STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515185	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Trail Healthcare Center	1115 Maplewood Avenue Lewisburg, WV 24901

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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 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 honor residents' rights to maintain respect and dignity. For Resident #29, the facility failed to ensure the resident's indwelling catheter urine collection bag was covered for privacy. This was true for one (1) of three (3) residents reviewed for the care area of urinary catheter. For Resident #57, the facility failed to ensure the resident received his meal drink when the other residents received their drinks. This was true for one (1) of eight (8) residents observed in the first floor dining room. For Resident #49, the facility failed to ensure the resident was not exposed to a staff member complaining about her job caring for residents. This was true for one (1) of two (2) residents reviewed for the care area of dignity. Resident Identifiers: #29, #57, and #49. Facility census: 78.Findings included:a) Resident #49 The facility's policy titled Catheter Care, with no dates of implementation or revision given, gave no guidance regarding privacy covers for urine collection bags for indwelling urinary catheters. Upon observation on 03/16/2026 at 3:00 PM, Resident #49's urine collection bag for his suprapubic catheter did not have a privacy cover. The urine collection bag was hanging from the bed frame away from the door and could only be visualized by people entering the room and walking around to the other side of the resident's bed. On 03/18/2026 at 9:27 AM, Resident #49's urine collection bag continued to not have a privacy cover. Although the urine collection bag continued to hang from the bed frame away from the door, the bag was visible from the hallway through the bed, which was slightly elevated. Light yellow urine was visualized in the urine collection bag. Unit Manager (UM) #34 confirmed Resident #49's urinary catheter urine collection bag did not have a privacy cover. UM #34 stated a privacy cover would be placed on the collection bag. b) 100 Hall Dining Room Observation On 03/17/26 at 12:15 PM, Resident #57 was observed in the dining room on 100 hall with no drinks. There were seven (7) other residents in the dining room who had drinks on the table in front of them. Interview with RN #64 confirmed Resident #57 did not have anything to drink while all of the others did. RN #64 stated Resident #57 did not have anything yet because he is on thickened liquids and gets his drinks when his tray comes out. c) Resident #49 Review of the facility's Resident's Rights policy revealed that each resident should be treated with respect and dignity and staff should care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's (continued on next page)

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	individuality. On 03/17/26 at 9:38 AM, Resident #49 reported Nurse Aide #68 complains as she is providing care to Resident #49 and her roommate that she has had enough of this place and these people. Review of the Quarterly Minimum Data Set, with an assessment reference date of 03/03/26, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of 15, indicating that she was cognitively intact. An interview with Executive Director (ED) began at approximately 10:30 AM in which the resident's allegations were made known to ED. The fact that the Nurse Aide failed to refrain from making verbal comments made out of frustration which would be demeaning to residents who required extra assistance in carrying out their activities of daily of living was discussed and acknowledged by the ED.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and staff interview, the facility failed to ensure activities of daily living were completed for dependent residents. This was true for two (2) of four (4) residents reviewed under the care area of activities of daily living throughout the Long-Term Care Survey Process. Resident Identifiers: #88 and #57. Facility Census: 79.Findings Included: a) Resident #88 On 03/19/2026 at 11:15 AM, a record review was completed for Resident #88. The documentation for 01/2025 and 02/2025 found showers and bed baths were not provided for Resident #88. The following dates show the length of time the resident did not receive showers or bed baths: --01/11/25-01/18/25 seven (7) days --02/12/25-02/22/25 10 days On 03/19/26 at 12:25 PM, the Director of Nursing (DON) confirmed showers and bed baths were not provided to the resident during the above-mentioned timeframes. b) Resident #57 On 03/16/2026 at 2:44 PM, it was observed that Resident #57 had long fingernails on both hands which also had limited range of motion (ROM). An interview with Occupational Therapist (OT) #66, at 2:05 PM on 03/18/26, confirmed Resident #57 needed nails trimmed. The Director of Nursing was interviewed, at 3:59 PM on 03/18/26, and stated Resident #57's nails definitely needed cut.

