility on one-on-one supervision like in the past until another facility was found? The DON responded, the decision was made and the resident was not allowed to return to the facility. The DON did not answer the question regarding the one-on-one supervision. The DON was, also, asked, why was this incident of behavior different than the previous behaviors noted in the past? The DON did not answer this question. The DON did confirm the resident did not have active discharge planning in place and the resident was not permitted to return to the facility. An interview was held with the Administrator on 07/01/25 at approximately 9:00 AM. The Administrator stated, I reported this to the proper State agencies when it happened, the behavior of the resident made the other residents unsafe.

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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. Based on record review and staff interview, the facility failed to provide an accurate and complete record for Resident #58. This was true for one (1) of nine (9) residents reviewed during the survey process. Resident Identifier: #58. Facility Census: 57. Findings Include: a) Resident #58 On 07/02/25 at 8:40 AM, a record review was completed for Resident #58. The review found the resident had been transferred to an acute care facility on multiple occasions. The transfer form dated 02/02/23 was incorrect and the correct date was 03/26/24. An additional transfer form dated 03/26/24 was incorrect and the correct date was 08/09/24. On 07/02/25 at 8:55 AM, the Director of Nursing (DON) was notified regarding the incorrect dates on the transfer forms. The DON confirmed the dates were incorrect. The DON stated, sometimes the nurses get in a hurry and do not review the transfer form dates.

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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 maintain an infection control program for removal of dirty dishes, old food and drinks from the dining room for Resident #31 and storage of the oxygen cannula and tubing and a soiled bath basin for Resident #47. These were random opportunities for discovery. Resident Identifiers: #31 and #47. Facility Census: 57.Based on observation and staff interview, the facility failed to maintain an infection control program for removal of dirty dishes, old food and drinks from the dining room for Resident #31 and storage of the oxygen cannula and tubing and a soiled bath basin for Resident #47. These were random opportunities for discovery. Resident Identifiers: #31 and #47. Facility Census: 57. Findings Include: a) Resident #31 Upon arrival to facility on 07/01/25 at 3:15 AM, an observation of dirty dishes from the evening meal with old food and drinks which included: tea, milk, macaroni and cheese with bread stuffed into a bowl, which had Resident #31's meal ticket under the dinner plate. Also, a styrofoam cup with lid and straw with no name or room number was observed sitting randomly on dining room table. On 07/01/25 at 3:20 AM, Licensed Practical Nurse (LPN) #7 and #24 were notified. LPN #24 removed the dishes from the dining room. b) Resident #47 On 07/01/25 at 3:28 AM, an observation was made in Resident #47's room. The observation found an oxygen cannula and tubing laying in the floor by the bed as well as a used pink bath basin. The resident was noted with confusion and could not answer questions regarding the items in the floor. On 07/01/25 at 3:31 AM, Nurse Aide (NA) #43 was notified and removed the tubing and bath basin from the floor. On 07/01/25 at 3:40 AM, the Director of Nursing (DON) was notified and stated, the resident may have threw the items in the floor.

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F 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough space and equipment to meet each resident's needs Based on observation and staff interview the facility failed to ensure hallways were free from clutter and allowed resident a direct access down the hallway. This was a random opportunity for discovery and had the potential to affect a minimal number of residents residing in the Long-Term Care Facility. Facility census: 57 Findings include:During the initial our of the facility on 07/01/25 at 3:20 AM surveyor observed wheelchairs, geri chairs, and mechanical lifts parked on the right side of the hall along with a large portable Air Conditioning unit. On the left side of the hall was a linen cart and a geri chair, this blocking a direct path up or down the hallway.On 07/01/25 at 3:30 AM Licensed Practical Nurse (LPN) #7 confirmed the hall did not have a direct path for residents to easily get through.