

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Dawnview LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Diane Drive Fort Ashby, WV 26719	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153</p> <p>An IJ at F600 was called on 04/03/24 at 1:26 PM . A Plan of Correction (POC) was approved on 04/03/24 at 4:56 PM. The IJ was abated on 04/04/24 at 10:15 AM.</p> <p>Based on record review, observations and staff interviews, the facility failed to protect a defenseless, non communicative resident from sexual abuse and to ensure other residents were protected from sexual abuse. This failed practice had the potential to affect all residents residing in the facility. Resident identifiers: #14 and #20. Facility census: 49.</p> <p>Findings included:</p> <p>Review of the policy and procedure titled Abuse, Neglect and Exploitation dated reviewed/revised 03/22/23 stated that reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specific time frames: immediately, but not later than 2 hours after the allegation is made . In addition Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>An unannounced two (2) complaint investigations (#31427, #31733) was conducted with entrance on 04/02/24 at 11:10 AM. The facility was exited on 04/04/24 with reentrance on 04/08/24 and exited on 04/10/24.</p> <p>Findings included:</p> <p>On 03/29/24 at 11:12 AM, a Registered Nurse (RN) #36 made the following general note:</p> <p>Resident was caught with his hand in the shirt of an incapacitated person. Intervention occurred while hand was under the shirt, near the waist line, on the abdomen. Resident was trying to reach further at the time of incident. He continued to try and get near the targeted resident multiple times throughout the day but was unable to. Staff were aware and vigilant in redirected resident to his room and activities. The alleged perpetrator was Resident #20 and the victim was Resident #14.</p> <p>The State Agency did not received an Initial Reporting of Allegations until 04/01/24 at 13:53 (1:53 PM) when the incident was reported to the Nursing Home Administrator (NHA). The reporting was completed for Resident #20 and Resident #14.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a) Resident #14</p> <p>Resident #14 was admitted on [DATE] and readmitted on [DATE]. Diagnoses included Dementia, depression and cognitive communication deficit. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/05/24 found a Brief Interview for Mental Status (BIMS) of 00. Which indicated a severe loss of cognition. The MDS noted there had been no behaviors noted from the last MDS.</p> <p>b) Resident #20</p> <p>Resident #20 was admitted on [DATE]. Diagnoses included Dementia, depression and anxiety disorder. A review of the quarterly MDS with an ARD of 03/08/24 found a BIMS of 00 which indicated a severe loss of cognition. The MDS noted there had been no behaviors noted from the last MDS. Resident #20 had no verbal communication.</p> <p>On 04/02/24 a request was made to the Nursing Home Administrator (NHA) for all reportable's from January 2024 through March 2024. There were two (2) residents listed with dates of 01/18/24 and 02/19/24 respectfully. When the NHA was asked if there were any other reportable's, the NHA stated that she had just received an allegation and was being investigated and reported. The sexual abuse occurred on 03/29/24 and was not reported until 04/01/24. This involved an allegation of sexual abuse from resident to resident.</p> <p>On 04/03/24 at 9:40 AM, the NHA produced the reportable regarding the complaint. After further review of employee statements, The NHA found the Registered Nurse (RN) #36 did intervene as well as Nurse Aides (NA's) to remove the perpetrator from the victim. RN #36 failed to notify anyone until 04/01/24. The NHA was not informed of the incident until 04/01/24. The NHA stated that she was aware that the incident needed to be reported within two (2) hours. She had obtained a statement with the RN involved who was on vacation. All but one NA had provided a statement. In addition, the NHA stated that education had been started on 04/01/24 regarding what was sexual abuse for all staff but not sure if this included abuse reporting. The NHA was asked for any evidence when or how the staff monitored Resident #20 after the incident occurred.