STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Center	1000 Lincoln Drive South Charleston, WV 25309

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and staff interviews, the facility failed to ensure Resident #81, Resident #49, and Resident #51's medical power of attorney (MPOA) were contacted in a timely manner when these residents experienced a change in their condition. This was true for three (3) of three (3) residents sampled for notification of changes during the Long-Term Care Survey Process. Census: 122 Resident identifier: #81, #49, #51c) Resident #51 On 04/02/26 at 9:00 AM, an investigation into a complaint was completed. The record review for Resident #51 found a change of condition dated 03/24/26. The resident did not have medical decision-making capacity. However, upon further review the resident was notified, but the Health Care Surrogate (HCS) was not. The resident was noted with worsening lower back pain. On 04/02/26 at 9:05 AM, the Administrator was notified that the HCS was not notified of the change in condition. The Administrator confirmed the HCS should have been notified. Findings include: A policy titled Change in Condition: Notification of, states a Center must immediately inform the patient, consult with the patient's physician, and notify, consistent with their authority, the patient's representative, where there is an accident involving the patient which results in injury and has the potential for requiring physician intervention; and a significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications. A) Resident #81 Resident #81 has a Change in Condition form regarding a fall dated 03/23/26 that shows the facility attempted to contact Resident #81's Medical Power of Attorney (MPOA) without success. Resident #81 has a MPOA and an alternate MPOA listed on his profile to contact in case of an emergency. An interview with Director of Nursing (DON) at 4:50PM on 04/07/26 confirmed the facility did not attempt to contact the alternate MPOA/emergency contact regarding the resident's fall on 03/23/26. B1) 11/27/25 (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a note dated 11/27/25 at 3:49PM, a change in condition was reported with behavioral symptoms. The same note reads, nurse obtains urine specimen via straight cath resident tolerates well. The Power of Attorney (POA) was notified per the documentation on the change of condition form at 4:00PM. Resident #49's son stated in an interview on 03/31/26 at 9:20AM that he had been at the facility the morning of 11/27/25 and no one said anything about this procedure. He stated he did not become aware of this until it had already been completed. An interview with Director of Nursing at 4:37PM on 04/01/26 confirmed that Resident #49's POA was notified of procedure after it had been done according to documentation. B2) 12/18/26 Resident #49 had a fall on 12/18/25 with an incident report dated 12/18/25 at 9:15PM. According to the Change in Condition form, the physician was notified at 10:03PM, but the resident's Power of Attorney (POA) was notified on 12/19/25 at 9:44AM. An interview with Director of Nursing (DON) at 4:37PM on 04/01/26 confirmed Resident #49's POA was not notified in a timely manner according to documentation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible This was true for The Transitional Care Unit dining and 6 out of 12 sampled residents. Resident identifiers: #135, #136, #7, #17, #3, and #29. Facility Census:122 a) Resident #77 On 03/31/2026 at 3:50 PM, observation of the resident's room revealed a container of bleach cleaning wipes (Micro-Kill), identified as a white bottle with a blue lid, left unattended at the resident's bedside. The container was observed to be within reach and accessible to the resident, indicating it was not stored in a secure or supervised location. The presence of a chemical cleaning agent at the bedside created the potential for accidental exposure, ingestion, or misuse, which could result in harm to the resident. This observation is inconsistent with standard safety practices requiring hazardous materials to be properly labeled, stored, and secured to prevent resident access. At approximately 4:06 PM on 03/31/2026, an interview was conducted with the Director of Nursing (DON), who confirmed that the cleaning wipes were not appropriately secured at the time of observation. The DON acknowledged that cleaning agents should not be left unattended in resident care areas and should be stored in designated, secured locations when not in use. There was no evidence to indicate that measures were in place at the time of observation to prevent resident access to the cleaning product. The unsecured item was removed from the resident's bedside following surveyor identification of the concern. Proper storage and handling of hazardous chemicals is necessary to maintain a safe and sanitary environment and to protect residents from avoidable risks of injury or exposure. b) Resident #135: During an entrance interview with Resident # 135 on 03/31/26 at 10:45 AM, it was observed in her bathroom above the sink that the drywall was loose with chunks and pieces falling from the wall into the sink. On 03/31/26 at 10:48 AM, In an interview with RN #46, she acknowledged the dry wall chunks that fell from the wall and in the sink were an accident hazard. She stated she would get maintenance down there right away for repairs. On 04/08/26 at approximately 9:30AM, a recheck of Resident #135's room with the Administrator, it was observed the drywall patch and chunks of drywall spillage was not yet repaired. She acknowledged the disrepair and stated she would make sure the maintenance department would attend to it immediately. c) Resident #136: On 03/31/2026 2:38 PM, during the entrance interview with Resident #136, a medicine cup was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed on her bedside table with a white creamy substance in it. Upon asking the resident what was in the cup she stated it was Bio-Freeze medicine left there for her to rub on her feet because they hurt. On 03/31/26 at 2:40PM During an interview with Registered Nurse # 46, she stated even though the resident was alert and oriented, she was not care planned to give herself medications and that it shouldn't have been left there. She removed it from her bedside and disposed of it On 03/31/2026 at 2:46 PM, the DON acknowledged he had been made aware of the Bio-freeze left at a