

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2025
NAME OF PROVIDER OR SUPPLIER  Cedar Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE  302 Cedar Ridge Road Sissonville, WV 25320	

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 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interview the facility failed to provide an environment for residents free from neglect and physical harm for one (1) of four (4). This failed practice caused physical harm to Resident #105. Resident #105 fell out of bed and injured his left arm. The failed practice was determined by the state survey team to have been corrected prior to entrance and will be cited at past non-compliance. Resident identifier: #105. Facility census: 104.</p> <p>Findings include:</p> <p>a) Resident #105</p> <p>Medical Record review revealed Resident #105 was a [AGE] year old admitted for long term care. He had the following diagnoses: diabetes, hypokalemia, dementia, dysphagia, thyroid disorder and history of falls. He lacked capacity and had a Brief Interview For Mental Status (BIMS) score of 5. A score of 5 indicated severe cognitive impairment.</p> <p>Review of an internal investigation completed by the facility revealed Resident #105 had a fall on 04/19/25. According to the facility's investigation this fall resulted in an injury to the left arm related to entrapment of the arm between mattress and rail.</p> <p>Nurse Aide #135's statement reflected that Resident #105 was last seen in bed on 04/19/25 between 2:30 AM and 3:00 AM. Nurse Aide #135 was assigned to the resident on the night of 04/19/25. Nurse Aide #135 was terminated as a result of the investigation completed by the facility.</p> <p>A review of a statement collected by the facility from Nurse Aide (NA) #64 revealed she clocked in on 04/18/25 at 7:00 PM. NA #64 said that NA #135 left at 3:00 AM. NA #135 advised NA #64 that she had finished her round and that everyone had been checked and changed. According to NA #64, NA #110 was supposed to come in at 3:00 AM but had called in to report he was running late. NA #121 came over from south to help NA #64 deal with the fact that NA #110 had not shown up for work. NA #64, NA #121 completed checks on their respective assigned hallways and then went to cover NA #110's assignment.</p> <p>Review of the facility's investigation revealed Resident #105 was found by NA #64 on 04/19/25 at 5:10 AM.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A statement dated 04/19/25 written by Nurse Aide #64 stated, When I walked into (Resident #105's) room I saw (Resident #105) laying in the floor face down with his left arm stuck between the bed and bed rail. His left arm was extended over his head and his arm was twisted. I ran over to him and tried to remove his arm from the bedrail but it was so tight I couldn't do it by myself. I yelled for (Licensed Practical Nurse #97) and she came in to help me try to remove his arm from the bed rail again and we were unsuccessful. LPN #97 yelled for (name of staff) who was working on third assignment, and she came in and began to assist us. After a few seconds (name of staff) and I were able to free his arm from the bed. During this time (Nurse Aide #121) came in the room and said she was going to get the lift and lift pad so we could safely get him off of the floor and back into the bed so we could check him out. While we waited on her to get back with the lift and lift pad I was holding (Resident #105's) right hand and (name of staff) was holding his left hand. (name of staff) asked Resident #105 to squeeze her hand with his left hand and he was unable to do so. I asked him to squeeze my hand with his right hand and he successfully did. When we got him out of the floor with the lift, we noticed that he had a knot coming from his left armpit. LPN #97 tried to call the doctor who advised her to call 911. I did notice when I first went into his room that his bed was placed way higher than normal. I frequently work second assignment and know he has a tendency to roll out of the bed I make sure his bed was to the floor all the way down. His call light and bed remote were both in the floor. His headboard was placed against the wall with both rails up. I do not remember seeing him have on any antislip socks at the time of his fall. We checked his brief once he was in the bed and he was dry.</p> <p>On 05/14/25 during an interview with the administrator, the administrator stated NA #135 left the facility at 3:03 AM on 04/19/25 without letting her supervising nurse know. The Administrator stated during an interview, on 05/14/25, that it was her expectation that all residents were visually observed and provided if care if needed at least every (2) hours. It was confirmed that this resident was not checked on for over two (2) hours.</p> <p>Following the fall Resident #105 was transferred to the Emergency Department and found to have an arterial tear to the left arm. He received surgical intervention to repair the artery and muscle. The resident did not return to the facility.</p> <p>The facility provided a copy of an In-Service Sign-In Sheet dated 04/21/25. The topic and description was Shift to Shift report (walking around) must take place at the end of your shift with the oncoming CNA/Nurse. If you leave the floor for lunch, break or your shift is over you must report to your nurse/supervisor that you are leaving so your assignment can be reallocated to who is covering for you.