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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 interview, and staff interview, the facility failed to ensure palatable food. The baked potatoes for the noon meal on 03/18/26 were not thoroughly cooked. This was a random opportunity for discovery that had the potential to affect more than a limited number of residents. Resident Identifiers: #18, #15, #60, #13, #4, #38, #74, #20, #40, #9, #73, #22, #37, #68, #66, and #10. Facility Census: 78.Findings included:a) Second Floor Dining Observation On 03/18/2026 at 12:25 PM, Resident #18 and Resident #15 were observed dining in their room. The residents stated the baked potatoes that were served to them were not thoroughly cooked and were too hard for them to eat. Resident #15 stated she was unable to eat the baked potato due to her dentures. Both residents demonstrated the potatoes were not thoroughly cooked by sticking their forks in them. The forks did not easily go into the potatoes. The residents stated the potato had been cut in half in the kitchen. On 03/18/26 at 12:27 PM, Resident #60, who was also dining in her room, stated her potato was not thoroughly cooked and she was unable to eat it. On 03/18/26 at 12:30 PM, the Director of Nursing (DON) was asked to observe Resident #18 and Resident #15's baked potatoes. She stated she would get replacements or substitutes for the residents. She was also informed that Resident #60 also could not eat her baked potato. On 03/18/26 at 12:33 PM, Resident #13 and Resident #4 were asked about the baked potatoes served to them. These residents were also dining in their room. Resident #13 stated her baked potato was too hard for her to eat. She stated she was full and did not want a replacement or substitute. Resident #4 stated her baked potato was hard, but she could eat it if she cut it into small pieces and put sour cream on it. She did not want a replacement or substitute. On 03/18/26 at 12:37 PM, Residents #38, #74, #20, and #40 were observed dining together in the second-floor dining room. They were noted to have not eaten their baked potatoes. They stated they could not eat the potatoes because they had not been cooked all the way through. Unit Manager #34 was notified and stated he would get some mashed potatoes for the residents. b) First Floor Dining Observation On 03/18/2026 at 12:45 PM, Resident #9 and Resident #73 were observed dining in their room. The residents stated the baked potatoes served to them were undercooked and were too hard for them to eat. Both residents stated they would rather have the mashed potatoes that were offered as a replacement. On 03/18/26 at 12:47PM, Resident #22, who was also dining in her room, stated her potato was not thoroughly cooked and she would like to have the mashed potatoes instead. On 03/18/26 at 12:50 PM, Resident #37 and Resident #68 were asked about the baked potatoes served to them in the dining room. These residents also requested mashed potatoes as a replacement. Resident #66 stated her baked potato was too hard for her to eat. She stated she was full and did not want a replacement or substitute. On 03/18/26 at 12:37 PM, Residents #75, and #10 were observed dining together in their room. They (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated they were unable to eat their baked potatoes because they were not completely cooked all the way through and were too hard to cut. c) Staff Interviews On 03/18/26 at 12:55 PM, the Kitchen Account Manager stated she was made aware the baked potatoes were undercooked after the trays reached the previously served floor and the had started offering mashed potatoes as replacements. In an interview with the Dietary District Manager #117 at 3:40 PM, she stated the potatoes were temped at 148 degrees Fahrenheit and she had stopped the line and checked one of the potatoes before the tray carts were delivered to the floors. It was discovered the potatoes sent to the floors were under cooked too late to change the menu. After the discovery, the kitchen staff prepared mashed potatoes as a replacement and the Kitchen Account Manager then went to the floors and offered the replacement mashed potatoes for residents who wanted them. She also stated she felt the larger size of the potatoes caused them not to cook completely through.

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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, interview and policy review the facility failed to properly store food in accordance with professional standards of practice.This had the potential to affect more than a limited number of residents in the facility. Facility census 79. Findings included: Cold Storage PolicyOn 03/17/26 at 3:30 PM a review facility policy labeled HCSG Policy 019, Food Storage: Cold Foods. Procedures, number 5 stated, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.a) Initial Tour of KitchenDuring initial kitchen visit, on 03/16/26 at 11:45 AM, the kitchen account manager acknowledged one (1) opened box of frozen omelets and one (1) opened box frozen biscuits with the inner plastic unsealed and left open to air.In an interview with the kitchen account manager on 03/16/26 at 11:50 AM, she acknowledged the frozen omelets and biscuits was left open to air after breakfast prep.b) Second Visit to KitchenOn 03/17/2026 at 11:30 AM, during the second Kitchen visit, the Dietary District Manager #117 acknowledged the following observation of unsanitary conditions during lunch preparations: -Employee #112 wiped up spilled soup off the counter using only her gloves, and returned to the tray line without changing her gloves or washing her hands.In a later observation, she walked over 3 feet away from the tray line, touched the out side of the food service cart twice and then returned to finish meal preparation also without changing her gloves or washing her hands.

