STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515178	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Haven Center	2720 Charles Town Road Martinsburg, WV 25401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facility failed to develop and/or implement care plans related to Hospice services and meal intake percentages. This failed practice was found true for (3) three of 23 residents reviewed for care plan accuracy during the Long-Term Care Survey Process. Resident identifiers #65, #5, #12. Facility Census 65.Findings included: a) Resident #5 On 01/20/26 at 8:16 AM, a review of physician orders and Resident #5's care plan was completed as it related to nutrition. The care plan in part stated,monitor intake all meals. A review of meal percentage documentation (which outlines how much a resident consumed at each meal) revealed 15 out of 30 days reviewed where not all meals were entered: -12/20/25, only one (1) meal was recorded. -12/22/25, only two (2) meals were recorded. -12/23/25, only two (2) meals were recorded. -12/26/25, only one (1) meal was recorded. -12/28/25 only one (1) meal was recorded. -12/30/25, only two (2) meals were recorded. -12/31/25, only one (1) meal was recorded. -01/01/26, only two (2) meals were recorded. -01/03/26, only two (2) meals were recorded. -01/04/26, only one (1) meal was recorded. -01/08/26, only two (2) meals were recorded. -01/09/26, only one (1) meal was recorded. -01/12/26, only two (2) meals were recorded. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-01/14/26, only one (1) meal was recorded. -01/16/26, only two (2) meals were recorded. On 01/20/26 at approximately 1:00 PM, the DON confirmed that the facility had failed to document all three (3) meal percentages for Resident #5. b) Resident #12 Review of Resident #12's comprehensive care plan showed the following focus was initiated on 02/01/21 and most recently revised on 07/24/23: [Resident #12] is at nutritional risk r/t [related to] hx [history] of: Parkinson's, cellulitis, DM2 [diabetes type II], Diarrhea, vomiting, Hyperkalemia, CKD [chronic kidney disease] stage 4, Atherosclerotic heart disease, UTI [urinary tract infection], Anemia, Edema, TIA [transient ischemic attack], Obesity, Depression, PNA [pneumonia], Fluid overload, COPD [chronic obstructive pulmonary disease], GERD [gastroesophageal reflux disease], Constipation, HTN [hypertension], hx of insignificant expected weight loss (fluid overload: was given diuretic: resolved), repeated falls, significant weight loss (weight stabilized). An intervention initiated on 02/01/21 was to Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake. Resident #12's meal intake percentage documentation was reviewed for the previous 30 days. Meal intake percentages were not documented for all three (3) meals on the following dates: -On 12/22/25, only two (2) meals were documented. -On 12/23/25, only two (2) meals were documented. -On 12/24/25, no meals were documented. -On 12/25/25, no meals were documented. -On 12/26/25, only one (1) meal was documented. -On 12/27/25, no meals were documented. -On 12/29/25, no meals were documented. -On 12/30/25, no meals were documented. -On 12/31/25, only one (1) meal was documented. -On 01/01/26, only two (2) meals were documented. -On 01/03/26, only one (1) meal was documented. -On 01/04/26, no meals were documented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 01/05/26, only two (2) meals were documented. -On 01/06/26, only one (1) meals was documented. -On 01/07/26, only two (2) meals were documented. -On 01/08/26, only two (2) meals were documented. -On 01/09/26, only two (2) meals were documented. -On 01/10/26, only one (1) meal was documented. -On 01/11/26, only one (1) meal was documented. -On 01/12/26, no meals were documented. -On 01/13/26, only two (2) meals were documented. -On 01/14/26, no meals were documented. -On 01/15/26, only two (2) meals were documented. -On 01/17/26, no meals were documented. -On 01/18/26, no meals were documented. On 01/20/2026 at 9:52 AM, the Director of Nursing confirmed Resident #12's meal intake percentages were not recorded every meal as specified in her care plan. c) Resident #65 A record review on 01/20/26 at 12:09 PM, revealed an order for Resident #65 stating the resident admitted to Hospice Services on 12/17/25. Further record review of Resident #65's care plan, revealed that a Hospice care plan had not been put in place. During an interview on 01/20/26 at 1:30 PM, the Director of Nursing (DON) confirmed that the Hospice care plan was not in there and, further stated, We do not have it. I do not know why. We put everything else in. I guess we just missed it.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on resident interview, staff interview, and food tray temperatures, the facility failed to serve food that was palatable and at an appetizing temperature. The facility failed to ensure hot foods were served hot and cold foods were served cold. This practice was true for three (3) of the four (4) hallways tested for milk on the beverage carts and food tray temperatures for two (2) of two (2) meal trays tested throughout the survey process. Facility census 65 Findings included a) Policy Review Review of the facility's policy read in part, all foods will be held at appropriate temperatures, greater than 135 degrees (or as state regulation requires) for hot foods and less than 41 degrees for cold food b) Palatable and Food Temperatures Interviews with 18 of 23 sampled residents revealed consistent complaints of the meals not being palatable because hot foods were being served cold. A test tray, on 01/19/26 at 2:00 PM, was served to surveyors to test the palatability of the food. The meal palatability tray revealed the Salisbury steak tasted bland and the scallop potatoes had minimal flavor and were barely warm. Review of resident council minutes and food committee minutes revealed the following details:. -Resident Council requested the State Agency (SA) attend a food committee meeting on 01/20/26 at 2:15 PM. Resident Council members as a whole agreed that the food was cold. The Dietary Manager (DM) in attendance acknowledged that she had heard those complaints and was working on getting some plate warmers. Further in the meeting, the Resident Council as a whole asked if the food was homemade. The DM told them that some of it was and some of it wasn't. The SA asked the DM if the Salisbury steak served yesterday was homemade? The DM replied, No, it was a hamburger with brown gravy. An observation for meal service, on 01/19/26 at 12:36 PM, revealed [NAME] #82 placing approximately 12 plates on the counter then placing meal tickets (which include the resident name, dietary order, and room number) beside each plate. Then the cook began to add each individual meal item one-by-one to all 12 plates. It took up to 10 minutes to ensure all 12 plates were ready to be served. For residents eating in the dining room, the Certified Nursing Assistants (CNAs) would take each plate to the dining room. For residents in their rooms, the tray aide would place each plate on a tray then add the tray to the meal delivery cart. Once the meal delivery cart was full, the tray aide would transport it to the assigned hallway. On 01/20/26 at 1:54 PM, food temperatures were taken from a test tray for each meal item being served. The Dining Manager was responsible for taking the temperatures of each item and verified the following cold foods as being too hot.Peaches - 52.2 degrees Fahrenheit (F)Milk - 48.0 degrees F The noon meal pass was observed on 01/21/26 at 1:27 PM. The meal being served included:-Hotdog with relish and mustard-Baked beans-Chicken noodle soup-Ice cream. Resident #66 reported the hotdog and soup are very cold. The resident also noted the ice cream very soft. Resident #9 reported the hotdog could be warmer but it would do. Resident #38 reported the hotdog was cold, the plate is cold, the soup is semi warm. The SA requested a test tray and the Dining Manager was responsible for taking the food temperatures. The Dining Manager also verified the hotdog and chicken noodle soup were too cold. She also confirmed the ice cream and the milk were too warm. -Hotdog - 105.6 degrees Fahrenheit (F)-Chicken noodle soup - 147.7 degrees F-Ice cream very soft -Carton of milk - 51.1 degrees F

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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, record review and staff interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety. This practice had the potential to affect more than a limited number of residents receiving nourishment from the kitchen. Facility census: 65.Findings include: a) Policy Review of the facility's policy for food storage reads in part, Food is to be stored, prepared, distributed and served in accordance with professional standards. Ensuring food service safety, sanitary condition and the prevention of foodborne illnesses. b) Kitchen Tour On 01/19/2026 at 8:00 AM during an initial walk through, [NAME] #82 was observed without a hairnet and had a cap on with dread unrestrained.Additionally, the following items were verified by [NAME] #82:-There was a dried sticky substance on top of the ice maker.-Food debris was found in a container holding lids.-A dried, red sticky residue was in the two (2) bowl sink.