</p> <p>On 05/14/25 the administrator stated NA #135 left the facility at 3:03 AM on 04/19/25 without letting her supervising nurse know. A review of the facility's investigation revealed Nurse Aide #110 was scheduled to report to work at 3:00 AM on 04/19/25. Investigation revealed that NA #110 had called in to report he would be arriving for work late and later that morning called in to report he would not be there for the entire shift.</p> <p>During an interview on 05/14/25 at approximately 10:35 a.m., the Administrator stated, During our investigation, we discovered the issue and immediately began to correct the issue. We done separate training related to this finding. Education was completed to all NAs by 05/01/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided a copy of an In-Service Sign-In Sheet dated 04/21/25. The topic and description was Shift to Shift report (walking around) must take place at the end of your shift with the oncoming CNA/Nurse. If you leave the floor for lunch, break or your shift is over you must report to your nurse/supervisor that you are leaving so your assignment can be reallocated to who is covering for you.</p> <p>The Administrator said after this incident they went through the building and assessed all residents' bed/bed rails for the space between the mattress and the side rail.</p> <p>Observations made by the survey team during the investigation did not reveal any potential entrapment areas between the mattress and side rails.</p> <p>A bed safety evaluation was performed on 01/27/25. Review of evaluation revealed Step #5 (Risk Factor Evaluation and #7 (Check for Zones of Entrapment) were not completed. There was no documentation in Step #5 and #7.</p> <p>A fall risk assessment was completed on 01/28/25. Results of assessment were that Resident #105 was a fall risk and was care planned for fall risks.</p> <p>Documentation review revealed that all NAs were provided education on correct procedure when performing a shift-to-shift report (walking around). Sign-in sheets for the in-service were reviewed and staff interviews with Nurse Aide (NA) #110, #79, #12, and #77 verified training completed.</p> <p>On 05/14/25 at approximately 12:19 p.m., interview with Nurse Aide (NA) #110. The surveyor asked the NA to explain the shift-to-shift report process. NA #110 correctly explained the process.</p> <p>On 05/14/25 at approximately 1:13 p.m., conducted an interview with Nurse Aide (NA) #79. Asked the employee what procedure they would follow if they had to leave or at change of shift. NA #79 stated, I would notify who is in charge and I would give a report to whoever is taking care of my residents. Education was completed and verified by a signature sheet on 04/21/25.</p> <p>On 05/14/25 at approximately 1:41 p.m., the surveyor conducted an interview with Nurse Aide (NA) #12. The surveyor asked the employee what procedure they would follow if they had to leave or at change of shift. NA #12 stated, I would give a report to oncoming CNA and do a walk around. Education was completed and verified by a signature sheet on 04/21/25.</p> <p>On 05/14/25 at approximately 1:47 PM, the surveyor conducted an interview with Nurse Aide (NA) #77. NA #77 was asked what procedure they would follow if they had to leave or at the change of shift. NA #77 stated, I would give report and do a walk around. If I had to leave, I would notify who was in charge. Education was completed and verified by a signature sheet on 04/21/25</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and staff interview, the facility failed to ensure Resident #31, #37, #105 and #53 had an accident-free environment. Excessive gaps were found with no gap fillers at the foot of three (3) residents' beds. One (1) resident had his arm entrapped between the mattress and side rail.</p> <p>Excessive gaps in danger zones on a resident bed can lead to serious injuries including death. This created an immediate jeopardy situation that began on 05/13/25 at 10:00 AM and ended on 05/14/25 at 12:00 PM. Resident identifiers: #31, #37, #105 and #53. Facility census: 104.</p> <p>Findings include:</p> <p>a) On 05/13/25 between the hours of 9:30 AM through 10:00 AM, observations of all the beds in the facility revealed that the mattresses had no gap fillers and there were gaps greater than approximately 5 inches in resident beds. This allowed for a space at the foot of the bed that could allow the entrapment of Resident #31, Resident #37, and Resident #53.</p> <p>On 05/13/25 at approximately 11:40 a.m., an interview with the Maintenance Assistant (MA) on 05/13/25 at approximately 11:40 a.m. verified these findings.</p> <p>The facility was notified of the Immediate Jeopardy (IJ) at 12:40 PM on 05/13/25. The facility submitted their first abatement plan of correction (POC) at 1:49 PM on 05/13/25. The state agency requested changes and the second abatement POC was submitted on 05/13/25. The plan of correction was accepted on 05/13/25 at 3:33 PM.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The plan of correction stated, Maintenance Director fixed the gap at the foot of beds for Resident #31, #37, and #53 on 05/13/25 and used the bed safety measuring tool to ensure it passed. All residents of the facility have the potential to be affected. The Maintenance Director/designee conducted an audit on 5/13/25 utilizing the bed safety tool to ensure the head/foot of beds passed according to manufacturer guidelines with any corrective action immediately upon discovery. The Director of Nursing (DON)/designee conducted an audit on 5/14/25 of residents beds that require gap filler to ensure it is in place with any corrective action immediately upon discovery. Re-education was provided by the Nursing Home Administrator (NHA) to the maintenance department on 5/13/25 regarding the use of the bed safety measuring device to be used to conduct