STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515168	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne Healthcare Center	6999 Route 152 Wayne, WV 25570

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations, staff interviews and resident interviews, the facility failed to ensure resident's call lights were within reach, and to ensure residents did not have long waits for call lights to be answered. This failed practice had the potential to affect a limited number of residents. Resident Identifiers #6, #21, and #27. Facility Census: 59Findings Included: a) Resident #21 On 05/19/26 at12:00 PM, it was observed that Rsident #21 was laying in her bed trying to reach her call bell on the floor beside her bed causing her to almost roll out of the bed. Registered Nurse #34 was alerted, came into the room, and confirmed she was unable to get her call light and began to assist her. b) Resident # 27 On 05/20/26 at 11:59 AM Resident #27 was heard calling out for help. She was observed sitting in her wheelchair, near the foot of her bed, while her call bell was clipped to her pillow at the head of the bed and out of her reach. Registered Nurse #34 was alerted and came into the room, confirmed her call light was not within reach, then assisted putting her back into bed. c) Resident #6: During Enteral tube care, it was observed Resident #6's call light was on her left side. This resident suffered a stroke with left sided weakness and when asked to hit the call light button, the resident could not reach across body to use the call light. This was confirmed by staff member RN #34. This event took place on 05/21/2026 at 10:58 AM. This was discussed with Nursing Home Administrator on 05/21/26 at 11:08 AM. Resident #6s care plan was edited after this conversation to reflect call bell be placed on the right side of the resident.

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 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 resident interview, observation and staff interview facility failed to ensure meals are prepared and served in methods to conserve nutritive value, flavor, appearance and in a pleasing, palatable presentation. This failed practice had the potential to affect more than a limited number of residents. Resident identifiers: #49, #28, #39, #18, #24,#12, #9 , #47 and #15. Facility census: 59. Findings includeA) Regulation review for 483.60 (d) reads in part.-Food prepared by methods that conserve nutritive value, flavor, and appearance.-Food and drink that is palatable, attractive, and at a safe and appetizing temperature.B) During dining observations on 05/19/2026 at around 12:45 PM Resident (49) reports, the vegetables would be better if it wasn't mushy., Resident (28) diet slip shows resident is to have double portions however did not receive double portion of lasagna nor cauliflower. Resident (39) reports this cauliflower is too mushy and brown, Resident (18) diet slip shows dysphagia puree, to receive puree breaded chicken patty for meal however received puree lasagna. Resident (24) feeding assistant/activity director reports She will not touch the cauliflower, it is too discolored. Dining room observation. Cauliflower brown in color, very soft for regular and dysphagia advanced diets. Resident number nine (9) did not receive the ordered magic cup for the lunch tray. District Manager for Food and Nutrition verified the cauliflower was over cooked, Resident (18) did not receive the puree breaded chicken, Resident (28) and the resident did not receive double portions. Resident nine (9) did not receive the magic cup with her meal. Review of the production sheet showed needing puree chicken for one (1) serving. During a staff interview with cook (13) verified it was prepared but not served, reporting I must have missed it.-On 05/19/2026 at around 1:30 PM During an interview with resident (15), reporting, The food, especially the vegetables are mushy when we get them. Pointed at cauliflower on plate reporting this is not supposed to be brown and mushy.- On 5/19/26 at around 2:00pm during a follow up interview with resident (47), reporting they cook the vegetables to death, this is supposed to be cauliflower but it is brown mush-On 05/19/26 at around 1:30PM. During follow up interview with resident (34), reporting this meal today would have been better if they did not cook the cauliflower to death, it is brown and mushy. - On 05/19/2026 at around 10:26 AM. During an interview with resident (47), reporting The vegetables are usually cooked way too much. Sometimes you can not tell what they are supposed to be.- On 05/19/26 at around 2:00PM. During a follow up interview with resident (47), reporting this is what I am talking about, my diet card says it is cauliflower but I am not sure, this is brown mush.

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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 observation 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 the resident's personal products and unsanitary practices. Resident Identifier: #27. Facility census: 59Findings Included: During a facility walk-through on 05/20/26 at 12:10 PM, we observed 1 wheelchair (w/c) in the A hallway with holes in the seat, exposing the inner padding near the front left screw and 1 Geri-Chair located outside the Central Shower Room with rips and tears down both sides of the back rest and on the right armrest, exposing the inner padding. On 5/20/26 at 2:00 PM, during an interview/walk-through with the Infection Preventionist, the B Hall Nurse manager was present. She confirmed the wheel chair and Geri-Chair had tears and holes exposing inner padding and stated the facility would remove and repair them.