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

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

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility failed to store and dispose of garbage and refuse properly. One (1) of the three (3) dumpsters located outside of the facility had one sliding door that was open. During two different observations of the kitchen during the survey process, the lid for the trash can located in the dining room was not on, and was sitting on the floor. This was a random opportunity for discovery that has the potential to affect every resident at the facility. Facility census: 122.Findings include: a) Healthcare Services Group policy #30 titled Dispose of Garbage and Refuse states: All garbage and refuse will be collected and disposed of in a safe and efficient manner.The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris.Appropriate lids are provided for all containers.b) 04/01/2026 at 12:19 PM This surveyor noticed that one of the garbage dumpsters located outside of the dining room had one of the doors opened without any employee around. The Director of Nursing verified these findings at 12:23 PM and said I will have someone go outside, and close the door. I notified the Healthcare Services Group (HCSG) District Manager (DM) at 12:25 PM, she verified this finding, and the door to the dumpster was closed at 12:26 PM. c) 04/02/2026 at 10:25 AM This surveyor went to the kitchen to ask for the diet guides for today, and found one (1) trash can with the lid sitting on the floor. The HCSG DM came to see what I needed, and she immediately put the trash can lid on, and I let her know that both of the trash cans outside of the dish room are soiled and need to be cleaned. She said I will take care of this. I asked her if she has a cleaning schedule posted, and she stated 'not at this time, it is being revamped.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and staff interview, the facility failed to ensure a dignified experience with toileting for Resident #3, catheter care for Resident #29 and dining for Resident #17. This was true for three (3) of 39 residents reviewed during the survey process. Resident Identifiers: #3, #29, and #17. Facility Census: 122.Findings Include: a) 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, maybe 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, 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. b) 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. NA #57 did not pull the privacy curtain before the care was provided. The resident's bed is closest to the bedroom door. On 04/07/26 at 10:59 AM, the South Unit Manager was notified and confirmed the privacy curtain should have been closed. On 04/07/26 at 11:05 AM, the Administrator and the Director of Nursing (DON) were notified and confirmed the privacy curtain should have been closed prior to the catheter care. The Administrator stated, We will get her in here and provide education immediately. On 04/07/26 at 11:25 AM, the facility procedure entitled, Catheter: Indwelling urinary-Care of was reviewed. Number 4 of the procedure states, Explain procedure and provide privacy. c) Resident #17 A policy titled Resident Rights Under Federal Law, states the purpose of the policy is to treat each resident with respect and dignity, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their self-esteem and self-worth. Resident #17 was served his lunch tray on 04/02/26 at 12:47 PM in his room. The nurse aide was observed by State Surveyor setting the tray on the end of the bed next to the bedside commode and leaving the resident's room. Upon entering the room, the State Surveyor observed the bedside commode had the lid open and had bloody stool in the bucket. An interview with Administrator at 12:55 PM confirmed the bedside commode should have been emptied before lunch or the lid closed while Resident #17 was eating to promote the resident's dignity.

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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 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. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for 17 of 71 resident rooms observed during the long-term care survey process. Rooms 119, 120, 121, 124, 125, 126, 201, 204, 205, 206, 207, 209, 210, 212, 213, and 305. Facility Census: 122.Findings include: Genesis Policy titled OPS200 Safe and Homelike Environment states: The resident has the right to a safe, clean, comfortable, and homelike environment that de-emphasizes the institutional character of the setting. 03/31/2026 at 10:30 AM a) room [ROOM NUMBER] - (Resident #74) has wall damaged near the bathroom sink. b) room [ROOM NUMBER] - (Resident #60) has three areas on the wall and the ceiling that are were damaged. c) room [ROOM NUMBER] - (Resident #72) the wallpaper near the tv has a large piece ripped off. There was one area on the bathroom ceiling and one on the bathroom wall that needed to be painted. The windowsill was dusty and the top of the wardrobe was dusty. d) room [ROOM NUMBER] - (Resident #16) has a large area of wall damage across from the bathroom that needs to be painted. 04/06/2026 at 2:30 PM On 04/06/26 at 2:30 PM Administrator #148 accompanied this surveyor to the rooms listed above and acknowledged the damage and stated I will have maintenance paint those areas today. I will have housekeeping clean room [ROOM NUMBER] today. She gave this surveyor a list of facility repairs needed, that were identified in August 2025. She also stated the facility is waiting on a quote from a company named Groundworks to complete some of the repairs. e) room [ROOM NUMBER] Resident #135 and #46 shared a bathroom The following was observed in this shared bathroom: -unfinished drywall patches above the sink around the wall -unfinished drywall patches around the wall to the right of the toilet, -loose and missing areas of caulking around the sink/wall -plastic sink pipe covering came off and laying under the sink. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Peeling paint above the sink on the right wall During an interview with Registered Nurse #46 on 03/31/26 at 3:30 PM, she acknowledged the plastic pipes, unfinished drywall patches, loose caulking and peeling paint around the sink and stated, I don't know much about that, but I'll report it to get maintenance down here for repairs. During an interview with the DON 03/31/26 4:00 pm he stated he was made aware of the issues in room [ROOM NUMBER]. In a facility walk through on 04/08/26 at 9:15 AM with the Administrator the Administrator acknowledged the dry wall, sink caulking, and pipe wasn't completely repaired yet, stated she would make sure the repairs were reported to the maintenance department immediately. On 03/31/26, a tour of the Transitional Care Unit (TCU) was completed with the Director of Nursing (DON) from 10:41 AM through 11:20 AM. All bathrooms appeared dirty, dingy and dark. All observations of the rooms on the TCU are as follows: f) room [ROOM NUMBER]: sink was leaking on the floor of the bathroom as well as through the wall to the corridor, baseboards in the bathroom were pulling away from the walls, unfinished sheet rock, a black substance at the base of the toilet and two (2) lights were burnt out g) room [ROOM NUMBER]: unfinished sheet rock and a strong urine smell in the bathroom and a black substance at the base of the toilet h) room [ROOM NUMBER]: unfinished sheet rock and a strong urine smell in the bathroom, a black substance at the base of the toilet, commode running constantly i) room [ROOM NUMBER]: unfinished sheet rock as well as an area needing patched in the bathroom, a black substance at the base of the toilet j) room [ROOM NUMBER]: unfinished sheet rock in the bathroom and a black substance at the base of the toilet k) room [ROOM NUMBER]: unfinished sheet rock in the bathroom and a black substance at the base of the toilet l) room [ROOM NUMBER]: unfinished sheet rock as well as an area needing patched in the bathroom, strong urine smell, a black substance at the base of the toilet m) room [ROOM NUMBER]: unfinished sheet rock in the bathroom, toilet paper holder missing and five (5) lights bulbs burnt out n) room [ROOM NUMBER]: unfinished sheet rock in the bathroom and a black substance at the base of the commode o) room [ROOM NUMBER]: unfinished sheet rock in the bathroom, tiles loose and falling from shower wall, sink needs replaced and a black substance at the base of the toilet (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p) room [ROOM NUMBER]: ceiling needs repaired, unfinished sheet rock in the bathroom, sink needs replaced and a black substance at the base of the toilet On 03/31/26 at 11:30 AM, the Administrator was notified of the issues found. The DON confirmed being present during the tour of the TCU and that the findings were correct. The Administrator stated, I will do an audit . On 03/31/26 at approximately 1:45 PM, the Administrator stated, I have completed my audit .we will get started on these issues immediately.

