STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515169	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Center	1000 Lincoln Drive South Charleston, WV 25309

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on family interview, record review and staff interview, the facility failed to notify the resident's representative of two (2) significant changes for Resident #123. This was true for one (1) of one (1) residents reviewed during the survey process. Resident identifier: #123. Facility Census: 122. Findings Include: a) Resident #123 On 05/14/25 at 10:39 AM, an interview was held with Resident #123's representative. The representative stated, They (the facility) didn't call me when two (2) different incidents happened to (Resident #123). I was very upset and felt someone should have called me. On 05/14/25 at 11:35 AM, a record review was completed. The review found a physician determination of capacity dated 05/27/23, which indicated the resident lacked capacity due to Alzheimer's disease. The review, also, found the resident representative was not notified about two (2) changes in conditions. The first change in condition was on 02/12/25, when the resident was noted with an elevated pulse/heart rate while resting. The second change in condition was on 02/21/25, when the resident was noted with an altered mental status, weakness, shortness of breath, nausea and vomiting and lethargy. The resident remained in the facility during each event and was treated in-house by the on-call physicians. On 05/14/25 at 1:30 PM, the facility policy entitled, Change in Condition: Notification of states, A Center must immediately inform the patient, consult with the patient's physician, and notify, consistent with their authority, the patient's representative, where there is: .A significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) . Under the heading purpose, to provide appropriate and timely information about changes relevant to the patient's condition. On 05/14/25 at 12:45 PM, the Director of Nursing (DON) and the Administrator were notified and confirmed the resident's representative should have been notified.

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