resident's bedside, and reported, staff education on medications at bedside started on that date. On 03/31/26, during an tour of the TCU dining room at 10:30PM, It was observed that sheet rock chunks approximately 1/2 inch in size and saw dust piles with small wood splinters in the lower kitchen cabinets. This was true for all shelves in the bottom cabinets to the right and left of the sink and also in the island cabinets across from the sink. These cabinets were of easy access by all residents who enter that unit dining room. During an interview with the night shift supervisor on 03/31/26 at 10:43PM, she acknowledged the sheet rock chunks and wood splinters/saw dust in the bottom cabinets and stated the debris was left over from the recent remodel and that she did not know the cabinets were left like that. d) Resident #3 An initial interview was held with Resident #3 on 03/31/2026 at 11:14 AM. Resident #3 stated, They won't take me to the bathroom .they said if I fall I'll sue them .if someone will help me I can use the wheelchair and the bars in the bathroom .they tell me to use the brief or bed pan .I cannot have a bowel movement in a brief. One or two of the girls will take me, the rest will not. On 04/02/2026 at 1:30 PM, a lift transfer evaluation dated 01/27/26 indicated the resident was dependent for transfers using the mechanical lift with two (2) staff members. This was the last documented lift transfer evaluation until 04/02/26. The care plan under the focus area of dependent for ADL (activities of daily living) care, a review found two (2) interventions regarding toileting. The first intervention states, (Name of Resident) is dependent on staff for toileting, lower body dressing and transfers; and, mechanical lift for transfer x2 dependent. (Typed as written.) However, a review from 03/03/26 through 04/02/26 under the tasks tab for toileting found the resident was assisted to the toilet via wheelchair on 10 occasions with staff assistance x 1 (one) and the mechanical lift was not used. After Surveyor intervention, the Director of Nursing (DON) did a lift transfer assessment on 04/02/26 at 1:34 PM. Upon completion of the assessment, the resident was changed from a mechanical lift for transfers to a gait belt. The DON stated, she is a dialysis patient, may be therapy felt she was too inconsistent to make her a gait belt. An additional interview was held with the resident on 04/02/26 at 1:40 PM. The interview was asking the resident to explain how the staff transferred her when not using the mechanical lift. The resident stated, they put the wheelchair beside the bed, they assist me to stand, then I stand and pivot and get in the wheelchair. Then they take me to the bathroom, and I use the bars to stand. The staff member pulls my pants down and helps me to sit down. Once I am finished, I stand back up using the bars, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then the staff cleans me, pull my pants up and I get back in the wheelchair. I was able to do this when I was still in the hospital. Some of the people tell me I cannot get up to go to the bathroom, they say if I fall, I can sue them. I don't know why they haven't let me use the bathroom .I have been using the bathroom for many years .I can fall out of bed or wherever, I could sue them if I fall. I'm not someone who sues people. I just want to use the bathroom .I am unable to have a bowel movement in the brief or when I use the bedpan .my stomach really hurts when I need to go and I can't go to the bathroom. The man (DON) was just here and said I really did good when I showed him, I was able to do it (transfer with the gait belt). On 04/02/26 at 1:50 PM, the DON stated, I've updated the care plan, and put in a request for physical therapy to address toileting tasks and request to use the commode. On 04/02/26 at approximately 2:20 PM, an interview was held with the Administrator. The Administrator confirmed the issue with the transfer status for Resident #3. The Administrator stated, I understand this is an issue .we are doing a facility-wide audit for transfers. An interview was held with the Director of Rehabilitation Services (DORS) on 04/02/26 at approximately 3:00 PM. The DORS stated, we communicated with the floor in February, 2026 to change the resident to a gait belt. e) Resident #29 On 04/07/2026 at 10:43 AM, catheter care was observed for Resident #29 which was being completed by Nurse Aide (NA) #57. Upon completion of the catheter care, the NA asked the resident did he want to get up in his wheelchair. The resident stated, yes. After assisting the resident to the side of the bed in a seated position, NA #57 put the resident's shoes on him. The NA assisted the resident to a standing position by holding under the resident's arm and pivoted the resident in front of the wheelchair and plopped the resident down in the wheelchair. On 04/07/26 at 10:59 AM, the South Unit Manager was notified and was asked how the transfer should be completed? The South Manager confirmed the resident was a gait belt transfer. NA #57 was interviewed at this time as well. NA #57 stated, I'm sorry I was nervous .I should have used the gait belt. On 04/07/26 at 11:05 AM, the Administrator and the Director of Nursing (DON) were notified and confirmed the gait belt should have been used with Resident #29. The Administrator stated, We will get her here and provide education immediately. f) Resident #7 During a tour of the facility on 04/07/26 at approximately 10:45AM, State Surveyor noticed that a fall mat was placed at the right side of Resident #7's bed, but that the bed was not in the lowest position. Resident #7 is care planned for a fall mat to the right side of the bed and bed in low position as resident is at risk for falls related to impaired mobility. An interview with Director of Nursing (DON) at 11:00AM on 04/07/26 confirmed resident's bed is not in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g) Resident #17 A lift assessment dated [DATE] indicated Resident #17 should use a total lift full body sling for transfers. A change in condition communication form dated 09/25/25 that the facility used to communicate a fall, reads: Resident noted on floor in room on knees near bed. Unassisted attempt to transfer from [Bedside commode] BSC to bed. In an interview with Director of Nursing (DON) at 10:30AM on 04/06/26, he stated a resident should not have a BSC in the room if they are using a total lift for transfers.