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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, resident interview and staff interview, the facility failed to develop and/or implement the care plan for Resident #3 and #29's transfer status, #7's fall precautions, #31's fractures, #96 and #87's shower preference and #46's gradual dose reduction (GDR) of psychotropic drugs. This was true for seven (7) of 39 residents reviewed during the survey process. Resident Identifiers: #3, #29, #7, #31, #96, #87, and #46. Facility Census: 122. Findings included a) Resident #87 Clinical documentation reviewed on 04/02/2026 at 11:38 AM revealed the resident's care plan specified showers on Tuesdays and Fridays to support the resident's hygiene needs and preferences. However, review of the resident's activities of daily living (ADL) documentation indicated this established care plan was not consistently followed. Instead, the resident routinely received bed baths in place of scheduled showers. Record review documented the resident received bed baths on the following dates: 03/10, 03/11, 03/12, 03/14, 03/15, 03/16, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/27, 03/28, 03/29, 03/30, 03/31, and 04/01/2026. In contrast, showers were documented only on 03/13, 03/26, 04/02, and 04/03/2026, demonstrating a pattern of deviation from the established care plan schedule. This pattern indicates the resident's individualized care plan for hygiene was not consistently implemented as written. The repeated substitution of bed baths in place of showers reflects a lack of adherence to resident-specific care directives and may impact resident preference, dignity, and overall quality of care. This concern was confirmed with the Director of Nursing (DON) on 04/02/2026 at approximately 12:00 PM, who acknowledged the discrepancy between the care plan and documented care provided. Failure to consistently follow the established care plan has the potential to result in unmet resident preferences and diminished quality of individualized care. b) Resident #46 A record review, completed on 04/06/2026 at 10:00 AM, revealed: -A physician order, dated 03/19/2026, for Olanzapine Oral Tablet Disintegrating 5 MG. Give 1 tablet by mouth at bedtime for antipsychotic. -In a Monthly Medication Regimen Review, completed on 03/20/2026 at 2:32 PM, the consulting pharmacist recommended a Gradual Dose Reduction of Resident #46's Olanzapine. A Gradual Dose Reduction (GDR) refers to the stepwise tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. -On 03/20/2026, the attending physician agreed to and signed off on the GDR. The new order should have read, Olanzapine 2.5 MG. Give 1 tablet by mouth at bedtime. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of the March 2026 Medication Administration Record (MAR) revealed the physician order had never been updated. Resident #46 continued to receive the Olanzapine at the original dose of 5 MG (once per day) on the following dates and times: 03/20/2026 at 7:51 PM 03/21/2026 at 10:41 PM 03/22/2026 at 9:37 PM 03/23/2026 at 10:17 PM 03/24/2026 at 10:03 PM 03/25/2026 at 10:37 PM 03/26/2026 at 8:55 PM 03/27/2026 at 10:08 PM 03/28/2026 at 10:11 PM 03/29/2026 at 9:12 PM 03/30/2026 at 9:01 PM 03/31/2026 at 8:58 PM 04/01/2026 at 9:13 PM 04/02/2026 at 11:22 PM Resident #46 continued to receive the higher dose of Olanzapine from 03/20/26 – 04/02/2026, for a total of 14 days. Upon request, the Director of Nursing (DON) produced a copy of the care plan for Resident #46. The care plan focus stated: Resident is at risk for complications related to the use of antipsychotic drugs. The care plan goal stated: Resident will have the smallest most effective dose without side effects throughout the next review period. The care plan interventions stated: Gradual dose reduction as ordered. During an interview on 04/06/2026 at 12:16 PM, the (DON) was asked why the gradual dose reduction was not completed. The DON stated, I think it got overlooked, that's all I got for you. The Administrator was interviewed on 04/06/2026 at 3:37 PM. The Administrator acknowledged that the attending physician had signed off on a GDR for Resident #46. It was also acknowledged that Resident #46 had received an excessive dose of his/her antipsychotic medication for 14 days. When (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asked why the GDR was not done, the Administrator stated, I don't know, I feel it just wasn't done. c) 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, 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 where ever, 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. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d) 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 should the transfer 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 in here and provide education immediately. e) 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 and therefore the care plan was not being implemented. g) Resident #31 A review of Resident #31's care plan revealed there is no indication of resident's fractures mentioned in relation to her comprehensive care. An interview with Director of Nursing at approximately 4:00PM on 04/06/26 confirmed the care plan did not include mention of Resident #31's fractures. h) Resident #96 A review of Resident #96's care plan reveals he prefers to take a shower. The bathing task documentation shows that Resident #96 was not offered a shower from 03/24/26 to 03/31/26. An interview with Administrator at 9:48AM on 04/02/26 confirms Resident #96 did not receive a shower from 03/24/26 to 03/31/26 with no refusals and that his care plan states he prefers showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview the facility failed to ensure resident received the care and services to help them maintain and or attain their highest practicable physical, mental and psychosocial well being. For Resident #14 there was a delay in starting an ordered antibiotic. The facility did not notify the physician when the residents blood sugar was over 400 for Resident #12. For Resident #48 the facility failed to provide prompt wound evaluation and treatment. Finally for Resident #87 the facility failed to ensure basic hygiene tasks were performed to keep the resident from scratching his own skin. This was true for four (4) of 39 sampled residents. Resident Identifiers: #14, #12, #48, and #87. Facility Census: 122. b) Resident #12 On 03/06/2026 at 12:00 PM, a blood glucose fingerstick reading of 413 mg/dL was obtained. This value exceeds the facility's defined critical threshold for hyperglycemia. Review of the clinical record revealed no documented evidence that the physician was notified of this critical result. Facility protocol for blood glucose monitoring and physician notification was reviewed and confirmed that the physician is to be notified for blood glucose readings less than 70 mg/dL or greater than 400 mg/dL. No documentation was identified to indicate physician notification, new orders, or clinical interventions in response to the elevated blood glucose level. During an interview on 03/06/2026 at 2:40 PM, the nurse practitioner (NP) confirmed that the physician should have been notified of the blood glucose reading of 413 mg/dL and acknowledged that failure to do so is not consistent with facility protocol. c) Resident #48 On 03/31/2026 at approximately 10:30 PM, observation revealed Resident #48 lying in bed with multiple open, circular areas noted on the right outer thigh. The areas exhibited redness surrounding the wound edges, and active bleeding was observed. During the observation, the resident verbalized pain, stating, I can't do this again tonight. At that time, Licensed Practical Nurse (LPN) #13 asked the resident if he would like a bandage applied, to which the resident responded, Yes. LPN #13 was observed obtaining supplies from the treatment cart and applying a bandage to the affected areas. A review of the clinical record revealed no documented evidence of assessment, treatment, or wound care provided on 03/31/2026 at approximately 10:30 PM. Further review of the medical record revealed no documentation of wound care, assessment, or treatment from 03/31/2026 through 04/07/2026. On 04/07/2026 at 11:49 AM, the Director of Nursing (DON) confirmed that the resident's wounds had not been treated since 03/31/2026. d) Resident #87 On 03/31/2026 at 9:29 AM, observation revealed the resident had long, untrimmed fingernails and visible scratches present behind the right ear. The affected area appeared reddened with superficial skin breakdown. An interview conducted with the resident's wife at that time indicated awareness of the condition, and she stated that the resident's fingernails were trimmed following the observation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/02/2026 at 9:05 AM, follow-up observation by the surveyor, in the presence of the Director of Nursing (DON), revealed that scratches remained present behind the resident's right ear, indicating lack of resolution. There was no observable evidence at that time that the area had been fully treated or had healed. A review of the clinical record revealed no documented evidence of a wound assessment, treatment, or monitoring of the scratched area following the initial observation on 03/31/2026. During interview on 04/02/2026, the DON acknowledged the presence of the scratches and stated that the nurse practitioner (NP) would be notified, a wound assessment would be completed, and nursing assistants would be interviewed to determine contributing factors. The DON further indicated that the incident would be reported as neglect. Findings Include: a) Resident #14 A review of Resident #14's medical record found a Urinalysis Culture and Sensitivity which was resulted on 12/24/25 at 10:02 am. A further review of the electronic medical record found a note entered by the Nurse Practitioner on 12/24/25 at 11:42 am which read as follows, .Long-term care resident of the center being seen today to follow-up on final urine culture results. She did have complaints recently of some dysuria, which she does report continues. A urine specimen was obtained via straight cath, with initial UA results appearing negative. However, final culture results are back today, positive for greater than 100,000 colonies of E. coli. She has no complaints other than dysuria today Assessment & Plan:E. coli UTI: I have ordered Bactrim DS 1 orally every 12 hours for 5 days. Her eGFR was 42 on 11/12/25.A review of the medication administration record found the order for Bactrim DS 1 orally every 12 hours was not entered into the medical record until 12/26/25. A review of the medication administration record (MAR) for the month of 12/2025 found the first dose of bactrim was not administered until 12/26/25 at 9:00 PM. An interview with the Director of Nursing (DON) on 04/07/26 at 1:18 PM, confirmed there was a delay in starting the antibiotic ordered by the Nurse Practitioner. He was unable to provide an explanation as to why the medication was not started or 12/24/25. He confirmed the pharmacy did make a delivery to the facility on [DATE] and 12/25/25. An interview with the DON he confirmed that there was a delay from 12/24/26 to 12/26/26 and the medication should have been started before that.

