STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E148	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Hopemont	150 Hopemont Drive Terra Alta, WV 26764

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to ensure menus meet the nutritional needs of residents and menus were followed. This failed practice had the potential to affect more than a limited number of residents: Resident Identifiers:. #1, #4, #5, #11, #15 and #18. Facility Census: 47.e)Resident #4 On 02/16/2026 at approximately 12:00 PM a meal tray was delivered to Resident #4 room. It was placed down and when opened the tray was observed to contain the following: Tray contained Full chicken breast (not cut up and not diet appropriate) Polenta Summer squash was missing and was subbed w/ spinach (not diet appropriate) Roll (not diet appropriate) Malt vinegar - missing Margarine - missing Chocolate pudding was missing and subbed out w/ brownie (not diet appropriate) Coffee Soy milk The Residents diet is Minced and moist with nectar thick liquids. This is a requirement per Speech therapy #77, who confirmed Resident #4 is a high aspiration risk and pockets their food. There were four (4) items on the residents tray (marked above) as not diet appropriate. This tray was delivered by LPN #21 and when called back into the room to confirm the contents do not meet the prescribed dietary requirements she stated that the chicken should not have been a whole piece, should be shredded. She then took the chicken in the lid and said she will be back with it corrected. Went back to check if the tray was corrected and the family stated they never came back with (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	anything and that all they fed Resident was the polenta since that is all he was able to eat off it. Resident #4 was full and didn't need the rest of the tray. Further interview with Speech Therapist #77 on 02/16/2026 at 02:17 PM she stated the following: When told about what appeared on his tray for lunch she said mmmhmm that sounds about right, this is the problem we have here. Im only in my first few weeks there and i have see this issues multiple times. Yes , if Ed was fed the diet you describe to me he would be at risk for aspiration. Diets are not consistent from the kitchen and it is very hit or miss. On 02/17/2026, the second day of the survey Resident #4 meal tray was incorrect again and this time contained: Minced and moist dietary items - Ham and gravy, squash and peppers, mashed potatoes, vanilla pudding. All of these items were prepared to the correct dietary requirements of Resident #4. Drinks Two (2) Fruit punch and soy milk, both of which were not thickened at all. According to Resident #4 orders all liquids shall be Nectar Thick. Interview conducted on [DATE] at 12:50ˆPM with CNA #46 when asked if those two (2) beverages are correct thicknesses. CNA #46 stated that she wasn't sure if they were right but didn't look like it. The CNA removed the fruit punch and said they would get a new one that was the correct thickness. Interview with ADMIN on [DATE] at 1:00ˆPM,, when shown the soy milk they stated that it definitely was not correct and went down with me to the kitchen to find out why. Admin also stated, only the kitchen can thicken any liquids, the floor staff is not trained/qualified. Interview with Kitchen manager #91 on [DATE] at 1:10ˆPM,, stated that the soy milk was not right and she will make a new one. Findings included: a) The facility's policy and procedure for Meal Service (Tray Line) stated, Purpose: To ensure that all meals are served safely, accurately, and attractively to residents/patients . b) On 02/16/2026, during the Dining Observation, tray card discrepancies were as follows: Resident # 15 did not receive chocolate pudding or fruit as printed on his tray card, Resident #11 did not receive PU4 Marbled Brownies as printed on his tray card, and Resident #1 not receive chocolate pudding as printed on his tray card. At 12:41 PM, Nurse Aide #18 confirmed the try cards and food that was not received. On 02/16/2026 at 12:50 PM, Dietary Aide #18 confirmed Resident #5 did not receive chilled peaches, MT2 Punch, MT2 Cold Tea or MT2 lemonade as printed on his tray card. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/17/2026, the menu stated PU4 Snickerdoodle cookie and -vanilla ice cream were the desserts for mechanically altered diets. AT 12:17 PM, Corporate Health Care Services Dietary Manager #99 stated that pudding was the dessert for any remaining mechanically alternated diet. c) On 02/17/2026 at 12:45 PM, [NAME] #98 stated, Hey [NAME] .we don't have enough vegetables. Account Manager #91 confirmed there were not enough vegetables to complete lunch. The account manager replaced the southwest vegetables with a salad without approval of Registered Dietician #100. d) On 02/17/2026, the menu stated a coconut fruit bar was to be served for dessert. The residents were served cheesecake with fruit on top and pudding for dessert, not a coconut fruit bar. Corporate Health Care Services Dietary Manger 99# reported that the dessert was a coconut fruit bar. No coconut was tasted in the cheesecake with fruit on the top by two state surveyors. Account Manager #91 confirmed the coconut fruit bar was not served and stated, We ain't got coconut.