</p> <p>The General Note Nursing on 03/29/24 at 11:12 AM stated Resident (#20) was caught with his hand in the shirt of an incapacitated person (#14). Intervention occurred while hand was under the shift, near the waist line, on the abdomen. Resident (#20) was trying to reach further at the time of the incident. Resident (#20) was redirected from the resident (#14). He continued to try and get near the targeted resident multiple times throughout the day but was unable too. Staff were aware and vigilant in redirected resident to his room and activities.</p> <p>The following was the phone interview with RN #36 by the NHA on 04/02/24. The interview was as follows:</p> <p>Have you witnessed (resident initials) inappropriately touching residents or attempting to? Give details.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Friday, 3/39 - I was at the top of the 100 hall at the med (medication) cart, heard one of the aides say (resident name redacted), stop that. I looked over and saw (female resident name redacted) wheelchair was against the wall near the bathroom and (male resident first name redacted) was in his chair facing her. His hand was under her shirt at the waistline. I came over and removed his hand from her. I told him that was inappropriate, and he could not do that. He laughed. We moved (male residents first name redacted) away from her but he continued to try to go near her. Eventually we took him to the dining room and redirected him by working on a puzzle.</p> <p>If so, what was done to protect the resident?</p> <p>Staff monitored (male resident first name redacted) and eventually had to remove him from the area of where (female first name redacted) sat. No other issues during the shift.</p> <p>What was done to protect other residents?</p> <p>Monitored (male resident first name redacted) whereabouts. No other issues during the shift.</p> <p>Did you report it to the supervisor?</p> <p>No. I documented it and passed it along in report.</p> <p>NA #34 stated that, on 03/29/24 at approximately 1:30 PM, Resident #20 had his arm going up Resident #14 shirt. I took him away from the situation. I told my nurse. I also told all the other aides so they would keep him away from her. Interview by the NHA conducted on 04/03/24.</p> <p>NA's #45 and #7 during an interview on 04/02/24 both stated that they saw Resident #20 putting his hand up the shirt of Resident #14. Both stated they moved them away from each other and into another area. Both reported the incident to their nurse.</p> <p>Resident #20 was placed on 1:1 starting on 04/01/24 at 4:00 PM.</p> <p>On 04/02/24 at 6:18 PM Resident #20 was seen and evaluated by a consulting psych PMHNP-BC and ordered Prozac 10 milligrams every day for mood and inappropriate sexual behavior (ISB). Although an additional recommendation was made to discontinue 1:1 monitoring, the facility made the decision to continue the 1:1.</p> <p>A review of the evidence found staff scheduled to provide 1:1 monitoring since 04/01/24 at 4:00 PM. Random observations of Resident #20 found a staff member with him at all times. Observed sleeping in his room, sitting at the Nurses Station and walking in the hall.</p> <p>F600 Plan of Correction</p> <p>1. Resident #20 was immediately removed from the area of Resident #14. Resident #20 was monitored and redirected by nursing staff until he was placed on 1:1 observation on 4/1/24. No further contact was made between Resident #20 & Resident #14. Resident #20 was seen by psych provider on 4/2/2024 for supportive visit. Resident #14 was noted to exhibit no signs or symptoms of psychological distress or discomfort and has not had any changes to her normal behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. All current residents will be interviewed by a member of the department head team by 4/3/24 to determine if they have experienced or have witnessed any sexual abuse by another resident in the facility. All current residents with a BIMS score of 12 or less will be assessed by social work to determine their capacity to consent to sexual activity. The assessments will be completed by 4/3/24.</p> <p>3. Department Managers were educated by the Regional Clinical Consultant, RN on Non-Consensual Sexual Contact, Abuse, Neglect, Exploitation Policy. Education includes the identification of sexual abuse, stopping and reporting abuse, and the expectation the resident is to remain under direct observation until determined to no longer be a risk to other residents. Nursing Home Administrator, Regional Clinical Consultant and Department Managers will immediately begin education of employees until all current employees have received education. Any employee on LOA or not available to be reached by 4/3/24 will be educated prior to working their next scheduled shift. The NHA will ensure that education has been provided to them prior to beginning their shift.