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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.

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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 food tray temperatures, resident interviews and staff interviews, the facility failed to serve food that was attractive, palatable and at a safe and appetizing temperature to prevent foodborne illness. The facility failed to ensure hot foods were served hot. This failed practice was true for three (3) of three (3) meal trays tested throughout the survey process. Residents identified: #99 and #60. Facility census: 122.

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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, prepare, distribute and serve food in accordance with professional standards for food safety. Additionally, the facility failed to follow the proper sanitation practices for the kitchen and the food preparation equipment. The facility also failed to ensure that all employees that enter the kitchen have their hair properly restrained. This practice had the potential to affect more than a limited number of residents. Facility census: 122. Findings include: a) Healthcare Services Group (HCSG) policy #28 titled Environment states: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. All food contact surfaces will be cleaned and sanitized after each use. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. b) HCSG policy #27 titled Equipment states: All foodservice equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. All staff will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after each use. All non-food contact equipment will be clean and free of debris. c) Initial walkthrough of the kitchen on 03/31/2026 at 9:06 AM. The Healthcare Services Group (HCSG) District Manager (DM) accompanied this surveyor during, and acknowledged the following findings to be accurate. The facility did not follow the FDA Food Code or their own policies for the following: The can opener was soiled and needed to be cleaned The toaster's crumb tray needed to be cleaned The exhaust hood needed to be cleaned (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The stove top had food debris and grease build-up The top of the juice machine has dust build-up and needed to be cleaned The ice scoop holder's cover was broken off and needs to be replaced The ice scoop holder was soiled and needed to be cleaned There was black build-up on the dish room wall The walk-in refrigerator temperature was not recorded on 03/30/2026 for the evening shift The south pantry ice scoop holder was soiled The refrigerator in the south pantry needed to be wiped out with sanitizer on the inside The TCU pantry refrigerator needed to be wiped clean with sanitizer on the inside The microwave in the north pantry was soiled and needed to be cleaned The ice scoop holder in the north pantry was soiled and needed to be cleaned d) Dining Observation for lunch on 03/31/2026 at 12:25 PM The North hall beverage cart had multiple tumblers that were wet nesting. Nurse Aide (employee #49) took those off of the cart. The cart was also visibly soiled with food particles and debris. The Office Manager sent the cart back to dietary to be cleaned and asked for it to be sent back, so they could serve the residents beverages for lunch. The office manager and Nurse Aide #49 both agreed that the cart was soiled and the tumblers were wet. 12:28 PM The TCU hall beverage cart had tumblers that were wet nesting. Administrator #150 acknowledged that was an issue and sent those back to the kitchen. 12:30 PM The South hall beverage cart was visibly soiled with food particles and debris. Nurse Aide (employee #61) verified this. 04/01/2026 at 9:35 AM e) HCSG policy #18 titled Food Storage: Dry Goods states: All dry goods will be appropriately stored in accordance with the FDA Food Code. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. HCSG policy #24 titled Staff Attire States: (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. f) Follow up visit to the kitchen. A black substance on the dish room wall Two (2) opened loaves of bread not dated One (1) package of hamburger buns not dated Two (2) cleaning clothes not in a bucket with sanitizer The stove top has built up food particles and debris Two unidentified activity employees came into the kitchen without a hairnet on g) 04/02/2026 at 10:25 AM This surveyor went to the kitchen to ask for the diet guides for today, and found one (1) trash can with the lid sitting on the floor. The HCSG DM came to see what I needed, and she immediately put the trash can lid on, and I let her know that both of the trash cans outside of the dish room are soiled and need to be cleaned. She said I will take care of this. I asked her if she has a cleaning schedule posted, and she stated 'not at this time, it is being revamped. h) 04/02/2026 at 12:23 PM During dining observation this surveyor noticed that a popcorn maker located in the south dining room was soiled and not covered. I asked Nurse Aide (employee #7) if the popcorn maker should be cleaned and covered? She stated I know they are hard to clean and it should be covered. i) 04/02/2026 at 12:33 PM During dining observation, the dietary department sent three (3) resident meal trays down the hallway on a soiled black cart. I asked Nurse Aide (employee #88) to verify that the cart was sent out soiled, she stated the cart is soiled and was sent that way. At 12:35 PM the DON approached and verified that the resident meal trays should not have been sent out on a soiled cart and stated that I will clean it now. I also told the DON about the popcorn maker located in the south dining room, and he asked the Environmental Services (EVS) Account Manager (AM) to please take care of it. e) North Pantry/Nourishment Room storage: On 04/07/26 at 4:59 PM, while checking the night snack inventory, in the North Pantry Nourishment room, it was observed a plastic container of fruit was on the top shelf of the refrigerator with the lid partially open, exposing the fruit to air. Staff Interviews: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/07/26 at 3:30PM During an Interview with employee #11, she acknowledged the bowl of fruit with the opened lid and reclosed the lid. On 040/7/26 at 4:15PM Interview with the DON he acknowledged the fruit belonged to a resident and had been removed from the refrigerator and was replaced for the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to maintain an infection control program to prevent communicable diseases during clean linen transport, during catheter care for Resident #29, North and South shower rooms, soiled linen throughout the facility, Resident #9, #42, and #46's wheelchairs as well as the facility wheelchairs and Geri-chairs throughout the facility, and an unclean and unsanitary room for Resident #7. These were random opportunities for discovery. Resident Identifiers: #29, #9, #42, #46, #39, #25 and #7. Facility Census: 122. a) Resident #7 On 03/31/2026 at approximately 2:57 PM, observation of Resident #7's room