

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Ohio Valley Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Nicolette Road Parkersburg, WV 26104	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and staff interviews, the facility failed to maintain an infection control program which limits the transmission of pathogens and helps prevent the spread of disease, as evidenced by; Not having the correct enhanced barrier protection (EBP) sign indicators for residents rooms. There were lift pads left out on wheelchairs and on lifts. In the laundry room there were no cleaning logs and the air vent was off during the washing/drying process. Finally, the water control / maintenance program was missing logs, diagrams and service checks for the entire system. These were random opportunities for discoveries during the Long Term Survey Process and have the ability to affect more than a limited number of residents. Facility Census: 62. Findings Include: a) Enhanced Barrier Protection (EBP)While conducting facility rounding on 03/16/26 at approximately 12:30~PM it was observed the Enhanced Barrier Protection (EBP) signs on rooms 104, 105, 106, 107, 108 and 109, were all missing the required indicators to signify what resident the EBP precautions pertained to. This facility uses an orange dot on the name plate of the resident to indicate what resident is under the EBP, these rooms were all missing the orange dot marker.During an interview with Staff member #63 they stated I know who they go to because I work with them daily, but not sure how you would tell otherwise.During a secondary interview with Staff #89 they stated It's the orange dots, we put them on the names of who the EBP goes with.b) Lift padsMultiple lift pads which are used to aid in the transition of residents from bed to wheelchair and back, were noted to be left out / stored on wheelchairs and patient lifts in the hallways. These pads are to be stored away in an area to keep them clean and sanitary and not to allow for cross contamination from other staff, residents and family in the facility. Lift pads are to be treated like all other laundered linen and kept in an area which is covered and clean and not out in the open. They can be used multiple times for the same resident if not visibly soiled, however, they need to be stored in a sanitary manner. On the 100 hall there were five (5) wheelchairs and one (1) lift which had lift pads left out on them. The 200 hall had two (2) wheelchairs and one (1) lift which had lift pads stored out on them, two of those lift pads were visibly soiled.During an interview with Staff #89 on 03/16/26 at approximately 1:15~PM, they confirmed the facility stores the lift pads on the wheelchairs and lifts. That way they are always available when we need them.c) Laundry roomDuring inspection of the laundry area on 3/17/26 at approximately 2:46 PM, the air control vent was observed to be off and not creating the required air control / separation of the clean and dirty sides of the area. There must either be a physical separator, ie. a door or plastic drape, or the use of ventilation air flow to prevent pathogens from traveling from the dirty area to the clean linens. With the ventilation system off, this separation was not maintained.During an interview with Staff #80 they confirmed, the vent was off. I'll make sure we keep that vent on when doing the laundry.d) Water maintenanceThe water maintenance program was only able to produce logs of weekly required water temperatures being done. The rest of the required logs / checks were not being completed or the facility did not have records available at the time of the survey process. The facility was missing the water flow diagram, water testing, dead leg tests ect.On 3/18/26 at approximately 9:30 AM in an interview with the Administrator they confirmed, they did not have any of those documents but are working to resolve this issue. We don't have a water plan yet and the water system flushes are not completed either. We are waiting on corporate facilities to get us all of that.</p>		

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, record review and staff interview, the facility failed to implement and develop a comprehensive person-centered care plan which includes the measurable side effects of medications treating psychosocial needs, use of a communication board, and a preference to keep the room door closed. This was found during the Annual Long Term Care Survey Process. This was true for (3) three of 19 records reviewed. Resident identifiers: #12, #26 and #42. Facility census: 62. Findings include:</p> <p>a) Resident #12</p> <p>A review of Resident #12's Care plan found they receive antipsychotic medication related to psychosis with associated risks. The care plan read as follows:</p> <p>-- Problem start date of 09/15/22. Resident receives antipsychotic medication related to psychosis with associated risks. The care plan was void of any side effects nursing staff would need to monitor for. A review/revision was time stamped for 01/01/26 at 11:23AM.