STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515066	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and staff interview the facility failed to ensure all residents were treated with dignity and respect. This was true for five (5) residents and were random opportunities for discovery. Resident Identifiers: #69, #11, #62, #64, and #52. Facility Census: 115. Findings Include: a) Resident #64 Observation of the morning meal on 07/23/25 beginning at 8:08 AM found the resident sitting in her recliner in her room. The nurse aid took her a cup of cranberry juice and told the resident she had brought her a cup of juice. The resident was observed feeling around on her bedside table. She did not find the juice, nor did she take a drink. At about 8:15 AM Registered Nurse (RN) #112 went into the room and asked her how she was doing. The resident stated, I am just hungry. I am starved. The RN asked the resident if she wanted a drink of her juice and she assisted the resident in getting a drink. At 8:28 am the meal cart arrived on the floor from the kitchen. At 8:29 am Resident #64's roommate was served her meal and Resident #64's tray was left on the cart. The rest of the trays on the cart were served and Resident #64's tray was still on the cart. RN #112 was overheard asking Nurse Aide (NA) #86 if anybody needed assistance with their meal. The nurse aide stated. (Name of Resident #64) her tray is still on the cart we have to wait until the second cart comes out and the trays are all served. The RN stated if her roommate has her food you need to go ahead and feed her. NA #86 then took her tray in at 8:35 am. The NA asked the resident if she was ready to eat and the resident stated, I have been ready for two (2) hours. The nurse aide was trying to assist her and the resident said, I usually just eat with with my fingers. The resident told her to sit the eggs on her lap, and she would get them with her fingers. She told the NA multiple times, that's how they always do it honey. b) Resident #52 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the morning of 07/23/25 at 7:15 AM Resident #52 was observed lying in his bed. He was awake and was talking with the surveyor even though he was confused. The resident was noted to be NPO (Nothing by mouth). This had been determined the previous day during a record review. The residents tube feeding was connected and running at the correct rate. On his bedside table was a cup with a blue handle (this is the type of cup all residents who had ice water were given by the facility) inside the cup was a small amount of a yellowish thin liquid. Registered Nurse (RN) #74 was asked to come to Resident #52's room. She looked in the cup and asked the resident if he had peed in the cup (the resident is confused and was unable to answer) she said, I don't know what that is maybe pee maybe broth of some sort. She then told the resident who is to have nothing by mouth the following: I'm going to dump this out I will get you some fresh ice water. To which the resident replied. “That would be good. She then proceeded to say, it’s almost time for breakfast too. To which the resident replied, That will be great.Resident #52 is NPO and could have neither breakfast nor ice water. Corporate Resource Nurse (CRN) #106 later in the morning confirmed she had smelled the cup the resident had at bedside, and it was pee in the cup. c) Resident #69 On 07/22/25 at approximately 1:25 PM, an observation of Resident #69 being pushed up the hallway from the receptionist's desk to the main hallway by Receptionist #18 was made. As the Receptionist was pushing the resident, the Receptionist made the statement, You can't be hungry you just ate lunch. The resident was left in the main hallway of the facility. The resident was propelling herself in the main hallway. Nurse Aide (NA) #68 was walking up the main hallway. NA #68 was asked, Do you know this resident? NA #68 stated, She is on the other unit .I can take her back. NA #68 was then asked Do you think she could be hungry? NA #68 states, She loves sweets sometimes she doesn't eat her food .let me go see if she ate. On 07/22/25 at 1:28 PM, NA #3 returned with a copy of the Resident's lunch ticket. The ticket had 75% noted. NA #3 stated, She didn't like the broccoli soup. NA #3 was asked, Does she normally only eat sweets? NA #3 stated, She likes snacks .I'll go get her something. On 07/22/25 at 1:30 PM, the incident was reported to the Administrator and the Regional Corporate Nurse #106 regarding the Receptionist dismissing the Resident. d) Resident #11 On 07/23/25at 12:38 PM, Resident #11 was observed trying to feed herself. The resident was attempting to pick up food but was not picking anything up and was still attempting to eat what she had not picked up. The resident was sucking her fingers trying to eat melted sherbert. The resident was wearing a clothing protector and was attempting to eat the edge of the clothing protector thinking it was food in her lap. The resident was also observed trying to pick up food from the tablecloth. She was moving the spoon around the plate and not getting any food on the spoon. The resident was not assisted from 12:38 PM to 1:01 PM. At this time, the Interim Director of Nursing (DON) arrived to the dining room and sat down beside the resident. The DON began to assist the resident, allowing the resident to feed herself. The resident was noted with a good appetite. On 07/22/25 at 1:30 PM, the incident was reported to the Administrator and the Regional Corporate Nurse #106 regarding the Resident #11 attempting to feed herself without any assistance. e) Resident #62 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/23/25 at 12:39 PM, Resident #62 was observed feeding herself with a butter knife. At 1:03 PM, the Registered Dietician (RD) #109 gave the resident a bite of food on her fork and began redirecting the resident. On 07/22/25 at 1:30 PM, the incident was reported to the Administrator and the Regional Corporate Nurse #106 regarding Resident #62 attempting to feed herself with a butter knife.

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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, record review and staff interview, the facility failed to provide a safe, clean, homelike environment for Resident #11 and #96. This was a random opportunity for discovery. Resident Identifiers: #11 and #96. Facility Census: 115.Findings Include:a) Resident #11 On 07/22/25 at 10:45 AM, an observation of room [ROOM NUMBER] was made. The observation found Resident #11 sitting in a geri-chair with dried food and other debris on it. The resident was found facing the wall. There was no television or music playing. The resident appeared disheveled, and the room was noted with a foul odor of urine. The resident's fall mat was observed with a tear on the corner. The floor was sticky and food from breakfast as well as a plastic spoon were on the floor. The resident's clothes were dirty and were noted with a foul body odor. Her hair was disheveled. On 07/22/25 at 10:46 AM, Licensed Practical Nurse (LPN) #54 was asked, Who is caring for the residents in room [ROOM NUMBER]? LPN #54 responded, The nurse or aide? The Surveyor replied, the aide. On 07/22/25 at 10:49 AM, Nurse Aide (NA) #104 and NA #68 entered the room. At this time, both aides were asked Do you think these ladies look disheveled? NA #68 responded yes and NA #104 nodded her head yes. At this time, this surveyor requested the Regional Corporate Nurse (RCN) #106 come to the room. At 10:54 AM, RCN#106 entered the resident's room. RCN #106 looked around the room and agreed the room smelled like urine and the resident's fall mat was ripped. RCN #106 agreed the resident was disheveled and the overall care of the resident was poor. RCN #106 stated, Let me have someone get her in the shower .she needs a shower. b) Resident #96On 07/22/25 at 10:45 AM, an observation of room [ROOM NUMBER] was made. The observation found Resident #96 sitting in a geri-chair with dried food and other debris on it. The resident was found facing the wall. There was no television or music playing. The resident appeared disheveled, and the room was noted with a foul odor of urine. The resident's fall mat was observed with something wet underneath and a broken handle on the nightstand. The floor was sticky and food from breakfast as well as a plastic spoon were in the floor. The resident's clothes were dirty and was noted with a foul body odor. Her hair was disheveled. On 07/22/25 at 10:46 AM, Licensed Practical Nurse (LPN) #54 was asked, Who is caring for the residents in room [ROOM NUMBER]? LPN #54 responded, the nurse or aide? The Surveyor replied, the aide. On 07/22/25 at 10:49 AM, Nurse Aide (NA) #104 and NA #68 entered the room. At this time, both aides were asked Do you think these ladies look disheveled? NA #68 responded yes and NA #104 nodded her head yes. At this time, this surveyor requested the Regional Corporate Nurse (RCN) #106 come to the room. At 10:54 AM, RCN #106 entered the resident's room. RCN #106 looked around the room and agreed the room smelled like urine. RCN #106 agreed the resident was disheveled and the overall care of the resident was poor. RCN #106 stated, Let me have someone get her in the shower .she needs a shower. On 07/22/25 at approximately 11:15 AM RCN #106 and the Administrator confirmed the residents should have been showered, dressed in clean clothes and the room should have been cleaned.