STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515176	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampshire Center	260 Sunrise Boulevard Romney, WV 26757

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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 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, resident interview, and staff interview, this facility failed to ensure a safe, comfortable homelike environment. This failed process was a random opportunity of discovery during Long Term Care Survey Process. Facility census: 61. Findings include a) Resident #43 12/08/25 at 8:45AM observation of Resident #43 sitting in her wheelchair with a blanket wrapped around her, visibly shaking. Throughout interview with Resident #43, she informed this surveyor, I am so cold they just gave me a shower and it was so cold, I like to go early so its warm. 12/08/25 at 8:50A M interview with maintenance director and observing shower room temperature through maintenance director checking shower water temperature which read 94 degrees and room temperature reading 69.8 degrees. Maintenance director informed this surveyor, recovery for the water is usually 20 to 30 minutes, they need to wait in between showers. Maintenance director informed this surveyor, I have the parts ordered just waiting, I do have the tanks separated to try and keep the water warmer to the shower room. The maintenance director turned the heat up in the shower room to aide with warming the entire room. 12/08/25 at 8:55AM during an interview with Nurse Aide (NA) #44 was waiting to give a resident a shower. She informed the surveyor One resident said it was really cold this morning, sometimes I let them know what the temperature is, if they want me to continue with the shower, if not, we do bed bath. 12/08/25 at 8:55AM observation while in shower room, Nurse Aide (NA) #28 was in a stall with a resident when she turned the water on and began shower the resident informed her, Oh that's cold, NA #28 asked this resident if she wanted to stop, however the resident informed the nursing assistant no let's get it over with. 12/08/25 at 9:05AM interview with director of nursing, she informed this surveyor We offer alert residents to check the temperature of the showers before giving. We space the showers out to ensure recovery time. We also have two spa aides that work 6 AM to 2 PM, we will start offering later in the day as well until the parts come in to be corrected. b) Resident #32, Resident #29 During interviews on 12/07/25 at approximatley 12:25 PM with Resident #32 and at approximatley 1:15 PM with Resident #29, both had stated they have received multiple cold showers and or bed (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	baths over the last week or two. Resident #32 stated I have had to take two showers now in cold water. The water heater has been broken for weeks I think and the water is cold even after waiting a long time. While Resident #29 stated Water has been cold and since I get bed baths (residents choice) it makes it hard on me. On 12/08/25 at approximately 9:57 AM Maintenance Director temped the two rooms water, with hot side fully open and the highest recorded temp was 98 degrees Fahrenheit. During an interview with Maintenance Director on 12/08/25 at approximately 10:10 AM they stated Water heater has parts on order and the facility will cycle through showers to ensure water temp stays hot enough for the comfort of residents. Parts are on back order and delayed so we will make some adjustments to let the water tank recover better. c) Dirty Floor and Trash bags in activity area During entrance to the facility on [DATE] at approximately 11:40 AM it was observed that the Activities area at the end of the 400 hallway floor was visibly dirty with old food items and paper garbage. There were also around twenty-two (22) white garbage bags stacked in the right hand corner of the room from the floor all the way onto the table near the wall. While interviewing the Senior Administrator on 12/08/25 at approximately 11:11 AM the Senior Administrator stated they were aware of the white trash bags in the activity room. Senior Administrator said, They are Christmas donations that are on floor and back desk areas. The Senior Administrator also stated that the Health services group cleans all non resident common areas and office space. They usually follow a specific schedule and check twice a day on those areas, at least. Review of facility policies on 12/09/25 titled ENV205 cleaning of offices and non resident/common areas, showed cleaning should have been done prior to being observed upon entry to facility on that day. It is cleaned twice a day and as needed when visibly soiled. Review of a document titled OPS200 safe and homelike environment stated the environment refered to any area of the center frequented by patients but not limited to. OPS200 said the area shall remain clean and free of clutter at all time. It also stated Orderly an uncluttered physical environment shall be kept at all times.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff record review, staff interview, the facility failed to ensure all kitchen staff were up to date with their food handler cards. Two (2) of Eight (8) employees did not have food handler's cards. Interview with Dietary Manager, he confirmed these food handler cards were not obtained by expiration dates. This failed practice was a random opportunity for discovery during the Long Term Care Survey Process. Employee identifiers: #20 and #7. Facility census: 61.Findings include a) food handler cards ,record review for all staff in dietary department b) [NAME] #20 date of hire-05/03/2025, did not obtain Food Handler Card until 12/01/2025 c) [NAME] #71 date of hire 08/09/2025, did not obtain Food Handler Card until 12/01/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, resident interview, and staff interview, this facility failed to ensure menus were properly displayed with correct meal and that residents receiving meals were given the correct diet type. This failed practice had the potential to affect more than an isolated number of residents. Resident identifier: #49. Facility census: 67. Findings include: a) 12/07/25 at 11:40AM an observation of a menu board revealed an incorrect menu. Lunch on the board was listed as: Cheeseburger, cucumber salad, French fries, and peaches. Lunch served was maple sage turkey, stuffing, peas, dinner roll and pumpkin pie. During an interview [NAME] #17 confirmed meal was to be maple sage turkey, stuffing, peas, dinner roll, and pumpkin pie. 12/07/25 12:30PM Resident #49 received a menu for regular diet and needed one for consistent carbohydrate 12/07/25 2:30 PM during an interview with the Dietary Account Manager regarding the display menu next to the dining room entrance the Dietary Account Manager confirmed the correct menu was not on display. The Dietary Account Manager confirmed evening shift before they leave are to ensure menus are hung. Also reviewed with Dietary Account Manager that Resident #49 menu for the three week cycle was not correct diet, he reviewed and confirmed she needed one for Consistent Carbohydrate diet. F-803 Based on observation and interview with staff, and residents(Resident #49) This facility failed to ensure menus were followed and ensure residents needs. 12/07/25 1:00PM Met with resident #49, during interview, resident complained of meals usually not warm, cold at times, meals are not consistent, They do a lot of substitutions Resident #49 informed this surveyor, I received a three week menu but not for my diet, they gave me one for regular diet and I need a consistent carbohydrate Observed the three week menu was for a regular diet with Resident #49 name. Observed lunch meal ticket for Resident #49 was for consistent carbohydrate diet, noting certain items: 1/3 cup cornbread dressing and 1/2 cup broccoli florets marked out with cauliflower written, also no stuffing and mashed written. Resident #49 reported the vegetables are always mushy, potatoes too hard, not cooked enough. Sometimes the meat is tough 12/07/2025 2:00 PM Reviewed with Dietary Account Manager that Resident #49 complained her menu for the three week cycle is not correct diet, he reviewed and confirmed she needed one for Consistent Carbohydrate diet. 12/08/25 3:30PM Interview with Dining Account Manager regarding correct 3 week menu cycle for Resident #49 was given. F804 Following observation, resident interview and staff interview this facility failed to ensure meals were prepared to ensure nutritional value, palatability and preferred temperature. 12/08/25 11:45AM Review of tray line set up/ temperatures: [NAME] #71 confirmed temperatures as follows: Ground meat- 172.5, California Blend vegetable 198, Peas 192.2, Scallop potato- 168.8, Mashed potato- 169, Regular Salisbury steak-176.6 and Puree Salisbury Steak- 161.2. District Manager also on line and confirmed temperatures. 11:50AM Tray line begun12:00 PM First Cart to Unit12:03 PM Cart arrived to Unit , staff immediately begun tray deliveries 12:15PM Test Tray obtained: District Manager verified temps for test tray via taking the temperatures:Test tray temps: Salisbury steak- 103.6 Scallop Potato- 101.4 California Blend Vegetable- 97.7District Manager verified the plate was cool to touch. 12:40PM Resident #49 called this surveyor to room, upon entering she informed this surveyor the food is a little warmer today, however the potatoes are hard and the vegetable is mush.: Resident #49 handed this surveyor a potato- was firm to touch. 12:50PM Taste tray :Salisbury steak- bland, seasoningScallop potato- bland seasoning, potatoes were firm to touch, with bite.Vegetable- California blend mushy- overcooked in appearance

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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 observation, resident interviews, and staff interview, the facility failed to ensure food was prepared and served in a palatable, and attractive appearance for the residents that received their nutrition from the kitchen. This failed practice had the potential to affect more than an isolated number of residents. Facility census: 61. Findings include a) Resident #49 12/08/25 12:40 PM Resident #49 called this surveyor to room, upon entering she informed this surveyor the food is a little warmer today, however the potatoes are hard, and the vegetables are mush. Resident #49 handed this surveyor a potato. This potato was observed to be firm to touch. 12/08/25 12:50 PM a test tray was obtained from the kitchen The following was observed from tasting the items on the test tray:Salisbury steak- bland, seasoningScallop potato- bland seasoning, potatoes were firm to touch, with bite.Vegetable- California blend mushy- overcooked in appearance A review of the policy on 12/08/25 at 1:00PM, Titled [Food Temperatures], under purpose in part reads as follows :To serve food and drink that is palatable, attractive, and at a safe and appetizing temperature.

