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	01/08/2026

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on observations, interviews, and document reviews, the facility failed to thoroughly investigate reportable incidents and report the results of those investigations to the State Agency within five (5) working days of the incident and if the alleged violation was verified to include the appropriate corrective action taken. Resident identifiers: #70, #71, #73, and #121. Facility census: 111. a) A facility reported incident dated 04/13/25 involving Resident #70 and a facility reported incident dated 06/06/25 involving Resident #71 were reviewed having a Five (5) Day Follow-up Investigation Report submitted to the state agency. The facility's documentation was reviewed and the Five (5) Day Follow-up forms for each incident were in the facility's file with no proof of submission to the state agency. On 01/07/26 at 10:15 AM, the Director of Nursing (DON) confirmed there were no documentation emails, reported the Social Worker that reported the incidents no longer worked at the facility, and corporate was trying to retrieve the emails from her computer's email. On 01/07/25, the DON reported the emails were deleted after Ninety (90) days and corporate could not retrieve the emails. The DON confirmed the Facility Reported Incidents did not have a five-day follow-up submitted to the state agency. b) There was a documented change in condition on 04/19/25 that the victim was struck in the arm by Resident #73. There were no other incidents in Resident #121's medical record that alleges any other abuse. Resident #121 had a Brief Interview for Mental Status (BIMS) of 15 and had capacity. Resident #73 was diagnosed shortly after the incident with a Urinary Tract Infection (UTI). At the time of the alleged incident on 04/19/25, Resident #73 had capacity. During the survey process the facility reported incident (FRI) documents from 04/19/25 regarding Resident #121 and Resident #73 were reviewed. There was no documentation readily available to demonstrate that the facility submitted a five (5) day follow-up investigation report to the State Agency. During an interview, on 01/08/25 at 7:35 AM with Employee #56, the employee verified that there was no evidence that a five (5) day investigation report was sent to the State Agency.

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 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 observation, record review, staff interview, and resident interview the facility failed to develop and/or implement care plans related to activities, fall interventions, and Advance Directives (AD). This failed practice was found true for (3) three of 31 residents reviewed for care plan accuracy during the Long-Term Care Survey Process. Resident identifiers #5, #52, and #24. Facility census 111. c) Resident #24 On 01/05/2026, Resident #24 care plan was reviewed for the resident's Advanced Directive wishes. The resident's Advanced Directives were not care planned. The resident's care plan was confirmed by the Corporate Compliance Advisor. Findings include: a) Resident #52 The initial observation on 01/05/26 at 3:45 PM, revealed Resident #52's door shut, due to Covid precautions. Resident was lying in the bed. No stimulation was on in room. Further observation on 01/06/26 at 1:30 PM, revealed Resident #52's door shut. Resident was lying in bed. No stimulation was on in room. A record review on 01/07/26 at 9:45 AM, revealed an Activities care plan for Resident #52 that read as follows: Focus: (Resident #52 name) exhibits or is at risk for limitedand/or meaningful engagement related to:Cognitive loss/dementia. (Resident #52 name) does notwish to engage in group activities. He doesenjoy some individual activities such associal and pet visits, but spends most of histime resting in is room. Interventions include the following: (Resident #52 name) will be provided 2 to 3 one on one visits weekly.Further review of Resident #52's Activity Participation sheets for the months of 11/2025, 12/2025, and 01/2025 to date revealed that the one to one visits were not completed as care planned, and the resident had not attended any group activities. During an interview on 01/07/2026 at 10:15 AM, The AD stated, Yes, we are behind on our one to one visits because I am working on getting more staff. b) Resident #5 A record review on 01/07/26 at 5:30 PM, revealed that since 10/01/25 to present, Resident #5 has had (6) six falls. One fall with serious injury, and two of the falls was from bed one causing a skin tear to her right eye. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further record review revealed a falls care plan that reads as follows: Focus: Resident is at risk for falls: Impairedmobility. Fall on 8/30/25 no injuries. Fall on 9/15/25 no injuries noted Fall on 10/31/25 no injuries noted Fall on 11/12/25 no injuries Fall on 11/13/25 no injuries Fall on 12/8/25 no injuries Fall on 12/10/25 skin tear above R eye One of the interventions for falls initiated on 12/11/25 for a fall from bed, was bilateral fall mats to both side of the bed. An observation on 01/08/2026 8:40 AM, revealed Resident #5 lying in bed, no bilateral fall mats in place. During an interview and observation on 01/08/26 at 8:41 AM, The Director of Nursing (DON), confirmed that the fall mats were not in place, and stated, They might be getting cleaned, let me check. On 01/08/26 at approximately 8:45 AM, The Assistant Director of Nursing (ADON) was asked by State Agency (SA), Does the facility have spare fall mats to use, when other fall mats are being cleaned? The ADON replied, Yeah, we do. We put an order in and Maintenance brings them up.