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 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, record review and staff interview, the facility failed to keep the resident as free from neglect as possible. This failed practice had the potential to affect more than a limited number of residents. This was a random opportunity of discovery. Resident Identifiers: #11 and #96. Facility Census: 115. Findings include:a) Resident #11On 07/22/25 at 10:45 AM, an observation of room [ROOM NUMBER] was made. The observation found Resident #11 sitting in a geri-chair with dried food and other debris on it. The resident was found facing the wall. There was no television or music playing. The resident appeared disheveled, and the room was noted with a foul odor of urine. The resident's fall mat was observed with a tear on the corner. The floor was sticky and food from breakfast as well as a plastic spoon were in the floor. The resident's clothes were dirty and was noted with a foul body odor. Her hair was disheveled. On 07/22/25 at 10:46 AM, Licensed Practical Nurse (LPN) #54 was asked, Who is caring for the residents in room [ROOM NUMBER]? LPN #54 responded, the nurse or aide? The Surveyor replied, the aide. On 07/22/25 at 10:49 AM, Nurse Aide (NA) #104 and NA #68 entered the room. At this time, both aides were asked do you think these ladies look disheveled? NA #68 responded yes and NA #104 nodded her head yes. At this time, this surveyor requested the Regional Corporate Nurse #106 come to the room. At 10:54 AM, the Regional Corporate Nurse #106 entered the resident's room. The Regional Corporate Nurse #106 looked around the room and agreed the room smelled like urine and the resident's fall mat was ripped. The Regional Corporate Nurse #106 agreed the resident was disheveled and the overall care of the resident was poor. The Regional Corporate Nurse #106 stated, Let me have someone get her in the shower .she needs a shower. On 07/22/25 at 1:15 PM, a review of the bathing under the tasks tab from 06/23/25 through 07/22/25 was completed. The review found the resident received showers two (2) times within 30 days on 06/24/25 and 07/03/25. The shower schedule was reviewed for room [ROOM NUMBER]. The resident should have been given showers on Mondays and Thursdays. The resident should have an additional seven (7) showers within the documented 30 days. There were no refusals documented. On 0722/25 at approximately 2:00 PM, the Regional Corporate Nurse #106 confirmed the resident should have been given showers as scheduled. b) Resident #96On 07/22/25 at 10:45 AM, an observation of room [ROOM NUMBER] was made. The observation found Resident #96 sitting in a geri-chair with dried food and other debris on it. The resident was found facing the wall. There was no television or music playing. The resident appeared disheveled and the room was noted with a foul odor of urine. The resident's fall mat was observed with something wet underneath and a broken handle on the nightstand. The floor was sticky and food from breakfast as well as a plastic spoon were in the floor. The resident's clothes were dirty and was noted with a foul body odor. Her hair was disheveled. On 07/22/25 at 10:46 AM, Licensed Practical Nurse (LPN) #54 was asked, Who is caring for the residents in room [ROOM NUMBER]? LPN #54 responded, the nurse or aide? The Surveyor replied, the aide. On 07/22/25 at 10:49 AM, Nurse Aide (NA) #104 and NA #68 entered the room. At this time, both aides were asked do you think these ladies look disheveled? NA #68 responded yes and NA #104 nodded her head yes. At this time, this surveyor requested the Regional Corporate Nurse #106 come to the room. At 10:54 AM, the Regional Corporate Nurse #106 entered the resident's room. The Regional Corporate Nurse #106 looked around the room and agreed the room smelled like urine. The Regional Corporate Nurse #106 agreed the resident was disheveled and the overall care of the resident was poor. The Regional Corporate Nurse #106 stated, Let me have someone get her in the shower .she needs a shower. On 07/22/25 at 1:40 PM, a review of the bathing under the tasks tab from 06/23/25 through 07/22/25 was completed. The review found the resident received showers three (3) times within 30 days on 06/24/25 and 07/03/25 which was documented twice for this date. The shower schedule was reviewed for room [ROOM NUMBER]. The resident should have been given showers on Mondays and Thursdays. The resident should have an additional seven (7) showers within the documented 30 days. There were no refusals documented. On 0722/25 at approximately 2:00 PM, the Regional Corporate Nurse #106 confirmed the resident should have been given showers as scheduled.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, staff interview and family interview, the facility failed to complete a thorough investigation regarding an allegation of neglect for Resident #123. This was true for one (1) of seven (7) residents reviewed under the care area of neglect. This failed practice had the potential to affect more than a few residents. Resident Identfiers: #123 Facility Census: 115. Findings Include:a) Resident #123On 07/23/25 at 11:00 AM, a review of a facility-reported incident regarding Resident #123 was completed. The review found the allegation of waiting over a one (1) hour wait time for the resident to receive assistance. The five (5) day follow-up was reviewed at this time as well. The following was documented: On April 17, 2025 (Name of Resident)'s son reported that his father contacted him the previous eveing stating his call light had been on for 1 hour and 45 minutes and he needed to use the bathroom. The son drove 15 minutes to the facility and when he arrived he saw the call light on. He checked with his dad, who had a bowel movement. He got the attention of staff, who immediately changed his father. (Typed as written.) This was reported to the appropriate state agencies. (Name of Resident) is a short term resident at the facility. He is (age) and lacks capacity to make medical decisions according to the facility physician. He has diagnoses that include, but are not limited to: metastatic prostate cancer, metabolic encephalopathy, altered mental status, atrial fibrillation, peripheral vascular disease, type 2 diabetes, hypotension, and chronic kidney disease. He has strong support from his son (Name of son), who assists with all his medical affairs. (Typed as written.)Investigation: SW (social worker #93) interviewed the resident. He indicated a specific instance he had to wait for a CNA (certified nursing assistant), but did not recall exactly how long and did not recall what he needed assistance with. He indicated no mental anguish. (Typed as written.)(Name of Nurse Aide #86) was assigned to (Name of the Resident). She was suspended pending the investigation. She reported she checked on (Name of Resident) several times throughout the day and he had no complaints including at approximately 4:30 PM. She left for the day at 5:30 PM and did not see his call light on at that time. (Name of Nurse Aide (NA) #16) reported she made multiple rounds through the day with (Nurse Aide #86) including one at 4:30 PM at which point (Name of Resident) had no requests or concerns. (Typed as written.)(Licensed Practical Nurse (LPN) #4) reported (Name of NA #86) notified her when she left at 5:30 PM and reported she had completed a final check on all her patients. Near 6pm (Name of Resident's son) came to her and requested his dad be changed. At that time the call light was on. LPN #4 and NA #43 immediately changed him. He had a bowel movement. They changed his brief. His sheets were clean and dry and did not need changed. He had no redness or known irritation to his peri area. (Typed as written.)NA #43 reported she cannot recall for sure when (Name of Resident) 's light came on or how long it was on. She helped change him near 6pm. (Typed as written.)Unit Manager (UM) #111 completed a skin assessment on 04/17 indicating no skin issues. Social Worker (SW) #93 interviewed several other residents, who reported NO concerns regarding their care. (Typed as written.)Conclusion: Neglect is not substantiated. There is no physical harm and no known mental anguish. (Typed as written.) On 07/23/25 at 1:15 PM, an interview was held with LPN #4. LPN #4 stated, Two aides left early that day .they said they completed their rounds. That left me, one aide on the floor and one aide in the dining room. I was in one room and the aide on the floor was in another room. When I came out of the room, the resident's son was there and he was furious. He yelled at me and wanted to know why no one was helping his dad. I apologized and the aide and I went and changed the resident. I don't know if his call light was on or how long it was on. On 07/23/25 at 4:00 PM, an interview was held with SW #93 regarding the investigation. SW #93 felt he had completed the investigation and his determination was based on the information the resident was unable to provide; such as how long of a wait time and what his need was.An interview was held with the Medical Power of Attorney (MPOA) on 07/24/25 at 9:35 AM. The MPOA stated, I'll tell you what happened. He is no longer there. I got a call from my mother .she said my father had just called her and could not get anyone to help him, that he had to use the bathroom and no one would bring him a bed pan. So I drove to the facility which is about 15 minutes away and the call light was on .when I asked him did someone help him he said no it's to late. There were two (2) people sitting at the desk and I wanted to know why no one has helped him .they immediately apologized and changed him. They insinuated there wasn't enough staff .the next day I spoke with the Administrator and was told they would do an investigation .after making a call to my mother, then my mother calling me, then me driving here it was a while he was needing assistance.An interview was held with the Regional Corporate Nurse #106 on 07/24/25 at 9:15 AM. A discussion was held regarding the information obtained from the interviews. Regional

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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. Based on observation, record review and staff interview, the facility failed to develop and/or implement the care plan regarding Resident #11's need for meal assistance and cueing for meals, Resident #117's negative pressure wound therapy (wound vac) and turning and repositioning for Resident #122, #21, #63, #7, and #104. This was true for seven (7) of 16 residents reviewed during the survey process. Resident Identifiers: #11, #117, #122, #21, #63, #7 and #104. Facility Census: 115.a) Resident #7 On 07/22/25 at 9:00 AM, a record review found that Resident #7 has multiple pressure ulcers, including his glutes and thighs. He had a Braden Scale for Predicting Pressure Score Risk dated 07/08/25 with a score of fifteen (15) which indicated he was at risk for pressure ulcers. He had an order to cleanse the stage 2 to left and right glutes with IHWC (wound cleanser), apply sure prep to peri wound, apply zinc oxide and leave open to air. Review of his care plan states under the focus of skin breakdown that he is to be turned and repositioned every 1-2 hours. Review of his task sheet for the last thirty (30) days for GG bed mobility indicates he is back and forth from substantial/maximal assistance to dependent for bed mobility. Review of his task sheet for the last thirty (30) days for turning and repositioning every 1-2 hours indicates he is not turned or repositioned as required. Review of the care plan states to turn and reposition every 1-2 hours which the facility did not implement. The above findings were confirmed with Corporate Resource Nurse (CRN) #106 on 07/22/25 at 11:45 AM at which time she agreed the care plan was not implemented to turn and reposition the resident. b) Resident #21 On 07/21/25 at 1:03 PM a record review of the Treatment Administration Record (TAR) for July 2025 shows that Resident #21 did not have wound treatments as ordered by the physician. There was an order for wound care to his right and left heel, right and left elbow, and a pressure ulcer to his coccyx. Review of his care plan states to provide wound treatment as order which the facility failed to implement. The above findings were confirmed with (CRN) #106 on 07/22/25 at 11:45 AM at which time she agreed the care plan was not implemented for wound care. c) Resident #11 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/23/25at 12:38 PM, Resident #11 was observed trying to feed herself. The resident was attempting to pick up food but was not picking anything up and was still attempting to eat what she had not picked up. The resident was sucking her fingers trying to eat melted sherbert. The resident was wearing a clothing protector and was attempting to eat the edge of the clothing protector thinking it was food in her lap. The resident was also observed trying to pick up food from the tablecloth. She was moving the spoon around the plate and not getting any food on the spoon. The resident was not assisted from 12:38 PM to 1:01 PM. At this time, the Interim Director of Nursing (DON) arrived to the dining room and sat down beside the resident. The DON began to assist the resident, allowing the resident to feed herself. The resident was noted with a good appetite. On 07/22/25at 1:15 PM, the care plan was reviewed. Under the focus area of risk for decreased ability to perform ADL(s) (activities of daily living) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to recent illness and hospitalization. An intervention dated 02/27/25 states, provide resident with set up and supervision for queuing for eating. However, the tray ticket lists the resident as a feed assist. On 07/22/25 at 1:30 PM, the incident was reported to the Administrator and the Regional Corporate Nurse (RCN) #106 regarding Resident #11 attempting to feed herself without any assistance. The Regional Corporate Nurse #106 stated, She needs assistance and cueing while eating. The DON knows the resident needs assistance while eating. d) Resident #7 On 07/22/25 at 9:00 AM, a record review found that Resident #7 has multiple pressure ulcers, including his glutes and thighs. He has a Braden Scale for Predicting Pressure Score Risk dated 07/08/25 with a score of fifteen (15) which indicated he was at risk for pressure ulcers. He had an order to cleanse the stage 2 pressure to left and right glutes with IHWC, apply sure prep to peri wound, apply zinc oxide and leave open to air. Review of his care plan states under the focus of skin breakdown that he is to be turned and repositioned every 1-2 hours. Review of his task sheet for the last thirty (30) days for GG bed mobility indicates he is back and forth from substantial/maximal assistance to dependent for bed mobility. Review of his task sheet for the last thirty (30) days for turning and repositioning every 1-2 hours indicates he is not turned or repositioned as required. Review of the care plan states to turn and reposition every 1-2 hours which the facility did not implement. The above findings were confirmed with Corporate Resource Nurse (CRN) #106 on 07/22/25 at 11:45 AM at which time she agreed the care plan was not implemented to turn and reposition the resident. e) Resident #21 (continued on next page)

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Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/21/25 at 1:03 PM a record review of the Treatment Administration Record (TAR) for July 2025 shows that Resident #21 did not have wound treatments as ordered by the physician. There was an order for wound care to his right and left heel, right and left elbow, and a pressure ulcer to his coccyx. Review of his care plan states to provide wound treatment as order which the facility failed to implement. The above findings were confirmed with (CRN) #106 on 07/22/25 at 11:45 AM at which time she agreed the care plan was not implemented for wound care. f) Resident #63 On 07/21/25 at 1:03 PM a record review of the Treatment Administration Record (TAR) for July, 2025 shows that Resident #21 did not have wound treatments as ordered by the physician. He had wound care orders for his right and left elbow, his right and left heel and a pressure ulcer to his coccyx and left medial foot. The care plan stated to provide wound care as ordered which the facility faied to implement. The above findings were confirmed with the Corporate Resource Nurse #106 on 07/22/25 at 11:45 AM at which time she agreed the care plan was not implement wound care for the resident. g) Resident #104 On 07/24/25 at 10:00 AM record review and observation show Resident #104 had a pressure ulcer to his coccyx as well as his right leg and ankle. He had an order for wound care to venous wound to right ankle. The order also stated, “Cleanse wound with IHWC, apply sure prep, cover with foam dressing, monitor for skin integrity changes every day shift.” On 07/22/25 at 9:30 AM a record review found that Resident #104 had multiple pressure ulcers including his coccyx. He has a Braden Scale for Predicting Pressure Score Risk dated 05/08/25 with a score of eleven (11) which indicates he is at a high risk for pressure ulcers. Review of his care plan stated under the focus of skin breakdown that he is to be assisted in turning and repositioning every 1-2 hours. Review of his task sheet for the last thirty (30) days for GG bed mobility indicates he is mostly dependent for bed mobility. Review of his task sheet for the last thirty (30) days for turning and repositioning every 1-2 hours indicates he is not turned or repositioned as required. The care plan states to assist resident in turning and reposition every 1-2 hours which the facility did not implement. The above findings were confirmed with Corporate Resource Nurse #106 on 07/22/25 at 1:45 AM at which time she agreed the care plan was not implement to turn and reposition the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h) Resident #122 On 07/22/25 at 10:05 AM record review found that Resident #122 had multiple pressure ulcers including stage 2 to her left gluteus and an unstageable to her sacrum. She had a Braden Scale for Predicting Pressure Score Risk dated 06/20/25 with a score of ten (10 which indicates she is at high risk for pressure ulcers. Review of her care plan states under the focus of skin breakdown that she is to be assisted in turning and repositioning every 2-3 hours. Review of her task sheet for the last twelve (12) days for GG bed mobility indicates she was substantial/maximal assistance to dependent for bed mobility. Review of his task sheet for the last twelve (12) days for turning and repositioning as ordered indicates he was not turned or repositioned as required. Review of the care plan states the resident is to be assisted in turning and repositioning every 2-3 hours which the facility failed to implement. The above findings were confirmed with Corporate Resource Nurse #106 on 07/22/25 at 11:45 AM at which time she agreed the care plan was not implemented for turning and repositioning the resident. i) Resident #117 On 07/21/25 at 1:40 PM a record review of the Treatment Administration Record (TAR) for June and July 2025 showed that Resident #117 did not have wound treatments as ordered by the physician. The order stated “wound care cleanse diabetic ulcer to right foot 4th toe, cleanse venous wound to left leg Vashe soaked gauze for wound for 5 minutes. Apply calcium alginate cut to size of wound wrap with gauze and tape monitor for skin integrity changes, cleanse abrasion to top of left foot with IHWC, apply sure prep to peri wound and monitor for changes in skin integrity and signs and symptoms of infection, cleanse diabetic ulcer to right foot 4th toe wound cleanser, pat dry, apply sure prep, cleanse unstageable pressure ulcer to coccyx with IHWC, pat