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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>515189  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY COMPLETED<br><br>08/07/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Fairmont Rehabilitation and Healthcare Center LLC  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>130 Kaufman Drive<br>Fairmont, WV 26554 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <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 facility record review, medical record review, and interview, the facility failed to ensure a resident's Medical Power of Attorney (MPOA) was notified immediately concerning an allegation of abuse and to keep the MPOA updated on the findings. This practice affected two (2) of four (4) residents reviewed. Resident identifiers: #34. Facility census: 103. Findings include: R a) Resident #34 On June 14, 2025, a sexual abuse allegation was reported involving Resident #73, who had his hand down Resident #34's shirt. An investigation was conducted, and the residents were separated. Law enforcement, the MPOA, the Director of Nursing (DON), and the Administrator (ADM) were all notified. A quarterly MDS assessment on 06/27/25, showed Resident #34 with a BIMS score of 00, indicating severe cognitive impairment and lack of capacity. The 5-Day report verified the incident, confirming that Resident #73 inappropriately touched Resident #34. During an interview on 08/07/25, at 12:20 PM, Resident #34's responsible party stated she was initially made aware of a possible incident on June 14, 2025, but was later informed by the facility that it did not happen.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p> |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of policies, records, resident interviews, and staff interviews, the facility failed to protect the residents' right to be free from abuse, resulting in mental anguish for Resident #47, #34, and #83. Specifically, Resident #73 was reportedly touching female residents in the breast and vaginal area. This situation indicates that an unlimited number of female residents had the potential to be affected. The facility's lack of action to identify this unwelcome sexual contact and prevent its recurrence placed Residents #47, #34, and #83 at continued risk of sexual abuse prior to Surveyor intervention. Using the reasonable person concept, the facility's failure to protect the residents' right to be free from sexual abuse/resident-to-resident sexual aggression more than likely resulted in mental anguish and psychosocial harm for Residents #47, #34, and #83. Resident identifiers: #47, #34, and #83. Facility census: 103. Findings included: a) Policy Review The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, with a revision date of 2021, stated that residents have the right to be free from abuse which included sexual or physical abuse. It also mentioned a facility-wide commitment and resource allocation to protect residents from abuse by anyone, noting that it could be from other residents. Nowhere in the policy was there a definition of sexual abuse. However, the policy did direct that all possible incidents of abuse were to be identified and investigated. Additionally, the facility was to establish and implement a QAPI review and analysis of reports, allegations, or finding of abuse. It is important to note that at no point throughout the survey process did the facility report that they had self-identified Resident #73, who had capacity until mid-June 2025, as an individual who touched women without capacity in an unwanted sexual way. The facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, with a revision date of September 2022, stated that all reports of resident abuse are reported and thoroughly investigated by facility management. Findings of all investigations were documented and reported. This policy goes on to state: -If resident abuse is suspected, the suspicion must be reported immediately to the Administrator. -The allegation is immediately reported to the appropriate state agencies, the state long-term care Ombudsman, and the resident's legal representative. -Upon receiving any allegation of abuse, the Administrator is responsible for determining what actions (if any) are needed for the protection of residents. -All allegations are to be thoroughly investigated. -The individual conducting the investigation at a minimum will review the resident's medical record to determine if the resident's physical and cognitive status at the time of the incident. Observe the alleged victim, including his or her interactions with staff and other residents. Interview the person reporting the incident. Interview any witnesses to the incident. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Interview the resident's roommate, family members, and visitors. Document the investigation completely and thoroughly. -Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms. -Within five (5) business days of the incident, the Administrator will provide a follow-up investigation report which will describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. -The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation. Review of the Long-Term Care Nursing Home Program Reporting Requirements guidance from the Office of Health Facility Licensure &amp; Certification (OHFLAC) office describes sexual abuse as non-consensual sexual contact of any type with a resident. b) First Inappropriate Resident-to-Resident Incident On 01/26/24 at 5:30 PM, it was reported that Resident #73 and Resident #47 were unsupervised in the activity room. A staff member walked into the room and Resident #73 jumped and moved his hands from