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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. Based on observation, staff interview, and food tray temperatures the facility failed to serve food to residents that was at an appetizingtemperature. This failed practice was true for (1) of one (1) hallways tested for food tray temperatures throughout the Long-Term CareSurvey Process. Resident identifiers: #24 and #112. Facility census: 111. Findings Included: a) During an observation on 01/06/26 at 1:25 PM of the 220 hall meals being passed with only 2 staff members delivering all trays to residents on that hall. The District dietary manager took the temperature of the food, at time of service. Temperature of the food was as follows: French Fries 110 degrees Fahrenheit. Hamburger patty 113 degrees Fahrenheit. District Dietary Manager confirmed that the food was not served at 120 Degrees Fahrenheit at time of service. b) Resident #24 On 01/05/2026 at 12:30 PM, during the initial resident interviews, Resident # 24 reported the food was cold, especially at breakfast. c) Resident #112 During an interview on 01/05/26 at 3:15 PM, Resident #112's Medical Power of Attorney (MPOA) said that Resident #112's food is always cold and feels like it is because his hall is the last to be served. During an observation on 01/06/26 at 1:25 PM of the 220 hall meals being passed. District dietary manager took the temperature of the food, at time of service. Temperature of the food was as follows: French Fries 110 degrees Fahrenheit. Hamburger patty 113 degrees Fahrenheit. District Dietary Manager confirmed that the food was not served at 120 Degrees Fahrenheit at time of service.

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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 Store, prepare, distribute and serve food in accordance with professional standards for food service safety.This was a random opportunity for discovery and had the potential to affect multiple residents of the facility. Facility census: 111. Findings Included:On 01/05/26 at 11:45 AM, during Initial Brief Tour of Kitchen, with The Kitchen Dietary Manager, who acknowledged the kitchen the following observations:a) The kitchen refrigerator inside temperature was at 45 degrees verified via inside thermometer. b) The following was observed in the freezer :1 opened box of frozen burgers and 1 opened box of frozen fish filets, the plastic wrap was not sealed and the meat in each box were left opened to air.c) In the Prep cooler, it was discovered in the same container, stored with other produce, were over ripe oranges with brown spots on the outside peels d) On 01/06/26 at 1:50 PM a review facility policy labeled HCSG Policy 019, Food Storage: Cold Foods. Procedures, number 5 stated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. e) Staff Interviews:On 01/06/26 11:55AM, during meal prep tray line observation, with The Corporate Dietary Manager, who acknowledged the following :silverware with dried food spots on the tray.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and staff interview the facility failed to store garbage and refuse in a proper manner. Two (2) of three 3 (three) dumpsters were over filled and the lids were not closed. This had the potential to affect more than an isolated number of residents that resided in the facility. Facility census: 111.Findings Included:a) On 01/07/26 at 2:50PM, during initial observation of the dumpsters, with the Corporate Interim Administrator (CIA), the following was observed:A dumpster located on the front side of the facility was overfilled with the inability to completely close the lid.In the rear of the facility where 2 (two) dumpsters were located, the left one was observed to be overfull with the inability to completely close the lid.On 01/07/26 at 2:55 PM during an interview with the CIA, he acknowledged the dumpsters were over filled and the lids were unable to be completely closed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a complete and accurate medical records related for a Physician's Order of Treatment (POST) form and a resident's diet order. These failed practices had the potential to affect more than a limited number of residents. Resident identifier: #24 and #126. Facility Census: 111. Findings included: a) Resident #24 On [DATE], during the resident record review, Resident #24 had an order for DO NOT RESUSCITATE (DNR)-selective Do Not Intubate (DNI) which was active on [DATE]. The resident's POST form dated [DATE] stated, CPR - FULL Treatments. The documented differences between the order and care plan were confirmed by the Corporate Compliance Advisor (CCA). b) Resident #126 On [DATE], during Resident #26's record review, a diet order was not found on the resident's medical record. A diet order was not on the resident's medical record until the state surveyor intervened. On [DATE] at 01:55 PM, the CCA confirmed there was no initial diet order on the resident's medical record and stated, the Order is in there now.

