

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 10/16/2025
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on record review and staff interview, the facility failed to ensure that narcotics in the facility were managed and controlled in a safe manner. This is true for eleven (11) of eleven (11) residents reviewed during the survey. All residents that receive pain medication in the facility have the potential to be affected. This will be cited as past non compliance because the facility identified what had happened and took immediate steps to correct the failure to ensure it does not reoccur. All components of the of plan of correction were completed prior to this survey beginning. This did occur, however due to the facility identifying the missing medications and replacing them immediately for the Residents that remained in the facility no Residents were harmed by this incident. Resident Identifier: #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12. Facility Census: 112 Findings Include:a) Residents #11 and #12Resident #11On 10/15/25 at 9:10 AM, record review of a reportable facility incident revealed that on 06/28/25 when a staff member attempted to reorder Resident #11's Hydrocodone from the pharmacy they were told it could not be refilled because it had been filled on 06/15/25 with sixty (60) tablets. It was noted that thirty (30) tablets of the resident's Hydrocodone were missing from the medication cart. However, during the investigation Pharmacy provided facility signature for receiving sixty (60) tablets. The staff member that received the medication stated only thirty (30) tablets were received, however the staff member that updated the manifest documented there were sixty (60) tablets received. The allegation of misappropriation was reported to the appropriate facilities, including law enforcement. The facility could not confirm misappropriation at this time and indicated a medication count , re-education of the policy for receiving medications, documenting in the manifest as well as counting shift-to-shift medications. The facility notified the medical provider and obtained the appropriate pain medication the resident needed to keep her pain in control.Resident #12During the investigation of interviewing staff and the Pharmacy the facility was unable to locate the missing medication. The incident was substantiated as misappropriation, but the facility was unable to determine the nursing staff responsible. Re-education was provided to the Director of Nursing (DON) and all licensed nurses regarding controlled medications. A new monitoring procedure was placed at this time. The allegation of misappropriation was reported to the appropriate facilities, including law enforcement. While investigating the above allegation of misappropriation it was found that Resident #12 also was missing 26 doses of Oxycodone. The sign-out log for narcotics and the shift-to-shift count report were also missing. The facility notified the medical provider and obtained the appropriate pain medication the resident needed to keep his pain in control.b) Residents #2, #3, #4, #5, #6, #7, #8 and #9On 10/15/25 at 11:55 AM record review showed a reportable incident of missing medications was submitted to the appropriate agencies.The following medications were listed on the controlled destruction log as medications to be destroyed and the medications were to be locked in a lock box until a representative from Pharmacy and a licensed staff member destroyed the medications together. Resident #2 - 29 Oxycodone placed on logbook to be destroyed on 07/01/25Resident #3 - 10 Oxycodone placed on logbook to be destroyed on 07/09/25Resident #4 - 22 Hydrocodone placed on logbook to be destroyed on 07/14/25Resident #5 - 22 Hydrocodone/Norco placed on logbook to be destroyed on 07/14/25Resident #6 - 9 Hydrocodone placed on logbook to be destroyed on 07/14/25Resident #7 - 28 Hydrocodone placed on logbook to be destroyed on 07/29/25Resident #8 - 27 Hydrocodone placed on logbook to be destroyed on 07/29/25Resident #9 - 15 Oxycodone placed on logbook to be destroyed on 07/29/25When the Pharmacist arrived at the facility on 08/15/25 to destroy the appropriate medications that were logged in the book and located in the lock box, the above narcotics were missing. The allegation of misappropriation was reported to the appropriate facilities, including law enforcement. The allegation of drug diversion and misappropriation was substantiated, however it was undetermined how or when the medications were taken or by who.c) Resident #10On 10/15/25 at 10:23 AM record review of a reportable facility incident revealed that on 10/09/25 at 7:00 AM there was a discrepancy of the medication count of seven (7) 7.5-200 mg Hydrocodone tablets. The allegation of misappropriation was reported to the appropriate facilities, including law enforcement. An investigation was initiated, and the resident was interviewed as well as the staff. Resident #10 denied any previous missing doses of her pain medication. She has a BIMS of 15 and has capacity as per the Physicians Determination of Capacity.During the investigation it was determined that the Licensed Practical Nurse (LPN) was on duty from 7:00 PM until 6:00 AM on 10/08/25 had counted the medications and recorded the manifest with another LPN as her 2nd witness. There were no discrepancies noted at that time. On 10/09/25 at 6:00 AM LPN #7 relieved the LPN</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to complete all Physicians orders for wound treatment. This was true for one (1) of three (3) residents reviewed during this investigation. Resident Identifier: #1 Facility Census: #112 Findings Include:a) Resident #1On 10/16/25 at 9:10 AM record review of Resident #1 orders and Treatment Administration Records (TAR) for August, September and October 2025 found missing documentation as shown below. All orders and TAR's were reviewed for the period of 08/01/25 - 10/31/25. None of the following Physician orders were completed on 10/09/25, 10/16/25, 10/21/25 or 10/22/25.Clean DTI (deep tissue injury) to left buttocks with wound cleaner, pat dry, apply skin prep to area and leave open to air every day shift.Clean left outer foot (amputation site) with wound cleaner, pat dry, apply Betadine and leave open to air every day shiftClean venous ulcer to left dorsum 1st digit (hallux) with wound cleaner, pat dry, apply Betadine and leave open to air every day shift.Clean venous ulcer to right dorsum foot with wound cleaner, pat dry, apply Betadine and leave open to air every day shift.Clean venous ulcer to top of left foot with wound cleaner, pat dry, apply Betadine and leave open to air every day shift. None of the following Physician orders were completed on 10/08/25 or 10/10/25Cleanse abrasion to left elbow with wound cleanser. [NAME] dry and apply skin-prep to area and surrounding area. Leave open to air every day shift. Cleanse abrasion to left shin with wound cleanser, pat dry, apply sureprep and leave open to air every day shift.Cleanse diabetic wound to right lateral foot with wound cleanser, pat dry, paint with betadine and leave open to air every day shift.Cleanser stage 2 to sacrum with Vashe wound cleanser, pat dry, sure prep to periwound. Apply silicone barrier cream to wound cover with foam dressing every day shiftCleanse stage 2 to sacrum with Vashe wound cleanser, pat dry, sure prep to periwound, apply silicone barrier cream to wound, place fulfed xerofoam between buttock proximal of upper annus to prevent soiling of wound every day shift.Cleanse venous to left dorsum 1st digit (hallux) with wound cleanser, pat dry, paint with betadine and leave open to air every day shift.Cleanse venous to left dorsum 1st digit with wound cleanser, pat dry paint with betadine and leave open to air every day shift.Cleanse venous to left dorsum 3rd digit with wound cleanser, pat dry, paint with betadine and leave open to air every day shift.Cleanser venous to left dorsum 4th digit with wound cleanser, pat dry, paint with betadine, leave open to air every day shift.Cleanse venous to left medial foot with wound cleanser, pat dry, paint with betadine and leave open to air every day shift. Cleanse venous to right dorsum foot with wound cleanser, pat dry, paint with betadine and leve open to air every day shift.All of the above findings were confirmed with the Corporate Resource Nurse and the Administrator on 10/16/25 at 11:00 AM at which time they agreed the wound treatment was not completed as ordered by the Physician.</p>		