under Resident #47's shirt. At that time, Resident #73 had capacity and was believed to be cognitively intact. Resident #47 lacked capacity and had a BIMS of 09, indicating moderate cognitive impairment. The facility reported this incident to the appropriate state agencies as an unusual occurrence noting that the residents had reportedly touched each other. The facility intervention was to move Resident #47 to the opposite side of the building, body audits were performed, and safety checks initiated. There were no written statements from either resident. However, during an interview on 08/07/26 at 10:49 AM, Resident #47 reported she recalled the incident in question. She stated that [Resident #73's First Name] was the man that hurt her and repeatedly said that the facility does not believe her. Resident #47 described being in the activity room, Resident #73 pulling down his pants, taking her hand and making her touch his private parts. Resident stated: He put his hand in my shirt and touched my boob. She said she reported this to the facility. She also</p> |  |  |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p> |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Based on staff interviews, electronic medical record, facility record review and Operation Policy the facility failed to implement their written policy for thoroughly investigating allegations of sexual abuse. This was true of one (3) of three (3) residents reviewed for sexual abuse. Resident identifiers: #34, #83 and #47. Facility census: 103. A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, with a revision date of 2021, revealed that residents had the right to be free from abuse which included sexual or physical abuse. It also mentioned a facility-wide commitment and resource allocation to protect residents from abuse by anyone, noting that it could be from other residents. Nowhere in the policy was there a definition of sexual abuse. However, the policy did direct that all possible incidents of abuse were to be identified and investigated. Additionally, the facility was to establish and implement a QAPI review and analysis of reports, allegations, or finding of abuse. The facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, with a revision date of September 2022, stated that all reports of resident abuse were to be reported and thoroughly investigated by facility management. Findings of all investigations were to be documented and reported. This policy went on to state: If resident abuse is suspected, the suspicion must be reported immediately to the Administrator. The allegation is immediately reported to the appropriate state agencies, the state long-term care Ombudsman, and the resident's legal representative. Upon receiving any allegation of abuse, the Administrator is responsible for determining what actions (if any) are needed for the protection of residents. All allegations are to be thoroughly investigated. The individual conducting the investigation at a minimum will review the resident's medical record to determine if the resident's physical and cognitive status at the time of the incident. Observe the alleged victim, including his or her interactions with staff and other residents. Interview the person reporting the incident. Interview any witnesses to the incident. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Interview the resident's roommate, family members, and visitors. Document the investigation completely and thoroughly. Upon conclusion of the investigation, the investigator records the findings on approved documentation forms. Within five (5) business days of the incident, the Administrator will provide a follow-up investigation report which will describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation. Resident #73 On 06/22/25, a Nursing Note documented, Resident [#73] attempted to put his hands down a female resident's shirt, residents were placed in different areas away from each other. There is no evidence that this incident was documented as a possible allegation of sexual abuse. Resident #67 On 01/26/24 at 5:30 PM, it was reported that Resident #73 and Resident #67 were unsupervised in the activity room. A staff member walked into the room and Resident #73 jumped and moved his hands from under Resident #67's shirt. At that time, Resident #73 had capacity and was believed to be cognitively intact. Resident #67 lacked capacity and had a BIMS of 09, indicating moderate cognitive impairment. The facility reported this incident to the appropriate state agencies as an unusual occurrence noting that the residents had reportedly touched each other. The facility intervention was to move Resident #67 to the opposite side of the building, body audits were performed, and safety checks initiated. There were no written statements from either resident. A reportable review dated 09/06/24 revealed Resident #67 had reported an allegation of sexual abuse involving Resident #73. It was noted that Resident #67 was crying and expressing fear. Resident #67 stated that Resident #73 touched her breast and down there. A written statement from LPN #200 read, On 09/06/24 this nurse went to the dining room area to give the resident (Resident #67) her medications. The resident reported to this nurse that [Resident #73's First and Last Name] touched her breast inappropriately on 09/05/24 while she was sitting in the dining room area watching her tablet. The facility's Five-Day Follow-Up did not verify the allegation. However, the facility investigated the date of 08/14/24 when Resident #67 was restricted to her room for COVID isolation. There was no mention of the 09/05/24 incident that was reported by Resident #67 and documented in a written statement by LPN #200. Resident #34A review of a reportable found a sexual abuse allegation on 06/14/25 where Resident #73 had his hand down Resident #34's shirt. A review of the quarterly MDS, with an assessment reference date of 06/27/25, reflected that Resident #34 had a BIMS score of 00, indicating severe cognitive impairment. Resident #34 did not have capacity. A review of the 5 Day report revealed the incident was verified Resident #73. Resident #73 did inappropriately touch Resident #34. Resident #83A review of a reportable found a</p> |  |  |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>                                   |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, record review, resident interview, and staff interview, the facility failed to protect the residents' right to be free from abuse that resulted in mental anguish for Residents #47, #34, and #83. Resident #73 was reportedly touching female residents in the breast and vaginal area. An unlimited about of female residents had the potential to be affected. The facility's failure to thoroughly investigate, correct, and prevent inappropriate sexual contact placed Residents #47, #34, and #83 at continued risk of sexual abuse prior to Surveyor intervention. This created an immediate jeopardy situation. Facility census: 103. Findings included: a) Policy Review The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, with a revision date of 2021, stated that residents had the right to be free from abuse which included sexual or physical abuse. It also mentioned a facility-wide commitment and resource allocation to protect residents from abuse by anyone, noting that it could be from other residents. Nowhere in the policy was there a definition of sexual abuse. However, the policy did direct that all possible incidents of abuse were to be identified and investigated. Additionally, the facility was to establish and implement a QAPI review and analysis of reports, allegations, or finding of abuse. It is important to note that at no point throughout the survey process did the facility report that they had self-identified Resident #73, who had capacity until mid-June 2025, as an individual who touched women without capacity in an unwanted sexual way. The facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, with a revision date of September 2022, stated that all reports of resident abuse are reported and thoroughly investigated by facility management. Findings of all investigations were documented and reported. This policy goes on to state: -If resident abuse is suspected, the suspicion must be reported immediately to the Administrator. -The allegation is immediately reported to the appropriate state agencies, the state long-term care Ombudsman, and the resident's legal representative. -Upon receiving any allegation of abuse, the Administrator is responsible for determining what actions (if any) are needed for the protection of residents. -All allegations are to be thoroughly investigated. -The individual conducting the investigation at a minimum will review the resident's medical record to determine if the resident's physical and cognitive status at the time of the incident. Observe the alleged victim, including his or her interactions with staff and other residents. Interview the person reporting the incident. Interview any witnesses to the incident. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Interview the resident's roommate, family members, and visitors. Document the investigation completely and thoroughly. -Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms. -Within five (5) business days of the incident, the Administrator will provide a follow-up investigation report which will describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. -The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation. Review of the Long-Term Care Nursing Home Program Reporting Requirements guidance from the Office of Health Facility Licensure &amp; Certification (OHFLAC) office describes sexual abuse as non-consensual sexual contact of any type with a resident. b) First Inappropriate Resident-to-Resident Incident On 01/26/24 at 5:30 PM, it was reported that Resident #73 and Resident #47 were unsupervised in the activity room. A staff member walked into the room and Resident #73 jumped and moved his hands from under Resident #47's shirt. At that time, Resident #73 had capacity and was believed to be cognitively intact. Resident #47 lacked capacity and had a BIMS of 09, indicating moderate cognitive impairment. The facility reported this incident to the appropriate state agencies as an unusual occurrence noting that the residents had reportedly touched each other. The facility intervention was to move Resident #47 to the opposite side of the building, body audits were performed, and safety checks initiated. There were no written statements from either resident. However, during an interview on 08/07/26 at 10:49 AM, Resident #47 reported she recalled the incident in question. She stated that [Resident #73's First Name] was the man that hurt her and repeatedly said that the facility does not believe her. Resident #47 described being in the activity room, Resident #73 pulling down his pants, taking her hand and making her touch his private parts. Resident stated, He put his hand in my shirt and touched my boob. She said she reported this to the facility. She also expressed fear of Resident #73. Resident #73 was not care planned for inappropriate physical sexual behavior related to unknown etiology until 03/04/24. The goal at that time was, Will only engage in sexual activity with consenting partners. No where in the electronic medical record was</p> |  |  |