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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, policy review, record review and staff interview the facility failed to maintain an infection control program, designed to help prevent the spread of disease. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Resident identifiers: #52, #86, and #97. Facility census 111. Findings Include: a) Resident #52 An observation on 01/06/2026 at 12:40 PM, revealed a Droplet precautions sign on Resident #52's door that read as follows: Special Contact and Droplet Precautions Instructions for entering the room are as follows: * Perform hand hygiene before and after patient contact, contact with environment and after removal of Personal Protective Equipment (PPE). * Wear an N95 respirator, gown, face shield and gloves upon entering the room. * Keep room door closed. Encourage patient to wear a face mask when out of room and maintain social distancing. Perform all procedures/tests in patient room if able. * Pull curtain between roommates. Please do not remove dedicated or single use disposable equipment from this room. * When dedicated equipment is not possible, disinfect shared patient equipment with EPA-approved disinfectant, Further observation, revealed Laundry Aide #52 went into Resident #52's room, walked beside his bed and put socks in the drawer. No PPE was put on and no handwashing occurred. During an interview on 01/06/26 at 12:45 PM, The State Agency (SA) asked LA #52, if she had read the droplet precaution sign before she went into the room? LA #52 responded, I was told we didn't have to wear that stuff to just put up the laundry. b) The facility's policy for Patient Hand Hygiene stated, Staff should assist patients/residents (hereinafter patient) with hand hygiene after toileting and before meals, as needed. c) On 01/05/2026 at 12:25 PM, Resident #86 received her tray with no hand hygiene completed. Nursing Assistant #38 confirmed there was no hand hygiene performed prior to lunch meal and stated, I've gotta go get some resident's eating and then she would go back to sanitize the resident's hands. On 01/05/2026 at 12:36 PM, Resident #97 was not offered hand hygiene prior to being served her lunch meal. Social Worker #36 confirmed the resident did not receive hand hygiene and stated they usually have packets .we just hand out trays.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, staff interview, and record review the facility failed to keep needed items in reach of residents and provide necessary assistance to help maintain residents independence by not keeping call lights in reach of residents. This failed practice was a random opportunity for discovery and affected a limited number of residents during the Long-Term Care Survey Process. Resident identifiers: #51, and #72. Facility Census: 111. Findings Include:a) Resident #51The initial observation on 01/05/26 at 12:15 PM, revealed Resident #51 lying in bed repeatedly saying, I hurt, I hurt. Resident #51's call light was lying behind her bed.During an observation and interview, on 01/05/26 at 12:25 PM, Licensed Social Worker (LSW) #56, confirmed that Resident #51's call light was not in reach and that she felt like she could use the call light.A record review, on 01/06/26 at 1:00 AM, revealed a Fall Care plan for Resident #51 with an intervention dated 12/27/23 that reads as follows: Encourage resident to use call bell for staff assistance.b) Resident #72The initial observation on 01/05/26 at 12:15 PM revealed Resident #72 in bed. The bed was in the upright position. Residents call light was draped over the head of her bed. The call light was not in reach of the resident.During an observation and interview on 01/05/26 at 12:25 PM, LSW #56, confirmed that Resident #72's call light was not in reach and that she felt like she could use the call light.A record review on 01/06/26 at 1:15 PM, revealed a Nutritional care plan for Resident #72 with an intervention created on 10/14/25 that reads as follows: Place call light within reach at all times.