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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 complete and accurate medical records in the areas of pneumococcal vaccination consents for four (4) of five (5) residents reviewed for immunizations. Additionally, the facility failed to ensure complete and accurate medical records in the areas of medication administration records (MARs), medication and supplement orders, and skin assessments for three (3) of 25 residents reviewed during the Long-Term Care Survey Process. Resident Identifiers: #47, #9, #83, #2, #6, #5, and #27. Facility Census: 78. Findings included:a) Pneumococcal vaccination consents - Residents #47, #9, #83, and #2 Review of the facility's policy titled, Resident Pneumococcal Vaccines, with effective date 03/01/17 and most recent revision date 06/15/23, stated residents who had not received any pneumococcal vaccines would be offered pneumococcal conjugate vaccine (PCV) 20. According to the Centers for Disease Control and Prevention (CDC), the Advisory Counsel for Immunization Practices began recommending the PCV20 vaccination in 2024. Review of Resident #47's medical records show the resident received the PCV 20 vaccine on 03/09/26. Verbal consent for the pneumococcal vaccine had been obtained from the resident's representative on 02/27/26. This consent form was effective 10/29/13 and had been revised on 03/01/17. The form gave consent for the pneumococcal conjugate vaccine (PCV) 13 or the Pneumococcal Polysaccharide Vaccine (PPSV) 23 to be administered. Review of Resident #9"s medical records show the resident representative had verbally declined for the resident to receive pneumococcal vaccination on 03/03/26. This consent form was effective 10/29/13 and had been revised on 03/01/17. According to the consent form, the resident had been offered the pneumococcal conjugate vaccine (PCV) 13 or the Pneumococcal Polysaccharide Vaccine (PPSV) 23. Review of Resident #83's medical records show the resident had declined pneumococcal vaccination on 03/13/26. This consent form was effective 10/29/13 and had been revised on 03/01/17. According to the consent form, the resident had been offered the pneumococcal conjugate vaccine (PCV) 13 or the Pneumococcal Polysaccharide Vaccine (PPSV) 23. Review of Resident #47's medical records show the resident received the PCV 20 vaccine on 09/15/25. A consent for the pneumococcal vaccine had been signed by the resident's representative on 09/12/25 This consent form was effective 10/29/13 and had been revised on 03/01/17. The form gave consent for the pneumococcal conjugate vaccine (PCV) 13 or the Pneumococcal Polysaccharide Vaccine (PPSV) 23 to be administered. On 09/17/26 at 3:00 PM, the Infection Preventionist stated old consent forms had been used for these residents. She stated the consent forms should have been for PSV20 vaccination. b1) Resident #6 - enteral nutrition documentation Review of Resident #6's physician's orders showed an order written on 12/31/25 for Enteral Feed Order at bedtime Enteral nutrition via G-tube [gastrostomy tube] for bolus feeding of bolus of Nutren 1.5 250 mls [milliliters], flushing 60 mls before and after to provide additional: 375 kcals [calories], (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	17g PRO [protein], and 191 mls free water. (Order typed as written.) This order was on Resident #6's Medication Administration Records (MARs) with a space for the nurse to document the amount of enteral nutrition given in mls. The amount of enteral nutrition given on the February and March MARs was documented as follows: - 250 mls on 02/02/26, 02/03/26, 02/04/26, 02/08/26, 02/12/26, 02/16/26, 02/17/26, 02/19/26, 02/23/26, 02/24/26, 02/25/26, 03/01/26, 03/02/26, 3/03/26, 03/04/26, 03/09/26, 03/10/26, 03/11/26, and 03/16/26. - 100 mls on 02/01/26, 02/06/26, 02/07/26, 02/09/26, 02/13/26, 02/14/26, 02/20/26, 02/21/26, 02/22/26, 03/06/26, 03/07/26, 03/08/26, 03/13/26, 03/14/26, and 03/15/26- 370 mls on 02/05/26, 02/26/26. 02/27/26, 02/28/26, 03/05/26, and 03/17/26- 95 mls on 02/10/26- 15 mls on 02/11/26- 0 mls on 02/15/26- 310 mls on 02/18/26 - 191 mls 03/12/26 On 03/19/2026 at 9:26 AM, the Director of Nursing (DON) agreed Resident #6's enteral feeding amount had not been accurately documented. She stated when 100 mls were documented, the nurse probably meant that 100 percent of the feeding had been given. She stated 250 mls being documented probably recorded only the enteral feeding given and 370 mls being documented probably recorded the amount of enteral feeding and the water flushes combined. The DON stated 191 probably correctly recorded the amount of free water contained in the enteral feeding and water flushes combined. She was unable to explain the remainder of the documented amounts. The DON stated Resident #6 sometimes refused part or all of his nightly enteral feedings. She agreed refusals should be documented in the progress notes. There were no progress notes regarding the enteral feedings for 02/10/26, 02/11/26, 02/15/26 or 02/18/26. No further information was provided through the completion of the survey process. b2) Resident #6 - modular protein order Review of Resident #6's physician's orders showed an order written on 08/31/25 for Modular Protein in the morning for protein. The amount to be given was not specified. On 03/19/2026 at 9:26 AM, the Director of Nursing (DON) confirmed Resident #6's modular protein order did not contain the amount to be given. She stated she would have the order