</p> <p>4. The NHA, DON, or designee will administer quizzes daily until all employees validate understanding of education provided. Findings will be reported by the NHA or DON at the monthly Quality Assurance Performance Improvement (QAPI) Meeting for a period of 3 months to monitor progress towards improvement and recommendations.</p> <p>The following staff members were interviewed regarding the education presented by the facility for abuse reporting and what constitutes sexual abuse between 8:45 AM and 9:58 AM on 04/03/24:</p> <p>Housekeeping #4</p> <p>NA #34</p> <p>Med Records/Central Supply #81</p> <p>RN #69</p> <p>NA #70</p> <p>LPN #75</p> <p>Maintenance Director #84</p> <p>Maintenance Assistant #94</p> <p>OTA/DOR #76</p> <p>Activities Asst. #14</p> <p>Cook #29</p> <p>Dietary Aide #30</p> <p>NA #42</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153</p> <p>An IJ at F609 was called on 04/03/24 at 1:26 PM . A Plan of Correction (POC) was approved on 04/03/24 at 4:56 PM. The IJ was abated on 04/04/24 at 10:15 AM.</p> <p>Based on record review, reportables review, staff interviews, and policy review, the facility failed to report an allegation of sexual abuse within the required two (2) hour time. Resident identifiers: #14 and #20. Facility census: 49.</p> <p>Findings included:</p> <p>Review of the policy and procedure titled Abuse, Neglect and Exploitation dated reviewed/ revised 03/22/23 stated that reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specific time frames: immediately, but not later than 2 hours after the allegation is made . In addition Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>An unannounced two (2) complaint investigations (#31427, #31733) was conducted with entrance on 04/02/24 at 11:10 AM. The facility was exited on 04/04/24 with reenrance on 04/08/24 and exited on 04/10/24.</p> <p>On 03/29/24 at 11:12 AM, a Registered Nurse (RN) #36 made the following general note:</p> <p>Resident was caught with his hand in the shirt of an incapacitated person. Intervention occurred while hand was under the shirt, near the waist line, on the abdomen. Resident was trying to reach further at the time of incident. He continued to try and get near the targeted resident multiple times throughout the day but was unable too. Staff were aware and vigilant in redirected resident to his room and activities. The alleged perpetrator was Resident #20 and the victim was Resident #14.</p> <p>On 04/02/24 a request was made to the Nursing Home Administrator (NHA) for all reportable's from January 2024 through March 2024. There were two (2) residents listed with dates of 01/18/24 and 02/19/24 respectfully. When the NHA was asked if there were any other reportable's, the NHA stated that she had just received an allegation and was being investigated and reported. The sexual abuse occurred on 03/29/24 and was not reported until 04/01/24. This involved an allegation of sexual abuse from resident to resident.</p> <p>On 04/03/24 at 9:40 AM, the NHA produced the reportable regarding the complaint. After further review of employee statements, The NHA found the Registered Nurse (RN) #36 did intervene as well as Nurse Aides (NA's) to remove the perpetrator from the victim. RN #36 failed to notify anyone until 04/01/24. The NHA was not informed of the incident until 04/01/24. The NHA stated that she was aware that the incident needed to be reported within two (2) hours. She had obtained a statement with the RN involved who was on vacation. All but one NA had provided a statement. In addition, the NHA stated that education had been started on 04/01/24 regarding what was sexual abuse for all staff but not sure if this included abuse reporting. The NHA was asked for any evidence when or how the staff monitored Resident #20 after the incident occurred.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The State Agency did not received an Initial Reporting of Allegations until 04/01/24 at 13:53 (1:53 PM) when the incident was reported to the Nursing Home Administrator (NHA). The reporting was completed for Resident #20 and Resident #14.</p> <p>a) Resident #14</p> <p>Resident #14 was admitted on [DATE] and readmitted on [DATE]. Diagnoses included Dementia, depression and cognitive communication deficit. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/05/24 found a Brief Interview for Mental Status (BIMS) of 00. Which indicated a severe loss of cognition. The MDS noted there had been no behaviors noted from the last MDS.</p> <p>b) Resident #20</p> <p>Resident #20 was admitted on [DATE]. