STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515164	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyoming Healthcare Center	236 Warrior Way New Richmond, WV 24867

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 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 record review and staff interview, the facility failed to develop and implement comprehensive, person-centered care plans for Residents #5, #19, and #39, and failed to include required 1:1 visit interventions in the care plan for Resident #23, this was found true for four (4) of 17 care plans reviewed during the Long Term Care Survey Process. Resident identifiers: #5, #19, #39 and #23 Facility Census: 56Findings include:a) Residents #5, #19, #39During record review on 11/18/25 of residents #5, #19, #39 person centered care plan revealed all three (3) residents had the same Focus statement which read as follows; Resident is self-directed for activities in and out of the room daily, and Resident is dependent on staff for activities, cognitive stimulation or social interaction.On 11/19/25 at approximately 2:00 pm an interview with the Activity Director revealed not all residents were independent and dependent on activities and stated I can edit these and get them fixed now, when I initiate the care plan this comes up, I'll get these fixed today. confirming the care plans were not person centered for each resident.On 11/18/25 at 1:10 PM record review of the sensory list provided by the Activity Director shows Resident #23 is to be provided sensory activities daily.On 11/18/25 at 1:35 PM observation found Activities Leader #42 in Resident #23's room. She was speaking with the resident giving her some direction on doing an activity with poppers (a rubber game where the resident pops the circles from one side to another). The resident was not very interested, and the Activities Leader #42 left the room.During a conversation with the Activity Leader #42, she states there are some residents that have the sensory activity daily, and some have it every other day. She states she provides the activity either in their room or as a group in the activity room for about 15 minutes when performing the sensory activity. When ask what the activities consist of she states it could be one or more of the following. The activities consisted of: Lotion to their hands and/or arms, taking care of their dolls, squeeze balls, poppers, games, play dough or coloring.On 11/19/25 at 12:30 PM review of Resident #23's care plan does not have the one-one activity in place. The Focus reads Resident is self directed for activities in and out of room daily and Resident is dependent on staff for activities, cognitive stimulation or social interaction. The goal is: Resident will participate in activities of choice through review date. Interventions/Tasks are: 1) Assist with transport to activities as needed. 2) Assure that the activities are compatible with resident's physical and cognitive capabilities. 3) Invite resident to scheduled activities 4) Provide a schedule of activities available and 5) Residents preferred activities are talking with staff, family visits.On 11/19/25 at 1:10 PM during an interview with the Activity Director she stated the care plan should reflect the resident being on one-one sensory activities but confirmed that it is not.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview the facility failed to ensure Resident #57's Minimum Data Set was accurate in the area of dental status. This was true for one (1) of three (3) residents reviewed during the long term care survey process. Resident Identifier: 57. Facility Census: 56. Findings include: Resident number 57. On 11/18/2025 at 10:00 a.m., this surveyor observed resident #57 was missing front tooth of upper denture plate. On 11/19/2025 at 11:00 a.m., this surveyor completed a record review for Resident #57. The review revealed that the Minimum Data Set (MDS) dated [DATE] was inaccurate in Section L. Specifically, Section L indicated that the resident's dentures were not broken, which was inconsistent with the resident's actual condition.On 11/19/2025 at 11:30 a.m., the DON #49 supplied copy of MDS confirming the MDS was incorrect.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to ensure accurate diagnoses on the Preadmission Screening and Resident Review (PASARR) in coordination with the Medical Diagnostic Screening (MDS). This was found to be true for one (1) of three (3) residents reviewed during the annual survey process. Resident identifier: #8.Facility census: 56 Findings included: (A) Medical Record Review Resident #8 was first admitted to the facility on [DATE], with the following diagnoses related to mental illness/neurological diseases : DEPRESSION, UNSPECIFIED 05/02/2025 Present on AdmissionSCHIZOAFFECTIVE DISORDER, UNSPECIFIED 06/08/22 Present on AdmissionPARANOID PERSONALITY DISORDER 06/08/2022 Present on AdmissionBIPOLAR DISORDER, CURRENT EPISODE MIXED, SEVERE, WITHOUT PSYCHOTIC FEATURES 06/08/2022 Present on AdmissionVASCULAR DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY 06/08/2022 Present on AdmissionPARKINSON'S DISEASE WITH DYSKINESIA 10/01/23 Present on AdmissionEPILEPSY, UNSPECIFIED 05/22/24 Present on AdmissionHALLUCINATIONS, UNSPECIFIED 06/08/22 Present on AdmissionDuring his stay at the facility, the resident was also diagnosed with Anxiety Disorder, unspecified on 08/18/23. A review of the Medical Diagnostic Screening (MDS) Section I, dated 10/10/25, had the following diagnoses related to mental illness/neurological disorders:Non-Alzheimer's DementiaParkinson's DiseaseSeizure Disorder or EpilepsyAnxiety DisorderDepressionBipolar DisorderPsychotic DisorderThe Resident's most recent PASARR was completed on 09/12/25 by an acute care hospital. Section III of the MDS which lists Current Diagnosis does not have the following diagnoses marked, even though these were present upon admission to the nursing home facility:Seizure DisorderParanoid DisorderAffective Bipolar DisorderThe resident has had several hospitalizations since his first admission to the nursing home facility. These included 09/09/25 to 09/23/25; 10/10/25 to 10/22/25, and 11/06/25 to 11/12/25. In conclusion, the PASARR should have been updated upon Resident's readmission to the facility post hospitalization. B) Staff interview On 11/19/25 around 2:50 PM, the MDS Section I, PASARR dated 09/12/25, and the Diagnoses section of the Resident's medical record were reviewed with the Director of Nursing and Nursing Home Administrator. When the discrepancy were pointed out, the staff requested an opportunity to make sure the 09/12/25 PASARR was the most recent. At approximately 3:10 PM on 11/19/25, the DON stated 09/12/25 was the most recent PASARR and acknowledged the PASARR needed to be updated.