revised. c) Resident #5 On 03/18/26 at 11:15 AM, a record review was completed for Resident #5. The review found incorrect diagnoses for two (2) medications in the physician's orders. The following medication are as follows: --Losartan Potassium--high cholesterol --Spironolactone--hypokalemia Also, the review found a physician's order for anticoagulant monitoring. However, the resident was not taking an anticoagulant. On 03/18/26 at 12:18 PM, the DON confirmed the diagnoses were incorrect for the medications; and, the resident was not taking an anticoagulant. d) Resident #27 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/16/2026 at 2:38 PM, Resident #27 stated she had two (2) open areas on her stomach. Resident #27 did not know how the open areas got there and states that nursing is not treating them. A record review was completed on 03/19/26 at approximately 12:00PM. The record review revealed:-A physician progress note, dated 03/05/26, which noted Resident #27 had abdominal wounds.-A skin assessment, dated 03/09/26, which noted Resident #27 had no skin areas noted.-A skin assessment, dated 03/16/26, which noted Resident #27 had no skin areas noted. State Surveyor Registered Nurse observed and confirmed Resident #27's abdominal wounds 03/19/26 at approximately 12:25 PM. During an interview on 03/19/26 at 1:15 PM, the Director of Nursing (DON) stated she was unaware of any open areas on Resident #27's abdomen, but she would check the resident's chart. The DON then pulled up Resident #27's electronic medical record, reviewed the most recent skin assessment and stated Resident #27 did not have any open areas on her abdomen. The State Surveyor requested the DON pull up the physician progress note, dated 03/05/26, which reflected Resident #27 was noted to have open areas on her abdomen at that time. The DON acknowledged it had been documented resident had open areas and stated she would want to see for herself. The DON observed abdominal wounds at 1:21 PM and confirmed they were not documented on the 03/09/26 and 03/16/26 skin assessments.

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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, record review, and staff interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Transmission based precautions were not followed. A nebulizer mask was not stored in an appropriate sanitary manner. Food was not served in a sanitary manner. Additionally, wheelchairs had holes, cracks, and exposed padding which made the wheelchairs unable to be thoroughly cleaned. These were random opportunities for discovery. Resident Identifiers: #29, #14, #23, #62, #68, #51, #66, and #14. Facility census: 79 a) Resident #29 The facility's policy titled Standard Precautions and Transmission Based Precautions, with no implementation or revision dates given, stated staff would utilize the proper personal protective equipment (PPE) upon entering the room before contacting the resident or environment for residents on contact precautions. On 03/17.26 at 12:17 PM, Nursing Assistant (NA) #67 went into Resident #29's room to deliver the resident's lunch tray. NA #67 did not wear PPE to enter the resident's room. Outside Resident #29's room was a sign which said the following: Stop. Contact Precautions Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. When questioned, NA #67 stated she only needed to wear gown and gloves when providing care to the resident. NA #67 was asked to read the contact precautions sign outside Resident #29's room. She stated, I probably should have worn a gown and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #29's physician's orders showed an order written on 02/17/26 for enhanced barrier precautions (EBP) due to a suprapubic catheter. The resident had no order for contact precautions. However, the resident was noted to be receiving antibiotics for a catheter site infection until 03/19/26. On 03/17/26 at 12:42 PM, the Director of Nursing (DON) stated Resident #29 was no longer on contact isolation and was currently on EBP. She agreed that staff should follow the transmission-based precautions signage outside residents' rooms. The following order was written on 03/17/26, Contact Isolation related to: ESBL (extended spectrum beta-lactamase) every shift until 03/19/2026. On 03/17/26 at 3:00 PM, the Infection Preventionist confirmed Resident #29 was in contact isolation until 03/19/26, requiring staff to wear gown and gloves when entering his room. b) Resident #1 On 03/16/2026 at 12:50PM, Resident #1's nebulizer mask was observed lying on the bedside table. At 12:59 PM, Nurse Aide #43 confirmed the nebulizer mask was sitting on the bedside table and not inside of an oxygen bag. Nurse Aide #68 confirmed, at 12:20PM on 03/17/26, that Resident #1's nebulizer mask was left on the bedside table and not inside the oxygen bag. An interview with DON, on 03/18/26 at 3:30 PM, confirmed it is best practice for the nebulizer masks to be placed inside of the oxygen bag between treatments for infection control purposes. c) room [ROOM NUMBER] On 03/18/2026 at 11:22 AM, room [ROOM NUMBER] was on droplet precautions. Signage posted outside the door read as follows: EVERYONE MUST: including visitors, doctors and staff:-Clean hands when entering and leaving the room-Wear face mask (N-95 or higher, if available) -Wear eye protection (face shield or goggles)-Wear an isolation gown at door Nurse Aide #85 was observed going into room [ROOM NUMBER] with the gown open, draping down in front and not tied. Nurse Aide #85 also did not have a N-95 mask on nor eye protection. Nurse Aide #85 confirmed via droplet precaution signage on door that these items were necessary for entering room [ROOM NUMBER] and that she did not have them on at 9:46 AM on 03/18/26. Nurse Aide #76 was observed entering room [ROOM NUMBER] with no personal protective equipment (PPE). An interview with Nurse Aide #76 confirmed she was not wearing necessary PPE described on signage outside room [ROOM NUMBER] at 10:11AM on 03/18/26. Nurse Aide #20 was observed entering room [ROOM NUMBER] with gown not tied, no N95, and no eye protection. An interview with Nurse Aide #20 confirmed she did not wear necessary PPE described on signage outside of room [ROOM NUMBER] at 10:13 AM on 03/18/26. d) room [ROOM NUMBER] It was observed, on 03/18/2026 at 12:48 PM, Employee #20 delivered Resident #21's lunch tray with a contact isolation sign located outside the door without donning a mask, gown, and gloves. In an interview on 3/18/26 at 12:50 PM, Employee # 20 looked at the signage and stated, Oh. Even just to drop off trays? I wasn't doing any care. e) Resident #51 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It was observed, on 03/17/2026 at 12:52 PM, Staff Member #21 removed Resident #51's tray from the food cart, the lid covering the bowl of vegetables fell into the floor. Employee #21 was observed to pick up the lid off the floor, place it back on the tray, and then started to deliver it. In an interview with Employee identifier #21, she acknowledged the lid had fallen off the tray and stated, I did do that and I need to get her (Resident #51) another tray. f) Wheelchairs and Geri-chairs for Residents #23, #62, #68, and #14 room [ROOM NUMBER]: During an interview with resident #62, on 03/16/26 at 11:45 AM, a wheelchair near the resident's bed had rips and holes in the plastic cover on the curve of the left armrest, exposing the inner padding. room [ROOM NUMBER]: During entrance interview and observations on 03/16/26 at approximately 12:45 PM, it was observed that resident #23's wheelchair had a two inch tear midway down the left side arm down to the edge. First floor hallway observation: On 03/17/26 at 2:30PM, during an observation in the first floor hallway near the nurses station, Residents #14 and # 51 were sitting and talking. Resident #14's Geri Chair had a 3 inch tear in the outside shoulder area and also it was observed Resident # 51's wheel chair had an attached plastic cushion on right leg with a broken open zipper exposing the inner padding. g) Staff Interview During a facility walk through and interview with the infection preventionist, on 03/17/26 at approximately 3:35 PM, she acknowledged the above-listed wheelchairs and Geri-chair with exposed padding and stated she would make a list and take care of the wheelchairs needing repaired or replaced.

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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 resident interview, record review, and staff interview, the facility failed to honor a resident's choice about the schedule that was important to them, such as when the resident preferred to have a shower. This was true a random opportunity for discovery. Resident identifier: #49. Census: 79.Findings included: a) Resident #49 During an entrance interview, on Monday, 03/16/26 at 10:49 AM, Resident #49 stated staff told her she couldn't get her shower because State was in the building. She further stated that her husband visited daily, arrived around 4:00 PM - 5:00 PM, and she has repeatedly asked staff not to offer her to shower during her time with him, but they continued to do so. In an interview with Resident #49 at 1:45 PM on 03/19/26, she was in good spirits and stated she was excited and waiting for staff to take her for her shower.A record review, completed on 03/16/26, found that staff had documented Resident #49 had refused her shower at 17:59 PM. Further record review, completed on 03/19/26 at 9:00 AM, found the following showers were also documented as refused:-02/23/26 at 4:31 PM-02/26/26 at 4:56 PM -03/05/26 at 5:25 PM-03/09/26 at 5:18 PM-03/12/26 at 4:39 PM All offered shower times were documented during or around the times the resident's husband would have been visiting.b) Director Of Nursing (DON) Interview: On 03/19/26 at 11:53 AM, the DON stated the times on the electronic task records were when staff documents the showers given or refused for that day not the actual time the shower was offered and/or refused. The DON also stated there isn't log book with written sign off sheets providing actual times the showers are offered/refused and she was not able to provide documentations of actual offered shower or refusal times. c) Staff Interview During an interview on 03/19/26 at 12:03 PM, Nurse Aide #4 stated he does not give Resident # 49 showers as she prefers a female aide assist her. The nurse aide went on to state it is well known that her husband visits daily and arrives between 4:00 PM - 5:00 PM. He also stated that Resident #49 has refused her showers during her husband's visits on her scheduled shower days. Nurse Aide #4 offered to check with the resident about her shower scheduled that day. On 3/19/26 at 12:10 PM, during an observed conversation between Nurse Aide #4 and Resident #49, she stated she would like to shower right after lunch today. d) Interview with Resident #49's Husband During a phone interview with Resident #49's husband, on 03/19/26 at 1:30 PM, he stated the staff does often offer showers when he is visiting and she will refuse her shower.