revealed two full urinals placed on the floor at the bedside. Additionally, a brown-like substance was observed on the floor in multiple locations, including near the bedside commode. The bedside commode was noted to be soiled with a similar brown-like substance, indicating a lack of proper cleaning and sanitation. These findings were observed and confirmed at the time of observation with Nurse #16. b) Resident #9 During an interview with Resident #9 in room [ROOM NUMBER], on 03/31/26 at 10:45 AM, it was observed that both arms were ripped and split down the sides in the plastic cover exposing the inner padding on her wheelchair. c) Resident #42 During entrance interviews and observations on 03/31/26 at approximately 11:45AM, It was observed in room [ROOM NUMBER] that Resident #42's wheelchair had cracks in the back rest with exposed padding. Resident #42 stated the wheelchair was the one the facility gave her to use. h) Resident #46 During an interview with Resident #46 on 03/31/26 at 12:10 PM in room [ROOM NUMBER], a small hole in the middle of the seat on the edge of her wheelchair with exposed padding was observed. Observations on 03/31/26 at 10:00 AM found multiple wheelchairs and Geri-chairs in the halls with holes, tears, and exposed padding: -Geri-chair located outside room [ROOM NUMBER] was observed with a 1/2-inch-long tear towards the back of the right-side arm plastic covering exposing the inner padding. -Geri-chair located in the exit hallway to the courtyard was observed with holes and tears in the top edges of the back rest and the corner edge of the right arm pad had holes in the plastic cover with exposed inner padding. -Observation of a wheelchair in the hall outside Room# 301 found the seat was ripped with exposed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	padding -Observation of a wheelchair located next to the door leading to the North courtyard, was observed with a 1-inch-long tear in the left seat corner edge exposing the inner padding. In a facility walk through and interview with the director of nursing on 03/31/26 at 10:00 AM, he acknowledged the wheelchairs and Geri-chairs in the facility hallways with rips, and tears exposing the inner padding and stated he would start a list for the Infection Preventionist. During a facility walk through with the Administrator on 04/07/26 at 9:40 AM, She acknowledged the wheelchairs observed in room [ROOM NUMBER]. #301, and #306 with holes and tears exposing the inner padding and would add them to the list for the infection preventionist. Findings Include: On 03/31/26 at 10:45 AM, an observation of the Manager-In-Training (MIT) #144 pushing an uncovered clean linen cart was made. MIT #144 was interviewed at this time. MIT #144 stated, Oh, I didn't know. On 03/31/26 at approximately 12:45 PM, the Director of Nursing (DON) and the Administrator were notified. The Administrator confirmed the clean linen should be covered during transport. On 03/31/26 at approximately 2:15 PM, the facility policy entitled, Linen Handling was reviewed. Under number 3, the policy states, Clean linen shall be delivered to patient care units on covered linen carts with covers down. i) 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. After catheter care was completed, NA #57 did not remove the soiled gloves or complete hand hygiene. NA #57 pulled up Resident #29's brief and shorts, straightened his shirt, assisted the resident to a seated position on the edge of the bed, assisted with putting the resident's shoes on, transferred the resident to the wheelchair and moved the wheelchair by the handles with the soiled gloves. On 04/07/26 at 10:59 AM, the South Unit Manager was notified and confirmed the soiled gloves and hand hygiene should have been completed prior to assisting the resident after the catheter care was completed. On 04/07/26 at 11:05 AM, the Administrator and the Director of Nursing (DON) were notified and confirmed the soiled gloves and hand hygiene should have been completed after the catheter care was performed. The Administrator stated, we will get her in here and provide education immediately. On 04/07/26 at 11:25 AM, the facility procedure entitled, Catheter: Indwelling urinary-Care of was reviewed. Number 18 and 19 of the procedure states, Remove gloves and any other PPE (personal protective equipment) worn .perform hand hygiene. On 03/31/26 at approximately 10:06 AM, an observation of the North shower room was made. The observation found an open conditioner and body wash bottle lying on the shower room floor open with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the contents spilling out on a wet, unclean floor as well as multiple personal items and a soiled washcloth laying on a shower bed. On 03/31/26 at approximately 10:18 PM, the Administrator and Director of Nursing (DON) were invited into the North shower room. Both the Administrator and the DON confirmed the shower room and the shower bed were unclean. The Administrator stated, We will get it cleaned up. On 03/31/26 10:21 PM, an observation of the South shower room was made. The observation found multiple areas of a dried brown substance, two (2) band aids and one (1) bloody bandage as well as a broken top of a shampoo bottle in the floor of the shower. Three (3) soiled wash- cloths were observed on a shelf located in the shower area. On 03/31/26 at 10:25 PM, the DON was invited into the south shower room. The DON stated, let me get this cleaned up. On 03/31/26 at 10:30 PM, an observation revealed a soiled gown on a wheelchair and a soiled blue lift pad on a Geri chair located outside the South unit shower room. On 10/31/26 at 10:32 PM, the DON was notified and removed the soiled items from the wheelchair and the Geri chair. The DON stated, I'll take them to the soiled utility room.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record view and staff interview, the facility failed to ensure informed consent was obtained for psychotropic medications. This was found true for two (2) of five (5) residents reviewed. Resident #12 and Resident #46. Facility census: 122. a) Resident #12 A record review for Resident #12 revealed a physician order for Buspirone HCl 5 mg (milligram), to be administered as one (1) tablet by mouth. Further review of the clinical record revealed no documented evidence of informed consent for the use of Buspirone. Documentation indicated the medication was initiated on 03/01/26; however, there was no evidence that informed consent had been obtained prior to initiation of the medication. This finding was confirmed with the Director of Nursing (DON) on 04/01/26 at approximately 3:45 PM. Findings included: b) Resident #46 A record review for Resident #46 on 04/06/26 found the following physician order: Olanzapine oral tablet disintegrating 5 MG (Olanzapine) Give one (1) tablet by mouth at bedtime for antipsychotic. On 04/06/26 at 11:11 AM the surveyor asked the Director of Nursing (DON) for consent form. The one that was provided was dated 09/18/2025, for the anti-depressant drug named Lexapro. The DON stated this is the only one we have for her.

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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 record review, staff interview and observation, the facility failed to ensure call lights were within reach for dependent residents. This failed practice had the potential to affect a limited number of residents. Resident Identifiers: #19 and #47. Facility Census: 125.Findings included: a) Resident #19 On 06/03/26 at 12:25 PM, Resident #19's call light was not in reach. The call light was on the opposite side of the bed across from the resident who was sitting in her wheelchair. The Administrator confirmed the call light was not in reach and moved it within the resident's reach. The call light had been placed out of reach across the bed on the resident's paralyzed side. b) Resident #47 On 06/03/26 at 6:30 PM, Resident #47's call light was observed on the floor. At 6:35 PM, Activities Director #166 confirmed the call light was on the floor and picked it up, placing it within reach of the resident. The facility's policy and procedure for Call Lights stated, 4. Staff will ensure the call light is within reach of the patient and secured as needed.

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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 record review and interview, the facility failed to honor Resident #49's bathing choices from 03/23/26 to 03/31/26. This was true of one (1) of five (5) residents sampled for choices during the Long-Term Care Survey Process. Census: 122 Resident identifier: #49Findings include: a) Resident #49 Resident #49's care plan from 02/03/26 stated the resident prefered to take a shower.The bathing task for the month of March shows Resident #49 had a shower twice per week by Nurse Aide (CNA) #15 from 03/01/26 through 03/22/26. After that date, Resident #49 only had bed baths. Further, the bathing tasks showed there were no refusals of showers during that time frame. In an interview with Resident #49 and her son on 03/31/26 at 10:02 AM, she stated she only gets showers when NA #15 is working. She further stated she had not been asked if she wanted a shower since 03/22/26. An interview with Director of Nursing (DON) confirmed that according to documentation, Resident #49 has not been offered a shower since 03/22/26.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs. This was true for one (1) of five (5) residents reviewed under the Unnecessary Medications Pathway throughout the Long-Term Care Survey Process. Resident identifier: #46. Facility Census: 122 Findings included: a) Resident #46 A record review, completed on 04/06/2026 at 10:00 AM, revealed:-The following physician order, dated 03/19/2026: Olanzapine Oral Tablet Disintegrating 5 MG Give 1 tablet by mouth at bedtime for antipsychotic.-On 03/20/2026 at 2:32 PM, the consulting pharmacist recommended a Gradual Dose Reduction of Resident #46 (Olanzapine). A Gradual Dose Reduction (GDR) refers to the stepwise tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.-On 03/20/2026, the attending physician agreed to and signed off on the GDR. The new order should have read, Olanzapine 2.5 MG Give 1 tablet by mouth at bedtime.-Review of the March 2026 Medication Administration Record (MAR) revealed the physician order had never been updated.-Resident #46 continued to receive the (Olanzapine) at the original dose of 5 MG (once per day) on the following dates and times: 03/20/2026 at 7:51 PM. 03/21/2026 at 10:41 PM. 03/22/2026 at 9:37 PM. 03/23/2026 at 10:17 PM. 03/24/2026 at 10:03 PM. 03/25/2026 at 10:37 PM. 03/26/2026 at 8:55 PM. 03/27/2026 at 10:08 PM. 03/28/2026 at 10:11 PM. 03/29/2026 at 9:12 PM. 03/30/2026 at 9:01 PM. 03/31/2026 at 8:58 PM. 04/01/2026 at 9:13 PM. 04/02/2026 at 11:22 PM. During an interview on 04/06/2026 at 12:16 PM, I asked the Director of Nursing (DON) why this dose reduction was not completed? He stated I think it got overlooked, that's all I got for you. The Administrator was interviewed on 04/06/2026 at 3:37 PM. The Administrator acknowledged the attending physician for Resident #46 had signed off on a GDR and the resident had received an excessive dose of his/her antipsychotic medication for fourteen days. 04/06/2026 12:16 PM Resident #46 was re-admitted to the facility on [DATE]. The Registered Pharmacist completed a medication regimen review on 03/20/2026. The pharmacist recommendation stated: Routine Antipsychotic use must be evaluated by Doctor of Medicine (MD) on admission for potential Gradual Dose Reduction (GDR) or Discontinue (DC). Please consider reduction if appropriate. The facility's Physician agreed to this pharmacy recommendation and signed off on it on 03/20/2026. Per the pharmacy recommendation, and with the facility physician agreeing to it, the dose reduction for the antipsychotic Olanzapine should have changed the order from Olanzapine 5 MG, give one (1) tablet by mouth (PO) at bedtime to Olanzapine 2.5 MG, give one (1) tablet by mouth (PO) at bedtime. This never occurred, and Resident #46 continued on the original order for Olanzapine 5 MG. This surveyor asked the Director of Nursing (DON) why this reduction was not made? He stated I think it got overlooked, that's all I got for you. 04/06/2026 3:37 PM This surveyor asked Administrator #148 why this reduction was not made? She stated I don't know, I feel it just wasn't done. 04/06/2026 4:15 PM Administrator #148 gave me a copy of Resident #46 Medication Administration Record (MAR) for the Months of March 2026 and April 2026. Resident #46 continued to receive the higher dose of Olanzapine for fourteen days, March 20 - April 02 2026. Resident #46 was sent to the emergency room (ER) on 04/03/2026. She is still out of the facility (OOF) at this time. [NAME], [NAME] (46) [NAME], [NAME] - RESIDENT NOTE 04/02/2026 11:26 AM

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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 and staff interviews, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' current condition. This was true for two (2) of 39 residents sampled for accuracy of assessments during the Long-Term Care Survey Process. Census: 122 Resident identifier: #31, #57Findings included: A) Resident #31 A1) Section GGThe significant change Minimum Data Ser (MDS) dated [DATE] section GG, shows resident is ambulating 10 feet with supervision. A physical therapy Discharge summary dated [DATE] reveals Resident #31 was able to stand without moving in the parallel bars, but unable to take steps at that time.In an interview with Physical Therapist Assistant (PTA) #122 on 04/06/26 at 3:04PM, he stated Resident #31 has not been able to walk since the fractures occurred. A2) Section IThe same MDS, section I, does not have other fractures box checked indicating that Resident #31 does not have any fractures at the time of the MDS.Resident #31's diagnosis list includes fourth (4th) and fifth (5th) metatarsal fractures. An interview with Director of Nursing at approximately 4:00PM on 04/06/26 confirmed the MDS was inaccurate and did not include fractures in her diagnoses. B) Resident #57The Minimum Data Set (MDS) dated [DATE] has Resident #57 listed as being able to walk ten feet with supervision.The last physical therapy discharge date d 01/05/26 lists Resident #57 as not applicable in the walk ten feet section. In an interview with Physical Therapist Assistant (PTA) #122 at 2:44PM on 04/07/26, PTA #122 stated Resident #57 has not walked in the three (3) years he has worked in this facility. An interview with Administrator #148 at 2:50PM confirmed resident's MDS is inaccurate.