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, staff interview, and record review, the facility failed to prepare food in a form to meet individual needs. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #1, #8, #4 and #24. Facility Census: 47. Findings included: a) The facility's policy and procedure for Meal Supervision and Assistance stated, 5. Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow. On 02/16/26, when asked what diet levels are served at the facility, Dietary Aide #94 reported they serve puree, ground, minced and moist, and bite-sized -and stated, I just call them all ground. On 02/16/26 at 2:09 PM, the State Surveyor interviewed the Speech-Language Pathologist (SLP) regarding the diet consistencies served at the facility. The SLP reported the consistencies of the diets vary in what is served, but the diet levels she was told to use were: Puree, Minced and Moist, Soft and Bite-sized and Regular. On 02/17/26, Corporate Health Care Services Dietary Manager #99 stated that the only diet levels served are Regular, Puree, Easy to Chew and Minced and Moist (gravy on all food). On 02/17/26 at 2:55 PM, Registered Dietician (RD) #100 reported that the diet levels served in the facility included: Puree, Minced and Moist, Soft and Bite-sized, Easy to Chew and Regular. Descriptions of each diet level were given to the State Surveyor including thickened liquids by the RD. The RD reported they don't have anyone on a 'Ground' diet and said, We don't use it. On 02/17/2026, Corporate Health Care Services Dietary Manager #99 was asked by the state surveyor how do the cooks know what to serve when the tray cards vary with different diets. Resident #1's ordered diet was: Regular diet, Soft and Bite Sized texture, Thin consistency. Resident #8's ordered was: Regular diet, Minced and Moist texture, Thin consistency, Double protein. Account Manager #91 and Corporate Health Care Services Dietary Manager #99 were unable to state the difference and preparation and Corporate Health Care Services Dietary Manager #99 stated, I know what your asking. and reported the were consulting with corporate concerning diets and tray cards. On 02/17/26, the State Surveyor intervened because regular cheesecake with crust was brought out just as trays were ready to be served. The surveyor asked what was being served for residents' ordered puree and minced and moist. The menu production sheet stated that for pureed, the residents received a PU4 Snickerdoodle cookie and for Minced and Moist a vanilla ice cream. The residents were served pudding following surveyor intervention (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The following residents require a mechanically altered diet, according to the Diet Type Report: Easy to Chew - one (1) resident. Minced and Moist- five (5) residents. Soft and Bite Sized - nine (9) residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to ensure food was stored, prepared, distributed and served in accordance with professional standards. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 47.Findings included: a) The facility's policy for Labeling and Dating stated, A. All food items prepared, opened, or stored in the facility kitchen must be clearly labeled and dated., B.c.1.a) Label with the date the item is placed in storage and the date of discard - add 6 to today's date. and C.a. The Culinary Manager or designee will perform frequent checks of all food storage areas for proper labeling and dating. The Administrator reported items should be dated for seven (7) days. Dietary Aide #94 reported, [NAME] wants everything for three (3) days. b) On 02/16/2026 at 10:15 AM, the Kitchen Investigation was initiated with the Administrator. The following items were found and confirmed by the Administrator: Spaghetti uncooked noodles - not labeled.[NAME] Choice Gravy Mixes- no received or used by dates.Boxes of Gelatin - no use by date, one bag leaking, orange lime and lemon flavors.Pudding received 1/16/2026 with use by date 10/14/2025.Kellogg Corn Flakes dated 08/27/25 with use by date 10/23/25.Corn Flakes - dated 12/31/25 with no use by date and not labeled.Eggs - no used by date.Soup - no use by date. c) At 10:35 AM, the Kitchen Investigation was continued with Dietary Aide #94. The following items were found and confirmed by Dietary Aide #94: Juice glasses x10 - not labeled and not dated.Mixed glasses of juices - not labeled or used by dates.Whipped cream - opened, not sealed and no use by date.Cottage cheese - no use by date.Pre-thickened Liquids - opened and not dated.French Fries - not labeled and no use by date.Hashbrowns - not labeled , no open or use by date.Bag of Ice - opened and not sealed. d) At 10:50 AM, the panties on the halls were investigated with Dietary Aide #94. The following items were found and confirmed by Dietary Aide #94: B Hall Pantry at 10:50 AM:Lean Cuisine - not dated. Friendly's Celebration Cake - opened with no use by dateTai [NAME] egg rolls - opened and not dated.Package of Sauce - not labeled and not dated. A Hall Pantry - 11:00 AM:Ranch dressing - open and not datedNot labeled or use by dates on snacks for the following residents:1 Resident #47 - Peaches2. Resident #41 - pudding3. Resident #1 - cottage cheeses4. Resident #9 - pudding On 02/17/2026 at11:05 AM, the dishwashing process and temperatures were observed by the State Surveyor. o temperature for this date was logged. [NAME] #98 stated, No temps, yet. when asked if the dishwashing and rinse temperatures had been taken. [NAME] #96 confirmed that multiple loads of dishes had been completed and the dishwasher temperatures had not been checked or logged. The wash and rinse temperature were within normal limits when the dishwasher was run. [NAME] #96 confirmed the dishwasher temperature log had not been completed and stated, We haven't documented temps, yet. The facility's policy and procedure for Dish Machine Monitoring stated, A log will be utilized to document temperatures and or chemical sanitizer PPM to verify requirements are met and functioning.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation 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 with regards to the resident's personal products and unsanitary practices. This failed practice was a random opportunity for discovery. Resident identifiers: 8, 34, 36, and 38 Facility Census: 47. a) On 02/17/26 at 1:48PM, during a facility walk through it was observed that resident #'s 8, 34, 36, and 38's wheel chairs or Geri chairs had holes, rips and tears with exposed inner padding On 02/18/26 at 2:08 PM, during a facility walk through and interview with Assistant Director of Nursing (ADON) #79, she acknowledged the wheel chairs and Geri chairs in the resident rooms and the chairs in the activities room with holes, rips and tears exposing the inner padding. She agreed this was an infection control issue.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and interview with Resident [NAME], the facility failed to ensure survey results were readily accessible in an area where individuals wishing to examine them did not have to ask to see them. Facility Census: 47 Findings included: During Resident Council on 02/17/26 at 11:00 AM, it was revealed the survey book in the lobby was empty with a sign informing the reader to ask the front desk to see the book. An interview with Social Worker #47 on 02/17/26 at approximately 5:00 PM, revealed the book was kept behind the front desk to keep resident's from tearing the pages. The SW said at no time was the book accessible to anyone without them having to ask. There was a sign stating this, but it is important to note that the desk is unmanned at the end of a specific shift, daily. On 02/18/726 5:20 PM the surveyor observed an empty binder and in the lobby with a note stating survey results were available upon request.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 safe, clean, comfortable, and homelike environment for residents. This failed practice was observed to have affected a shared bathroom between room [ROOM NUMBER] and #215. Facility census: 47On 02/16/26 at 1:25PM, during a facility walk through it was observed that resident shared bathroom between room [ROOM NUMBER] and #215loose dark rusty pipes dirty buildup in the corners and around the base of the toiletcracked and loose drywall falling from the wall Dusty build up of hair and debris observed between the bathroom door and the [NAME] 02/18/26 at 12:40 PM, during a facility walk through and interview with the Assistant Director of Nursing (ADON) #79, she acknowledged the needed repairs in the resident rooms and hallways. she stated she would take note of it and make sure the issued would be added to the maintenance list.During a facility walk through and interview with the maintenance supervisor, on 02/17/26 at 1:15PM, he acknowledged the areas in need of attention in resident rooms, bathrooms, halls and in the solarium and stated he would close off the gap to make sure no one would be able to get into that area. He also called on maintenance staff to repair the conduit with the exposed electrical wiring. He reported that the facility did not have a plan of improvement. He has been in this position for approximately 6 weeks. The plan of improvement is high on his list and is planning to start it soon.During an interview with the executive director on 02/18/26 at 2:55 PM, he acknowledged the needed repairs and stated the a list of needed repairs would be sent to the maintenance department.