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on policy review, resident interview, and staff interview, the facility failed to ensure staff documented verbal grievances from residents and share the information with the grievance officer in order to ensure prompt efforts to resolve a grievance. This was true for one (1) of three (3) residents sampled for missing personal property throughout the Long-Term Care Survey Process. Resident identifier: 77. Census: 79.Findings included:a) Resident #77 Review of the facility's policy titled Resident Grievance revealed the following details:-Under Procedure: Upon admission and periodically throughout their stay, the facility will inform all residents of their right to file a grievance orally, in writing, or anonymously, about the care provided to or the treatment of any resident residing at the facility.-Under Preventing Ongoing Violations: Upon receipt of an oral, written or anonymous grievance submitted by a resident or other individual involved in resident care, the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated. During an interview on 03/16/26 at approximately 2:00 PM, Resident #77 stated she was missing several pajama tops. In a second interview, on 03/17/26 at approximately 12:00 PM, Resident #77 states she told Nurse Aide #61 on Sunday, 03/15/26 about the missing items. During an interview on 03/18/26 at 12:30PM, Nurse Aide #61 confirmed she was told on Sunday, 03/15/26, that Resident #77 was missing pajama tops. The Social Worker, who is also the facility's grievance officer, was interviewed on 03/17/26 at approximately 1:00 PM. The Social Worker stated she did not know that anything was missing. During an interview on 03/19/26 at 9:45 AM, the Social Worker stated she did not receive any information regarding missing items until the state agency made her aware on 03/17/26. The grievance policy was shown to social worker who confirmed the grievance system was not working and that staff were not always documenting verbal reports of a grievance/concern.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on policy review, resident interview, observation, and staff interview, the facility failed to identify a resident's statement as an allegation of verbal abuse and report it to the appropriate state agencies according to state law. This was true of one (1) of two (2) residents sampled for abuse throughout the Long-Term Care Survey Process. Resident identifier: #49. Census: 79.Findings included:a) Resident #49 Review of the facility policy titled [NAME] Virginia Abuse, Neglect, and Misappropriation revealed:-The policy defined mental abuse as the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. -Under Section V, Investigation of Incidents, the policy stated:An event may not be perceived by staff to constitute resident abuse neglect or misappropriation of resident property; however, if a resident, family member or visitor perceives an event to be abuse, neglect or misappropriation, the facility must report the event.In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow.The Director of Nursing (DON) and Executive Director (ED) receives reports of resident incidences.Additionally,the policy stated the following steps would be followed as appropriate:In the event the alleged perpetrator is a staff member that staff member will be removed from areas of resident living and interviewed by nurse on duty and asked to put their statement in writing, signed and dated.The staff member will be escorted off of the premises by another staff member. The accused staff member will be suspended by the ED pending the outcome of the investigation of the incident.According to the Office of Health Facilities Licensure and Certification (OHFLAC) reporting requirements, a facility must report an allegation of abuse to the Office of Health Facility and Licensure (OHFLAC) and Adult Protective Services (APS) within two (2) hours of the allegation being reported.On 03/17/26 at 9:38 AM, Resident #49 reported Nurse Aide #68 complains as she is providing care to Resident #49 and her roommate that she has had enough of this place and these people. Review of the Quarterly Minimum Data Set, with an assessment reference date of 03/03/26, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of 15, indicating that she was cognitively intact. An interview with Executive Director (ED) began at approximately 10:30 AM in which the resident's allegations were made known to ED. The fact that the Nurse Aidefailed to refrain from making verbal comments made out of frustration which would be demeaning to residents who required extra assistance in carrying out their activities of daily of living was discussed and acknowledged by the ED. A follow up interview with ED, at 1:30 PM on 03/17/26, was conducted and the ED stated the Social Worker interviewed the resident who made the same statement as to the surveyor. ED stated they did not see that the resident experienced any psychosocial harm, the facility did not identify this as abuse, and therefore had not reported the incident. Nurse Aide #68 was observed still working on the Resident #49's unit by state surveyors at this time. The facility's abuse and neglect policy was reviewed with the ED, specifically addressing the mental abuse definition and the investigation section of the policy. At 1:55 PM, the ED let the State Surveyors know she had reported the incident and sent Nurse Aide #68 home pending the investigation.

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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 ensure all diagnoses were included on the Pre-admission Screening and Resident Review (PASARR) for Resident #10. This was true for one (1) of five (5) residents reviewed under the care area of unnecessary medications. Resident Identifier: #10. Facility Census: 79. Findings Included: a) Resident #10 On 03/16/2026 at 3:59 PM, a review of the PASARR, dated 04/08/25, for Resident #10 was reviewed. The review found all diagnoses were not included on the PASARR. The following diagnoses were not included: --Moderate Intellectual Disabilities, added to the medical record on 04/08/25--Vascular Dementia, moderate with anxiety and psychotic disturbance, added to the medical record on 02/02/26 On 03/19/2026 at 10:21 AM, an interview was held with the Director of Social Services #70. The Director of Social Services #70 stated, I must have missed the diagnoses .I'll have to redo it.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, and staff interview, the facility failed to implement the care plan regarding an indwelling urinary catheter. This was true for one (1) of three (3) residents reviewed for the care area of urinary catheters. Resident Identifier: #29. Facility Census: 78. Findings included: a) Resident #29Resident #29's comprehensive care plan had a focus relating to an indwelling suprapubic catheter related to obstructive uropathy and overactive bladder. An intervention/task was Position catheter bag and tubing below the level of the bladder and provide privacy bag. Upon observation on 03/16/2026 at 3:00 PM, Resident #49's urine collection bag for his suprapubic catheter did not have a privacy cover. The urine collection bag was hanging from the bed frame away from the door and could only be visualized by people entering the room and walking around to the other side of the resident's bed.On 03/18/2026 at 9:27 AM, Resident #49's urine collection bag continued to not have a privacy cover. Although the urine collection bag continued to hang from the bed frame away from the door, the bag was visible from the hallway through the bed, which was slightly elevated. Light yellow urine was visualized in the urine collection bag. Unit Manager (UM) #34 confirmed Resident #49's urinary catheter urine collection bag did not have a privacy cover as instructed in the comprehensive care plan. UM #34 stated a privacy cover would be placed on the collection bag.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, staff interviews, and record review, the facility failed to ensure the retained documentation to reflect Resident #57 was given the choice on a daily basis to wear splints on both hands to prevent further decrease in range of motion. This was true for one (1) of three (3) residents sampled for limited range of motion (ROM) throughout the Long-Term Care Survey Process. Resident identifier: #57. Census: 79.Findings included:a) Resident #57 During an initial interview on 03/16/2026 at 2:43 PM. Resident #57 was observed to have limited ROM in both hands with no orthotics (externally applied medical device used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body) in place. Resident #57 was observed again on 03/17/26 and 03/18/26 with no orthotics in place. An interview with Occupational Therapist (OT) #66, at 2:15 PM on 03/18/26, confirmed Dynaflex splints were in Resident #57's closet. OT #66 stated education had been provided to aides for donning splints, but she has rarely seen them on the resident and his ROM has gotten progressively worse. The Director of Nursing (DON) was interviewed at 3:30 PM. The DON stated refusals of splints and donning of splints are not being documented at this time. The DON stated it was on the resident's Kardex (a quick-reference system used to organize and update essential patient information for Nurse Aides) that the splints should be donned on a daily basis. She went on to state it was just on the honor system as to whether or not the resident was asked about his splints and that the nurse should be documenting refusals in the progress notes on days he refused to wear them. Upon reviewing the last three (3) days of progress notes, there was no documented refusals regarding splints. A review of the electronic medical record revealed the donning of splints had been documented on the Treatment Administration Record (TAR) in March 2025 before a new physician order switched the type of splint being used to the Dynaflex splint. When the Dynaflex splint was ordered, it was not put on the TAR and therefore no documentation of splint wearing or resident refusal had been done since March 2025 on the TAR.