-A case of bananas with received date 12/23/25 were dark brown in color and very soft in the walk in refrigerator.-In the dry stock room, there was food debris in the bottom of the container holding packets of ketchup.-In the floor of the dry stock room there were several packets of sugar substitute.-In the reach-in refrigerator, there was a dried white substance along the edges inside of the door and along the gasket. On 01/20/25 at 11:41AM, the state agency surveyor observed insulated plate bases on the food delivery carts with wet nesting (practice of stacking wet dishes in a manner that does not allow proper air flow for drying.) Ten (10) of ten (10) bases were observed wet nesting. This was verified by the Dining Manager.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to ensure a complete and accurate medical record related to resident meal percentages. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents during the Long-Term Care Survey Process. Resident identifier #14. Facility census: 65.Findings include: a) Resident #14 A review of meal documentation (how much a resident ate during each meal) on 01/20/26 at 10:59 AM, for Resident #14 from 12/22/25 to 01/14/26, revealed that out of 23 days, only six (6) days had all three (3) meals documented. During an interview on 01/20/26 at 10:59 AM, the Director of Nursing (DON) confirmed they should be documenting for each meal that a resident receives.

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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 observation, record review, and staff interview, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. The resident's Peripherally Inserted Central Catheter (PICC line) dressing was not changed in accordance with professional standards of practice. This was true for one (1) of one (1) residents with PICC lines reviewed. Resident Identifier: #30. Facility Census: 65. Findings included: a) Resident #30 The facility's policy titled Dressing Change for Vascular Access Devices dated 2011 stated Peripherally Inserted Central Catheter (PICC line) dressings were to be changed every seven (7) days. On 01/19/26 at 9:10 AM, Resident #30 was noted to have a right arm peripheral catheter. The resident stated he was receiving intravenous antibiotics through the catheter. The catheter had a date of 01/07/26 written on the dressing to indicate when the dressing had last been changed. Review of Resident #30's medical records showed his right arm peripheral catheter was a PICC line that had been inserted in the hospital before the resident was admitted to the facility on [DATE]. Review of Resident #30's physician's orders showed no orders for PICC line dressing changes. On 01/19/2026 at 9:17 AM, the Director of Nursing (DON) confirmed the date on Resident #30's PICC line dressing was 01/07/26 and the dressing should have been changed. No further information was provided through the completion of the survey process.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, record review, resident interview, and staff interview the facility failed to follow resident's therapeutic diet for fortified foods. This failed practice was a random opportunity for discovery during the Long-Term Care Survey Process. Resident identifiers: #14, and #1. Facility census: 65.Findings included: a) Resident #1 Resident #1 had the following diet order written on 12/08/25, Regular/Liberalized diet, Regular texture, Standard Thin Liquids consistency, fortified food with all meals: oatmeal with breakfast, mashed potatoes with lunch and pudding with dinner. Resident #1, who was eating in her room, was served her lunch tray on 01/21/26 at 1:14 PM. Her lunch tray was served by the Kitchen Account Manager. The surveyor noted the resident didn't have mashed potatoes on her tray and fortified food was not noted on the resident's meal tray ticket. The Kitchen Account Manager stated, She's not on fortified food. On 01/21/2026 at 1:30 PM, the Administrator confirmed Resident #1 had an order for fortified food at each meal, but this was not noted on the resident's meal tray ticket. No further information was provided through the completion of the survey process. b) Resident #14 An observation on 01/21/26 at 1:15 PM, showed Resident #14 in her bed eating her lunch. A review of Resident #14's meal ticket on her tray read that she was to receive 1/2 cup of fortified mashed potatoes. The mashed potatoes were not on the tray. Resident #14 stated, There is a lot of times that I do not get the mashed potatoes. During an interview in Resident #14's room with the Director of Nursing (DON), on 01/21/26 at 1:20 PM, the DON confirmed that Resident #14 did not get fortified potatoes as ordered.