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	51E148	A. Building B. Wing	02/19/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on Record review and staff interview, the facility failed to provide quality care by not following or updating physicians orders as needed. This was discovered during the normal Long Term Survey Process and has the ability to affect more than a limited number of residents. Resident Identifiers: #4 and #5. Census 47.Findings included: a) Resident #5 On 02/16/26 at 3:00 PM, review of resident's physician orders reviewed an order for Geri call cord in room due to Cerebrovascular Accident (CVA) with inability to use standard call bell system. Start date of 11/25/25 On 02/16/26 at 4:00 PM, I observed resident's call light in room to be a regular, thumb press button call system. On 02/16/26 at approximately 4:20 PM, Restorative Nurse Assistant #34 was walking by resident's room and was asked if Resident #5 is ordered to have a specific type of call button. She looked in his room and then walked to the room next door and replied, He changed rooms with the resident next door and they didn't move his call light. When asked how long ago the rooms were changed, she could not recall and stated several weeks. On 02/16/26 at 5:20, an interview was help with Regional [NAME] President of Operations who acknowledge and reported she would discuss with administrated to correct immediately. Review of facility call lights policy, procedure #4 states Special accommodations will be identified on the resident's person-centered plan of care , and provided accordingly. Examples include touch pads, larger buttons, bright colors, etc.) b) Resident #4 During a record review of Resident #4 chart on 02/16/2026 at 4:18 PM it showed that he had active orders for turn and reposition every two (2) hours (Q2) to prevent skin breakdown. Resident #4 is currently on hospice care and had a large decline in their self care and activities of daily living (ADL) capabilities. In order to prevent skin breakdown and wound formation R#4 needs to be moved into different positions every two (2) hours by staff and this task documented in the system. There is no documentation as to the order being followed, nor turn and reposition notes in chart or task marked off completed. On 02/16/2026 at 4:22 PM when interviewed CNA #46 where they document the turn and reposition of residents, they stated we dont have a specific place, we just kinda do it.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible This failed practice was a random opportunity for discovery. Resident identifier: #8. Facility Census:47Findings included: a) During a facility tour on 02/17/26 at 2:40 PM, the following environmental accident hazards were observed: Solarium: A steady leak in the ceiling with a continuous drip was blocked off with a retractable post/belt barrier, The barrier did not encompass the entire restricted area leaving a 2(two) to 3(three) foot gap that anyone could freely walk through to the wet floor. Further observation found missing electrical conduit with jagged edges and exposed electrical wiring around the wall. 100 and 200 Hallways: -Plastic molded lower rub rails in both resident halls had separated with 1/4 inch to 1/2-inch finger sized gaps -Lower encased wall lighting boxes below handrails opened with glass bulb and electric wires exposed Shower Room: A half empty opened carton of Ensure plus drink with a straw was observed left sitting on the window shelf. room [ROOM NUMBER] -212 shared bathroom: -broken and loose drywall with 1/8 to1/4 inch sized pieces falling out of the wall onto the floor -2 (two) 1/4 inch bolts protruding from the wall in Residents shared bathroom Staff Interviews: During a facility walk through and interview with the maintenance supervisor, on 02/17/26 at 1:15PM, he acknowledged the areas in need of attention in resident rooms, bathrooms, halls and in the solarium and stated he would close off the gap to make sure no one would be able to get into that area. He also called on maintenance staff to repair the conduit with the exposed electrical wiring. During a facility walk through and interview with the maintenance supervisor, on 02/17/26 at 1:15PM, he acknowledged the areas in need of attention in resident rooms, bathrooms, halls and in the solarium and stated he would close off the gap to make sure no one would be able to get into that area. He also called on maintenance staff to repair the conduit with the exposed electrical wiring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the executive director on 02/18/26 at 2:55PM, he acknowledged the needed repairs and accident hazards and stated the maintenance department will receive a list of needed repairs. Resident #8 On 02/16/26 at 11:40ˆAM observation in Resident #8's Bathroom cabinet revealed Clorox Wipes, [NAME] pack and three (3) skin prep wipe packs. There was also an out of order sign in the shower and rust around the bottom shower pan that was in very bad disrepair. Social Worker #47 confirmed that the cleaning and prep supplies were not supposed to be left in residents' rooms. Oh, shoot those don't belong in there.