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	03/11/2026

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 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 accurate Minimum Data Set (MDS) assessments. This deficient practice had the potential to affect one (1) of three (3) closed records reviewed during the survey process. Resident Identifier: #60. Facility Census: 57. Findings included:a) Resident #60 Review of Resident #60's discharge return not anticipated Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/16/26, coded the resident's discharge destination as a short-term general hospital.According to a nursing note, written on 01/16/26 at 3:28 PM, Resident #60 was discharged home with home health. On 03/10/2026 at 3:05 PM, the Director of Nursing (DON) confirmed Resident #60 was discharged home and the discharge MDS was incorrectly coded regarding discharge destination.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interview, the facility failed to revise the resident's comprehensive care plan to reflect the resident's choices of long term care goal. This had the potential to affect one (1) of 30 residents reviewed in the Long-Term Care Survey Process. Resident Identifier: #6. Facility Census: 57. Findings Included:a) On 03/11/26 at 10:15 AM, a document review revealed resident's care plan stated the following: Page one (1), Patient with plans to discharge to home when there is an overall improvement in abilities. Date Initiated: 02/08/19Revision on: 02/08/19 Page 14, Resident has no plans for discharge secondary to long term care placement in the facility. Date Initiated: 08/28/24 Revision: 08/28/24 b) Interview with Social Worker, on 03/11/26 at 10:18 AM, who reported the initial focus should have been resolved but continues to show up on care plan as active. c) Interview with Administrator and Director Of Nursing, at approximately at 10:25 AM on 03/11/26, who acknowledged the care plan had both plans to return to the community and for long-term care on his care plan and that the care plan needed to be revised.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to honor a resident's Physician's Orders for Scope of Treatment (POST) form indicating the resident did not want cardio-pulmonary resuscitation. This deficient practice had the potential to affect one (1) of one (1) residents reviewed for the closed record category of death. This was determined to be past non-compliance beginning on [DATE] and ending [DATE]. Resident Identifier: #61. Facility Census: 57. Findings Included:a) Resident #61 The facility's policy titled Emergency Procedures, with no implementation or revision dates given, stated cardio-pulmonary resuscitation (CPR) would not be provided for residents having a valid physician order to withhold CPR per the resident's or resident's representative's request. Review of Resident #61's medical records showed the resident was admitted to the facility on [DATE]. The resident, who had the capacity to make his own medical decisions, completed a [NAME] Virginia Physician's Orders for Scope of Treatment (POST) form on [DATE]. The resident indicated he wanted no cardio-pulmonary resuscitation (CPR) in the event he had no pulse and was not breathing. The resident had a Do Not Resuscitate (DNR) order.Further review of Resident #61's medical records showed the following nursing note, written on [DATE] at 9:10 AM, This Unit Manager was notified by LPN [licensed practical nurse] that [resident] had collapsed in the floor. Upon assessment resident was cyanotic; pupils were fixed and dilated, no pulse detected. CPR was initiated, and 911 was notified, upon EMS [emergency medical services] arrival, code status was verified to be DNR and life-saving measures were discontinued and resident was pronounced dead by EMS at 9:02am. [Physician] and [resident's next of kin] were notified.During an interview on [DATE] at 9:00 AM, the Administrator stated education was provided to staff on [DATE] regarding ascertaining residents' correct code status prior to initiating CPR. She stated the matter was also brought before the Quality Assurance Performance Improvement [QAPI] committee in an ad hoc meeting on [DATE]. The ad hoc QAPI meeting held on [DATE] identified the root cause as an inexperienced nurse who had the incorrect electronic health record open when checking the resident's code status. A Performance Improvement Plan (PIP) was developed to include education and mock codes. The record of Inservice Training dated [DATE] had the following summary of inservice, Before initiating CPR, verify the resident's code status in the electronic medical record by checking the header. Ensure that you are looking at the correct resident's medical record. The Emergency Procedures and [NAME] Virginia Code Status Procedures are attached. Review the attached policies. All nursing and nurse aide staff received the inservice training in person or by telephone on [DATE] and [DATE]. Mock codes were documented from [DATE] through [DATE]. The mock codes were on-going. The mock codes were performed on all shifts and 23 mock codes had been conducted so far. On [DATE] at 9:00 AM through 9:15 AM, staff members were interviewed regarding steps to be taken when residents were found without pulses or respirations. Licensed Practical Nurse (LPN) #2 and LPN #67 identified checking the correct electronic health record to determine the residents CPR status before beginning resuscitative efforts. They identified the resident's CPR status as being contained in the banner on the first page of the resident's electronic health record and on the resident's electronic medication administration record (MAR). These could be accessed on computers on medication carts or at the nursing desk. Nursing Assistant NA #11 and NA #44 also identified checking the correct electronic health record to determine the residents CPR status before beginning resuscitative efforts. They identified the resident's CPR status as being contained on the resident kardex which could be accessed on kiosks in the hallway. They also identified the resident's CPR status as being contained in the banner on the first page of the resident's electronic health record which could be accessed on computers at the nursing desk.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations 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 with regards to resident hand sanitation before meals. This was true for Resident #53 and Resident #6. Facility census: 57. Findings included:a) Lunch Meal on 03/10/26 At 12:12 PM on 03/10/26, the State Agency (SA) observed Nurse Aide #65 passing lunch trays to Resident #53 and Resident #6. Nurse Aide #65 set up trays for both residents, who share the same room, without first offering hand sanitation to either resident. The nurse aide then exited the room and walked back to hallway. At 12:15 PM, the SA interviewed Nurse Aide #65 and inquired if she had provided hand sanitizing care. She replied, Um ., um. The nurse aide then walked over to the cart, grabbed some hand wipes, walked back into resident's room, and asked if they had eaten yet and if they would like to wipe their hands. When she exited the room she reported to this surveyor in the hallway, They hadn't eaten yet. The Facility Policies and Standard Procedures, Subject: Standard Precautions directs on page 3, Section II when to perform hand hygiene: Before eating/before feeding or assisting in dining room tray pass.