

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Fairmont Rehabilitation and Healthcare Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 130 Kaufman Drive 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review, resident interview, and staff interview, the facility failed to ensure there were sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promoted each resident's rights, physical, mental, and psychosocial well-being. This was a random opportunity for discovery throughout the complaint survey process. Resident Identifiers: #78, #79, #74, and #65. Facility census: 97. Findings included: a) Resident Council Minutes A review of resident council minutes, completed on 07/21/26 at 5:55 PM, revealed the following issues: -During the 03/26/26 resident council meeting, residents expressed concern about low staffing in the nursing department. -During the 04/20/26 resident council meeting, residents expressed concern about not getting their evening showers and call lights not being answered in a timely manner. -During the 05/28/26 resident council meeting, residents expressed concern about not getting snacks in the evening. Residents also expressed concern about staff shortage in the nursing department resulting in longer wait times. b) Staff Interview During an anonymous nurse interview, the nurse expressed the following concerns related to staffing in the building: Some days we only have three (3) Nurse Aides per side. We have a lot of two-person assist residents. Management wants each side of the building to send one Nurse Aide (NA) to the dining room. This leaves two (2) to serve meals on the floor. The nurse went on to report that residents are not always getting their scheduled showers because when they are staffed at the lowest level, it is hard for the NA's to get the showers done. The nurse also added that sometimes beds are left unmade and rooms left messy on the weekends. c) Resident #78 A medical record review was completed on 07/22/26 at 8:56 AM. Resident #78's Bath Days were scheduled for Tuesday and Friday on the evening shift. A 30-day lookback showed the following issues: Tuesday, 06/30/26 - no documentation on record Friday, 07/03/26 - no documentation on record Tuesday, 07/07/26 - no documentation on record Friday, 07/10/26 - Resident received a bed bath Tuesday, 07/14/26 - no documentation on record During an interview on 07/22/26 at approximately 4:50 PM, the acting Administrator and interim DON acknowledged the above-mentioned findings, which meant Resident #78 received one (1) of five (5) scheduled bed baths from 06/30/26 thru 07/14/26. No other information was given prior to exit. d) Resident #79 A medical record review was completed on 07/22/26 at 9:16 AM. Resident #79's Shower Days were scheduled for Monday and Thursday on the evening shift. A 30-day lookback showed the following issues: Thursday, 06/25/26 - Not Applicable was documented, indicating Resident #79 did not receive a bath or shower. Monday, 06/29/26 - Resident #79 received a shower. Thursday, 07/02/26 - Left blank, indicating Resident #79 did not receive a bath or shower. Monday, 07/06/26 - Left blank, indicating Resident #79 did not receive a bath or shower. During an interview on 07/22/26 at approximately 4:56 PM, the acting Administrator and interim DON acknowledged the above-mentioned findings, which meant Resident #79 received one (1) of four (4) (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled showers from 06/25/26 thru 07/06/26. No other information was given prior to exit. e) Resident #74 During a review of a facility reportable, dated 07/16/26 at 12:55 PM, it was revealed that Nurse Aide (NA) #80 reported Licensed Practical Nurse (LPN) #51 made her put Resident #74 to bed when he did not want to go. It was reported that LPN #51 stated she did not care what he wanted. This incident happened on 07/14/26 on the 7:00 PM - 7:00 AM shift. Social Worker #107 interviewed Resident #74 regarding the incident. When asked if he wanted to go to bed that evening, he said he did not want to go to bed but was put to bed anyway. When asked who made him, he said the nurse. The facility's corrective action plan was noted to be education on customer service and resident preferences. During an interview on 07/22/26 at approximately 4:45 PM, the acting Administrator and Interim Director of Nursing (DON) acknowledged the fact that Resident #74's rights had been violated when he was forced to go to bed at the LPN's request. No further information was given prior to exit. f) Resident #65A medical record review, completed on 07/21/26 at 8:00 PM, revealed that Resident #65 had filed a grievance on 05/28/26 stating that Nurse Aides told her if she goes back to bed that they won't be able to get her up to attend the evening activities. Section C of Resident #65's annual minimum data set (MDS), with an assessment reference date of 05/01/26, reflected that resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating that she was cognitively intact. g) Facility AssessmentA review of the Facility Assessment was completed on 07/22/26 at 1:11 PM. The facility assessment noted, This staffing plan is based on the facility assessment, along with facility-based and community-based risk assessments to inform staffing decisions to ensure that there are a sufficient number of staff to care for the residents' needs. The facility assessment went on to outline the following staffing needs;-Evening Shift Nurse Aide