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interview the facility failed to provide bed hold notification for residents being discharged /transferred. This is true for two (2) of two (2) resident's reviewed for discharge/transfer. Resident identifiers, Resident #117 and Resident #115. Facility Census 111. Findings included: b) Resident #115 Medical chart was reviewed for a hospitalization. The facility did not provide a bed hold notification for the resident being discharged to the hospital. On 01/07/26 at 01:00PM, Social Worker #56 confirmed there was no bed hold notification and reported that the resident was going to discharge anyway to another facility. Social Worker #56 reported the resident went to the hospital and discharged from the hospital to another skilled nursing facility. The social worker stated, Nurses aren't so good here about the bed hold policy. b) Resident #117 On 1/06/26 at 02:36 PM this surveyor was reviewing documentation of transfer of resident to hospital from this facility and asked for the following documents: Behold Notice, Transfer Notice and Ombudsman Notification. The Bed hold Notice was not given to tis surveyor upon request. On 01/07/26 at 10:51 AM interview with Nursing Administration #82 she reported she notified the Ombudsman but did not send a Bed Hold Notice to the resident/responsible party. Review of document titled Accounts Receivable Policies and Procedures, Policy Title AR102 Bed-Holds, second paragraph read as follows: When a resident/ patient (resident') is transferred out of the Center to a hospital or on therapeutic leave, the designee will provide the resident/representative with the written Bed Hold Notice & Authorization form.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview, the facility failed to complete a new Pre-admission Screening and Resident Review (PASARR) for residents with a newly evident or a possible serious mental health disorder. This was true for one (1) out of three (3) sampled residents reviewed under the PASARR pathway during the Long-Term Care Survey Process. Resident identifier: #1. Facility census: 111 Findings included: a) Resident #1 Record review revealed the most recent PASARR was completed 07/28/25. Resident #1 was given new diagnoses of Bipolar disorder, depression, anxiety on 08/06/25. During staff interview on 01/06/26 at approximately 1:00 PM, the director of Social service reported, We use meditelecare for psych services, once they update a diagnosis I am informed to update the PASSARR. At end of the week they send us a report of who was seen and any change given. Review of facility policy revealed, Social services will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if: 1:1 it is learned after admission that the Pre-admission Screening and Resident Review (PASRR) was not completed or is incorrect, or2:2 There is a significant change in status that results in new evidence of possible mental disorder, intellectual disability or a related condition. There was no evidence that the Director of Social service had initiated a new PASRR once new diagnosis was given.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and staff interview, the facility failed to ensure a baseline care plan was developed and implemented with instructions needed to provide effective and person-centered quality care. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #126. Facility Census: 111 Findings included: Resident #126 On 01/05/26, the resident's care plan was initially reviewed for diet and nutritional information due to no diet order found on Resident #126's medical record. On the resident's Care Plan Report, the only focus documented was for resident assistance for mobility related to recent hospitalization. Upon further review, no care plan focus, goals or interventions were listed for behavior/emotions, dementia care, nutrition or psychotropic medications were found on the resident's initial care plan. The resident's care plan was updated on 01/05/26 following surveyor intervention. On 01/05/26 at 1:55 PM, the Corporate Compliance Officer confirmed the care plan had only one focus for mobility

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation the facility failed to ensure a resident's care plan was revised in the areas of dialysis catheter and activities. Resident identifiers: #15 and #51. Facility Census: 111Findings included:a) Resident #15 On 01/07/26 a review of Resident #15's care plan revealed the following: Resident is scheduled for outpatient surgery on 10/21/25 to get dialysis catheter removed. Date initiated and created 10/19/25. Goals and interventions were also listed for time of procedure. On 01/07/26 2:38 PM, Resident #15 reported he had a dialysis catheter removed from his chest a few moths ago, around October and now has a fistula in his arm. He pulled down his shirt without being prompted and exposed the cite where his catheter once was and stated it had healed and that there were no issues. On 01/07/26 3:00 PM, Corporate Nurse #129 acknowledged that resident's care plan needed to be revised. b) Resident #51 The initial observation on 01/05/26 at 1:59 PM, revealed Resident #51 lying in her bed, saying repeatedly, I hurt, I hurt. There is no stimulation on in the room. Further observation on 01/06/26 at 2:00 PM, revealed Resident #51 lying in her