STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515156	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Tree Healthcare Center	1263 South George Street Charles Town, WV 25414

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment relating to maintenance services necessary to maintain a comfortable interior for resident room numbers 112, 119, 121, 123, 124, and 126, pest control for room #'s 118, 121,123,124, and 126 and Low to no water pressure in rooms [ROOM NUMBERS]. These failed practices were random opportunities for discovery. Census 98. Findings include:a) Maintenance Services:Upon survey entrance on 07/21/25 at 1:30PM, the following issues were observed in room [ROOM NUMBER]-bathroom areas: - approximate1/2-inch-long chip in the wood on the bathroom door near the handle- black scuff marks on backside of bathroom door- Rust spots across the white wall heater on the wall behind the toiletUpon survey entrance on 07/21/25 at 1:35 PM, the following issues were observed in room [ROOM NUMBER]-bathroom areas:- Cracks in caulking around the sink - Black scuffmarks on the back side of bathroom door- Black scuff marks on the sink next to water faucet baseUpon survey entrance on 07/21/25 1:40 PM the following issues were observed in room [ROOM NUMBER]-bathroom areas:- Black scuffmarks on the back side of bathroom door- Bathroom floor loose with air bubbles underneath - Black scuff marks on the sink next to water faucet base - Door jamb with holes and scrapes in the woodUpon survey entrance on 07/21/25 1:40 PM the following issues were observed in room [ROOM NUMBER]-bathroom areas: - Black scuffmarks on the back side of the bathroom door and on bathroom door - Black scuff marks on the sink next to water faucet base- Baseboard trim hanging loose from bathroom wallUpon survey entrance on 07/21/25 01:48 PM the following issues were observed in room [ROOM NUMBER], room and bathroom areas:- Black scuffmarks on the back side of bathroom door- hole in the drywall right wall behind beside table near bed #3- Rust spots across the white wall heater under the window - Scuff marks on wall above the heater b) Pest Control Resident Interviews:-During an interview with Resident #23 in room [ROOM NUMBER], on 07/21/25 at 1:00 PM, Employee # 42 came into the room, picked up a package of cookies off the floor and told Resident #23 the cookies couldn't be left out or the mice would get them. The resident stated he had seen mice in his room in the past week. -During an interview with Resident #58 in room [ROOM NUMBER], on 7/21/25 at 1:20 PM, she stated she sees mice all the time and saw one last Saturday night. It was observed there were 8 traps set in her room. -During an interview with Resident #20 in room [ROOM NUMBER], on 07/21/25 at 1:15 PM, he stated he had seen mice in his room last night and pointed to a mouse trap located under the wheelchair in his room.-In an interview with Resident #77 in room [ROOM NUMBER] on 07/22/25 at 9:45AM, he stated he had seen a mouse in his room the past weekend and again one in his room the night before. During a facility walk through with the Corporate RN, on 07/23/25 at 1:45PM, she acknowledged the maintenance issues in room [ROOM NUMBER], #119, #121, #123, #124, and #126 and Mouse citing's in resident's rooms. She stated she would make a list for the Maintenance Department. Facility Administrator interview:During an interview with The Facility Administrator on 07/24/25 at 11:20AM, he stated the facility has been logging the citing's of mice and working with a pest control company, acknowledged the mice were still a problem.c) Water Pressure - room [ROOM NUMBER], and (continued on next page)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#121:During a facility walk through on 07/21/25 at 1:25 PM, It was observed in room [ROOM NUMBER] and #121, that there was low to no water pressure from the bathroom faucets in each room.In an interview with Resident #51, on 07/21/25 at 1:25 PM, she stated the maintenance crew had worked on the sink a few weeks ago and the water barely runs now.During a facility walk through with the Corporate RN, on 07/23/25 at 1:45 PM, she acknowledged the water pressure was low and stated the issue would be added to the maintenance list.