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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 coordinate with the appropriate State-designated authority, to ensure that individuals with a mental disorder, intellectual disability or a related condition received care and services in the most integrated setting appropriate to their needs when completing/revising a Pre-admission Screening and Resident Review (PASARR). This was true for 1 of 30 residents sampled. Resident Identifier: #66. Facility census: 122. Findings Included:a) Resident #66On 04/01/26 at 11:00 AM record review found Resident #66 had the following medical diagnosis:Psychoactive Substance AbuseReview of the PASARR dated 04/01/26 found that this diagnosis was not identified on the PASARR.The above information was confirmed with The Social Worker on 04/02/26 at 10:00AM, who agreed that the additional medical diagnosis should have been on the PASARR.

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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, staff interview and resident interview, the facility failed to develop a baseline care plan for a resident ordered oxygen therapy by the physician. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #29. Facility Census: 125.Findings included: a) Resident #29 On 06/03/26, Resident #29's medical record was reviewed for oxygen therapy. Oxygen therapy orders were reviewed by the state surveyor. The resident's orders stated, Incentive Spirometer - encourage patient to use as often as tolerate, every day shift Pre tx: Evaluate heart rate, respiratory rate, Pulse Oximetry and Lung sounds in supplementary documentation. and Oxygen at 2 L/min Nasal Cannula, every shift for Shortness of Breath. The resident's baseline care plan was reviewed for oxygen therapy. No focus, goals or interventions were listed on the baseline care plan for oxygen therapy. The care plan was reviewed and confirmed with Corporate Registered Nurse #19 and the Director of nursing (DON). The federal regulatory guidelines for a baseline care plan were reviewed with Corporate Registered Nurse #19 and the DON.

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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 resident interview, staff intervew and record review, the facility failed to revise a care plan to indicate Resident #24's preference for night time care. This was true for one (1) of 39 residents reviewed during the survey process. Resident Identifier: #24. Facility Census: 122. Findings Include: a) Resident #24 On 04/06/2026 at 2:00 PM, a record review was completed for Resident #24. Also, a review of a facility-reported incident (FRI) dated 12/08/25 was reviewed. The allegation of neglect was noted in the FRI for Resident #24 regarding incontinence care at night time. The resident was interviewed on 04/06/26 at approximately 3:00 PM regarding the allegation of neglect. The resident stated, you know how it is .I don't remember that but I'm sure if I said it .it must have happened. An interview was held with the Social Services Director (SSD) on 04/06/26 at 3:00 PM. The SSD was asked, did you find any evidence the allegation of neglect was verified? The SSD stated, let me look over it. On 04/06/26 at 3:30 PM, an interview was held with the Administrator. The Administrator stated, the resident does want to woken up between the hours of 10PM-6AM .Resident will use call light to ask for care. At this time, a revision of the care plan was provided indicating the resident did not want to be awakened between the hours of 10:00 PM through 6:00 AM. An additional interview was held with Resident #24 on 04/06/26 at 3:50 PM. Resident #24 stated, if I need help I let them know .I usually sleep through the night .I wear my CPAP (continuous positive airway pressure) and I usually sleep well. The resident was unable to clarify if this intervention added to the care plan was indeed his preference.

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	515169	A. Building B. Wing	04/08/2026

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

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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 observation, staff interview, and family interview, the facility failed to ensure necessary activities of daily living (ADL) care, including personal hygiene and grooming, for two (2) of eight (8) of sampled residents. This was found true for Resident #87 and Resident #96. Facility census 122.a) Resident #87 On 03/31/2026 at approximately 2:24 PM, an interview was conducted with the resident's wife, who reported observing the resident with a dirty face, neck, and hands, as well as soiled bedding. She further stated that the resident's fingernails were long and untrimmed and reported observing scratches behind the resident's right ear, which she attributed to the resident scratching. The resident's wife indicated she personally trimmed the resident's fingernails, cleaned his face and neck, and requested staff assistance to change the resident's shirt and bedding. The reported observations indicate the resident was not maintained in a clean and well-groomed condition, and grooming needs, including nail care, were not adequately addressed by facility staff. The presence of long fingernails and resulting scratches raised concerns regarding the facility's provision of routine hygiene and prevention of avoidable injury. On 04/02/2026 at approximately 9:05 AM, observation of the resident was conducted with the Director of Nursing (DON), which confirmed the presence of scratches behind the resident's right ear. During interview, the DON acknowledged the findings and indicated that the Nurse Practitioner (NP) would be notified, a wound assessment would be completed, and staff interviews would be conducted to further investigate the concern. The DON further stated that the incident would be reported as neglect. Failure to ensure the resident was maintained in a clean, well-groomed condition and to prevent avoidable injury has the potential to negatively impact the resident's health, dignity, and overall well-being. b) Resident #96 In an interview with Resident # 96 on 03/31/26 at 11:33AM, he stated he had not had a shower in five (5) or six (6) days. Resident #96 had a care plan that reads, Provide resident/patient with extensive assist x 1 for bathing. According to bathing task documentation, Resident #96 had one (1) bed bath between 03/25/26 and 03/31/26 with no refusals documented during that time frame. Resident #96 was on the shower schedule for every Tuesday and Friday. An interview with Administrator at 9:48 AM on 04/02/26 confirmed Resident #96 did not receive a shower from 03/24/26 to 03/31/26 with no refusals and that his care plan states he preferred showers.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation and staff interview, the facility failed to ensure access to fluids at bedside for one (1) resident, placing the resident at risk for inadequate hydration. This was found at a random opportunity for discovery. This was found true for one (1) resident. Resident identifier: #77. Facility census: 122. a) Resident #77On 03/31/2026 at 3:07 PM, observation of the resident's room revealed no water present at the bedside. At approximately 3:15 PM, the observation was reviewed with LPN #16, who confirmed that no water was present at the bedside at the time of observation. There was no evidence to indicate that fluids had been recently offered or were readily accessible to the resident.Water was subsequently provided to the resident following surveyor intervention.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and staff interview, the facility failed to ensure an ongoing assessment of Resident #17's condition before, during and after dialysis treatment. This was true for one (1) of one (1) residents sampled for dialysis. Census: 122 Resident Identifier: #17Findings include: a) Resident #17 A policy titled Dialysis: Hemodialysis (HD)-Communication and Documentation, states following completion of the HD, the dialysis facility should complete and return the form and/or other communication to the Center with the patient. Upon return of the patient to the Center, a licensed nurse will:-Review the certified dialysis facility communication;-Evaluate/observe the patient; and -Complete the post-hemodialysis treatment evaluation using the Hemodialysis Communication Record.-Notify the certified dialysis facility if information about the patient is not returned with the patient and ask that it be faxed to the Center.-Document notification of certified dialysis facility regarding return of the form or other communication. Upon reviewing the Hemodialysis Communication Records for the past three (3) months, the following records were not completed by the dialysis center:01/03/2602/04/2602/23/2603/27/26 An interview with Director of Nursing (DON) and Administrator at 1:51PM on 04/06/26 confirmed dialysis records were not completed on the above dates and should have been reviewed upon resident's return and completed by nurse at that time.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation and staff interview, the facility failed to ensure that the resident was served foods consistent with the prescribed diet order, placing the resident at risk for choking and aspiration. This was found true of two (2) of two (2) residents reviewed. Resident #110 and Resident #114. a) Resident #114During dining observation, on 3/31/26 at approximately 12:30 PM it was noted that Resident #114, who was ordered a Dysphagia Advanced (Dys Adv) diet, was served whole grapes. The facility's diet guidelines indicate that foods should be provided in an appropriate consistency for a Dysphagia Advanced diet, such as applesauce or other modified textures, to reduce the risk of choking.Through surveyor intervention, whole grapes were removed from resident access and applesauce was substituted. This observation was confirmed with, Dietary Manager (DM), at 12:43 PM on 03/31/2026.b) Resident #110On 04/02/2026 at 12:25 PM, the surveyor observed that Resident #110, who was prescribed a Dysphagia Advanced (Dys Adv) diet, was served whole orange slices. Review of the dietary guidelines for a Dysphagia Advanced diet indicates that foods should be provided in a modified consistency, including chopped or appropriately prepared fruits to reduce the risk of choking. Through surveyor intervention, whole orange slices were removed from the resident's access. The observation was confirmed at the time with Dietary Manager at 12:25 PM.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on policy, observation, and resident and staff interviews, the facility failed to provide services to ensure Resident #49's physical needs were met by failing to provide lunch to Resident #49. This was true for one (1) of 13 residents sampled for abuse during the Long-Term Care Survey Process. Census: 122 Resident Identifier: #49Findings include: A policy titled Resident Rights Under Federal Law, states Patients/Residents (hereinafter resident) have the fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social, and spiritual values. At 12:43PM on 04/07/26, State Surveyor went in to Resident #49's room to observe lunch. Resident #49's son was present and stated that no one had been in the room yet to offer lunch to Resident #49. Interview with Certified Nurse Aide (CNA) #86 at 12:45PM, confirmed the aides were done passing trays on that particular hall. State Surveyor went to the lunch cart and found resident's tray on the cart with the ticket torn. A torn ticket indicates a refusal of a tray. In interviews with CNA #86, Activities Assistant #153, and Activities Assistant #154, all stated they did not offer the resident her tray and did not tear up her ticket. Director of Nursing (DON) #155 confirmed at 1:02PM that Resident #49 was not offered and did not receive her lunch tray. In an interview with Administrator at 1:08PM, Administrator confirmed this is considered neglect.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation and interview, the facility failed to ensure accurate pain assessment, timely reassessment, administration of medications in accordance with physician orders, and maintenance of an accurate medical record for one (1) of four (4) resident reviewed (Resident #48). Facility census: 122. a) Resident #48On 03/31/26 at approximately 10:30 PM, surveyors observed Resident #48 in his room. During this observation, the resident verbalized, I am in pain and My legs are hurting, A review of the clinical record revealed that Nurse #13 administered Tylenol 325 mg orally at 10:24 PM. Documentation further indicated that Nurse #13 completed a pain assessment at 10:24 PM, with the resident's pain level recorded as zero (0) at that time. This documented pain level is not consistent with the resident's subsequent verbal reports of pain observed at 10:30 PM. There is no documented evidence that a follow-up pain assessment or reassessment was completed after the resident voiced complaints of pain.Additionally, review of physician orders indicated Ativan 1 mg was prescribed for sublingual administration. Medication administration records reflect that the medication was administered orally rather than sublingually. This discrepancy was reviewed with the Nurse Practitioner, who clarified that the intended route of administration should be Ativan 1 mg by mouth. This clarification was confirmed with the Director of Nursing (DON) on 04/08/26 at 9:45 AM.