bed, turned toward the separation curtain. No stimulation on in the room. A review on 01/07/26 at 9:30 AM, of Resident #51's Activity participation for the months of 11/2025, 12/2025, and 01/2026 to date, revealed that the resident has had a significant decrease in her activity participation. During the month of 11/2025 Resident #51 was documented for (5) five individual activities daily, and participated in at least one group activity weekly as well as accepting the {Daily Chronical Delivery} During the months of 12/2025 and 01/2026 to date, Resident #51 was documented for (2) two individual activities daily, and had refused, was asleep, or had no documentation for group activity participation Further record review of Resident #51's care plan, revealed an Activity Care plan with the last revision date of 02/12/25 that read as follows: Focus: (Resident #51 name) states that while in the facility, it isimportant that she has the opportunity toengage in meaningful activities of herpreferences. [NAME] enjoys walking up anddown the halls using her rollator. She likesto socialize and eat in the dining room.[NAME] is often confused about where she isand what is going on. She can becomeagitated when she cannot get out of thefront door, (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but is usually easy to distractand redirect. Goal:[NAME] will have opportunities tomake decisions/choices relatedto/for self-directed involvementin meaningful activities throughnext review. [NAME] will express satisfactiondaily with independent pursuitsdaily through next review. Interventions: Encourage and facilitate residents activities preferences such as watching tv,relaxing, walking the halls, and religious services. I would benefit from accommodation for physical limitations by using a FWW. Resident prefers to be called by [NAME]. During an interview on 01/07/26 at 10:11 AM, The Activity Director (AD), stated, Yes, she has had a big change, We was waiting to see if she got better to add her to one to one visits, because sometimes she bounces back. The AD further confirmed that Resident #51's participation had decreased since 11/2025 and she had not been added to one on one visits. The AD further confirmed that Resident #51's Activity care plan had no additional interventions added since 02/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview the facility failed to provide a program of activities to meet the interest of and support the physical, mental, and psychosocial well-being of each residents. This failed practice was found true for (2) two of (2) two residents reviewed for activities during the Long-Term Care Survey Process. Resident identifiers #51, and #52. Facility Census 111. Findings Include: a) Resident #51 The initial observation on 01/05/26 at 1:59 PM, revealed Resident #51 lying in her bed, saying repeatedly, I hurt, I hurt. There was no stimulation in the room. Further observation on 01/06/26 at 2:00 PM, revealed Resident #51 lying in her bed, turned toward the separation curtain. No stimulation on in the room. A review on 01/07/26 at 9:30 AM, of Resident #51's Activity participation for the months of 11/2025, 12/2025, and 01/2026 to date, revealed that the resident has had a significant decrease in her activity participation. During the month of 11/2025 Resident #51 was documented for (5) five individual activities daily, and participated in at least one group activity weekly as well as accepting the {Daily Chronical Delivery} During the months of 12/25 and 01/26 to date, Resident #51 was documented for (2) two individual activities daily, and had refused, was asleep, or had no documentation for group activity participation Further record review of Resident #51's care plan, revealed an Activity Care plan with the last revision date of 02/12/25 that read as follows: Focus:(Resident #51 name) states that while in the facility, it is important that she has the opportunity to engage in meaningful activities of her preferences. [NAME] enjoys walking up and down the halls using her rollator. She likes to socialize and eat in the dining room. [NAME] is often confused about where she is and what is going on. She can become agitated when she cannot get out of thefront door, but is usually easy to distract and redirect. Goal:(Resident #51) will have opportunities to make decisions/choices related to/for self-directed involvement in meaningful activities through next review.