STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to provide a clean, comfortable, homelike environment. This failed practice was a random opportunity for discovery and had the potential to affect a limited number of residents during the Long-Term Care Survey Process. Facility Census: 91. Findings include: a) room [ROOM NUMBER]-B The initial observation on 07/30/25 at 11:16 AM, revealed in the bathroom of room [ROOM NUMBER]-B, around the entire base of the toilet was a dried orange, yellow and brown substance. The floor was sticky, and the bathroom had a strong urine odor. During an interview on 07/31/25 at 12:28 PM, The Housekeeping Supervisor (HS) confirmed that the bathroom was dirty, and stated, I will get that cleaned up.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure documentation that required transfer information was provided to the receiving hospital. This deficient practice had the potential to affect one (1) of two (2) residents reviewed for care area of hospitalization. Resident identifier: #21. Facility census: 91. Findings included:a) Resident #21 Review of Resident #21's electronic medical records showed the resident was transferred to the hospital on [DATE] due to a fall, altered mental status, and an elevated blood glucose level. Further review of Resident #21's electronic medical records did not reveal documentation regarding what information was sent to the hospital to which the resident was transferred. On 08/04/2025 at 3:07 PM, the Director of Nursing (DON) provided a document titled Acute Care Transfer Document Checklist. The document had Resident #21's name written on it, along with the date 07/13/25. The document gave the following instructions: Copies sent with resident, check all apply. The document contained two (2) lists with boxes to be checked. The first list stated, These documents should ALWAYS accompany patient and included a universal transfer form, face sheet, current medication list or current medication administration record, advance directives or Physician's Orders for Scope of Treatment form, facility capabilities list, transfer notification, bed hold policy and notification, and immunization record. The bottom of the form stated, By signing you agree that the above has been provided to the resident upon transfer to the hospital. The form was signed by the nurse and by the ambulance staff accepting the envelope of documents. The second list stated, Send these documents as INDICATED and included acute change in condition/nurse's progress note, most recent history and physical and any recent hospital discharge summary, recent physician, nurse practitioner, or physician's assistant orders related to acute condition, relevant lab results, and personal belongings sent with the resident. None of the items on the checklist had been checked to indicate the information was sent to the hospital with Resident #21 on 07/13/25. The Director of Nursing confirmed this checklist was the only document available regarding the information sent to the hospital with Resident #21 on 07/13/25. No further information was provided through the completion of the survey process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based upon record review and staff interview, the facility failed to accurately reflect the resident's diagnoses in the assessment. This was found to be true for one (1) of twenty-seven (27) residents reviewed during the annual survey process. Resident identifier: #9. Facility census: 91.Findings included: a) Resident #9 A review of the electronic health record reflects the Resident has the following diagnoses related to mental health:ANXIETY DISORDER, UNSPECIFIED 6/17/2024MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES 6/17/2024POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED 6/17/2024 The most recent Minimum Data Set (MDS) assessment was completed on 06/26/25. Under Section I: Active Diagnoses, Psychiatric/Mood Disorder, the facility only marked Post Traumatic Stress Disorder. Anxiety disorder or depression were not marked. These findings were reviewed with the Director of Nursing (DON) on 08/04/25 at 1:00 PM. The DON acknowledged the error.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 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 upon record review and staff interviews, the facility failed to update the Pre-admission Screening and Resident Review (PASARR) when new diagnoses were given. This was found to be true for two (2) of eight (8) residents reviewed during the annual survey process. Resident identifiers: #9, #42. Facility census: 91. Findings included: a) Resident #9 A review of the electronic health record reflected the Resident had the following diagnoses related to mental health:ANXIETY DISORDER, UNSPECIFIED 6/17/2024MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES 6/17/2024POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED 6/17/2024 The resident's most recent Pre-admission Screening and Resident Review (PASARR) was completed on 09/25/24 by the facility. Under the section III, MI/MR, Current Diagnosis, None was marked. There is a box for Major Depression, but it was not selected. There is also a selection for Other Relation Conditions, and it was not marked. Post Traumatic Stress Disorder (PTSD) and Anxiety could have been specified in that section. The resident's Medical Diagnostic Screening (MDS) assessment was last completed on 06/26/25. Under Section I Active Diagnoses, Psychiatric/Mood Disorder question, Post Traumatic Stress Disorder (PTSD) is marked. But, Anxiety Disorder is not marked, and Depression is not marked. Comparing the MDS and the PASARR, the diagnoses do not agree. Nor, do the diagnoses in the resident's electronic health record (EHR) agree with either the MDS or the PASARR. This was reviewed with the Director of Nursing (DON) on 08/04/25 at 1:00 PM. Comparing the documents, the DON agreed the diagnoses in the electronic health record were accurate, and the MDS and PASARR diagnoses were not coordinated. b) Resident #42 On 08/04/25 at 01:02 PM, Resident #42's PASARR and Diagnosis List were reviewed. A diagnosis of Post-Traumatic Stress Disorder was listed, but was not on the resident's PASARR. On 08/04/2025 at 01:27 PM, the Director of Nursing and Social Worker confirmed the PTSD diagnosis was not on the resident's PASARR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop and/or implement individualized care plans related to Activities, Depression, and Post Traumatic Stress Syndrome (PTSD). This failed practice was found true for (7) seven of 27 residents reviewed for care plan accuracy during the Long-Term Care Survey Process. Resident identifiers #5, #74, #83, #9, #13, #42, and #72. Facility census 91. a) Resident #9 Under the Activities Section of the Care Plan, the goal was Will have the opportunity to enjoy activities of choice through the next review date. Interventions were: Invite/encourage resident to attend activities daily. Provide resident with a calendar of scheduled activities. Remind resident at least 15 minutes prior to the start of the activity. Resident requires assistance with mobility to and from activities. However, the Care Plan did not state what activities the resident enjoys doing. This resident has diagnoses of PTSD, Anxiety, and Depression. Her Care Plan included Anxiety but did not address Depression or PTSD at all. b) Resident #13 A review of Resident #13's Care Plan revealed it was not personalized for the activities she liked to do. Under the Activities Section of the Care Plan, the goal was Will have the opportunity to enjoy activities of choice through the next review date. Interventions were: Invite/encourage resident to attend activities daily. Provide resident with a calendar of scheduled activities. The Care Plan does not state what activities the resident enjoys doing. The medical record contains progress notes dated 07/15/25, completed by the Activities Director, of resident attending bingo and social activities. When asked about the resident's preferred activities, the Director of Activities could state some of the things the resident enjoyed doing. When asked about why these were not included in the Care Plan, the Director stated he is not invited to attend the care plan meetings. This interview occurred on 08/04/2025 at 2:45 PM. During an interview with the Social Worker #6, on 08/04/25 at approximately 1:40 PM, when asked about the process for establishing a resident's Care Plan, she stated she normally developed the Care Plan by going through the medical record of the resident. When asked if she had a sign-in sheet for the people attending the Care Plan meetings, she stated she did not keep one. When asked if Dietary, Nursing, Activities, etc. attended the Care plan meetings, she stated, “no.” When asked if the resident or the resident's representative were invited to the meetings, she stated, “occasionally.” c) Resident #42 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/30/2025 at 12:19 PM, Resident #42's care plan was reviewed. The resident's care plan did not address the resident's diagnosis of Post-Traumatic Stress Disorder (PTSD). On 08/04/2025 at 01:27 PM , the Director of Nursing and Social Worker confirmed the resident's comprehensive care plan did not include PTSD. d) Resident #72 The most recent MDS, dated [DATE], indicates that the resident experiences pain that interferes with both sleep and daily function. This is documented under Section J (Pain Management), with responses marked “Yes” to both pain interference questions. Review of the resident’s care plan reveals a pain goal that reads: “Resident reports occasional pain. Staff to monitor and offer PRN medications.” However, this care plan lacks measurable objectives, timeframes, and person-centered details such as pain location, frequency, or severity. No evidence of interdisciplinary input or individualized planning related to pain goals or preferences was found. The July and August 2025 MARs confirm that Acetaminophen 650 mg PO Q6H PRN was administered for pain, but no scheduled pain medications were noted. While the TAR includes general documentation of PRN effectiveness, there was no ongoing evaluation or reassessment documented to determine whether the pain management approach remained adequate. Progress notes from 05/14/2025 and 06/11/2025 describe the resident as complaining of back or leg pain, including the statement, “It’s sore today, probably the weather.” No documented follow-up, care plan revision, or interdisciplinary discussion was noted in response. Close inspection of the MAR shows that staff tracked pain using a 1–10 scale in association with administration of Meloxicam, but this was not reflected in the formal care plan or used to update goals. On 08/04/2025 at 12:45 PM, the Social Worker stated that she did not have recollection of any recent updates to the resident's care plan. She stated that she had not communicated with the resident or representatives recently regarding pain management goals. When asked if she knew anything about why he refuses care (appointments/medications/direct care), she stated that there might not be a particular reason so much as the fact that he can be cantankerous and difficult. In an interview on 08/05/2025 at 10:13 AM, the unit nurse stated that from what she knew, the resident’s pain is “sporadic,” and that he often refuses pain medications because of how they make him feel. This was not reflected in the care plan for pain. e) Resident #5 A record review on 08/04/25 at 1:00 PM, revealed an Activity care plan initiated 05/27/2025 for Resident #5 that reads as follows: Focus: Activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: Will have the opportunity to enjoy activities of choice through the next review date. Interventions: Activities staff to provide in room visits and 1:1 visits. Invite/encourage resident to attend activities daily. Provide resident with a calendar of scheduled activities. Remind resident at least 15 minutes prior to start of activity. Resident requires assistance with mobility to and from activities. Further record review revealed an admission Activity Assessment that has the following marked as interest for Resident #5: crafts, music, being outdoors, watching TV, gardening, puzzles, animals, cooking, baseball games, and Bible study. A review of the Activity Participation Record (APR) for 05/2025 to 08/2025 revealed that Resident #5 had not received any one to one visits. During an interview on 08/04/2025 at 2:50 PM, The State Agency (SA), asked The Activity Director (AD) if he felt that Resident #5's care plan was personalized for activities? The AD replied, No, but I do not do my own care plans. The person that does the MDS does them. The AD confirmed that Resident #5 was not receiving one to one visits as care planned and that her care plan was not individualized to meet her needs. f) Resident #74 A record review on 08/04/25 at 12:30 PM, revealed an Quarterly Activity Progress note that reads as follows: Resident does not attend any activities. Resident is sometimes out in the dining area watching tv or in her room. Activities staff will continue to encourage resident to attend activities of her interest. Activities staff will also continue to complete in room visits once daily for this resident . Activities staff will complete one on ones twice weekly for this resident. Further record review revealed an Activity care plan that reads as follows: Focus: Social isolation r/t inability to makeneeds/wants known she has severe MRwhich limits her attention span. Goals: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Needs are met, continue goals.The residents needs will bemet through next review. Interventions: Activities staff to provide in room visits and 1:1. Invite/encourage the resident's family members to attend activities with the resident in order to support participation. Monitor nutritional status. The resident needs, adequate nutritional intake tomaintain normal activity level . Monitor/document for impact of medical problems on activity level. Resident requires assistance with mobility to and from activities. The resident needs assistance/escort activity functions. Further record review revealed that Resident #74 was admitted to the facility in 2016, and no activity assessments could be found. A review of the APR's for 05/2025, 06/2025, and 07/2025 revealed that according to the care plan Resident #74 was scheduled for 26 one to one visits and only received 18. During an interview ON 08/04/25 at 2:40 PM the Activity Director (AD) stated, I do not know why but I could not find an activity assessment on her. There has not been one done. She has been here since 2016, I have been doing this just for a year and I did not catch it. The State Agency (SA) asked the AD why her care plan was not personalized with her interest? The AD replied, I do not know, I do not do my own care plans, the MDS person does them. He confirmed that Resident #5's care plan was not personalized, and that she was not receiving one to one visits as scheduled. g) Resident #83 A record review on 08/05/2025 at 11:30 AM, revealed an Activities care plan for Resident #83 that reads as follows: Focus: Activities. Goal: Will have the opportunity to enjoy activities of choice through the next review date. Interventions: Activities staff to provide in room visits and 1:1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide resident with a calendar of scheduled activities. Remind resident at least 15 minutes prior to the start of activities. Resident requires assistance with mobility to and from activities. Further record review revealed an Annual Activities assessment dated [DATE] with current interest indicated as follows: Music, Watching TV, Talking/conversing, and animals. None of the above interests are indicated in the care plan. A review of the APR's for 05/2025, 06/2025, and 07/2025 shows that from 07/11/25 to present Resident #83 had only received (1) one, one to one visit. During an interview on 08/04/2025 at 2:50 PM, The State Agency (SA), asked The Activity Director (AD) if he felt that Resident #s 83's care plan was personalized for activities? The AD replied, No, but I do not do my own care plans. The person that does the MDS does them. The AD confirmed that Resident # 83 was not receiving one to one visits as care planned and that her care plan was not individualized to meet her needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on policy review, resident interviews, record review and staff interview, the facility failed to ensure residents and/or responsible party as well as required staff were included in care plan meetings. In addition, a care plan was not revised when new medications were added. This failed practice affected three (3) of 27 sample residents. Resident identifiers: #38, #86, #11. Facility census: 91.Findings included: a) Resident #11 On 08/04/2025, Resident # 11's Pharmacy Orders were reviewed. Two psychotropic medications, Tramadol and Lorazepam, were not included on the resident's comprehensive care plan. On 08/05/2025 at 08:51 AM, the Director of Nursing (DON) confirmed the medications were not included on the care plan and stated, Tramadol was recently started. and Okay. b) Resident #38 The Nursing Home Administrator (NHA) provided a copy of the policy titled Comprehensive Care Plans with a date reviewed/revised of 04/28/25 on 08/05/25 at 4:00 PM. A review of the policy found the following: The comprehensive care plan will be prepared by the interdisciplinary team, that includes, but is not limited to: the attending physician or non-physician practitioner designee involved in the resident 's care .' ; a Registered Nurse with the responsibility for that resident; a nurse aide with responsibility for the resident; a member of the food and nutrition services staff; the resident and the resident's representative, to the extent practicable. On 07/30/25 at 1:26 PM when Resident #38 was interviewed, she stated that she did not know what a care plan was. Resident #38's Brief Interview Mental Status (BIMS) score was 15 which reflects cognition is intact. The Social Worker (SW) was asked on 08/04/25 at 12:04 PM for evidence of care plan meetings as none were found in Resident #38's Electronic Medical Record (EMR). The SW produced a notebook on 08/04/25 at 12:10 PM with a form titled Care Plan Cheat Sheet. A review of the care plan cheat sheet found the Resident's Annual Minimum Data Set (MDS) had no evidence of who attended the care plan meeting 07/08/25. An interview was conducted on 08/04/25 at 1:40 PM with the SW. When asked to explain the facility care plan process, she stated that she (SW) and the MDS coordinator get the information to complete the paper Care Plan Cheat sheet and care plan from the EMR. No other disciplines are involved in the care plan process. She does mail a letter to the responsible party at either the beginning or end of each month but does not follow up to see if they are planning on attending the meeting. She does not send or give a letter or invite in-house residents to attend the meeting or go to the resident’s room to go over the care plan with the resident. c) Resident #86 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/30/25 at 11:22 AM when Resident #86 was asked about her care plan, she did not know what a care plan was. Resident #86's Brief Interview for Mental Status (BIMS) score was 15 which reflects cognition is intact. The Social Worker (SW) was asked on 08/04/25 at 12:04 PM for evidence of care plan meetings as there were none in Resident #38's Electronic Medical Record (EMR). The SW produced a notebook on 08/04/25 at 12:10 PM with a form titled Care Plan Cheat Sheet. A review of the care plan cheat sheet found for the Resident's admission Minimum Data Set (MDS) found no evidence of who attended the care plan meeting. An interview was conducted on 08/04/25 at 1:40 PM with the SW. When asked to explain the facility care plan process, she stated that she (SW) and the MDS coordinator get the information to complete the paper Care Plan Cheat sheet and care plan from the EMR. No other disciplines are involved in the care plan process. The SW mailed a letter to the responsible party at either the beginning or end of each month but did not follow up to see if they were planning on attending the meeting. She did not send or give a letter or invite in-house residents to attend the meeting or go to the residents room to go over the care plan with the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review the facility failed to provide an ongoing program of activities to meet the needs and interest of each resident. This failed practice was found true for (3) three of (6) six residents reviewed for activities during the Long-Term Care Survey Process. Resident identifiers #5, #74, #83. Facility Census 91.Findings include: a) Resident #5 During the initial observation on 07/30/25 at 10:30 am, showed Resident #5 lying in her bed, patting her blanket. Resident was hollering out. No stimulation was on in the resident's room.A record review on 08/04/25 at 1:00 PM, revealed an activity care plan initiated 05/27/25 for Resident #5 that reads as follows: Focus:Activities. Goal:Will have the opportunity to enjoy activities of choice through the next review date. Interventions:Activities staff to provide in room visits and 1:1 visits.Invite/encourage resident to attend activities daily.Provide resident with a calendar of scheduled activities.Remind resident at least 15 minutes prior to start of activity.Resident requires assistance with mobility to and from activities. Further record review revealed an admission Activity Assessment that has the following marked as interest for Resident #5: crafts, music, being outdoors, watching TV, gardening, puzzles, animals, cooking, baseball games, and Bible study. A review of the Activity Participation Record (APR) for 05/25 to 08/25 revealed that Resident #5 had not received any one-to-one visits. An observation on 08/04/25 at 2:15 PM, Showed Resident #5 lying in her bed, hollering out curse words. No stimulation was on in the resident's room. During an interview on 08/04/2025 at 2:50 PM, The State Agency (SA), asked The Activity Director (AD) if he felt that Resident #5's care plan was personalized for activities. The AD replied, No, but I do not do my own care plans. The person that does the MDS does them. The AD confirmed that Resident #5 was not receiving one-to-one visits as care planned and that her care plan was not individualized to meet her needs. During an interview on 08/05/25 at 1:00 PM, The AD stated, When my staff does the coffee cart in the mornings, they are supposed to be turning on residents' TV's. I will definitely get on this and check into it. b) Resident #74 During the initial observation on 07/30/25 at 1:30 PM showed Resident #74's room door was shut due to being on contact precautions. During an interview on 07/30/25 at 1:30 PM, Nursing Assistant (NA) #60 opened Resident #74's door and stated, We keep the door shut due to them being on contact precautions. NA #60 confirmed that no stimulation was on in Resident #60's room. A record review on 08/04/25 at 12:30 PM, revealed a Quarterly Activity Progress note that read as follows: Resident does not attend any activities. Resident is sometimes out in the dining area watching tv or in her room. Activities staff will continue to encourage resident to attend activities of her interest. Activities staff will also continue to complete in room visits once daily for this resident . Activities staff will complete one on ones twice weekly for this resident. Further record review revealed an Activity care plan that reads as follows:Focus: Social isolation r/t inability to makeneeds/wants known she has severe MRwhich limits her attention span. Goals:Needs are met, continue goals.The residents needs will bemet through next review. Interventions: Activities staff to provide in room visits and 1:1. Invite/encourage the resident's family members to attend activities with the resident in order to support participation. Monitor nutritional status. The resident needs, adequate nutritional intake tomaintain normal activity level. Monitor/document for impact of medical problems on activity level. Resident requires assistance with mobility to and from activities.The resident needs assistance/escort activity functions. Further record review revealed that Resident #74 was admitted to the facility in 2016, and no activity assessments could be found. A review of the Activity Participation Records for 05/25, 06/25, and 07/25 revealed that according to the care plan Resident #74 was scheduled for 26 one to one visit and only received 18. An observation on 08/04/25 at 2:15 PM, Showed Resident # 74's door was shut due to being on contact precautions. The State Agency (SA) knocked and asked permission to come in. The resident was sitting in her geri chair, and no stimulation was on in the room. During an interview ON 08/04/25 at 2:40 PM the Activity Director (AD) stated, I do not know why but I could not find an activity assessment on her. There has not been one done. She has been here since 2016; I have been doing this just for a year and I did not catch it. The State Agency (SA) asked the AD why her care plan was not personalized with her interest? The AD replied, I do not know, I do not do my own care plans, the MDS person does them. He confirmed that Resident #5's care plan was not personalized, and that she was not receiving one-to-one visits as scheduled. During an interview on 08/05/25 at 1:00 PM, The AD stated, When my staff does the coffee cart in the mornings, they are supposed to be turning on residents' TV's. I will definitely get on this and check into it. c) Resident #83 During the initial observation on 07/30/25 at 1:30 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Based on observation, record review, and staff interview, the facility failed to ensure the environment over which it had control was as free from accident hazards as possible. Hot water temperatures in resident areas exceeded 120 degrees Fahrenheit (F). This deficient practice was determined to be an immediate jeopardy situation that placed all residents at risk for burns from hot water. Facility census: 91.Findings included:a) Hot water temperatures The facility's policy statement titled Safe Water Temperatures, with no implementation or revision dates given, stated as follows:Direct care staff will monitor residents during prolonged exposure to to warm or hot water for any signs or symptoms of burns, and will respond appropriately. Staff will be educated on safe water temperatures upon employment and on a regular basis. Thermometers will be available as needed for use by all staff. Staff will report abnormal findings, such as complaints of water too cold or hot, burns or redness, or any problems with water temperatures (ex. water is painful to touch or causes redness) to the supervisor and/or maintenance staff.Water temperatures will be set to a temperature of no more than 110 degrees Fahrenheit (43.33 degrees Celsius), or the state's allowable maximum water temperature. Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits weekly and as needed. Documentation of testing will be maintained for 3 years and kept in the maintenance office. On 07/30/25 at approximately 8:00 AM, the hot water temperatures in rooms B #111 and A #127 were noted by surveyors to seem hot to touch.On 07/30/25 at 8:45 AM, the hot water temperature in the sink in room B #111 was checked by the Maintenance Supervisor with the surveyor observing. The water ran for two (2) minutes before the temperature was checked. The temperature was 121.1 degrees Fahrenheit. On 07/30/25 at 8:53 AM, the hot water temperature in the sink in room A #127 was checked by the Maintenance Supervisor with the surveyor observing. The water ran for two (2) minutes before the temperature was checked. The temperature was 126.3 degrees Fahrenheit.The Maintenance Supervisor confirmed the temperatures were too high. He stated he liked to keep the hot water temperatures between 105 to 110 degrees. He stated the building only has one mixing valve that serves all resident rooms and shower rooms. The Maintenance Supervisor stated water temperatures were monitored weekly. He provided documentation for the month of July 2025 showing weekly testing of the water in the shower rooms and six (6) randomly selected resident rooms in each hallway. For the month of July, recorded temperatures did not reach 110 degrees F. The temperature monitoring was last conducted on 07/24/25. On 07/30/25 at 10:30 AM, the facility was informed an immediate jeopardy situation existed due to the water temperature in resident areas exceeding 120 degrees, which placed residents at risk for burns. On 07/30/25 at 4:00 PM, the State Agency accepted the following Plan of Correction: Corrective Measures for Resident(s) Affected: The maintenance director adjusted the mixing valve to the hot water on 07/30/25 at approximately 10:30 AM and flushed the remaining hot water. The facility will continue to monitor all residents' rooms' water temps immediately, then in 30 minutes, then in one-hour times 4 hours, and then every shift in affected resident rooms. Any out-of-range temperatures will be reported to the NHA [Nursing Home Administrator] and DON [Director of Nursing], and the hot water to that sink and/or shower will be shut off. Anticipated date of compliance is 07/30/25. Identification of others with the potential to be affected: All facility residents have the potential to be affected. On 07/30/25 at 10:30 AM the facility-initiated water temperature checks in each resident's room to ensure temperatures are in the safe temperature range of 95-110 degrees. Each shift starting 07/30/25 supervisor will check water temperatures in affected resident rooms to ensure that temperatures are in the safe temperature range of 95-110 degrees. Any out-of-range temperatures will be reported to the DON and NHA< and the hot water to that sink will be shut off. The anticipated date of compliance is 07/30/25. Measures to Prevent Recurrence: Facility Safe water temperature policy has been reviewed by Corporate Compliance Nurse. The Director of Nursing or designee-initiated education with all departments on the safe water temperature policy. Education included safe water temperature ranges for hot water and the need to report findings such as water temperature being too hot or cold, redness or burns or any problem with water temperatures to the supervisor and maintenance immediately. The anticipated date of compliance is 07/30/25. The facility Orientation Process will be adjusted to include a review of the safe water temperature policy. Anticipated date of compliance will be 07/30/25 and ongoing. The nursing supervisors will receive education on obtaining a water temperature and the need to immediately check the temperature upon notification of staff memers of water temperature concerns. The anticipated date of compliance is 07/30/25. The Facility Administrator completed one on one education with the maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview and staff interview, the facility failed to provide appropriate treatment and services to restore a resident's normal eating skills. This failed practice was found to be true for Resident #6 during the annual survey process and had the potential to affect a limited number of residents. Resident Identifier: #6. Facility Census: 91. Findings included: a) Resident #6 On 07/30/25 at 9:55 AM, the state surveyor interviewed Resident 6 as part of the annual survey process. The resident stated he could not eat anymore because he aspirates and gets pneumonia. The resident reported he had not had any Speech Therapy (ST) for swallowing difficulties. The resident's diet order was noted as follows :NPO diet, NPO texture, NPO (nothing by Mouth) consistency. The State Surveyor interviewed the Director of Nursing (DON) on 07/31/25 at 11:30 AM. The DON reported the Speech-Language Pathologist (SLP) had retired and speech therapy services were provided via Telehealth pending the results of a resident's Modified Barium Swallow Study (MBSS). The DON reported Resident #6's last MBSS was in 2016. The resident's last SLP Evaluation was completed on 02/01/23. The resident was discharged from speech therapy services for dysphagia on 02/13/23. Diet recommendations included: Solids: - Any/all solids/liquids and Liquids-Thin cup/IDDSI 0, Thin Straw/IDDSI 0. Progress Note dated 05/12/25 stated, Pt. seen by telehealth to assess if appropriate to have chewing gum following MD request. Pt. is currently NPO receiving g-tube feedings as primary source of nutrition/hydration. Pt. presents with reduced alertness, poor positioning and currently on ABT for PNA. Pt. is not appropriate for gum/anything by mouth at this time 2'2 high risk of aspiration. Pt. agreeable. Continue Oral care and elevated HOB during g-tube feedings. Reconsult SLP if change in status. The resident was screened quarterly on 04/24/25 and 06/12/25 with no ST services indicated at this time. The resident received Physical Therapy (PT) services during the 06/12/25 quarterly screen. The facility's screening Policy Statement stated, Therapy Services will perform for needed services for all new admissions and readmissions to the facility. The patient has had several hospitalizations with Admitting and Discharge Diagnoses of Recurrent aspiration pneumonia . On 03/12/24, the resident's admitting diagnosis from (name of local hospital) was acute on chronic hypoxemic: respiratory failure Recurrent aspiration. On 06/08/24, the resident's admitting and discharge diagnosis from (name of local hospital) was Aspiration pneumonia. On 06/24/24, DMC Discharge summary stated, This gentleman is well known to our service and has had multiple admissions over the last 12 months, requiring HPNC to bipap and intubation. He has been deemed to have capacity, is known to aspirate, he does not wish to change his diet, nor does he want a feeding tube. On 07/20/2024. The resident's discharge summary stated: Recurrent Aspiration pneumonia and regular diet. On 03/06/25 the resident was hospitalized at (name of local hospital) with an admitting dx of Sepsis due to left lower lobe aspiration type pneumonia. Discharge summary stated, mechanical soft diet. Discharge from (name of local hospital) dated 03/28/25 had an admitting and discharge diagnosis of Aspiration pneumonia. Discharge summary dated [DATE], had a discharge diagnosis with Dysphagia with recurrent aspiration. Informed Decision to Refuse to Follow Physician's Dietary Orders and Release of Liability were completed on the following dates:- 01/24/2016 1500 cal diet- 02/22/2016 Nectar thick liquids- 11/10/2021 Nectar thickened liquids Dietary order changes were as follows: Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 12/27/2021 Regular diet, Regular texture, Regular consistencylow residue diet x3 days the resume previous dietDiet Completed 07/27/2022Regular diet, Regular texture, Regular consistencyregular thin liquidsDiet Discontinued 02/1/2023 Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 04/12/2023 Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 10/24/2023 Regular diet, Chopped texture, Thin Liquids consistencyDiet Discontinued 01/21/2023 Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 12/03/2023 Regular diet, Chopped texture, Thin Liquids consistencyDiet Discontinued 12/16/2023 Regular diet, Pureed texture, Thin Liquids consistencyDiet Completed 12/28/2023 Regular diet, Chopped texture, Thin Liquids consistencyDiet Discontinued 12/31/2023 Regular diet, Chopped texture, Thin Liquids consistencyDiet Discontinued 02/01/2024Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 03/13/2024 Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 03/27/2024 Regular diet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to provide medically-related social services to assist the resident in attaining or maintaining their mental and psychosocial health. This was found to be true to one (1) of six (6) residents reviewed during the annual survey process. Resident identifier: #9. Facility census: 91. Findings included:a) Resident #9Upon admission to the facility on [DATE], the Resident had a diagnosis of Post Traumatic Stress Disorder (PTSD), Anxiety and Major Depressive Disorder, Recurrent and Severe. The diagnosis for PTSD was also found on her Pre-admission Screening and Resident Review Assessment. A review of her medical record documents revealed, a Social Service Assessment, was performed by the Director of Social Services on 06/20/24. Section G of this document consisted of a Trauma Screen. The resident responded No to all the questions, thus scoring negative for trauma. Resident #9's care plan document stated she had a communiction problem related to choosing not to speak at times. Her score on her Brief Interview for Mental Status (BIMS) at the time of admission was nine (9). There were no indications that the Social Services Assessment was completed with the resident's representative's input. The Social Services Assessment completed on the resident failed to probe for any PTSD triggers. Further, there was no referral for psychological evaluation, or psychological services offered. The Director of Social Service's notes and assessment do not address PTSD at all. There were no attempts to determine triggers for PTSD.An interview with the DON on 08/04/2025 1:00 PM reviewed MDS, Care Plan, PASARR, Social Worker notes, no referral for psych. She acknowledged they were missing.On 08/04/2025 at approximately 1:40 PM, an interview was completed with the Director of Social Services. When she was asked why the resident did not have care plan goals or interventions for depression or PTSD, psychological referral for evaluation and treatment or behavioral services offered, the Director of Social Services stated she did not feel it was necessary because the resident had responded no to all the questions under the Trauma Screening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 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, and staff interview the facility failed to store, distribute and serve food in accordance with professional standards for food service safety. This failed practice was a random opportunity for discovery and the potential to affect more than a limited number of residents during the Long-Term Care Survey Process. Facility census: 91. Findings include: a) Kitchen An observation on 08/05/25 at approximately 12:45 PM revealed the cook was starting to fix plates. The first plate the cook pulled out of the plate holder was wet. The cook then placed a tuna hoagie and chips on the plate. The cook then handed the plate to the kitchen aide to put on the tray cart. The cook then pulled out the next plate that was wet and put chopped tuna on it. The State Agency (SA) asked, Are all of those plates wet? The Certified Dietary Manager (CDM) started pulling plates from the plate holder and all the plates that she pulled off were wet. The CDM stated, Go get Styrofoam trays from our emergency stock and serve lunch on those today? The CDM then went to check out the dishwasher and stated, I found the problem, the dishwasher was out of the dry assist for the dishes. The CDM further confirmed that the serving plates were wet and could draw bacteria.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review and staff interview, the facility failed to provide specialized rehabilitation services for speech therapy. This failed practice was found to be true for two (2) of two (2) residents during the annual survey process and had the potential to affect a limited number of residents. Resident Identifiers: #6 and #84. Facility Census: 91. a) Resident #84 A record review on 08/04/25 at 11:45 AM, revealed that Resident #84 was ordered a regular diet, regular texture, thin liquids diet on 02/07/25. The diet was changed on 07/25/25 to a regular diet, puree texture, thin liquids. A record review of Resident #84's weights shows that her actual admission weight, taken the day after admission was 116.4 pounds (lbs.) and her current weight taken on 07/07/25 was 110 lbs. Further record review revealed that Resident #84 had ordered supplements throughout the weight loss but had not had any Speech Therapy Consults before her diet was downgraded to the puree texture. During a telephone interview on 08/04/25 at 12:58 PM, The Registered Dietician (RD) stated, I would agree that it is a big downgrade in diet to go from regular texture to puree without a speech consult first. During an interview on 08/04/2025 at 3:20 PM, The Director of Nursing (DON) stated, I just started education with my staff saying that they cannot downgrade a diet that far without a speech consult. That there are steps that need to be followed. b) Resident #6 On 07/30/25 at 9:55 AM, the state surveyor interviewed Resident 6 as part of the annual survey process. The resident stated he could not eat anymore because he aspirates and gets pneumonia. The resident reported he had not had any Speech Therapy (ST) for swallowing difficulties. The resident's diet order was noted as follows :NPO diet, NPO texture, NPO (nothing by Mouth) consistency. The State Surveyor interviewed the Director of Nursing (DON) on 07/31/25 at 11:30 AM. The DON reported the Speech-Language Pathologist (SLP) had retired and speech therapy services were provided via Telehealth pending the results of a resident's Modified Barium Swallow Study (MBSS). The DON reported Resident #6's last MBSS was in 2016. The resident's last SLP Evaluation was completed on 02/01/23. The resident was discharged from speech therapy services for dysphagia on 02/13/23. Diet recommendations included: Solids: - Any/all solids/liquids and Liquids-Thin cup/IDDSI 0, Thin Straw/IDDSI 0. Progress Note dated 05/12/25 stated, Pt. seen by telehealth to assess if appropriate to have chewing gum following MD request. Pt. is currently NPO receiving g-tube feedings as primary source of nutrition/hydration. Pt. presents with reduced alertness, poor positioning and currently on ABT for PNA. Pt. is not appropriate for gum/anything by mouth at this time 2'2 high risk of aspiration. Pt. agreeable. Continue Oral care and elevated HOB during g-tube feedings. Reconsult SLP if change in status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was screened quarterly on 04/24/25 and 06/12/25 with no ST services indicated at this time. The resident received Physical Therapy (PT) services during the 06/12/25 quarterly screen. The facility's screening Policy Statement stated, Therapy Services will perform for needed services for all new admissions and readmissions to the facility. The patient has had several hospitalizations with Admitting and Discharge Diagnoses of Recurrent aspiration pneumonia . On 03/12/24, the resident's admitting diagnosis from (name of local hospital) was acute on chronic hypoxemic: respiratory failure Recurrent aspiration. On 06/08/24, the resident's admitting and discharge diagnosis from (name of local hospital) was Aspiration pneumonia. On 06/24/24, DMC Discharge summary stated, This gentleman is well known to our service and has had multiple admissions over the last 12 months, requiring HPNC to bipap and intubation. He has been deemed to have capacity, is known to aspirate, he does not wish to change his diet, nor does he want a feeding tube. On 07/20/2024. The resident's discharge summary stated: Recurrent Aspiration pneumonia and regular diet. On 03/06/25 the resident was hospitalized at (name of local hospital) with an admitting dx of Sepsis due to left lower lobe aspiration type pneumonia. Discharge summary stated, mechanical soft diet. Discharge from (name of local hospital) dated 03/28/25 had an admitting and discharge diagnosis of Aspiration pneumonia. Discharge summary dated [DATE], had a discharge diagnosis with Dysphagia with recurrent aspiration. Informed Decision to Refuse to Follow Physician's Dietary Orders and Release of Liability were completed on the following dates: - 01/24/2016 1500 cal diet - 02/22/2016 Nectar thick liquids - 11/10/2021 Nectar thickened liquids Dietary order changes were as follows: Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 12/27/2021 Regular diet, Regular texture, Regular consistencylow residue diet x3 days the resume previous dietDiet Completed 07/27/2022 Regular diet, Regular texture, Regular consistencyregular thin liquidsDiet Discontinued 02/1/2023 Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 04/12/2023 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 10/24/2023 Regular diet, Chopped texture, Thin Liquids consistencyDiet Discontinued 01/21/2023 Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 12/03/2023 Regular diet, Chopped texture, Thin Liquids consistencyDiet Discontinued 12/16/2023 Regular diet, Pureed texture, Thin Liquids consistencyDiet Completed 12/28/2023 Regular diet, Chopped texture, Thin Liquids consistencyDiet Discontinued 12/31/2023 Regular diet, Chopped texture, Thin Liquids consistencyDiet Discontinued 02/01/2024 Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 03/13/2024 Regular diet, Regular texture, Nectar Thickened Liquids consistency(Mildly thicken Liquid) Free water protocolDiet Discontinued 03/27/2024 Regular diet, Pureed texture, Nectar Thickened Liquids consistency(No salt packet)Diet Discontinued 03/27/2024 Regular diet, Pureed texture, Nectar Thickened Liquids consistency(No salt packet)Diet Discontinued 06/08/2024 Regular diet, Pureed texture, Nectar Thickened Liquids consistencyDiet Discontinued 06/24/2024 NPO diet, NPO textureDiet Discontinued 07/20/2024 Regular diet, Regular texture, Regular consistencyfor diet changeDiet Discontinued 11/11/2024 Regular diet, Regular texture, Regular consistencyfor diet changeDiet Discontinued 11/20/2024 Regular diet, Chopped texture, Regular consistencyfor diet changeDiet Discontinued 03/06/2025 Regular diet, Regular texture, Regular consistencyfor diet changeDiet Discontinued 03/07/2025 NPO diet, NPO texture, NPO (Nothing by Mouth) consistencyDiet Active 05/07/2025 On 08/04/2025 at 10:06 AM, the Regional Rehab Manager was interviewed via phone. The Director of Rehab (DOR) was on vacation. The Regional Rehab Manager reported that the previous SLP had retired in October of 2024. Speech therapy services are contracted with hospitals for outpatient speech therapy services. A telehealth evaluation is completed via telehealth and if therapy is recommended, they go to (name of hospital) for outpatient therapy services. The Regional Rehab Manager reported the screening process as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Screening Procedure - nursing referral to rehab via Point Click Care, based on hospital discharge paperwork. -Quarterly Long Term Care (LTC screenings) are interdisciplinary - refer if a change. -DOR tracks screens for significant change and quarterly for LTC residents. -DOR attends Interdisciplinary Meetings (IDT)meetings and Care Plan Meetings. -Protocol for change in diet or swallowing difficulty - notified by nursing or updated during meetings - daily or as scheduled. On 08/05/2025 at 8:52 AM, the DON reported the staff meet every morning to discuss changes, incidents/accidents and significant changes and that there was no actual IDT meetings. On 08/05/2025 at 3:34 PM - Resident #6 was interviewed by the State Surveyor and the resident reported he would like to eat and stated, I'd like to, but I know I can't. He reported it had been three (3) months since he had something to eat by mouth. The patient reported he had not had swallowing therapy or exercises, no swallowing x-rays, or any tests to check to see if he could eat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 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. For five (5) of six (6) residents reviewed for the care area of advance directives, the Physician Order for Scope of Treatment (POST) forms were incomplete. For two (2) of three (3) residents reviewed for the care area of beneficiary notices, the beneficiary notices were incomplete. For one (1) of six (6) residents reviewed for the care area of nutrition, the admission weight documentation was incorrect. Resident Identifiers: #86, #60, #21, #4, #94, #62, #72, and #84. Facility census: 91. Findings included:a) Resident #72 The facility failed to verify and document the legal authority of the resident’s designated representatives, failed to ensure the validity and proper execution of the resident’s POST (Physician Orders for Scope of Treatment) form, and failed to retain complete documentation of consent for high-risk physical interventions. The resident’s record included a signed Checklist for Surrogate Selection dated 11/17/22 identifying Son #1 as the medical power of attorney (MPOA). However, the most recent POST form on file, dated 11/18/22, reflected only a verbal consent and lacked a physical signature from either of the resident’s officially recognized representatives. The witness signatures were minimally legible and marked by a strikethrough, offering insufficient assurance of proper execution or witnessing. At the time the POST form was completed, the [NAME] Virginia Department of Health and Human Resources (DHHR) was listed as the official healthcare surrogate. No documentation was found to demonstrate communication with DHHR regarding transition of decision-making authority, nor were there clinical notes indicating that surrogate authority had been formally transferred or discontinued. Despite documentation indicating that Son #1 visited frequently and maintained regular contact by phone, the facility did not initiate follow-up to obtain a valid POST with written, verified consent from the authorized representative(s), nor did it clarify which individual currently held legal authority to direct care decisions. On 08/04/2025 at 12:30 PM, this surveyor interviewed the facility’s Social Worker regarding the process for obtaining written signatures on POST forms. When asked how the facility ensures that POST forms are fully executed with physical signatures, the Social Worker stated that she does not have an official process in place for securing signatures following verbal acknowledgements. She explained that while she “sometimes” mails the forms to out-of-state representatives, they are “more often than not” unreturned. She was unable to provide documentation showing any follow-up efforts related to Resident #72’s POST form or confirmation that it had been physically signed by the authorized representative. These failures created ambiguity regarding the resident’s legal representation and undermined the validity of the POST form on file, placing the facility at risk for acting on treatment orders without properly verified consent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, the medical record contained a Consent for Use of Side Rails dated 07/17/2023, recommending the use of partial side rails on both sides for “Transfers T&R” (turning and repositioning). The form listed associated risks, including entrapment, bruising, injury from falls, and reduced mobility. However, in the section designated for representative authorization, the form stated only “verbal consent obtained.” No signature, printed name, date, or legal designation was provided to confirm that the resident’s MPOA had authorized the intervention. The absence of a completed signature block rendered the consent form invalid and incomplete. On 08/05/2025, this surveyor interviewed the facility’s Social Worker, who stated that LPN #36 was responsible for obtaining consent for bedrail use. Upon review of the resident’s authorization form, the Social Worker confirmed it stated “verbal consent obtained” but was unable to identify who provided the consent or whether a representative had been contacted. She stated she was unfamiliar with the consent process used by the nurse. In a follow-up interview, LPN #36 confirmed that she obtained verbal consent but had forgotten to document the name of the individual who gave it. She explained that she typically tried to complete authorizations and consents at admission and obtained verbal or written consent “as she is able.” She acknowledged the omission and apologized. b) Resident #4 On 07/30/2025 at 12:42 PM, Resident # 4's Physician's Orders for Scope of Treatment (POST) form was reviewed. Verbal consent was given on 04/24/25 with only one witness signature obtained. Resident #4's POST form was not given to the responsible party to review and sign. 0n 7/31/2025 at 10:20 AM, the Social Worker confirmed the signatures for the POST forms when verbal consent was given were not obtained and POST forms were not sent to the responsible party. The Social Worker stated, I do not send anything. c) Resident #94 07/31/2025 at 9:12 AM , Resident #94's Advance Beneficiary Notice (ABN) was reviewed for a Medicare Part A Skilled Service Episode beginning 03/11/2025 with ending date 03/27/2025. Verbal Consent was obtained from the resident's Health Care Surrogate (HCS) on 03/25/25. On 07/31/2025 at 09:27 AM, the Social worker confirmed there was no attempt by the facility to obtain signatures. The Social Worker stated, I just got the verbal consent. and That would be a lot of postage. The social worker then stated, I guess I could start mailing them. The facility's policy and procedure for Advance Beneficiary Notices: Delivery Requirements stated, d. If the notice cannot be hand-delivered (for example such as in the case of an incompetent resident and the representative is out of town) a telephone notice shall be made, followed up immediately with a mailed, emailed faxed or hand-delivered notice. Documentation shall comply with form instructions regarding telephone notices. d) Resident #62 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/31/2025 at 9:12 AM , Resident #62's Advance Beneficiary Notice (ABN) was reviewed for a Medicare Part A Skilled Service Episode beginning 02/27/2025 with ending date 04/04/2025. Verbal Consent was obtained from the resident's Medical Power of Attorney (MPOA) on 03/25/2025. On 07/31/2025 at 09:27 AM, the Social worker confirmed there was no attempt by the facility to obtain signatures. The Social Worker stated, I just got the verbal consent. and That would be a lot of postage. The social worker then stated, I guess I could start mailing them. The facility's policy and procedure for Advance Beneficiary Notices: Delivery Requirements stated, d. If the notice cannot be hand-delivered (for example such as in the case of an incompetent resident and the representative is out of town) a telephone notice shall be made, followed up immediately wit a mailed, emailed faxed or hand-delivered notice. Documentation shall comply with form instructions regarding telephone notices. e) Resident #21 Physician's Orders for Scope of Treatment (POST) form guidance A POST form is a document that outlines a patient's preferences for medical treatment, particularly in situations involving serious illness or end-of-life care. For residents that do not have the capacity to make medical decisions, the form can be completed by their Medical Power of Attorney [MPOA] or Health Care Surrogate. According to the manual titled Using the POST Form: Guidance for Health Care Professionals, available on-line at www.wvendoflife.org, If the incapacitated patient’s MPOA representative or health care surrogate is unavailable at the time of form completion, this section can be signed by two witnesses for verbal confirmation of agreement from the patient’s MPOA representative or health care surrogate. The form should be signed at the earliest available opportunity. Resident #21 Review of Resident #21's medical record showed a POST form dated 05/14/24. Verbal consent for the POST form had been obtained from the resident's MPOA. The consent was witnessed by two (2) staff members who signed the form. However, a signature from the MPOA had not been subsequently obtained. On 07/30/2025 at 1:52 PM, Resident #21's MPOA was interviewed. She stated she visited the resident almost every week. f) Resident #60 Review of Resident #60's medical record showed a POST form dated 07/26/24. Verbal consent for the POST form had been obtained from the resident's Health Care Surrogate (HCS) but the form was not signed by any staff members who witnessed the verbal consent. Additionally, a signature from the HCS had not been subsequently obtained. g) Resident #85 Review of Resident #85's medical record showed a POST form dated 08/21/23. Verbal consent for the POST form had been obtained from the resident's MPOA but the form was only signed by one (1) staff member who witnessed the verbal consent. Additionally, a signature from the MPOA had not been subsequently obtained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h) Resident #84 A record review on 07/31/25 at 9:30 AM, revealed that Resident #84 was admitted to the facility and had an admission weight of 140.7 pounds (lbs.). Her weight on 07/07/25 was 110 lbs. Further record review showed that Resident #84 was admitted to this facility from (an area hospital named) with a discharge weight of 128 lbs. During a telephone interview on 08/04/25 at 12:58 PM, The Registered Dietician (RD) stated, I did my assessments by her actual admission weight taken the next day after her admission which was 116.4 lbs. During an interview on 08/04/2025 at 3:20 PM, The Director of Nursing (DON) confirmed that the admission weight in the chart was incorrect and that it should have been struck out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515196	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nella's at Autumn Lake Healthcare	499 Ferguson Road Elkins, WV 26241

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review and staff interview, 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. The facility failed to follow appropriate infection control practices during medication administration. The facility also failed to follow enhanced barrier precautions. These were random opportunities for discovery. Resident Identifiers: #27 and #6. Facility Census: 91.Findings included:a) Resident #27 The facility's policy titled Medication Administration, with no date of implementation or revision documented, gave instructions to take care not to touch medications with bare hands while removing the medications from their source. On 07/31/2025 at 9:23 AM, Registered Nurse (RN) #33 was observed administering medications to Resident #27. The medications were contained in blister packs. Each dose was individually sealed within the pack and needed to be pushed through the package by the nurse. When two (2) of the resident's medications, clonazepam and sertraline, were removed from the blister packaging, they fell onto the uncovered medication cart. RN #33 then used her bare fingers to put the medications in the medication cup to be administered to the resident. On 07/31/25 at 8:45 AM, the Director of Nursing (DON) stated medications dropped on the top of the medication cart should be discarded and bare hands should not be used to touch medications. No further information was provided through the completion of the survey. b) Resident #6 The facility's policy titled Enhance [sic] Barrier Precautions, with no implementation or revision dates given, stated enhanced barrier precautions (EBP) would be followed for residents with indwelling medical devices. The policy also stated that gown and gloves would be worn during high-contact resident care for residents in EBP. Feeding tube care or use was included in the list of high-contact resident care activities. Review of Resident #6's physician's orders showed an order written on 05/13/25 for enhanced barrier precautions to be maintained at all times for wounds and gastroscopy tube.On the door to Resident #6's room was a sign stating, Enhanced Barrier PrecautionsEveryone Must:Clean their hands, including before entering and when leaving the room. Providers and staff must also:Wear gloves and a gown for the following High-Contact Resident Care Activities.DressingBathing/ShoweringTransferringChanging LinensProviding Hygiene Changing briefs or assisting with toiletingDevice care or use: central line, urinary catheter, feeding tube, tracheostomy Wound Care: any skin opening requiring a dressing On 08/04/2025 at 12:18 PM, Licensed Practical Nurse (LPN) #5 was observed flushing Resident #6's gastroscopy tube and connecting a bag of enteral feeding to infuse over one (1) hour. To provide the treatment, LPN #5 wore gloves but did not wear a gown. On 08/04/2025 at 12:26 PM, the Director of Nursing confirmed gowns should be worn by staff performing enteral flushes and feeding. No further information was provided through the completion of the survey process.