STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515155	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierpont Center at Fairmont Campus	1543 Country Club Road Fairmont, WV 26554

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 residents Minimum Data Set (MDS) assessment correctly reflected Resident #38's physical status. This failed practice was a random opportunity for discovery and had the potential to effect a limited amount of residents during the complaint survey. Resident identifier #38. Facility Census 108. Findings Include:a) Resident #38A record review on 02/17/26 at 1:30 PM revealed a current Activities of Daily Living care plan for Resident #38 that read as follows:Focus:Resident/patient requires assistant/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Limited mobility.Goal:Resident/patients ADL care needs will be anticipated and met throughout the next review period.Interventions include the following: Provide resident with dependent assistance of 2 for bed mobility.Provide resident with set up substantial/maximal assist of 1 for toileting.Provide resident with substantial/maximal assist of 1 for dressing.Provide resident with partial/moderate, substantial/maximal, dependent assistance, assist of 1 for personal hygiene (grooming).Provide resident with substantial/maximal assistance assist of 1 for bathing.Further record review of Resident #38, revealed a diagnosis that includes dependence on wheelchair, difficulty in walking, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side. A review of Resident #38's MDS, with an Assessment Reference Date (ARD) of 11/11/25, Section GG0115 is coded as 0 upper and lower extremity limitations in range of motion. GG0120, mobility devices, is coded as none. During an interview on 02/17/26 at 4:15PM, The Director of Nursing (DON) confirmed that the MDS was coded wrong, per the residents physical status.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review, staff interview, and family interview the facility failed to provide care and services in accordance with professional standards of practice, by not providing supervision of incapacitated residents at out of facility doctor appointments. This failed practice was found true for (1) one of (3) three residents reviewed for doctor appointments during the complaint survey. Resident identifier #38. Facility Census 108. Finding include:a) Resident #38A record review on 02/17/26 at 1:30 PM, revealed Resident #38's most recent Physician's Determination of Capacity form dated 08/22/2024 indicating that he was incapacitated. Further record review of the last Brief Interview for Mental Status (BIMS) completed for Resident #38 on 02/10/26, revealed a BIMS score of 99.Resident #38's current Activities of Daily Living (ADL) care plan focus read as follows:Resident/patient requires assistant/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Limited mobility.Continued review of Resident #38's notes, revealed a general patient note dated 12/16/24 that read as follows:Resident is alert, verbal with his normal confusion, skin intact, went out today in wheelchair transported by facility van to Urology appointment. Foley catheter was changed at this appointment and scheduled in 4 weeks to be changed again 0n 1/14/25 at 10:45am with Urology. Resident returned back to facility alert, Foley intact and draining clear yellow urine, resident has no complaints. Urology reported that resident is to no longer come to his appointments alone as he became very upset, agitated and destructive when having to wait. MD and scheduler aware.Since the above incident Resident #38 has had (7) appointments to the urology center where he was transported by the facility van.During a phone interview on 02/17/26 at 1:45 PM, The Health Care Surrogate (HCS) for Resident #38 stated, Yes, they leave him at appointments all the time with no one from the facility supervising him. Urology is where he goes the most. I have taken him a time or two. I am told when they take him they just leave him sitting in the waiting room. I do not understand why it is ok to leave him unattended.During an interview on 02/17/26 at 2:00 PM, Activity Assistant (AA) #92 (who is the van driver for appointments) stated, I get a schedule weekly for who has an appointment. Typically with appointments if the resident does not have capacity an aide goes with them if the family can not come.State Agency (SA) asked AA #92 Is there anytime in particular that you can remember with Resident #38 where he was left at his Urology appointment AA #38 replied, His son is supposed to come, but I can only remember him being there once maybe twice. I take him inside and then I wait in the van in the parking lot.During a phone interview on 02/17/26 at 2:30 PM, the Receptionist at the Urology office said that she has been working there for about a year. She said that from what she can recall that resident cannot talk and he was definitely there in the waiting room by himself in March and April of last year. She said that he never says a word and just sits there looking very sad. She also said that another receptionist might know more but she is off right now.