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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 update the resident's care plan prior after completion of the quarterly assessment as required. At the time of the survey, the care plan for Resident #4 had a target date of 10/24/25 and had not been revised when the quarterly assessment was completed in early October 2025. This was true for one (1) of five (5) residents reviewed for the care area of unnecessary medications during the long term care survey process. Resident Identifier: #4. Facility Census: 56Findings include:A review of Resident #4's medical record revealed a comprehensive care plan with 10/24/25 as the target date for all goals contained on the care plan. Further review showed a quarterly Minimum Data Set (MDS) assessment had been completed in early October 2025. The care plan had not been reviewed upon completion of this assessment and the target dates had not been updated. no evidence that the care plan had been reviewed or updated on or after 10/24/2025. An interview conducted on 11/18/25 at 1:00 p.m., with the Director of Nursing (DON} #49 confirmed the care plan for resident #4 had not been updated since 10/24/25 and acknowledged that the care plan should have been revised after the quarterly assessment was completed and was not.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to ensure that necessary hearing and/or vision aides and services were provided and maintained in accordance with professional standards of practice for one (1) of three (3) residents reviewed for the care area of hearing and vision. Resident #55 was never seen by the audiologist or optometrist in regards to hearing and vision impairments. The resident had a signed consent on file for the services but the facility failed to follow through and did not ensure the resident was evaluated for new glasses and hearing aides. Resident Identifier: #55. Facility Census: 56. Findings include:On 11/17/25 at 10:30 a.m., Resident #55 was observed without their hearing device. The resident reported they were awaiting new hearing aids and new glasses.A review of the resident's record on 11/19/25 at 1:00 p.m. indicated that the admission minimum data set (MDS) documented the resident as having both hearing and vision impairments.On 11/19/25 at 2:30 p.m., an interview with the facility administrator revealed the facility could show no evidence the resident had been seen by the audiologist or the optometrist. She confirmed he had signed a consent to be seen but there was no evidence to suggest he had been seen despite his hearing and vision impairments which were identified by the facility on his MDS admission assessment in 02/2025.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based upon record review and staff interview, the facility failed to ensure the Medical Director responded to the Pharmacist's irregularities reported on the medication regimen review (MRR). This was found to be true for one (1) of five (5) residents reviewed during the long term care survey process. Resident identifier: #6. Facility census: 56Findings included: (A) Medical Record Review Resident #6 had the following diagnoses in the medical record related to mental illness/neurological diseases: UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY 05/07/2025 During StayANXIETY DISORDER, UNSPECIFIED 04/28/2024 During StayMAJOR DEPRESSIVE DISORDER, RECURRENT, MILD 04/23/2024 Present on admission The resident had the following medication orders: hydrOXYzine HCl Oral Tablet 25 MG (Hydroxyzine HCl)Give 25 mg by mouth two times a day for anxietyPharmacy Active 6/23/2025 Sertraline HCl Oral Tablet 100 MG (Sertraline HCl)Give 100 mg by mouth one time a day for depressionPharmacy Active 6/23/2025 traZODone HCl Oral Tablet 50 MG (Trazodone HCl)Give 25 mg by mouth at bedtime for depressionPharmacy Active 6/22/2025 The facility's consultant pharmacist was conducting monthly medication regimen reviews (MRR). An irregularity was marked on the MRR by the pharmacist for the report dated 06/23/25. The irregularity report was not located in the medical record, so this was requested from the facility on 11/18/2025 at 11:39 AM. The irregularity report was requested again at 2:50 pm on 11/18/25. At approximately 3:10 pm on 11/18/25, the DON provided the irregularity report. The irregularity report requested the Medical Director to Please reassess the PRN psychotropic order and consider: (1) Updating the order to include an initial duration of 14 days (2) discontinuing the order if appropriate at this time. The Medical Director had not taken any action on the recommendation. B) Staff interview Upon review of the document with the DON on 11/18/25 at approximately 3:12 PM, she acknowledged this had been missed getting completed.