dry, apply Negative Pressure Wound Therapy (NPWT) and change dressing every Monday, Wednesday and Friday. Use black foam when replacing dressing, every day shift every Mon, Wed, Fri. and to cleanse venous wound to left leg Vashe soaked gauze to wound for 5 minutes, apply calcium alginate cut to size of wound wrap with gauze and tape monitor for skin integrity changes every day shift.” Review of the task for bed mobility and for turning and repositioning found the resident was not turned as required to prevent or heal pressure ulcers. Review of the focus in the care plan for skin breakdown stated the staff was to assist the resident in turning and repositioning every 1-2 hours which the facility did not implement. Also, the resident had a wound vac as per her orders stated above. The care plan was not developed for the wound vac or treatments for wound care on the care plan. The above findings were confirmed with the Corporate Resource Nurse #106 on 07/23/25 at 2:58 PM who agreed the staff did not implement or develop the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and staff interview the facility failed to ensure Resident #59's care plan was revised to reflect the residents history of falls. This was true for one (1) of seven (7) residents reviewed in regards to Facility Reported Incidents during a complaint survey. Resident Identifiers: #59 . Facility Census:115. a) Resident #59A review of a facility reported incident (FRI) found Resident #59 suffered a fall on 08/10/24. A review of the facility's five-day follow-up report found the following, .He does have fall precautions in place, and secondary to this incident, his bed will now be placed against the wall to prevent falling from the bed. A review of the resident's current care plan on 07/22/25 found the resident had no care plan focus statement, goals, or interventions related to being at risk for falls and/or a history of falls. A revision history of the care plan found that on 02/21/25 the following focus statement was resolved Resident is at risk for falls: impaired mobility. This was added to Resident #59's care plan on 08/12/24 two (2) days after his last fall and the subject of investigated FRI and was resolved on 02/21/25 along with the goal and the interventions. An interview with the Corporate Resource Nurse (CRN) #106 at approximately 2:45 PM confirmed Resident #59's current care plan did not reflect his history of falls.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to provide ADLs to dependent residents. This was true for five (5) of seven (7) residents reviewed for the care area of ADL care during the complaint survey. Resident Identifiers: #11, #96, #21, #119, and #16. Facility Census: 115.Findings Included: a) Resident #21 On 07/23/25 9:00 AM record review of showers for this dependent resident were reviewed. Review of the shower schedule indicates that Resident #21 is scheduled for showers Tuesday and Friday evenings. He was scheduled for a shower but did not receive one on the following dates (six (6) days) 06/24/25, 07/04/25, 07/11/25, 07/15/25, 07/15/25 and 07/18/25. This was confirmed with the Corporate Resource Nurse #106 on 07/23/25 at 2:00 PM at which time she agreed the resident missed several of his showers. b) Resident #119 On 07/23/25 9:30 AM record review of showers for this dependent resident were reviewed. Review of the shower schedule indicates that Resident #119 was scheduled for showers Tuesday and Friday evenings. She was scheduled fand received a bed bath on 03/11/25 and did not receive another shower/bed bath until 03/24/25 (13 days later). This was confirmed with the Corporate Resource Nurse #106 on 07/23/25 at 2:00 PM at which time she agreed the resident missed several of her showers within that time range. c) Resident #16 On 07/21/25 Resident #16 was overheard telling the business office manager that she probably smelled bad because she was not getting her showers like she was supposed to. This conversation occurred in the afternoon outside of the conference room where the surveyors were sitting. A review of Resident #16's record found the resident is to receive a shower on Tuesday and Friday on dayshift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #16 on the morning of 07/22/25 revealed the resident was displeased with her ability to get a shower at the facility. She stated I am supposed to get a shower every Tuesday and Friday but that does not always happen. She stated, I am supposed to get one today. I am going to go look on the board to see if I am up there. When asked why she does not get her showers she stated, Its usually because they don't have enough help. She stated, Sometimes I do refuse but not that often. Only if I don't feel good or if the water is too cold. Who wants to take a cold shower. However, a review of the past 60 days found the resident should have received 18 showers if showered every Tuesday and Friday. Resident #16 had only received 5 showers during this time frame. She had documented refusals on four (4) of the days reviewed. She received three (3) bed baths. On five days there was no documentation to show why resident #16 did not get her shower. This was confirmed with Corporate Resource Nurse (CRN) #106 on the afternoon of 07/22/25. d) Resident #11 On 07/22/25 at 10:45 AM, an observation of room [ROOM NUMBER] was made. The observation found Resident #11 sitting in a geri-chair with dried food and other debris on it. The resident was found facing the wall. There was no television or music playing. The resident appeared disheveled and the room was noted with a foul odor of urine. The resident's fall mat was observed with a tear on the corner. The floor was sticky and food from breakfast as well as a plastic spoon were in the floor. The resident's clothes were dirty and was noted with a foul body odor. Her hair was disheveled. On 07/22/25 at 10:46 AM, Licensed Practical Nurse (LPN) #54 was asked, who is caring for the residents in room [ROOM NUMBER]? LPN #54 responded, the nurse or aide? The Surveyor replied, the aide. On 07/22/25 at 10:49 AM, Nurse Aide (NA) #104 and NA #68 entered the room. At this time, both aides were asked do you think these ladies look disheveled? NA #68 responded yes and NA #104 nodded her head yes. At this time, this surveyor requested the Regional Corporate Nurse #106 come to the room. At 10:54 AM, the Regional Corporate Nurse #106 entered the resident's room. The Regional Corporate Nurse #106 looked around the room and agreed the room smelled like urine and the resident's fall mat was ripped. The Regional Corporate Nurse #106 agreed the resident was disheveled and the overall care of the resident was poor. The Regional Corporate Nurse #106 stated, Let me have someone get her in the shower .she needs a shower. On 07/22/25 at 1:15 PM, a review of the bathing under the tasks tab from 06/23/25 through 07/22/25 was completed. The review found the resident received showers two (2) times within 30 days on 06/24/25 and 07/03/25. The shower schedule was reviewed for room [ROOM NUMBER]. The resident should have been given showers on Mondays and Thursdays. The resident should have an additional seven (7) showers within the documented 30 days. There were no refusals documented. The care plan documentation states, Provide resident with extensive assist of 1 for bathing. (Typed as written.) On 0722/25 at approximately 2:00 PM, the Regional Corporate Nurse #106 confirmed the resident should have been given the showers as scheduled. e) Resident #96 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/22/25 at 10:45 AM, an observation of room [ROOM NUMBER] was made. The observation found Resident #96 sitting in a geri-chair with dried food and other debris on it. The resident was found facing the wall. There was no television or music playing. The resident appeared disheveled and the room was noted with a foul odor of urine. The resident's fall mat was observed with something wet underneath and a broken handle on the night stand. The floor was sticky and food from breakfast as well as a plastic spoon were in the floor. The resident's clothes were dirty and was noted with a foul body odor. Her hair was disheveled. On 07/22/25 at 10:46 AM, Licensed Practical Nurse (LPN) #54 was asked, who is caring for the residents in room [ROOM NUMBER]? LPN #54 responded, the nurse or aide? The Surveyor replied, the aide. On 07/22/25 at 10:49 AM, Nurse Aide (NA) #104 and NA #68 entered the room. At this time, both aides were asked do you think these ladies look disheveled? NA #68 responded yes and NA #104 nodded her head yes. At this time, this surveyor requested the Regional Corporate Nurse #106 come to the room. At 10:54 AM, the Regional Corporate Nurse #106 entered the resident's room. The Regional Corporate Nurse #106 looked around the room and agreed the room smelled like urine. The Regional Corporate Nurse #106 agreed the resident was disheveled and the overall care of the resident was poor. The Regional Corporate Nurse #106 stated, Let me have someone get her in the shower .she needs a shower. On 07/22/25 at 1:40 PM, a review of the bathing under the tasks tab from 06/23/25 through 07/22/25 was completed. The review found the resident received showers three (3) times within 30 days on 06/24/25 and 07/03/25 which was documented twice for this date. The shower schedule was reviewed for room [ROOM NUMBER]. The resident should have been given showers on Mondays and Thursdays. The resident should have an additional seven (7) showers within the documented 30 days. There were no refusals documented. The care plan documentation states, Provide patient with assist of 1 for bathing. (Typed as written.) On 0722/25 at approximately 2:00 PM, the Regional Corporate Nurse #106 confirmed the resident should have been given the showers as scheduled.

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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. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and staff interview the facility failed to perform wound treatments as ordered by the physician. This was true for three (3) of five (5) residents reviewed for wound treatments. Resident Identifiers: #21, #63 and #117. Facility Census: 115Findings include:a) Resident #21On 07/21/25 at 1:03 PM a record review of the Treatment Administration Record (TAR) for July, 2025 shows that Resident #21 did not have wound treatments as ordered by the physician.On 07/04/25 a wound care order was not complete for Skin tear right elbow cleanse with hydrating form cleanser Sure prep wound cover with adhesive foam dressing every day shift for wound care. On 07/20/25 a wound care order was not complete for Sure prep left elbow cover adhesive foam dressing for comfort per resident request every day shift.On 07/20/25 a wound care order was not completed on day shift for Apply skin prep to right heel and ensure that heels are offloaded. Monitor skin for any changes to skin integrity every day and night shift for wound. On 07/20/25 a wound care order was not complete for Cleanse pressure ulcer to coccyx with in house wound cleanser (IHWC), pat dry, supply medihoney and monitor for changes in skin integrity every day shift for wound care. On 07/20/25 a wound care order was not complete on day shift or Cleanse stage II to left medical foot with wound cleanser, pat dry, apply sureprep every shift every day and night shift. On 07/20/25 a wound care order for Cleanse stage 2 pressure ulcer to left heel with Vashe soaked gauze for 5 minute, pat dry and apply Santyl to wound bed daily and PRN for soiled dressings, cover with foam dressing. Monitor skin for any changes to skin integrity and signs and symptoms of infection. On 07/04/25 and 07/20/25 a wound care order was not complete for Medi honey wound/burn dressing external paste (wound dressing) Apply to coccyx topically every day shift for pressure ulcer to coccyx.b) Resident #63On 07/21/25 at 1:10 PM a record review of the Treatment Administration Record f(TAR) for June and July, 2025 shows that Resident #63 did not have wound treatments as ordered by the physician.On 06/20/25 a wound care order was not complete for Cleanse area around suprapubic catheter with IHWC, pat dry, cover with dry drain sponge, every day shift. On 06/30/25 a wound care order was not complete for Cleanse stage 3 pressure to right gluteus with wound cleanser, pat dry and apply Medi honey sheet then cover with border gauze daily every day shift for open area. On 07/20/25 a wound care order was not complete for day or evening shift for biofreeze, roll on external gel 4% menthol (topical analgesic) apply to left shoulder topically two times a day for pain.On 07/20/25 a wound care order as not complete to cleanse area around suprapubic catheter with IHWC, pat dry, cover with dry split gauze every day shift.On 07/20/25 a wound care order was not complete to Cleanse Stage 4 pressure ulcer to right gluteal fold with IHWC, apply Vashe soaked gauze for 5 minutes, remove and pat dry, pack wound with calcium alginate rope and cover with foam dressing every day shift for wound care. c) Resident #117On 07/21/25 at 1:40 PM a record review of the Treatment Administration Record f(TAR) for June and July, 2025 shows that Resident #117 did not have wound treatments as ordered by the physician. On 06/26/25 and 06/27/25 a wound care order was not complete to Cleanse diabetic ulcer to right foot 4th toe wound cleanser, pat dry and apply sure prep daily on day shift.On 06/26/25 and 06/27/25 a wound care order was not complete to Cleanse venous wound to left leg Vashe soaked gauze for wound for 5 minutes. Apply calcium alginate cut to size of wound wrap with gauze and tape monitor for skin integrity changes every day shift.On 7/02/25 a wound care order was not complete to Cleanse abrasion to top of left foot with IHWC, apply sure prep to peri wound and monitor for changes in skin integrity and signs and symptoms of infection every day shift. On 07/02/25 a wound care order was not complete to Cleanse diabetic ulcer to right foot 4th toe wound cleanser, pat dry, apply sure prep daily every day shift.On 07/02/25 a wound care order was not complete to Cleanse unstageable pressure ulcer to coccyx with IHWC, pat dry, apply Negative Pressure Wound Therapy (NPWT) and change dressing every Monday, Wednesday and Friday. Use black foam when replacing dressing, every day shift every Mon, Wed, Fri.On 07/02/25 a wound care order was not complete to cleanse venous wound to left leg Vashe soaked gauze to wound for 5 minutes, apply calcium alginate cut to size of wound wrap with gauze and tape monitor for skin integrity changes every day shift.The above findings were confirmed with the Corporate Resource Nurse #106 on 07/22/25 at 1:58 PM who agreed the wound care was not provided on above instances.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and staff interview the facility failed to ensure residents received treatment or services to prevent or heal pressure ulcers. This was true for four (4) of five (5) residents reviewed for turning and repositioning. Resident Identifiers: #7, #104, #117 and #122. Facility Census: 115.Findings Included:a) Resident #7On 07/22/25 at 9:00 AM record review found that Resident #7 has multiple pressure ulcers, including his glutes and thighs. He has a Braden Scale for Predicting Pressure Score Risk dated 07/08/25 with a score of fifteen (15) which indicates he is at risk for pressure ulcers.Review of his care plan states under the focus of skin breakdown that he is to be turned and repositioned every 1-2 hours. Review of his task sheet for the last thirty (30) days for GG bed mobility indicates he is back and forth from substantial/maximal assistance to dependent for bed mobility. Review of his task sheet for the last thirty (30) days for turning and repositioning every 1-2 hours indicates he is not turned or repositioned as required.The facility does not document every 1-2 hours, they do however document every shift if they completed the turning and repositioning as required during their shift. Thirty three (33) of the eighty seven (87) opportunities to turn and reposition the resident to assist in preventing or assist in healing a pressure ulcer were not documented. 06/23/25 - two shifts not documented06/24/25 - two shifts not documented06/26/25 - two shifts not documented06/27/25 - two shifts not documented06/28/25 - one shift not documented06/29/25 - two shifts not documented06/30/25 - two shifts not documented07/03/25 - one shift not documented07/04/25 - one shift not documented07/05/25 - one shift not documented07/06/25 - two shifts not documented07/07/25 - two shifts not documented07/08/25 - one shift not documented07/10/25 - two shifts not documented07/12/25 - one shift not documented07/13/25 - two shifts not documented07/16/25 - one shift not documented07/17/25 - two shifts not documented07/18/25 - one shift not documented07/19/25 - one shift not documented07/20/25 - two shifts not documentedb) Resident #104On 07/22/25 at 9:30 AM record review found that Resident #104 has multiple pressure ulcers including his coccyx. He has a Braden Scale for Predicting Pressure Score Risk dated 05/08/25 with a score of eleven (11) which indicates he is at a very high risk for pressure ulcers. Review of his care plan states under the focus of skin breakdown that he is to be assisted in turning and repositioning every 1-2 hours. Review of his task sheet for the last thirty (30) days for GG bed mobility indicates he is mostly dependent for bed mobility. Review of his task sheet for the last thirty (30) days for turning and repositioning every 1-2 hours indicates he is not turned or repositioned as required.The facility does not document every 1-2 hours, they do however document every shift if they completed the turning and repositioning as required during their shift. Twenty (20) of the eighty seven (87) opportunities to turn and reposition the resident to assist in preventing or assist in healing a pressure ulcer were not documented. 06/23/25 - one shift not documented06/26/25 - one shift not documented06/27/25 - two shifts not documented06/28/25 - one shift not documented06/29/25 - one shift not documented07/01/25 - two shifts not documented07/03/25 - one shift not documented07/10/25 - one shift not documented07/12/25 - two shifts not documented07/13/25 - one shift not documented07/14/25 - one shift not documented07/17/25 - two shifts not documented07/18/25 - two shifts not documented07/19/25 - one shift not documented07/21/25 - one shift not documentedc) Resident #117On 07/22/25 at 9:45 AM record review found that Resident #117 had multiple pressure ulcers including her coccyx. She has a Braden Scale for Predicting Pressure Score Risk dated 05/08/25 with a score of sixteen (16) which indicates she is at risk for pressure ulcers.Review of her care plan states under the focus of skin breakdown that she is to be assisted in turning and repositioning every 1-2 hours. Review of her task sheet for the last thirty (30) days for GG bed mobility indicates she was dependent for bed mobility. Review of his task sheet for the last thirty (30) days for turning and repositioning every 1-2 hours indicates he is not turned or repositioned as required.The facility does not document every 1-2 hours, they do however document every shift if they completed the turning and repositioning as required during their shift. Nine (9) of the eighty seven (87) opportunities to turn and reposition the resident to assist in preventing or assist in healing a pressure ulcer were not documented. 06/23/25 - one shift not documented06/26/25 - one shift not documented06/27/25 - one shift not documented06/28/25 - one shift not documented06/29/25 - one shift not documented06/30/25 - one shift not documented07/09/25 - one shift not documented07/12/25 - two shifts not documentedd) Resident #122On 07/22/25 at 10:05 AM record review found that Resident #122 had multiple pressure ulcers including a stage 2 to her left gluteus and an unstageable to her sacrum. She has a Braden Scale for Predicting Pressure Score Risk dated 06/20/25 with a score of ten (10 which indicates she is at high risk for pressure ulcers Review of her care plan states under

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review and staff interview the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible to prevent injury to the residents. Nurse Aide (NA) #12 transferred Resident #56 from the tilt shower chair to her bed using a stand and pivot method. The residents care plan, Kardex and physician orders all indicated Resident #56 was to be transferred via a total lift with the assistance of two (2) staff members.Resident Identifier: #56. Facility Census: 115. Findings Include: a) Resident #56 On 07/28/25 at 10:48 AM NA #12 was observed transporting Resident #56 back to her room from the shower room. The resident was in a tilt back shower chair at this time. NA #12 was observed taking Resident #56 into her room. No other staff members were observed in the room. At 10:51 AM another NA entered the room. At 10:52 AM the second NA exited the room with the tilt back shower chair. At 10:56 AM NA #12 opened the door to the residents room. Resident #56 was laying on her bed. Under her was a blue lift pad. NA #12 was asked how he transferred her to the bed he stated, I just picked her up. Not really picked her up she stood and I pivoted her to the bed she can still stand a little. A review of Resident #56's medical record found the following intervention related to Resident #56's transfer status, Provide resident/patient dependent with 2 staff members for transfers via mechanical lift with large blue pad. This intervention was added to the care plan on 04/26/23 and was revised on 02/11/25.A review of the residents kardex found the following in regards to the residents transfer status, Provide resident/patient dependent with 2 staff members for transfers via mechanical lift with large blue pad. A review of the medical record found the following physician order, Occupational Therapy(OT)-Evaluation & treatment as recommended Patient to be transferred via lift for all transfers [NAME] medium split lift pad dated 05/27/24 and was the active order at the time of the observation. The above findings were shared with Corporate Resource Nurse (CRN) #106 at 11:08 am on 07/28/25. At 11:17 am on 07/28/25 the interim Director of Nursing (DON) stated she had spoken to OT and found the resident was able to stand and pivot with a gait belt. She did confirm this information was not in the record at the time of the observations and record review by the surveyor. The surveyor asked when the last time Resident #56 was treated by Occupational Therapy. The Interim DON stated she would have to find out and get back to me. Later in the afternoon the facility provided a OT note dated 03/19/24 which contained the following sentence, Patient performed transfer into geri chair with maximal assist. Facility staff indicated this was the most recent note in which occupational therapy had mentioned the residents transfer status. The surveyor asked about the order which was entered on 05/27/24 which indicated occupational therapy wanted the resident to be transferred via a mechanical lift with a two (2) person assist. It was pointed out the order was entered on 05/27/24 which was more than two (2) months after the note which was provided. The facility staff remained silent at that time. Later in the afternoon the facility provided an evaluation from OT dated 07/28/25 which indicated OT would be working with the resident in regards to transfers. (Please note this evaluation was completed after the surveyors observation of the incorrect transfer.) The facility also provided a nursing communication sheet dated 07/28/25. This communication was from OT to nursing and read as follows: Patient to change to a stand pivot transfer with gate [SIC] belt and assistance of one, needing partial /moderate assistance for safest bed to chair - chair to bed transfers. Again this communication was completed after the surveyor's observation of the incorrect transfer. The statement given to the facility by NA #12 read as follows (typed as written): Put Miss (Last name of Resident #56) on shower bed without lift told them I help put her in chair one person not two put her in chair myself. I felt that she stand on her feet ant put her in chair an di the tranfer safely care plan need to be update. I work with her all the time. Review of Resident #56's task sheets for transfers for the previous 60 days found on the following occasions NA #12 documented Resident #56 was totally dependent on staff for transfers with the assist of two (2) staff members:-- 06/02/25 at 2:32 PM and 4:17 PM -- 06/03/25 at 11:17 AM an 3:40 PM -- 06/04/25 at 3:17 PM -- 06/06/25 at 10:07AM -- 06/11/25 at 9:51 AM and 3:16 PM -- 06/13/25 at 2:37 PM and 3:25 PM -- 06/16/25 at 12:10 PM and 3:55 PM-- 06/18/25 at 4:14 PM -- 0620/25 at 10:30 AM -- 06/23/25 at 12:22 PM -- 06/24/25 at 10:25 AM -- 06/25/25 at 11:33 AM -- 06/30/25 at 2:59 PM and 4:18 PM -- 07/01/25 at 10:44 AM and 5:06 PM -- 07/02/25 at 9:03 AM -- 07/03/25 at 11:59 AM-- 07/04/25 at 9:50 AM -- 07/07/25 at 1:34 PM -- 07/08/25 at 12:36 PM and 4:19 PM -- 07/09/25 at 10:56 AM and 4:13 PM -- 07/11/25 at 11:32 AM and 4:05 PM -- 07/14/25 at 12:09 PM and 4:21 PM -- 07/17/25 at 1:15 PM -- 07/18/25 at 1:48 PM -- 07/19/25 at 12:35 PM -- 07/21/25 at 1:23 PM and 4:17 PM. -- 07/22/25 at 2:45 PM -- 07/23/25 at 11:07 AM and 4:29 PM In the previous 60 days NA #12 never

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, caregiver interview and staff interview, the facility failed to ensure each resident maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible. This was true for four (4) of four (4) residents reviewed. This failed practice resulted in actual harm for Resident #64 who since the time of her admission has lost a severe amount of weight. The facility failed to track her consumption of meals, provide assistance at mealtimes and failed to implement the dietician's recommendation for a house supplement and the resident continued to lose weight. For Resident #119 #11 and #96 the facility failed to track their meal consumptions to identify any potential nutrition problems before the resident suffers weight loss or dehydration. Resident Identifiers; #119, #11, #96, and #64. Facility Census: 115.Findings Include: a) Resident #64 A review of Resident #64's medical record on 07/22/25 found the following weights recorded: 06/03/25- 117.8 pounds (lbs.) 06/10/25 - 118.4 lbs. 06/17/25 - 116 lbs. 06/24/25 - 111.6 lbs. 07/01/25- 111.4 lbs 07/09/25 - 109.7 lbs. 07/16/25 - 106.8 lbs. 0723/25 - 102 lbs. (this weight was obtained in the presence of the surveyor.) The percentage of weight loss was calculated using the following formula: (usual weight - actual weight) / (usual weight) x 100 = % of body weight loss For the first month in the facility the weights used were the weights from 06/03/25 and 07/01/25: (117.8-111.4)/117.8x100 = 5.43 percent. This is considered a severe weight loss in 30 days. Resident # 64 has continued to lose weight her most recent weight was 102 lbs. If the most recent weight is used to calculate weight loss since admission the following percentage is obtained: (117.8-102)/117.8X100=13.41 percent. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Further review of the record found the following current orders pertaining to the residents nutritional status: Weekly weights x 4 weeks then monthly ordered on 07/02/25. House Supplement twice a day ordered on 0703/25. Both these orders came about when the Licensed Dietician reviewed the resident on 07/0225 after the severe weight loss in 30 days was captured. Further review of the record found the following progress notes and assessments related to Resident #64's weight loss. -- Progress note effective date 07/07/25 at 12:49 PM read as follows, :Weight warning Value: 111.4 Vital Date: 07/01/25. MDS -5.0 percent change over 30 days. Resident feed assist as she is blind and deaf. Care ongoing. -- Progress note with an effective date of 07/02/25 at 11:39 AM read as follows: Weight warning Value: 111.6 Vital Date 06/24/25 2:14 PM. -5.0 change over 30 days Resident is on regular diet with good PO intakes. Feeding ability varies. All meals served in bowl Kennedy cup to aid in self feeding. Resident is visually impaired and needs to be set up. Resident to continue current diet as ordered - appropriate with potential to meet needs. House Supp BID (twice a day) and weekly weights X4 weeks. Will follow for need to start further nutritional intervention. NP/MD/LD aware. The Licensed Dietician completed two (2) nutritional assessments on Resident #64 at of the time of this review. The first was on admission and was completed on 06/05/25 this assessment indicated that meal intakes since the time of admission the resident is eating 75 percent of her meals (Please note the resident was admitted on [DATE] and only had 4 meals documented prior to the LD's assessment. She was missing documentation for one (1) meal per day since her admission). The LD identified no nutritional concerns on admission. The second and final LD assessment was completed on 07/02/25 when the residents severe weight loss was identified. This assessment identified the resident had lost 5% of her body weight in one month. The LD noted the resident was consuming 75 percent of her meals in the seven day look back period. (Please note the intake for meals was only documented on 10 occasions during the 7 day look back period leaving 11 meals with no documentation entered and not available for the LD to review.) The LD made the following recommendations: House Supplement BID (twice daily) and weekly weights X4. Will follow for need to start further nutritional intervention. Review of the weekly weights found the resident continued to lose weight every week. The first week she lost 1.7 pounds. The second week she lost 2.9 pounds for a total of 4.6 pounds since the dieticians review. However, no additional notes or assessments were completed until after the surveyor [NAME] to question the residents weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	An interview with the LD in the afternoon of 07/22/25 confirmed she was aware of the residents weight loss. She stated, I am going to look at her again today. She indicated she recommended house supplements and to assist the resident with her meals. When asked how she could accurately assess the residents meal intake when the intakes are not consistently documented she stated, I can only work with what is available to me. A comprehensive review of meal intakes documented by the facility was completed by the surveyor on the afternoon of 07/22/25 found from 06/03/25 until 07/21/25 a total of 49 days. Resident #64 was served a total of 147 meals and the staff tracked the amount consumed on 76 occasions. At approximately 3:00 PM on 0722/25 the surveyor entered the room of Resident #64. The resident had a visitor who identified herself as the residents previous caregiver when she was at home. She stated, I have been here since about 12:15 pm. The surveyor asked the visitor if the resident had drank her shake. She stated, They have not brought her in anything like that. The MAR was reviewed prior to going to the room and 100 % of the supplement was documented as consumed. The surveyor then went to the kitchen and requested a list a of the supplements they send to the residents each day. The Dietary Manager (DM) provided the list and Resident #64 was not on the provided paper. The CDM confirmed the kitchen sends the supplements. She was asked if she could look and see if Resident #64 ever received a supplement. She looked at her computer and confirmed Resident #64 had never received a supplement from the kitchen. However a review of the medication administration record (MAR) at approximately 2:30 PM on 07/22/25 found on the following dates and times the nurses documented resident Resident #64 consumed 100 percent of her supplement despite never receiving it from the kitchen: 07/03/25 at 10:00 am and 2:00 pm. 07/04/25 at 10:00 am and 2:00 pm. 07/05/25 at 10:00 am and 2:00 pm. 07/10/25 at 10:00 am and 2:00 pm. 07/11/25 at 10:00 am and 2:00 pm. 07/12/25 at 10:00 am and 2:00 pm. 07/13/25 at 10:00 am and 2:00 pm. 07/14/25 at 10:00 am and 2:00 pm 07/15/25 at 10:00 am and 2:00 pm 07/16/25 at 10:00 am and 2:00 pm 07/17/25 at 10:00 am and 2:00 pm (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	07/18/25 at 10:00 am and 2:00 pm 07/19/25 at 10:00 am and 2:00 pm 07/20/25 at 10:00 am and 2:00 pm 07/21/25 at 10:00 am and 2:00 pm Observation of the morning meal on 07/23/25 beginning at 8:08 AM found the resident was sitting in her recliner in her room. The nurse aid took her in a cup of cranberry juice and told the resident she had brought her a cup of juice. The resident was then observed feeling around on her bed side table. She did not find the juice nor did she take a drink. At about 8:15 AM Registered Nurse (RN) #112 went in to the room and asked her how she was doing. The resident stated, I am just hungry. I am starved. The RN asked the resident if she wanted a drink of her juice and she assisted the resident in getting a drink. At 8:28 am the meal cart arrived on the floor from the kitchen. At 8:29 am Resident #64's roommate was served her meal and Resident #64's tray was left on the cart. The rest of the trays on the cart was served and Resident #64's tray was still on the cart. RN #112 was overheard asking Nurse Aide (NA) #86 if anybody needed assistance with their meal. The nurse aide stated. (Name of Resident #64) her tray is still on the cart we have to wait until the second cart comes out and the trays are all served. THe RN stated if her roommate has her food you need to go head and feed her. NA #86 then took her tray in at 8:35 am. The NA asked the resident if she was ready to eat and the resident stated, I have been ready for two (2) hours. The nurse aide was trying to assist her and the resident said, I usually just eat with my fingers honey. The resident told her to sit the eggs on her lap and she would get them with her fingers. She told the NA multiple times, that's how they always do it honey. At 8:45 am the attending physician went in to see the resident. He told her he was glad she was eating. She stated, I was starved. His reply was, Well you are. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	An additional observation of the noon time meal on 0723/25 found the resident resident eating her meal in the dining room on her unit. The observation began at approximately 12:30 PM. When the surveyor entered the dining room the resident was seated at a table with her meal in front of her. The meal consisted of a tuna salad sandwich (cut in half) a bowl of potato salad and a cup of sherbert. The resident was holding half of her sandwich and had just begun to eat it. She ate the entire half she was holding. Once finished with that half of her sandwich the resident felt around the table and found the second half of her sandwich. She attempted to pick it from bowl it was in. She only managed to get the slice of bread off the top of the sandwich. At this time Registered Nurse (RN) #94 who assisting other residents with their meal motioned to the Clinical Reimbursement Coordinator was standing near Resident #94 and told the CRC the resident needed help. At this time the CRC came over and cut up the remaining part of the tuna salad sandwich and put the residents spoon in it. Once the resident finished the top piece of bread she picked up from the sandwich she again felt around the table and found the bowl with the spoon in it she picked up the spoon which had no food on it and put it in her mouth. She then laid it down and began eating the remaining part of the tuna salad sandwich with her hands. She at only a couple more bites. She then felt around and found her potato salad she took a couple bites of it with her fingers. During this time no staff had assisted with her meal other than the one time the CRC cut up her sandwich. The LD then came over and the resident told her she did not like that potato salad. The LD put some salt and pepper on it but the resident stated she did not like it. The LD removed the potato salad from the table. At this time Resident 64 was observed feeling around for her sherbert she could not find it at first then the LD came over and helped her find it. The LD then stayed with the resident and helped her find sherbert after every bite and helped the resident ensure the sherbert was on her spoon. With the help of the LD the resident was able to eat her sherbert with her spoon. The resident requested for the staff to go to her room and bring her some muffins he son had brought. The staff did assist the resident with that request and the resident ate the entire bag of the mini muffins. At this time Nurse Aide (NA) #21 picked up the residents tray ticket and wrote something on it. The surveyor reviewed the ticket and found NA #21 had documented the resident had consumed 100 percent of her meal despite the fact the resident only hate a bit more than half her sandwich and did not eat her potato salad. An interview with the LD at 1:11 pm confirmed the resident did not eat 100 percent of her meal. She did state it was okay to give her credit for the muffins but that would still not be considered 100 percent. Further review of the tray ticket found the resident was to be assisted with all her meals. This meal observation was shared with the Nursing Home Administrator (NHA) and the Corporate Resource Nurse (CRN) #106 immediately after the interview with the LD. They agreed that what was describe would not be considered feeding assistant. CRN #106 stated they should sit down with her and help her. Findings Included: b) Resident #119 On 07/24/25 at 9:00 AM record review of Nutritional Assessments and meal intakes for Resident #119 shows insufficient documentation for an accurate nutritional assessment. According to the last Nutritional Assessment performed prior to the resident being transfered to the hospital it was stated that the resident did have a weight loss of 9%. It states per the Activities of daily living (ADL) documentation the resident was eating 44% of her meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	According to documentation of meal intakes for 03/01/25 through 04/01/25 (32 days) there were 44 missing documentations out of a possible 96 entries. It was reviewed with the Corporate Resource Nurse #106 on 07/24/25 at 10:10 AM when she agreed a more accurate nutritional assessment could be made with accurate meal intakes documented for every meal. Resident #11 On 07/23/25 at 2:00 PM, a record review was completed for Resident #11. The review included meal intake percentages for 06/23/25 through 07/22/25. The review found 42 of 90 meals were documented. Three refusals were noted as well. However, 45 meals were not documented in the resident record. A review found the resident's weight had remained stable. However, the facility physician and/or the registered dietician would not be able to evaluate the resident's meal consumption and nutritional needs. On 07/23/25 at approximately 3:30 PM, the Regional Corporate Nurse #106 was notified of the missing meal percentages. The Regional Corporate Nurse #106 confirmed all meals should be documented. Resident #96 On 07/23/25 at 2:40 PM, a record review was completed for Resident #96. The review included meal intake percentages for 06/23/25 through 07/22/25. The review found 44 of 90 meals were documented. However, 46 meals were not documented in the resident record. A review found the resident's weight has remained stable. However, the facility physician and/or the registered dietician would not be able to evaluate the resident's meal consumption and nutritional needs. On 07/23/25 at approximately 3:30 PM, the Regional Corporate Nurse #106 was notified of the missing meal percentages. The Regional Corporate Nurse #106 confirmed all meals should be documented.

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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 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. Based on observation, record review and staff interview the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to weight loss and dehydration. This was true for one (1) of one (1) resident reviewed for the care area of Feeding Tubes during a complaint survey. Resident Identifier: #52. Facility Census:115. Findings Include: a) Resident #52 A review of Resident #52's medical record found a physician's order which read: Enteral feed order one time a day Glucerna:1.5 cal at 70 ML (Milliliters) per hour for 20 hours This order was current at the time of this review and began on 07/15/25. The resident was to be started on the feeding at 2:00 PM and unhooked at 10:00 AM the following day. At 4:15 PM on 07/22/25 an observation of Resident #52 with the Corporate Resource Nurse (CRN) #106 found Resident #52's feeding was running. The rate on the pump was observed to be running at only 60 ML per hour instead of the ordered 70 ML per hour. CRN #106 asked Licensed Practical Nurse (LPN) # 32 to confirm Resident #52's order. The LPN reviewed the electronic medical record (EMR) ad confirmed the rate was supposed to be set at 70 ML per hour. CRN #106 asked her to correct the rate on the pump.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515066	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and staff interview the facility failed to ensure all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. This was true for two (2) of five (5) personnel records reviewed during the extended survey. Employee Identifiers: Nurse Aide (NA) #86 and NA #13. Facility Census: 115. Findings Include: a) Nurse Aide #13 A review of NA#13's competency check offs for the calendar year of 2024 found she had only completed two (2). One (1) for hand hygiene and one (1) for Putting on and taking of personal protective equipment. During an interview with the Nursing Home Administrator (NHA) at 3:12 PM on 07/28/25 confirmed NA #13 only had these two (2) check offs completed. b) Nurse Aide #86 A review of NA#86's competency check offs for the calendar year of 2024 found she had only completed two (2). One (1) for hand hygiene and one (1) for Putting on and taking of personal protective equipment. During an interview with the Nursing Home Administrator (NHA) at 3:12 PM on 07/28/25 confirmed NA #86 only had these two check offs completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515066	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and staff interview the facility failed to ensure all nurse aides received an annual performance evaluation. This was true five (5) for five (5) employee personnel records reviewed. This failed practice has the potential to affect more than an isolated number of residents. Employee Identifiers: #86, #13, #21, #5, and #95. Facility Census: 115. Findings Include: a) Performance Reviews On 07/28/25 in the early afternoon the yearly performance evaluations were requested for Nurse Aide (NA) #86, #13, #21, #5 and #95. On 07/28/25 at 2:41 PM during an interviedw with Corporate Resource Nurse (CRN) #106 it was revealed that the facility did not have any of the five (5) performance evaluations requested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515066	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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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 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 medical record review and staff interview the facility failed to ensure a complete and accurate medical record. The facility failed to document meal percentages in the Tasks portions of medial records for Resident #121. Facility Census: 115Findings included: a) Resident #121A review of Resident #121's tray cards revealed that the resident was scheduled to receive meal tray on the day of 05/31/25. A review of Resident #121's task documentation for meals had no information for the one day he was present in the facility on 05/31/25. Nurse Aide #43 was interviewed on 07/24/25 at 3:14 PM and reported that Resident #121 was admitted to the facility and left the facility against medical advice the same day as 05/31/25. She stated that he had been arguing with his family because he wanted to go home and they wanted him to stay for treatment. She reported that he was angry when the kitchen did not immediately send out his trays for lunch and breakfast on the food carts, but she had gone to the kitchen to get them for him for both meals, and he refused them both and did not document the refusals.