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility failed to ensure the physician acknowledged Montly Medication Review's for residents. Resident identifiers: #2, #4, #31, and #36. Facility census: 47. Findings included: a) Resident #2 Physician Recommendation Forms were not reviewed by the physician for psychoactive medications for the following dates: 11/15/25, 12/17/25, 01/15/26 and 02/16/26. On 02/19/26 at 1:00 PM, the Regional Clinical Operations Manager of Acquisitions and the Administrator confirmed there were no medication forms reviewed and signed by the physician secondary to the physician refusing to sign and the previous Director of Nursing receiving the recommendations and not getting them signed by the physician. b) Resident #31 Physician Recommendation Forms were not reviewed by the physician for psychoactive medications for the following date: 12/17/25. On 02/19/26 at 1:00 PM, the Regional Clinical Operations Manager of Acquisitions and the Administrator confirmed there were no medication forms reviewed and signed by the physician secondary to the physician refusing to sign and the previous Director of Nursing receiving the recommendations and not getting them signed by the physician. c) Resident #4 Physician Recommendation Forms were not reviewed by the physician for psychoactive medications for the following dates: 11/15/2025, 12/17/2025, 01/17/2026 and 02/16/2026. On 02/19/2026 at 12:10 PM, Medical Records #32 stated they were all given to either the MD or DON to be looked at and signed off as needed. They were told to not handle them anymore since the sale. Secondary interviews on 02/19/2026 at 1:00 PM, with the Regional Clinical Operations Manager of Acquisitions and the Administrator confirmed there were no medication forms reviewed and signed by the physician secondary to the physician refusing to sign and the previous Director of Nursing receiving the recommendations and not getting them signed by the physician. d) Resident #36: On 02/19/26 12:11 PM, Record review and staff interviews found the Physician Recommendation Forms were not reviewed by the physician for psychoactive medications for the following dates: 11/15/25, 12/17/25, 01/15/26 and 02/16/26. On 02/19/26 at 1:00 PM, the Regional Clinical Operations Manager of Acquisitions (RCOMA) and the Administrator confirmed there were no medication forms reviewed and signed by the physician secondary to the physician refusing to sign and the previous Director of Nursing receiving the recommendations and not getting them signed by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E148	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, record review and staff interview, the facility failed to ensure residents were receiving therapeutic diets as ordered by the physician. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #1 and #8. Facility Census: 47. Findings included: a) Different diet levels per staff interview:1. The facility's policy and procedure for Meal Supervision and Assistance stated, 5. Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow.2. On 02/16/2026, Dietary Aide #94, when asked what diet levels are served at the facility, the dietary aide reported they have puree, ground, minced and moist, and bite-sized -and stated, I just call them all ground.3. On 02/16/2026 at 2:09 PM, the State Surveyor Interviewed the Speech-Language Pathologist (SLP) for diet consistencies served at the facility. The SLP reported the consistencies of the diets vary in what is served, but the diet levels she was told to use were: Puree, Minced and Moist, Soft and Bite-sized and Regular.4. On 02/17/2026, Corporate Health Care Services Dietary Manager #99 sated that the only diet levels served are Regular, Puree, Easy to Chew and Minced and Moist (gravy on all food).5. On 02/17/2026 at 2:55 PM, Registered Dietician (RD) #100 reported the diet levels served in the facility included: Puree, Minced and Moist, Soft and Bite-sized, Easy to Chew and Regular. Descriptions of each diet level were given to the State Surveyor including thickened liquids by the RD. The RD reported they don't have anyone on a 'Ground' diet and we don't us it. b) On 02/17/2026, Corporate Health Care Services Dietary Manager #99 was asked by the state surveyor how do the cooks know what to serve when the tray cards vary with different diets. Resident #1's ordered diet was: Regular diet, Soft and Bite Sized texture, Thin consistency. Resident #8's ordered was: Regular diet, Minced and Moist texture, Thin consistency, Double protein. Account Manager #91 and Corporate Health Care Services Dietary Manager #99 were unable to state the difference and preparation and Corporate Health Care Services Dietary Manager #99 stated, I know what your asking. and reported the were consulting with corporate concerning diets and tray cards. c) On 02/17/2026, the State Surveyor intervened, as trays were being ready to be served and regular cheesecake with crust was brought out, and asked what was being served for residents' ordered puree and minced and moist. The menu production sheet stated that for pureed, the residents received a PU4 Snickerdoodle cookie and for Minced and Moist a vanilla ice cream. The residents were served pudding following surveyor intervention d) The following residents are ordered a mechanically altered diet per the Diet Type Report:1) Easy to Chew - one (1) resident.2) Minced and Moist - five (5) residents.3) Soft and Bite Sized - nine (9) residents.