the inspection as they evaluate gaps and potential entrapment risks between head/foot of beds with a post-test by the NHA/designee prior to the beginning of the next shift to work. New maintenance staff will be provided education, including post-test during orientation by the NHA/designee. Re-education was provided by the DON/designee to all the nursing staff on 5/13/25 regarding residents that require gap fillers on the bed to ensure the placement with a post-test to validate understanding. Any nursing staff not available during this time frame will be provided re-education, including post-test by the DON/designee prior to the beginning of the next shift to work. New nursing staff to be provided education, including post-test during orientation by the DON/designee. The Maintenance Director/Designee will monitor resident beds with any change in bed frame, mattress or bedrail utilizing the bed safety measuring device starting 5/13/25 to ensure the head/foot of beds pass according to manufacturer guidelines daily for 2 weeks including weekends and holidays then 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then randomly thereafter. The DON/designee will monitor residents with gap fillers on bed starting 5/14/25 to ensure the placement of gap filler daily for 2 weeks including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 weeks then randomly thereafter. Results of monitors will be reported by the DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved then randomly thereafter as determined by the QIC committee.</p> <p>After observation of the implementation of the abatement POC, the IJ was abated at 12:00 PM on 05/14/25.</p> <p>b) Resident #105</p> <p>Medical Record review revealed Resident #105 was a [AGE] year-old admitted for long term care. He had the following diagnoses: diabetes, hypokalemia, dementia, dysphagia, thyroid disorder and history of falls. He lacked capacity and had a Brief Interview for Mental Status (BIMS) score of 5. A score of 5 indicated severe cognitive impairment.</p> <p>Medical Record Review (MRR) revealed Resident #105 had a fall on 04/19/25 at 5:10 AM. This fall resulted in an injury to the left arm related to entrapment of the arm between mattress and rail.</p> <p>Nurse Aide #135 was assigned to the resident on 04/19/25. According to Nurse Aide #135's statement the resident was last seen in bed on 04/19/25 between 2:30 AM and 3:00 AM. On 05/14/25 during an interview with the administrator, the administrator stated NA #135 left the facility at 3:03 AM on 04/19/25 without letting her supervising nurse know. Nurse Aide #135 was terminated because of the investigation completed by the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Witness statements that were collected by the facility and reviewed by the survey team revealed the resident's bed was at waist level when he was found following the fall. Following the fall Resident #105 was transferred to the Emergency Department (ED) and found to have an arterial tear to the left arm. He received surgical intervention to repair the artery and muscle.</p> <p>Review of the facility's investigation revealed Resident #105 was found on 04/19/25 at 5:10 AM.</p> <p>A statement dated 04/19/25 written by Nurse Aide #64 stated, When I walked into (Resident #105's) room I saw (Resident #105) laying in the floor face down with his left arm stuck between the bed and bed rail. His left arm was extended over his head and his arm was twisted. I ran over to him and tried to remove his arm from the bedrail, but it was so tight I couldn't do it by myself. I yelled for (Licensed Practical Nurse #97) and she came in to help me try to remove his arm from the bed rail again and we were unsuccessful. LPN #97 yelled for (name of staff) who was working on third assignment, and she came in and began to assist us. After a few seconds (name of staff) and I were able to free his arm from the bed. During this time (Nurse Aide #121) came in the room and said she was going to get the lift and lift pad so we could safely get him off of the floor and back into the bed so we could check him out. While we waited on her to get back with the lift and lift pad I was holding (Resident #105's) right hand and (name of staff) was holding his left hand. (name of staff) asked Resident #105 to squeeze her hand with his left hand and he was unable to do so. I asked him to squeeze my hand with his right hand and he successfully did. When we got him out of the floor with the lift we noticed that he had a knot coming from his left armpit. LPN #97 tried to call the doctor who advised her to call 911. I did notice when I first went into his room that his bed was placed way higher than normal. I frequently work second assignment and know he has a tendency to roll out of the bed I make sure his bed is to the floor all the way down. His call light and bed remote were both in the floor. His headboard was placed against the wall with both rails up. I do not remember seeing him have on any anti-slip socks at the time of his fall. We checked his brief once he was in bed and he was dry.</p> <p>A bed safety evaluation was performed on 01/27/25. Review of evaluation revealed Step #5 (Risk Factor Evaluation and #7 (Check for Zones of Entrapment) were not completed. There was no documentation in Step #5 and #7.</p> <p>On 05/13/25 at 5:30 PM the Administrator said after this incident they went through the building and assessed all residents' bed/bed rails for the space between the mattress and the side rail.</p> <p>Observations made by the survey team during the investigation did not reveal any potential entrapment areas between the mattress and side rails.</p>		