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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 interview the facility failed to store and serve food in accordance with professional standards for safe food service. This practice had the ability to affect all Residents that get their nutrition from the kitchen. Facility census: 98. During a Dining Room Observation on 07/21/2025 at 12:45 PM, Nurse Aide(NA), #70 was observed touching multiple surfaces while setting up Resident #77's tray and then feeding him without washing hands or using hand sanitizer. In an interview with NA #70 on 07/21/25 at 12:55 PM, she acknowledged she did not wash or sanitize her hands after touching multiple surfaces before setting up Resident #70's tray and then feeding him. An observation on 07/24/25 at 11:30 AM, found: the walk-in freezer with sausage patties , pancakes, and Salisbury steak patties open to air. 3 ice cream cups on the floor. During an interview with the Dietary Manager 07/24/25 at 1:12 PM she verified the food was open to air. She also verified the ice cream cups on the floor and at this time placed the ice cream cups back in the box.

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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 observations and staff interviews, 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 washing, medical equipment, and meal tray place This practice had the potential to affect all residents that reside in the facility. Facility census: 98.Findings included: a) An observation on 07/21/25 at 12:20 PM of the dining room lunch meal tray pass found the staff using three (3) trays to pass meals. Staff would pass lunch to a resident. Return to the service line and pass the tray down through the staff to the stream table to be used for the next resident without cleaning the tray. During an interview with Licensed Practical Nurse #9 she stated that this is the practice serving meals in the dining room. She verified the service tray is never cleaned between residents. b) On 07/22/25 between the hours of 7:45 AM and 7:55 AM., observation revealed Employee #89 failed to offer residents any type of hand sanitation to Resident #94 and #21 during breakfast in the main dining room. During the same observation period, observed Employee #114 failed to offer residents any type of hand sanitation to Resident #88 and #37 during breakfast in the main dining room. Interview with Employee #117 verified this deficient practice. c) Resident #72:During an interview with resident #72, on 07/22/25 at 1145AM, a wheelchair near the resident's bed, had rips and holes in the plastic cover on both arm rests, and on the top of the back rest and on the seat, exposing the inner padding. Resident #72 stated that the wheelchair belonged to her. d) Resident #77:During an interview with Resident #77 on 07/22/25 at 2:35 PM, it was observed a Geri-Chair with scratches and tears in the head rest, exposing the inner padding. During a facility walkthrough and interview with The Facility Corporate RN on 07/23/25 at 3:10 PM, she acknowledged both Resident #72's wheelchair and #77's Geri chair needed repair.

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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 observations and staff interviews, the facility failed to ensure the call system was accessible to residents while in their bed or other sleeping accommodations within the resident's room. This failed practice was a random opportunity for discovery. Resident Identifiers #23, and #50. Facility Census: 98. Findings include:a) Resident #23On 07/21/25 at 12:35 PM upon the facility entrance and interview with Resident #23, it was observed that Resident #23 was sitting on the side of his bed, and the call light was on the floor approximately 3 feet away from him. The resident walks with a walker and could not reach his call light. b) Resident #50On 07/22/25 at 2:35 PM, it was observed that Resident #50 asked surveyor to get a nurse for her roommate in bed #1 but her call light was not within reach. She was sitting on the right side of her bed, and the call button was hanging off the left side of the bed on the floor.c) Staff Interviews:Nurse Aide (NA) #48On 07/22/25 at 12:45 PM in an interview with staff member NA #48, She acknowledged the call light was not within Resident #23's reach.Licensed Practical Nurse (LPN) #17On 07/22/25 at 2:43 PM, in an interview with LPN, #17, she acknowledged the call button was not within reach of Resident #50 and stated that she was unaware the call light was not within resident's reach because a Nurse Aide had just been in the room with the resident.