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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 record review, observation, and staff interviews, the facility failed to ensure Resident #57 was offered sufficient fluid intake to maintain proper hydration. This was true for one (1) of two (2) residents sampled for hydration throughout the Long-Term Care Survey Process. Resident identifier: #57. Census: 79.Findings included:a) Resident #57 Review of the facility policy titled General Hydration Services revealed the following expectations:-Provide fresh water at bedside in the proper consistency and drinking device, if appropriate. Review of physician orders revealed Resident #57 had an order for honey thickened liquids in a Kennedy cup with meals and at bedside. Review of Resident #57's care plan revealed the resident was at risk for dehydration and directed staff to provide assistance with fluid intake as needed. On 03/16/2026 from approximately 1:00PM until approximately 4:00PM it was observed that Resident #57 had no fluids available in resident's room. On 03/17/26 at Resident #57 was observed to have no drinks in the room at 10:02 AM. At 10:18 AM, Resident #57 had a drink placed on his bedside table at the foot of his bed out of reach of the resident. This was confirmed by Nurse Aide #44 at 12:10 PM. At 3:31 PM, Resident #57 was observed again in his room with no drink and witnessed by another state surveyor. An interview with Director of Nursing (DON), at 3:30 PM on 03/18/26, confirmed resident should have water available at his bedside for aides to assist resident with hydration.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interviews, the facility failed to ensure Resident #1 received oxygen therapy as ordered by physician. This was true for one (1) of one (1) residents sampled for respiratory care throughout the Long-Term Care Survey Process. Resident identifier: #1. Census: 79.Findings included:During an initial interview, on 03/16/26 at 1:15PM, it was observed by two (2) surveyors that Resident #1's oxygen concentrator was set on 5L/min (5 liters per minute). A review of Resident #1's physician orders reveal the following order: O2 [Oxygen] at 2L via NC [Nasal Cannula] continuous as needed. During a second observation, on 03/17/26 at 10:14 AM, Resident #1's oxygen was set at 5L/min. During a third observation, on 03/17/26 at 12:20 PM, Nurse Aide #68 confirmed the oxygen was set at 5L/min. Registered Nurse (RN) #22 was alerted that Resident #1's oxygen was set at 5L/min. RN #22 confirmed the physician order was for oxygen at 2L/min and that Resident #1 was set at 5L/min at 12:30 PM on 03/17/26.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, record review and staff interview, the facility failed to update the daily staff postings at the beginning of the shifts regarding changes in staffing numbers. This was true for nine (9) of nine (9) daily staff postings reviewed under the care area of staffing throughout the Long-Term Care Survey Process. Facility Census: 79.Findings Included: a) Daily Staff Postings On 03/17/2026 at 11:00 AM, a review of nine (9) daily staff postings was completed. The review found all nine (9) daily staff postings had not been updated at the beginning of the shift to indicate changes in staffing. The dates were as follows: --02/15/25-a decrease in nurse aides from seven (7) to six (6) on the 6:00 PM-6:00 AM shift.--11/29/25-a decrease in licensed practical nurses from four (4) to three (3) on the 6:00 PM-6:00 AM shift.--11/29/25-a decrease in licensed practical nurses from three (3) to two (2) on the 7:00 PM-7:30 AM shift.--12/26/25-a decrease in licensed practical nurses from four (4) to three (3) on the 7:00 PM-7:30 AM shift.--12/26/25-a decrease in registered nurses from one (1) to zero (0) on the 7:00 AM-3:30 PM shift.--12/26/25-a decrease in registered nurses from one (1) to zero (0) on the 8:30 AM-5:00 PM shift.--01/02/26-a decrease in registered nurses from one (1) to zero (0) on the 5:00 AM-1:00 PM shift.--01/02/26-a decrease in registered nurses from one (1) to zero (0) on the 7:00 AM-3:30 PM shift.--01/02/26-a decrease in registered nurses from one (1) to zero (0) on the 8:30 AM-5:00 PM shift. An interview was held with the Nursing Staff Scheduler #33 on 03/17/26 at 1:15 PM. The Nursing Staff Scheduler #33 was asked, Why are the staffing numbers not changed at the beginning of shift? The Nursing Staff Scheduler stated, Sometimes I don't know about call-ins until 2 or 3 days later .the staffing numbers are not changed at the beginning of each shift. On 03/17/26 at 2:30 PM, an interview was held with the Administrator. The Administrator stated, She should be aware of the call-ins.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, record review, and staff interview, the facility failed to ensure residents were provided adaptive eating equipment as ordered by the physician. This deficient practice had the potential to affect one (1) of eight (8) residents reviewed for the care area of nutrition. Resident Identifier: #13. Facility Census: 78.Findings included: a) Resident #13Review of Resident #13's physician's orders revealed an order written on 01/23/26 for the resident to have a Kennedy cup with meals and at bedside. A Kennedy cup is a lightweight plastic cup with a handle and a lid to prevent spills. On 03/18/26 at 9:00 AM, Resident #13 was noted to have a plastic one-handled coffee cup on her overbed table. The cup did not have a lid. The cup appeared to have soda in it, as there was also a can of soda on her overbed table. On 03/18/2026 at 12:19 PM, Registered Nurse (RN) #69 was observed delivering Resident #13's lunch tray to the resident's room. The lunch tray did not have a Kennedy cup on it. The resident continued to have the coffee cup on her overbed table. The resident's meal tray ticket indicated the resident was to have a Kennedy cup with her meals. RN #69 confirmed Resident #13's tray ticket indicated the resident was to have a Kennedy cup. She obtained a Kennedy cup from the beverage cart in the hallway and provided it to the resident. The resident stated she would like some water, and RN #13 stated she would get that for the resident.