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	51E148	A. Building B. Wing	02/19/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and staff interviews, the facility failed to ensure care was promoted in a manner that maintained or enhanced the resident's dignity and respect during the dining experience. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #18 and #24. Facility Census: 47.Findings included:a) Resident #18On 02/16/2026, Resident #18 was served by the staff,. The resident requested silverware from the State Surveyor as he was attempting to use his table mates dirty soiled napkin. The resident was served a piece of whole chicken breast and a salad. Nurse Aide #60 confirmed the resident did not receive silverware and got a black plastic spoon for the resident to use. Resident #24 was observed eating his lunch meal with plastic silverware.The resident's desserts were served in plastic bags and not on a regular dessert plate. On 02/16/2026 at 12:33 PM, the Administrator confirmed the desserts were served in a plastic bag.On 02/16/2026, during the initial dining room investigation, the State Surveyor observed all the residents eating lunch on their trays. At 12:33 PM, the Administrator confirmed the resident's food was not removed form their trays and their plates were not placed on the table for their meal.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on record review and staff interviews, the facility failed to monitor, evaluate and document restraints for residents. This was discovered during the Long Term Survey Process and had the ability to effect more than a limited number of residents. Resident Identifier: #6. Facility census: 47. Findings Include: a) Resident #6 On 02/16/2026 at approximatley 4:00 PM a record review was done on Resident #6. The record review revealed it stated that Resident #6 had a diagnosis of Huntington's Disease. This disease can limit a person's functional status and control of limbs. For Resident #6 safety they had orders to have a wheel chair restraint belt on while in a wheel chair at all times. Resident #6 also had orders for limb restraint for Inter-Muscular (IM) Injections, due to the disease process making it hard to stay still during these procedures. The orders from the medical record were as follows: Broda Chair with quick release pelvic restraints while out of bed to maintain optimal upright position. Monitor Q 30 minutes and release Q 2 hours x 15 minutes for ROM, toileting and repositioning. Dx-huntingtons disease May restrain patient for IM injection as needed related to patient safety. Resident #6's care plan also showed the need for restraints, but to assess and document for skin breakdown and wounds. Care Plan Reivew revealed: Focus Resident #6 uses physical restraints cross leg seat belt in chair due to Huntington's Disease Date Initiated: 11/10/2025 Revision on: 11/10/2025 Goal Resident #6 will utilized the least restrictive device and remain free of complications related to restraint use, including contractures, skin breakdown, altered mental status, isolation or withdrawal Date Initiated: 11/10/2025Interventions Ensure The resident is positioned correctly with proper body alignment while restrained. Date Initiated: 11/10/25 IDT to review at least quarterly for least restrictive device Date Initiated: 11/10/25 observe for decline in mood, change in behavior, decrease in adl self performance, decline in cognitive ability or communication, contracture formation, skin breakdown, s/sx of delirium, falls/accidents/injuries, agitation, weakness. Date Initiated: 11/10/2025 Provide a meaningful program of activities that accommodates restraint use without drawing unwanted attention. Provide restraint-free time during activities when possible to supervise closely. Date Initiated: 11/10/2025 RESTRAINT USE: Restraint type: cross leg seat belt while up in chair Check hourly, release and reposition at least every 2 hours. Date Initiated: 11/10/2025 Revision on: 11/10/2025 The resident needs to be toileted every 2 hours and as needed During an interview with the Administrator and MD on 02/16/26 at approximately 4:20 PM about the restraints they said they would remove the IM one but the resident will still be in the wheel chair restraints as they are needed for his safety. Further record review was completed on 02/17/26 at 2:50 PM to look for any documentation for the restraints being used on Resident #6. No restraint documentation were located and/or provided to the Survey team prior to exit. A secondary interview with RN #79 and NA #46 on 02/17/26 at 3:15 PM was conducted and when asked where they document restraint checks every two hours and skin assessments, they stated We dont have anywhere to document restraint checks and never have.