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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 observation and staff interview, this facility failed to ensure food was procured, stored, served in a sanitary way, this failed practice was a random opportunity for discovery during the Long Term Care survey process. Facility census: 61. Findings include: a) 2/07/2025 11:45AM observation upon entering the kitchen revealed a mop bucket, chemicals on floor next to bread rack, mops and brooms out leaning near the wall next to manager office- [NAME] #71,confirmed these items are out and need to be behind the janitor closet. Wet nesting to pans on shelf and x2 pans not inverted. [NAME] #71, confirmed the wet nesting and pans needed to be inverted. Spices were spilled on a shelf. [NAME] #71, confirmed. Hand sink trash can with brown liquid spilled on top of a lid. [NAME] #71 confirmed this needed cleaned. Food debris noted on bottom shelves of 2 of 3 tables. A sticky substance was also observed. [NAME] #71 confirmed this needed corrected. 12/07/2025 12:30 PM during dining room observation the following was observed:Cook # 71 was handling items with gloves during tray line then picked up dinner roll with gloved hand not utensil. [NAME] #71 did not wash her hand or utilize a utensil. When questioned [NAME] #71 confirmed she did not change gloves or use utensils to obtain the dinner roll. 12/07/25 12:15 PM an observation in the nourishment room revealed no temperature logs noted in the room, peanut butter container outdated as of 12/06/25. [NAME] #71 confirmed and removed, Floor, sink area with food debris noted, some paper cups- butter cups, jelly cups on floor near trash can and refrigerator. [NAME] #71 confirmed these findings. [NAME] #71 informed this surveyor I think housekeeping cleans here daily On 12/07/25 at 1:30 PM observation revealed a refrigerator that had a container of boiled eggs with open date of 12/02/25 with no use by date. [NAME] #17 confirmed and removed the item. Observation also revealed food debris on the wall behind the trash can and food debris on the trash can lid. Cook#17 confirmed and said, This should have been done yesterday. [NAME] #17 said, I guess something came up and they didn't get to it

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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 observations and interviews, the facility failed to maintain and provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections. Areas of concern were the dirty laundry room, Hallway 100, Hallway 300/400, and the Shared bathroom for room [ROOM NUMBER]/109. Facility Census: 61. b) 300 and 400 hall soiled lift slings On 12/07/25 at approximately 11:40 AM upon entrance to the facility, it was observed that four slings were left draped over lifts and chairs in both the 300 and 400 hallways. The 300-hall had one (1) sling that was visibly dirty left hooked to the lift and thrown over the main lifting arm left in hall. The 400-hall had one (1) sling left out draped over the lift after being used, as well as lift slings that were dirty left in chairs down at the end of the 400 hallways. Slings once used are not to be left out in the hallway as this can increase risk of spreading contaminates around the facility. Clean slings are to be stored under a covered area if left in hallways or in clean storage rooms, so they stay as sanitary as possible in between uses. During an interview with the Senior Administrator (SA) at approximately 11:00 AM on 12/08/25 the SA stated, Those slings do not belong on the lifts, they have a proper area to be stored and should not be left out dirty ever. Review of a policy on 12/09/25 titled OPS200 safe and homelike environment it was noted under the sanitary requirement definition that Preventing the spread of disease-causing organisms by keeping patient care equipment clean and properly stored. was not followed. c) 100 hall Open Brief On 12/07/25 at approximately 11:40 AM upon entrance to the facility, it was observed that one (1) package of resident briefs were opened and left on a chair out in the main hallway of the 100 section. Review of a policy on 12/9/25 titled OPS200 safe and homelike environment revealed:Orderly uncluttered physical environment shall be kept; this was not followed and Items for resident are not to be stored out in hallways.Sanitary Preventing the spread of disease-causing organisms by keeping patient care equipment clean and properly stored. The facility did not follow their policy on keeping resident use items clean and sanitary. Exposing them to anything out in the hallways once the packs were open. d) cleaning wipes in bathroom On 12/07/25 at approximately 11:40 AM upon entrance to the facility, it was observed that one (1) container of cleaning wipes (Cauiwipes, pink top wipes) were on the floor of the bathroom that was shared with room [ROOM NUMBER] and #109. During an interview with the Senior Administrator (SA) the SA stated that those Cleaning supplies are not supposed to be left in any areas where residents and families can get into them. Findings Include the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Dirty Laundry Room During an inspection of the Dirty Laundry Room on 12/09/25 at approximately 9:35 AM, accompanied by the Laundry Manager (LM), the room was found to be very warm and humid. Further inspection revealed that the venting system was not operational. The venting system maintains negative pressure in the dirty laundry room and prevents the movement of pathogens into the corridors and the Clean Laundry Room. The Maintenance Director (MD) was notified of the issue by the LM and was unable to restart the venting system. The MD stated that he would inspect the system and report back. At approximately 11:40 AM on 11/09/25, the MD confirmed the vent motor was not working. He stated he was in the process of replacing it. The MD said he was unaware of how long the system had been not operational.