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility failed to honor and facilitate the resident's choice and right to self-determination regarding the resident's preference for showers. Resident Identifier #80. Facility Census: 98.a) Resident #80During an interview on 07/22/25 at 12:09 PM, Resident #80 reported that she was scheduled for showers on Tuesdays and Fridays. She expressed a desire to have more frequent showers but noted that the staff were unable to accommodate her request. Additionally, she indicated that once she is seated on the shower chair, she can shower herself; the only assistance she required was with scrubbing her back.A review of records on 07/23/25 at approximately 10:54 AM revealed the following:Resident #80's preferences dated 02/05/25 revealed the resident's answer to the question;How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? was Very Important!Record review on 07/23/25 at approximately 1:55 PM revealed the following:06/25/25 - Bed Bath06/28/25 - Response Not Required07/02/25 - Response Not Required07/05/25 - Response Not Required07/09/25 - Response Not Required07/12/25 - Response Not Required07/16/25 - Response Not Required07/19/25 - Response Not Required b) Resident #19On 07/22/25 at approximately 10:57 AM, Resident #19 stated that he did not remember when he had last had a shower. The resident had a Brief Interview for Mental Status (BIMS) of 4. A review of shower records revealed the resident had not received showers or bed baths between 07/16/25 and 07/23/25 - a period of six (6) days, as evidenced by the record below:-06/29/25 - Shower-07/02/25 - Bed Bath-07/06/25 - Bed Bath-07/09/25 - Shower-07/13/25 - Refused-07/16/25 - Shower No additional shower records were provided by the facility for review.During an interview with the Director of Nursing (DON) on 07/23/25 at 3:15 PM, the DON reviewed the shower log and stated that she could not understand why the documentation stated, Response Not Required.DON confirmed that the documentation did not indicate showers were provided to Resident #80 and Resident #19. Additionally, there was no documentation that residents had refused showers.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on resident and staff interviews, the facility failed to ensure an allegation of suspected staff to resident verbal abuse was reported to the appropriate State Agencies, within a 2-hour time frame. This failed practice was a random opportunity for discovery. Resident identifier: #47 Facility Census: 98. Findings Include: a) Resident #47 Interview with Resident #47, on 07/22/25 at 9:35AM, she reported Licensed Practical Nurse (LPN) #35 had called her a liar two (2) nights previous when she reported she had not had a bowel movement in five (5) days and asked for a laxative. Facility Policy and Standard Procedures Policy #NS1018-03:Mental Abuse is the use of verbal or nonverbal conduct which causes or had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation and may be considered a type of mental abuse.During an interview with the Facility Administrator on 07/22/25 at 9:44 AM, the suspected staff to resident abuse was reported and he stated he would investigate it. In a follow up interview with the Facility Administrator on 07/24/25, H stated he had not made a report to the appropriate agencies as he had not spoken to LPN #35. She was off the date it was reported to him, but she was scheduled to work that afternoon and was waiting to talk to her regarding the report.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to provide residents with assistance during showers. Resident Identifiers #80 and #19. Facility Census: 98.a) Resident #80 Findings Include: During an interview on 07/22/25 at 12:09 PM, Resident #80 reported that she is scheduled for showers on Tuesdays and Fridays. She expressed a desire to have more frequent showers but noted that the staff were unable to accommodate her request. Additionally, she indicated that once she is seated on the shower chair, she can shower herself; the only assistance she requires is with scrubbing her back. A perusal of records on 07/23/25 at approximately 10:54 AM revealed the following: A resident #80's preferences dated 2/05/25 revealed that the resident's answer to the question; How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? was Very Important Record review on 07/23/25 at approximately 1:55 PM revealed the following:06/25/25 - Bed Bath06/28/25 - Response Not Required07/02/25 - Response Not Required07/05/25 - Response Not Required07/09/25 - Response Not Required07/12/25 - Response Not Required07/16/25 - Response Not Required07/19/25 - Response Not Required b) Resident #19On 07/22/25 at approximately 10:57 AM, Resident #19 stated that he did not remember when he had last had a shower. The resident has a Brief Interview for Mental Status (BIMS) of 4.However, a review of shower records revealed that the resident had not received showers or bed baths between 07/16/25 and 07/23/25 - a period of six (6) days, as evidenced by the record below: 06/29/25 - Shower07/02/25 - Bed Bath07/06/25 - Bed Bath07/09/25 - Shower07/13/25 - Refused07/16/25 - Shower No additional shower records were provided by the facility for review. During an interview with the Director of Nursing (DON) on 07/23/25 at 3:15 PM, the DON reviewed the shower log and stated that she couldn't understand why the documentation stated, Response Not Required". DON confirmed the documentation did not indicate showers were provided to Resident #80 and Resident #19. Additionally, there was no documentation that any residents had refused showers.

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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 observations, interviews, and record reviews, the facility did not implement proper monitoring and assessments for a resident who had close contact with another resident diagnosed with Varicella. Additionally, the facility failed to recognize and assess the potential risks to other residents due to unrestricted access to all areas of the facility by this resident. This was a random opportunity for discovery. Resident Identifier: #63 and #38. Facility Census: 98. Findings include:a) Resident #38Findings included:On 07/23/25 at approximately 10:42 AM, Resident #38 was observed under contact isolation. Record review revealed that Resident #38 had been moved out of the room she shared with Resident #63. Further record review revealed the following:A note was entered on 07/23/25 at 9:10 AM for Valacyclovir HCl Oral Tablet 1 GM. Give 1 tablet by mouth every 8 hours for shingles for 7 Days.Valacyclovir is a prescription antiviral medication used to treat infections caused by herpes simplex virus (HSV) and varicella-zoster virus (VZV).Another note on 07/23/25 at 9:58 AM stated the resident would be on contact Isolation related to shingles.Nursing observations, evaluation, and recommendations were documented as follows: Patient presents with clusters of red rash located to right buttock. She states burning/stinging sensation that radiates to right thigh area.The primary care provider (PCP) responded with the following feedback:A. Recommendations: Serum varicella zoster igg/igm, varicella zoster PCR, ValtrexB. New Testing Orders:C. New Intervention Orders:Further record review on 07/24/25 at approximately 10:15 AM revealed that on 07/23/2025 6:02 PM Varicella PCR specimen obtained per order from right posterior thigh. The lab slip was completed and placed in specimen refrigerator.On 07/23/2025 9:03 PM Valacyclovir HCL oral table 1 gm was not given due to being unavailable. A note dated 07/24/2025 at 1:58 AM revealed the following: Resident remains on isolation d/t possible shingles per previous nurse. Resident reports no complaints of pain/discomfort at this time. VSS. Call light, bed control and hydration are within resident's reach. Valacyclovir HCL 1gm is not available at this time per 3-11 nurse.A note dated 07/24/2025 10:31 AM revealed the following: Resident remains on contact isolation for possible shingles and has been maintained. Labs are pending for confirmation. She denies any concerns or discomfort thus far.b) Resident #63 At approximately 11:05 AM on 07/23/25, during an interview with Resident #63, he stated, my wife is in isolation due to an infection and pointed to the other bed in the room, which had been stripped of its bed linen and mattress. When questioned about whether he had contracted chickenpox during his childhood, the resident stated that he had not. The resident, who was in a wheelchair, stated that he was the only artist in the facility and that he was allowed to go everywhere.Upon being asked whether anyone had checked his temperature, the resident stated that he did not have orders for temperature checks. He went on to ask, Why are you asking me these questions? During an interview with the Nurse Practitioner (NP) on 07/23/25 at 11:40 AM, the Nurse Practitioner (NP) noted there was no need to confine Resident #63 to his room, as he had not exhibited any signs of infection. However, the NP did not mention any measures that would be put in place to monitor Resident #63 for potential signs or symptoms of infection.At approximately 11:55 AM on 07/23/25, the Regional Clinical Nurse (RCN) was asked what steps were being taken to verify that Resident #63 had not contracted the infection. And since Resident #63 was mobile, what precautions were being taken to ensure that the virus did not spread. RCN stated that Resident #63 had not shown any signs of infection and could not be isolated based on the chance that he had contracted the virus. RCN further stated that the facility had implemented temperature checks and skin assessments to monitor Resident #63. During the record review on 07/24/25 at approximately 10:15 AM the following order was revealed: 07/23/25 at 3:08 PMVital Signs Q (every) shift X 72 hours for 3 DaysA review of Resident #63's Treatment Administration Record (TAR) revealed that the first temperature check was performed on 07/23/25 during the evening shift.Record review revealed that these interventions were implemented after surveyor intervention on 07/23/25 at 11:55 AM.

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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 record review, observation, and staff interview the facility failed to ensure theresident environment over which it had control was as free from accident hazards aspossible. This failed practice was a random opportunity for discovery, Resident Identifier #69Facility Census 98 Findings Include:a) Resident #69During the facility entrance interview on 07/22/25 at 1:45 PM an observation revealed a medicine cup of ointment creme was left on the bedside table. Resident #69 stated it was ointment the nurse aides left there for her to use on her bed sores. In an interview with LPN # 6 on 07/22/25, at 1:48 PM, she stated she did not know what the medicine cup of ointment was and stated it should not have been left in the resident's room.