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	51E148	A. Building B. Wing	02/19/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on staff interview and documentation review the Facility failed to complete [NAME] Virginia Pre-admission Screening with new diagnosis of Major Depressive Disorder. This is true for Resident #3. Facility Census 47. Findings Included:a) Resident #3 On 02/16/26, a review wascompleted of a document titled [NAME] Virginia Department of Health and Human Resources Pre-admission Screening (PAS) dated for 11/13/24. For Resident #3, on Question #30 the answer was marked a. None. Upon Review of Resident #3's diagnosis list, resident was diagnosed with Major Depressive Disorder, Recurrent, Moderate on 11/15/24. Interview with Administrator on 02/17/26 at 5:25 PM who acknowledged Resident #3 did not have a new PAS did not contain his new diagnosis of Major Depressive Disorder.

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	51E148	A. Building B. Wing	02/19/2026

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, record review and staff interview, the facility failed to provide a well -balanced diet taking into consideration preferences. The failed practice had the potential to affect a limited number of residents. Resident Identifier: #30. Facility Census: 47. Findings included: a) Resident #30 Resident #30's diet order stated, Consistent Carbohydrate, Regular, Thin, and no added salt, no beef or pork ,yogurt at Breakfast and Lunch.: On 02/17/2026 at 12:31 PM, [NAME] #98 served the resident ham on her tray. Following state surveyor intervention, Dietary Aide #97 removed Resident #30's tray from delivery cart and confirmed the tray card stated food allergy for milk and no beef or pork. [NAME] #98 stated, I ain't got anything .only pork. and It depends on her mood. - referring to if the resident eats pork or not. The resident received a peanut butter and jelly sandwich. The facility does not provide an alternate menu, but resident's can choose something from the always available menu according to Account Manager #91.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, record review, staff interview and resident interview, the facilitate failed to ensure the resident received food that accommodated allergies, intolerances and preferences. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #30. Facility Census: 47. Findings included: a) Resident #30's diet order stated, Consistent Carbohydrate, Regular, Thin, and no added salt, no beef or pork ,yogurt at Breakfast and Lunch. On 02/17/26 at 12:31 PM, [NAME] #98 served the resident ham on her tray. Following state surveyor intervention, Dietary Aide #97 removed Resident #30's tray from delivery cart and confirmed the tray card stated food allergy for milk and no beef or pork. [NAME] #98 stated, I ain't got anything .only pork. and It depends on her mood. - referring to if the resident eats pork or not. The resident received a peanut butter and jelly sandwich. The facility does not provide an alternate menu, but resident's can choose something from the always available menu according to Account Manager #91. On 02/16/2026 at 12:50, Resident # 30 had milk on her tray. The resident was observed to drink some of the milk and stated, I don't like milk so they had to put allergic. Nurse Aide #60 confirmed the resident had milk with her lunch meal. Resident #30's Dietary Profile was reviewed. The following items were listed: Allergy to milk, No beef or pork. and yogurt at breakfast and lunch. Yogurt was not observed on the resident's tray on 02/16/26 and 02/17/26 at lunch by this state surveyor.