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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 medical record review and staff interview, this facility failed to ensure care plans were updated to reflect current resident needs. This practice affected (1) of 20 care plans reviewed during Long Term Care Survey. Resident identifier #10. Census 61.Findings include a) Resident #10 A medical review for Resident #10 found a care plan and minimum data set (MDS) for bowel and bladder continence, reviewed and last updated on 06/06/20. The care plan was documented, Usually continent of bladder and bowel uses toilet. Recent MDS annual dated 06/24/24 revealed the resident was frequently incontinent of bladder and always incontinent of bowel. During an interview with the MDS coordinator, she verified this should be updated to reflect the change with bladder continence.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow a physician's order for the administration of insulin. This was a random opportunity for discovery. Resident identifier: #3. Facility Census: 61.Findings Includea) Resident #3During record review on 12/10/25 it was noted that Resident #3 had been administered fifty-four (54) units of short-acting insulin, instead of the prescribed fifty-four (54) units of long-acting insulin on 01/20/25 at approximately 8:00 pm. The Change-in-Condition documentation noted that the Clinician was notified at 8:40 PM.The record review also revealed that the resident had been prescribed the following medications:A short-acting insulin -NovoLog Flex Pen Subcutaneous Solution Pen-Injector 100/Unit/ML. (Insulin Aspart). Inject subcutaneusly before meals for DM (diabetes mellitus).A long action insulin - Basaaglar Kwik Pen-Subcutaneous Solution Pen Injector 100 Unit/ML (Insulin Glanrgine). Inject 54 units subcutaneously two times a day for DM II.Further record review revealed a physician's note dated 01/20/5 which stated: [Resident] is a [AGE] year-old female who I am acutely evaluating as accidental administration of short-acting insulin and instead of long-acting insulin at 54 units occurred this evening. I have ordered dextrose-containing fluids, high-glucose-content oral supplements, vigilantly monitoring blood glucose levels. The resident has been notified to let staff know if she feels weird in any way. Nursing has been instructed to hold all diabetic medications. If failure of IV occurs, she drops below 130 at any point, or becomes symptomatic, she will require urgent presentation to the ED. While interviewing Resident #3, on 12/10/25 at 8:32 AM, the resident stated that she had been made aware of the medication error after the facility began implementing interventions on 01/20/25. The resident stated that she had been scared and complied with all the interventions prescribed by the physician. During an interview with the Director of Nursing (DON) at approximately 9:55 AM, on 12/10/25, the DON confirmed that the nurse had not administered the medication as prescribed by the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. This was a random opportunity for discovery of Resident #7's bed safety. Resident Identifier: #7. Facility census: 61. a) Resident #7 During an observation of Resident #7's bed, a 6-inch gap was found between footboard & mattress. Resident #7 was observed in bed with a blanket rolled up and put on one side of the footboard and a mattress gap for his feet to rest on. During an interview 12/09/25 at 1:35 PM the DON verified the footboard and mattress gap could cause entrapment. She stated that she would call the maintenance department to get it fixed immediately. No further information was provided prior to the end of the survey on 12/10/25 at 11:30 AM.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, resident interview, staff interview the facility failed to ensure diet needs were being provided correctly (1) one of (7) seven reviewed for diets and nutrition. Resident identifier: #49. Facility census: 61. Findings include a) Resident #49 12/07/25 12:30PM, met with Resident #49 during interview, the resident complained of meals not usually being warm, cold at times, and not consistent, Resident #49 said, They do a lot of substitutions Resident #49 informed this surveyor, I received a three week menu but not for my diet, they gave me one for regular diet and I need a consistent carbohydrate Observation of the three week menu revealed it was for a regular diet with Resident #49 name. Observation of the lunch meal ticket for Resident #49 revealed it was for consistent carbohydrate diet, noting certain items: 1/3 cup cornbread dressing and 1/2 cup broccoli florets marked out with cauliflower written, also no stuffing and mashed written. Resident #49 reported Vegetables are always mushy, potatoes too hard, not cooked enough. Sometimes the meat is tough. 12/07/25 2:30PM during an interview with Dietary Account Manager for Resident #49 the Dietary Account Manager confirmed her menu for the three (3) week cycle was not the correct diet. Dietary Account Manager reviewed and confirmed Resident #49 needed one for Consistent Carbohydrate diet.