

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 11/13/2025
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on record review and staff interview, the facility failed to ensure a complete and accurate comprehensive care plan in the area of medication refusals. This deficient practice had the potential to affect one (1) of three (3) residents in the survey sample. Resident Identifier: #111. Facility Census: 110. Findings included: a) Resident #111 Review of Resident #111's medication administration record (MAR) and progress notes showed the resident began refusing medications on 09/04/25, the day after admission to the facility. Medications refused included atorvastatin for hyperlipidemia, dapagliflozin for diabetes, divalproex for depression, famotidine for gastroesophageal reflux disease, insulin for diabetes, losartan for hypertension, melatonin for sleeplessness, metformin for diabetes, metoprolol for hypertension, and trazodone for depression. The medication refusals were frequent. On 11/13/25, the following focus was written on Resident #111's comprehensive care plan, Resident/Patient is resistive to care related to: Alzheimer's Disease hx [history] of resisting care, refusing medications; combative with staff; at times will refuse male caregivers. No goal or interventions had been written. On 11/13/25 at 11:30 AM, the Director of Nursing (DON) acknowledged Resident #111 had not been care planned timely for medication refusals. No further information was provided through the completion of the complaint investigation process.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure complete and accurate medical records. Psychiatric telemedicine notes contained an inaccurate history of present illness (HPI) for Resident #111. This was a random opportunity for discovery. Resident Identifier: #111. Facility Census: 110. Findings included: a) Resident #111 Review of Resident #111's medical records showed the resident was seen by psychiatric telemedicine services on [DATE], [DATE], and [DATE]. Each of the notes written during these sessions had the following paragraph for history of present illness (HPI): 92 -year-old widowed female with a hx [history] of dementia, depression, anxiety. She was initially admitted to [facility] on [DATE] after an acute hospital stay at [hospital name]. [Resident's name] ambulates without assistance. She has three children, one is deceased . Son, [name] is HCS [health care surrogate] and supportive. However, the resident's age, admission date, first name, and HCS's name were incorrect in this paragraph. The other sections in the entire note appeared correct for the resident. On [DATE] at 11:30 AM, the Director or Nursing (DON) acknowledged the HPI contained in Resident #111's psychiatric telemedicine services notes was incorrect. She stated the HPI information written in Resident #111's notes applied to another resident with the same surname as Resident #111. No further information was provided through the completion of the complaint investigation.</p>		