</p> <p>Further review of Resident #12's Care plan found they receive an antidepressant medication related to depression with associated risks. The problem statement related to this read as follows:</p> <p>-- Problem start date of 09/15/22. Resident receives antidepressant medication related to Depression with associated risks. The problem statement was void of any side effects nursing staff need to monitor for in the problem area. A review/revision was time stamped for 01/01/26 at 11:23AM.</p> <p>Diagnosis related to these care plans included:</p> <p>-- Unspecified psychosis not due to a substance or known physiological condition.</p> <p>-- Anxiety disorder, unspecified.</p> <p>-- Major depressive disorder, recurrent, unspecified.)</p> <p>Review of the Medication Administration Record (MAR) shows an order to monitor for side effects related to medication ordered :Anti-psychotic medication every shift: Sedation, Drowsiness, Dry Mouth, Constipation, Blurred Vision, Extra Pyramidal Reaction, Weight Gain, Edema, Postural Hypotension, Sweating, Loss of Appetite, Urinary Retention.</p> <p>Review of the MAR shows an order to monitor for side effects related to medication ordered: Anti-depressant every shift: Sedation, Drowsiness, Dry Mouth, Blurred Vision, Urinary Retention, Tachycardia, Muscle Tremor, Agitation, Headache, Skin Rash, Photosensitivity (skin), Excess Weight Gain.</p> <p>Staff interview with the Minimum Data Set (MDS) Coordinator. On 03/18/26 at around 12:30PM the MDS Coordinator after his review of the care plan reported, this is usually how I write these, I did not add any side affects for the Certified Nursing Assistants (CNAs) to monitor for since they are in the Medication Administration Record (MAR). This surveyor questioned if the CNAs have access to the monitoring tool in the MAR which he replied no. I will review this and add the possible side affects so the CNAs have an understanding.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b) Resident #28</p> <p>During an interview on 03/16/26 at 12:23 PM the resident only responded by shaking her head yes/no, she did not verbally communicate.</p> <p>Resident #28's care plan was reviewed found the following problem statement:</p> <p>Problem: I am alert, I do have aphasia noted and I am unable to verbally communicate my needs. I am able to respond to yes/no questions, this is not always 100% accurate. I do not have capacity to make my own medical decisions, I have a responsible party to do so for me. I am here for rehab with the goal to return home if my spouse can safely meet my needs and manage my care at home.</p> <p>Further review of the care plan found no intervention related to a communication board.</p> <p>During an interview on 3/17/26 at 10:07 am with LPN #4 when asked how she communicates with Resident #28, she stated she shakes her head yes/no to questions and she also has a communication board but she refuses to use it.</p> <p>During an interview on 3/17/26 at 10:10 AM with Activity Director #91, when asked how she communicates with Resident #28 she stated, she answers yes/no questions. When asked about a communication board, she did not know about the board. She then went to get another staff member. Restorative Aide #63 said, Resident #28 has a communication board but refuses to use it. She also stated we just know her.</p> <p>An interview with Director of Nursing (DON) on 3/17/26 at 10:45 AM confirmed, there was no mention of a communication board in Resident #28's care plan.</p> <p>c) Resident #42</p> <p>A review of Resident #42's care plan found the following intervention, I prefer to have my room's door shut for privacy. Please respect my preferences. Explain safety concerns while being courteous.</p> <p>During an observation and interview with Registered Nurse (RN) #81 on 3/18/26 at 8:30 AM it was confirmed Resident #42's door was opened, when asked why she stated she didn't know why it was open unless she just wanted it open at this time. When Resident #42 was asked if she wanted her door shut and she shook her head yes.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on record review and staff interview the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was true for five (5) out of five (5) employees reviewed during the long term care survey process. Employee identifiers #18, 62,52,46 and 36. Facility census: 62.Findings include: a) On the afternoon of 03/17/26 the competency reviews for Nurse Aide(NA)s #18, 62, 52, 46 and 62 were requested from the Nursing Home Administrator(NHA).On the afternoon of 03/18/26 the NHA confirmed the facility did not have any competency reviews for the NAs #18, 62, 52,46, and 62.