Ratio of Staff to Residents or HPRD (Hours per Resident day) was documented as .97-Night Shift Nurse Aide Ration of Staff to Residents or HPRD was documented as 0.46.h) Review of Hours per Patient Day (HPPD) DataReview of the following 11 dates revealed the facility was not meeting the expected staffing levels:-02/19/26 Evening Nurse Aide (NA) Per Patient Day (PPD) was 0.45-02/19/26 Night Shift NA PPD was 0.33-02/20/26 Evening NA PPD was 0.45-02/20/26 Night Shift NA PPD was 0.33-03/27/26 Evening NA PPD was 0.48-03/27/26 Night Shift NA PPD was 0.33-04/06/26 Evening NA PPD was 0.45-04/06/26 Night Shift NA PPD was 0.27-04/08/26 Evening NA PPD was 0.57-04/09/26 Evening NA PPD was 0.42-04/09/26 Night Shift NA PPD was 0.32-04/10/26 Evening NA PPD was 0.66-04/10/26 Night Shift NA PPD was 0.26-04/16/26 Evening NA PPD was 0.51-04/16/26 Night Shift NA PPD was 0.28-04/21/26 Evening NA PPD was 0.53-04/21/26 Night Shift NA PPD was 0.26-04/23/26 Evening NA PPD was 0.65-04/23/26 Night Shift NA PPD was 0.29-04/26/26 Evening NA PPD was 0.44-04/26/26 Night Shift NA PPD was 0.25During an interview on 07/22/26 at approximately 5:00 PM, the acting Administrator and Interim Director of Nursing (DON) acknowledged the NA PPD hours failed to meet the expectation set forth in the facility assessement. No other information was given prior to exit.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review and staff interview, the facility failed to ensure resident preferences were honored related to when a resident was put to bed. This was a random opportunity for discovery throughout the complaint survey process. Resident Identifier: #74. Facility Census: 97. Findings included: a) Resident #74 During a review of a facility reportable, dated 07/16/26 at 12:55 PM, it was revealed that Nurse Aide (NA) #80 reported Licensed Practical Nurse (LPN) #51 made her put Resident #74 to bed when he did not want to go. It was reported that LPN #51 stated she did not care what he wanted. This incident happened on 07/14/26 on the 7:00 PM - 7:00 AM shift. Social Worker #107 interviewed Resident #74 regarding the incident. When asked if he wanted to go to bed that evening, he said he did not want to go to bed but was put to bed anyway. When asked who made him, he said the nurse. The facility's corrective action plan was noted to be education on customer service and resident preferences. During an interview on 07/22/26 at approximately 4:45 PM, the acting Administrator and Interim Director of Nursing (DON) acknowledged the fact that Resident #74's rights had been violated when he was forced to go to bed at the LPN's request. No further information was given prior to exit.		

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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 record review and staff interview, the facility failed to ensure it reported results of all abuse/neglect investigations to the appropriate state offices within 5 working days of the incident and/or the initial report. This was true for two (2) of 10 facility reported incidents reviewed throughout the complaint survey process. Resident Identifiers: #63 and #14. Facility census: 97. Findings included: a) Resident #63 A record review was completed on 07/20/26 at 2:00 PM. It was noted that there was an Initial Reporting of Allegations regarding alleged resident-to-resident verbal abuse, dated 05/20/26, that was submitted to the appropriate state agencies. The Five-Day Follow-Up Investigation Report was not submitted to the appropriate state agencies until 06/15/26. Social Worker #8 reported, during an interview conducted on 07/21/26 at approximately 11:30 AM, that there had been a change in administrative leadership around that time and some items were later identified as needing to be followed-up on. b) Resident #14 A record review was completed on 07/20/26 at 2:00 PM. It was noted that there was an Initial Reporting of Allegations regarding alleged resident-to-resident physical abuse, dated 12/02/25, that was submitted to the appropriate state agencies. The Five-Day Follow-Up Investigation Report was not found in the facility's reportable file. During an interview on 07/22/26, Social Worker #8 reported that the five-day follow-up report had gone unsubmitted until surveyor intervention noting this particular report had been handled by previous administrative leadership and the five-day report must have been overlooked.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, electronic medical record review, and review of the facility's Abuse, Neglect, Exploitation policy, the facility failed to take corrective action to prevent further potential abuse/neglect by failing to complete education with staff on transfers. This was true of one (1) of five (5) residents reviewed for abuse during a complaint survey. Resident identifier: #102. Census: 97. Findings included: a) Resident #102A Summary of facility reported incident dated 06/05/26 at 9:40 AM at included: The resident reported that an aide hurt her leg when she was put to bed yesterday No visible injury; no bruising, scratches, lacerations, wounds, bleeding or redness; Redness did express pain upon assessment and facility immediately ordered xray Investigation initiated immediately; staff suspended pending the outcome of the investigation; staff and resident interviews initiated; body audits initiated for residents unable to be interviewed. The five-day-follow-up was reviewed. The five-day-follow-up was submitted to the state agency on 06/15/26 at 4:03 PM. The follow up review revealed: Resident #102 was found to have a fracture. The nurse aide (NA) was suspended pending an investigation. The investigation was conducted. Resident #102 was sent to the hospital for an initial follow up; doppler completed at hospital ruling out blood clot. Upon return from hospital Resident #102 continued to complain of pain; she was ordered an x-ray at that time. X-ray revealed a fracture. The facility completed interviews with staff regarding transfer status. Body audits/interviews were completed. Alleged victim confirmed suffering a fracture as a result of the event. The Nurse Aide was terminated. A review of Resident #102's Care Plan revealed, Resident transfers with extensive assist of two staff. A continued review of the facility reported incident (FRI) revealed Resident #1 had expressed pain related to her left leg. Resident was sent to the emergency room on [DATE]. The diagnosis report revealed Resident # 102 had a blood clot in her left calf and was started on Eliquis. She returned to the facility the same date. Continued review found that Resident #102 continued complaints of pain, the facility received a new order for Tramadol on 06/08/26. Subsequent review revealed an radiograph (X-ray) was obtained on 06/11/26 with diagnosis of a fracture of her fibula and tibia. On 07/22/26, a review of the reportable found education of staff following this substantiated incident. On 07/22/26, approximately 3:00 PM an interview with the intriarm Director of Nursing stated that there was education was completed for transfers to ensure the same type of incident did not reoccur.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview and record review, the facility failed to ensure a resident's discharge documentation was completed for a resident discharged to the hospital. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #100. Facility Census: 97. Findings included: a) Resident #100 Resident #100's medical record was reviewed for a discharge from the facility. The medical record did not contain a change of condition for discharge, the discharge location of the resident, a summary of the residents medical condition, a disposition of personal effects, or a disposition of medications. No discharge paperwork was completed and the discharge process was not followed. On 07/22/26 at 2:24 PM, the Administrator and Social Worker #107 reported the police were involved with the discharge. Social Worker #107 reported she thought the resident was transferred to (name of local hospital). Social Worker #107 reported she would look for discharge paperwork. No additional information was given to the State Surveyor. At 3:55 PM, the State Surveyor reviewed the discharge with no documentation with the Administrator. The Administrator confirmed the lack of discharge notification and stated, I understand. The policy and procedure for Transferor discharge as related to transfer or discharge Documentation in the medical Record stated, 1. when the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: a). The basis for the transfer or discharge; b. That an appropriate notice was provided to the resident and/or legal representative; c. The date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medical, physical, and mental condition; g. Disposition of personal effects; h. Disposition of medications; i. Others as appropriate or as necessary, and j. The signature of the person recording the data in the medical record. I		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review, resident interview, and staff interview, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain adequate grooming and hygiene. This was true for two (2) out of six (6) residents reviewed for showers throughout the complaint survey process. Resident Identifiers: #78, and #79. Facility census: 97. Findings included: a) Resident #78 A medical record review was completed on 07/22/26 at 8:56 AM. Resident #78's Bath Days were scheduled for Tuesday and Friday on the evening shift. A 30-day lookback showed the following issues: Tuesday, 06/30/26 - no documentation on record Friday, 07/03/26 - no documentation on record Tuesday, 07/07/26 - no documentation on record Friday, 07/10/26 - Resident received a bed bath Tuesday, 07/14/26 - no documentation on record During an interview on 07/22/26 at approximately 4:50 PM, the acting Administrator and interim DON acknowledged the above-mentioned findings, which meant Resident #78 received one (1) of five (5) scheduled bed baths from 06/30/26 thru 07/14/26. No other information was given prior to exit. b) Resident #79 A medical record review was completed on 07/22/26 at 9:16 AM. Resident #79's Shower Days were scheduled for Monday and Thursday on the evening shift. A 30-day lookback showed the following issues: Thursday, 06/25/26 - Not Applicable was documented, indicating Resident #79 did not receive a bath or shower. Monday, 06/29/26 - Resident #79 received a shower. Thursday, 07/02/26 - Left blank, indicating Resident #79 did not receive a bath or shower. Monday, 07/06/26 - Left blank, indicating Resident #79 did not receive a bath or shower. During an interview on 07/22/26 at approximately 4:56 PM, the acting Administrator and interim DON acknowledged the above-mentioned findings, which meant Resident #79 received one (1) of four (4) scheduled showers from 06/25/26 thru 07/06/26. No other information was given prior to exit.		