(Resident #51) will express satisfaction daily with independent pursuits daily through next review. Interventions:Encourage and facilitate residents activities preferences such as watching tv,relaxing, walking the halls, and religious services.During an interview on 01/07/26 at 10:11 AM, The Activity Director (AD), stated, Yes, she has had a big change, We was waiting to see if she got better to add her to one-to-one visits, because sometimes she bounces back. The AD further confirmed that Resident #51's participation had decreased since 11/25 and she had not been added to one-on-one visits. The AD further confirmed that Resident #51's Activity care plan had no additional interventions added since 02/2025. b) Resident #52 The initial observation on 01/05/26 at 3:45 PM, revealed Resident #52's door shut, due to Covid precautions. Resident was lying in the bed. No stimulation was on in room. Further observation, on 01/06/26 at 1:30 PM, revealed Resident #52's door shut. Resident was lying in bed. A record review on 01/07/26 at 9:45 AM, revealed an Activities care plan for Resident #52 that read as follows: Focus:(Resident #52 name) exhibits or is at risk for limited and/or meaningful engagement related to: Cognitive loss/dementia. (Resident #52 name) does notwish to engage in group activities. He does enjoy some individual activities such associal and pet visits but spends most of his time resting in is room. Interventions include the following:(Resident #52 name) will be provided 2 to 3 one on one visits weekly.Further review of Resident #52's Activity Participation sheets for the months of 11/25, 12/25, and 01/25 to date revealed that the one-to-one visits were not completed as care planned, and the resident had not attended any group activities. During an interview on 01/07/26 at 10:15 AM, The AD stated, Yes, we are behind on our one-to-one visits because I am working on getting more staff.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and staff interview the facility failed to ensure the environment in which it had control of to be as free from accident hazards as possible, by not ensuring fall prevention interventions were being followed. This failed practice was found true for (1) one of (3) three residents reviewed for falls during the Long-Term Care Survey Process. Resident identifier: #5. Facility census: 111.Findings Include: a) Resident #5 A record review, on 01/07/26 at 5:30 PM, revealed that from 10/01/25 to present, Resident #5 has had (6) six falls. One (1) fall with serious injury, and two (2) of the falls were from bed one causing a skin tear to her right eye. Further record review revealed a falls care plan that read as follows:Focus: Resident is at risk for falls: Impaired mobility.Fall on 08/30/25 no injuries.Fall on 09/15/25 no injuries notedFall on 10/31/25 no injuries notedFall on 11/12/25 no injuriesFall on 11/13/25 no injuriesFall on 12/8/25 no injuriesFall on 12/10/25 skin tear above R eye One of the interventions for falls initiated on 12/11/25 for a fall from bed, was bilateral fall mats to both side of the bed. An observation on 01/08/2026 8:40 AM, revealed Resident #5 lying in bed, no bilateral fall mats in place. During an interview and observation on 01/08/26 at 8:41 AM, The Director of Nursing (DON), confirmed that the fall mats were not in place, and stated, They might be getting cleaned, let me check. On 01/08/26 at approximately 8:45 AM, The Assistant Director of Nursing (ADON) was asked by State Agency (SA), Does the facility have spare fall mats to use, when other fall mats are being cleaned? The ADON replied, Yeah, we do. We put an order in and Maintenance brings them up.

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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 record review, staff interview and resident interview, the facility failed to ensure staff supports the nutritional well-being of the residents while respecting the individual's right to make choices about their diet and taking the resident's preference into consideration. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #24 and #97. Facility Census: 111. Findings included: a) The facility's policy and procedure for Dining and Food Preferences stated the resident's Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software system. b) Resident #24 On 01/05/26 at 12:40 PM, Resident #24's tray card was reviewed. Apple Juice 8 oz was printed on the tray card. The resident did not have apple juice on her tray. The resident stated, I've never gotten apple juice. When I first came in they asked my preference, but did not get it. Administration Staff #120 confirmed the resident did not get apple juice ,but reported the resident asked for punch. c) Resident #97 On 01/05/26 at 12:40 PM, Resident # 97's tray card was reviewed. Chocolate milk - 1 cup - was printed on the tray card. The resident did not receive milk. Administration Staff #120 confirmed the resident did not have milk on her tray.