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on record review and staff interview the facility assessment failed to state the break down of staffing needed to care for the residents based on their acuity levels. This failed practice had the potential to affect more than a limited number of residents. Facility census: 62. Findings include: a) A review of the facility assessment with a review date of 02/16/26 found no staffing levels were identified in regards to the number of direct care staff needed to care for the residents based on the acuity level of the residents housed at the facility. In fact the facility assessment contained no break down to reflect the acuity level of the residents housed in the facility to base staffing off of. During the Nursing Home Administrator (NHA) interview on 03/18/26 at 1:13 PM he verified there was no break down of staff in the facility assessment as required.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on staff interview and record review the facility failed to provide the required training for two (2) out of five (5) employees reviewed for training during the long term care survey process. Nursing Aide (NA) identifiers #62 and 18. Facility census: 62. Findings include: a) NA #62 On the afternoon of 03/17/26 the training record for NA #62 was requested from the Nursing Home Administrator (NHA). On 03/18/26 at 12:54 PM the NHA provided the training record for NA #62. Upon review of the training record it was noted there was only ten (10) hours of training. The NHA confirmed NA #62 did not have the full 12 hours of training as required. b) NA #18 On the afternoon of 03/17/26 the training for NA #18 was requested from the NHA. On 03/18/26 at 12:54 PM the NHA provided the training record for NA #18. Upon review of the training record it was noted there was only six (6) hours of training. The NHA confirmed NA #18 did not have the full 12 hours of training as required.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interviews and record reviews during a recertification survey, the facility did not ensure timely notification to the physician of Resident's significant weight loss. This is true for one (1) of three (3) Resident's reviewed for weight loss. Resident identifiers: Resident #5. Facility census: 62. Findings include:a) Resident #5An observation on 03/17/26 at 8:08 AM, found the resident was in her room struggling to feed herself. Her hand was shaky, and she was dropping food.A medical record review on 03/17/26 at 12:24 PM revealed a severe weight loss. Resident #5 weighed 114.6 pounds (LBS.) on 01/25/26 and weighed 101.4 LBS. on 02/22/26 equaling an 11.52% in weight loss. Resident #5s Weight log showed:03/08/2026 -Weight: 105.2 lbs / Body Mass Index (BMI): 16.9802/22/2026 -Weight: 101.4 lbs / BMI: 16.3601/25/2026 -Weight: 114.6 lbs / BMI: 18.4901/21/2026 -Weight: 113.0 lbs / BMI: 18.24Subsequent review of the resident's medical record showed it did not contain documentation of Resident #5's physician being notified of the significant weight loss.During an interview on 03/17/26 at approximately 1:32 PM the Director of Nursing (DON) stated, the facility does not document meal intakes. She also verified no residents receive supplements or scheduled snacks.During an interview on 03/18/26 at approximately 9:13 AM with the Director of Nursing (DON), she confirmed the physician was not notified of significant weight loss for Resident #5.A subsequent review of Resident #5s medical record revealed on 03/18/26 at 9:48 AM after surveyor intervention, the facility notified the Physician of the recent weight loss. The physician advised to add a diagnosis of unspecified protein-calorie malnutrition to the chart and begin dronabinol 2.5mg daily for appetite stimulation and an Order to check CMP on Friday.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>Based on Interviews and record review, the facility failed to update the Minimum Data Set (MDS) with a Significant Change in status for Resident #9. No significant change in status assessment was completed within 14 days of a significant change in a resident's medical status as per regulations. This was discovered during the the Long Term Care Survey Process and was true for one (1) of 19 sampled residents. Resident Identifier: Resident #9. Facility Census: 62 Findings Include: During an interview with Resident #9 and their roommate on 03/16/26 at approximately 12:51 PM, they stated they had a fall in their room on water on 1/20/26. It was unwitnessed by staff, but was seen by the roommate who alerted the staff Resident #9 had fallen and hit her head after slipping on some water Resident #9 had spilled. Notes in the chart about the incident show the facility followed all their protocols and notified the Medical Power of Attorney (MPOA), Medical Doctor (MD) and took vitals prior to sending the resident to the hospital on 1/20/26. The facility staff called emergency room (ER) department for an update on Resident #9's condition and were informed R#9 had a fracture of the cervical spine (neck) in the C2 area. Further testing was performed at the ER prior to the resident returning to the facility. It was noted the resident refused all care and treatment at the ER and this was cleared by their MPOA. Resident #9 was to wear a C-collar for spinal support during the healing process at all times as per the discharge notes. An Interdisciplinary Team (IDT) meeting was held to discuss the updates needed to Resident #9's care and healing process. The orders and care plan for the resident were updated to reflect these changes, but no Significant Change In Status Assessment MDS was completed after these changes were made. A Significant Change In Status Assessment is required per regulations if: Chapter 2 of the RAI Manual covers SCSA. A significant change is a major decline or improvement in a resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; Impacts more than one area of the resident's health status; and Requires interdisciplinary review and/or revision of the care plan. Additionally, the SOM states a Significant Change in Status Assessment (SCSA) is a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline. A fall with major injury will trigger a need for a Significant Change In Status Assessment as it will lead to Significant Change in Status as well as the Self-Limiting aspect of an injury and time it will take to heal. Resident #9's neck fracture impacted all of her activities of daily living (ADLs) as well increased need for monitoring and medications. Record review of the MDSs on 3/17/26 found no Significant Change in Status Assessment completed within the required time frame of 14 days of the event. There were only the required annual and quarterly MDS assessments in the residents chart. Interviews were conducted on 3/17/26 at approximately 11:32 AM with the Administrator and MDS coordinator. The MDS coordinator stated I am not sure those [fall and fracture] would trigger a CIC change that needs to be done. I will look into that for you and see what the manual states. I will get back to you shortly, I'll be honest I didn't think those two events would qualify for CIC being completed. The Administrator later stated I do probably think that one was needed for the fall with injury,</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and staff interview, Resident #42 care plan was found to not be revised to address Resident #42 dental issues. This was true for one (1) of 19 sampled residents reviewed during the long term care survey process. Resident Identifier #42. Facility Census: 62. Findings include: During record review and resident interview it was found that resident #42 had a toothache from 12/02/25 to the present time. This was not addressed in Resident #42's care plan. This was confirmed to be true by the Director of Nursing (DON) on 03/18/26 at 9:27 AM.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations and interviews, the facility failed to ensure the resident environment remained as free from accident hazards as possible. During a random opportunity for discovery, the following issues were identified: A treatment cart was left unlocked and unattended and oxygen tanks were stored improperly. These failed practices had the potential to effect more than a limited number of resident currently residing in the facility. Facility census: 62. Findings Include:</p> <p>a) Treatment Cart</p> <p>On 03/18/26 at 8:50 AM, an observation of an unlocked, unattended treatment cart was made. The cart was in a place easily accessible allowing access to these treatment supplies by residents, unauthorized persons, or visitors.</p> <p>At 8:56 AM, Licensed Practical Nurse (LPN) #4 confirmed during an interview the treatment cart was left unlocked and unattended. She stated she did not have a key for the cart and, at that time, asked LPN #23 if they possessed one.</p> <p>At 9:10 AM, the Director of Nursing confirmed while the treatment cart key is kept locked up, all nurses have access to it.</p> <p>b) Oxygen tank storage</p> <p>It was observed on 3/18/26 at approximately 8:45 AM three (3) oxygen tanks were being stored behind the nurses station between the 100 and 200 hallways. The tanks were in rolling carts without regulators and not in the proper metal cages. These pose an explosion / fire risk and must always be kept in a secure location in the facility.</p> <p>The area the tanks are normally stored in, the medication room did not have the proper signage and therefore was not able to be used according to Staff #4. [Life safety] told us we can't store them in the medication room anymore because we don't have the right sign for them. So they moved them out here for now.</p> <p>The Administrator confirmed, [Life Safety] said the sign was not the approved one and they will order the proper one today.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observation, record review and staff interview the facility failed to ensure Resident #42 maintained acceptable parameters of nutritional status. Resident #42 suffered a severe weight loss and the facility failed to ensure the resident was reviewed by the licensed dietician and/or interventions were put into place to prevent further weight loss. This was true for one (1) of six (6) residents reviewed for the care area of nutrition during the long term care survey process. Resident Identifier: #42. Facility Census: 62.a) Resident #42 An observation of Resident #42 in her bed on 03/16/26 at approximately 1:30 PM, found her noon time meal was on her over the bed table and was untouched, The resident indicated she did not want to eat. A review of Resident #42's medical record found the following weights: -- 05/30/25 - 170.2 pounds (Lbs.) -- 07/18/25 - 169.5 Lbs. -- 09/16/25 - 171.5 Lbs. -- 12/26/25 - 166 Lbs. -- 02/20/26 - 148.8 Lbs. From 12/26/25 to 02/20/26 Resident #42 lost 10.36 percent of her body weight. This represents a severe weight loss. On the afternoon of 03/17/26 the Director of Nursing (DON) was asked were the facility tracks their meal percentages for each resident. She stated, We do not do that here. She further stated, we have a very liberalized eating program and we use quality ingredients. She further stated, we monitor there weights closely and offer substitutes if they do no eat. She indicated she works closely with the Dietician and the Physician and weight loss is not a problem here. Further review of the medical record found a physician's order which indicated the resident was to be weighed in the first and third week of each month. However after reviewing the weights it was found Resident #42 was not weighed twice a month as ordered. The medical record did contain nursing notes which indicated the resident often refused weights. When asked about interventions for Resident #42's weight loss the DON stated, the dietician did not see her when she was here last and she does not know why. When asked if she had notified the Dietician of Resident #42's severe weight loss she stated, I did not tell her but she should catch that on her own. The DON stated, the Dietician comes weekly on Thursdays and makes recommendations as needed for residents with nutritional concerns. Resident #42's weight loss was identified on 02/20/26 when she allowed them to weigh for the first time in two (2) months. The dietician was at the facility on 02/26/26, 03/05/26, and 03/12/26 and did not review and/or make recommendations for Resident #42. The DON on 03/18/26 in the afternoon stated, The dietician will see her tomorrow. A final review of the medical record on 03/18/26 found not interventions were put into place to address Resident #42's severe weight loss.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Ohio Valley Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Nicolette Road Parkersburg, WV 26104	
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)		
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>Based on record review and staff interview the facility failed to ensure nurse staff postings were correct. There were seven (7) out of 14 days of incorrect nurse staff postings. This failed practice had the potential to effect more than an isolated number of residents. Facility census: 62. The nurse staff posting was requested from the Nursing Home Administrator (NHA) on 03/17/26 for the timeframe of 02/08/26 to 02/22/26. On 03/18/26 the NHA provided the nurse staff posting and the hours per patient day (HPPD) report. This surveyor compared the staff posting to the HPPD report and found on the following days the nurse staff posting was incorrect: --02/08/26 the HPPD report indicated 125 nursing hours but the nurse staff posting indicated 131 nursing hours.--02/11/26 the nurse staff posting indicated only one (1) hour of RN coverage, however the time detail report provided by the NHA indicated there was eight (8) hours of RN coverage on this date. --02/12/26 the HPPD report indicated 208.75 nursing hours but the nurse staff posting indicated 193 nursing hours.--02/26/26 the HPPD report indicated 163.5 nursing hours but the nurse staff posting indicated 179 nursing hours.--02/17/26 the nurse staff posting indicated 5 hours of RN coverage and the time detail report indicated 4.75 hours of RN coverage.--02/20/26 the nurse staff posting indicated 5 hours of RN coverage and the time detail indicated 7.25 hours of RN coverage.--02/22/26 the HPPD report indicated 170 nursing hours but the nurse staff posting indicated 178 nursing hours.</p>		