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	51E148	A. Building B. Wing	02/19/2026

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation and staff interviews, the facility failed to follow prescribed dietary order for liquid consistency for the residents. Resident identifier: #4. Facility census: 47. Findings Include: a) Resident #4 On 02/16/26 at approximately 12:00 PM a meal tray was delivered to Resident #4 room. It was placed down and when opened the tray was observed to contain the following:Tray contained Full chicken breast (not cut up and not diet appropriate)Polenta Summer squash was missing and was subbed w/ spinach (not diet appropriate)Roll (not diet appropriate)Malt vinegar - missingMargarine - missingChocolate pudding was missing and subbed out w/ brownie CoffeeSoy milk The Residents diet was Minced and moist with nectar thick liquids. This was a requirement per Speech therapy #77, who confirmed Resident #4 was a high aspiration risk and pocketed their food. This tray was delivered by LPN #21 and when called back into the room to confirm the contents did not meet the prescribed dietary requirements, she stated that The chicken should not have been a whole piece, should be shredded. She then took the chicken in the lid and said she would be back with it corrected. The surveyor back to check if the tray was corrected and the family stated they never came back with anything and that all they fed Resident was the polenta since that is all he was able to eat off it Further interview with Speech Therapist #77 on 02/16/26 at 02:17 PM when told about what appeared on his tray for lunch she said mmmhmm that sounds about right, this is the problem we have here. I'm only in my first few weeks there and I have seen these issues multiple times. Yes , if (resident #4's name) was fed the diet you describe to me he would be at risk for aspiration.Diets are not consistent from the kitchen, and it is very hit or miss. On 02/17/2026, the second day of the survey Resident #4 meal tray was incorrect again and this time contained: Drinks Two (2) Fruit punch and soy milk, both of which were not thickened at all. According to Resident #4 orders all liquids should be Nectar Thick. Interview conducted on 02/17/26, at 12:50ˆPM with NA #46 when asked if those two (2) beverages were correct thicknesses. NA #46 stated that she was not sure if they were right but did not look like it. The NA removed the fruit punch and said they would get a new one that was the correct thickness. During an interview with the administrator on 02/17/26 at 1:00ˆPM, when shown the soy milk they stated that it was not correct and went down to the kitchen to find out why. The Administrator also stated that only the kitchen can thicken any liquids, the floor staff is not trained/qualified.During an interview with Kitchen Manager (KM) #91 on 02/17/26 at 1:10ˆPM, KM #91 stated that the soy milk was not right and she would make a new one.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation and staff interview, the Facility failed to provide a resident with an assistive device during meals by not providing nosey cup. This was a random opportunity for discovery. Resident identifierz: #6. Facility Census: 47. Findings Included:a) Resident #6 On 02/17/26 at approximately 12:50 PM, Resident #6 was observed dining in the dining room with assistance from Nurse Aide #74. Observation of Resident #6's tray card revealed he was to have one nosey cup, not present on his tray. He did have cold tea, orange juice and and milk all served in regular clear plastic cups. An interview with Nurse Aide #74 was conducted 02/17/26 at 12:55 PM revealed they were not familiar with a nosey cup and these were the cups that resident normally used at meals. Review of Care Plan for Resident #6 stated the following: Focus: Resident presented with potential for nutritional risk related to diagnosis major depressive disorder, vitamin D deficiency. Receiving a mechanically altered diet with thickened liquids to ease chewing/swallowing concerns secondary to dx of Huntington's Disease, dementia, and History of Traumatic Brain Injury. Interventions included: Thickened liquids, double protein, no straws, nosey cup for all fluids. Review of Facility's Policy and Procedure tiled, Adaptive Feeding Equipment 3.Policy, Section C, d. Dietary must be notified of adaptive equipment needs and ensure equipment is placed on tray at each meal.

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	51E148	A. Building B. Wing	02/19/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide accurate documentation by listing inaccurate diagnosis of Post Traumatic Stress Disorder for a resident. This was a random opportunity for discovery. Resident Identifier: #1. Facility census: 47. Findings included: a) Resident #1 On 02/16/26 during documentation review, it was observed that Resident #1 had a diagnosis of Post Traumatic Stress Disorder (PTSD) onset of 09/7/23 on his diagnosis list. Upon further review of his records, this diagnosis nor treatment for said diagnosis could be found. An interview with Social Services Director (SSD) on 02/17/26 at 4:11 PM revealed the diagnosis had been taken off the Matrix and Minimum Data Set (MDS) assessment per suggestion of their corporate MDS coordinator due to lack of proof resident had this diagnosis. SSD reported Resident #1's intake information nor in-house diagnostic information suggested Resident #1 had a diagnosis of PTSD. An interview with Administrator on 02/18/26 at approximately 2:00 PM, he relayed per the facility's Corporate MDS Coordinator, the facility has no record of origin of resident having PTSD diagnosis. No assessments, it was not on any History and Physical and they could not find where it was on any admissions or discharge paperwork. Administrator reported it is unclear how the diagnosis got added to resident's diagnosis list.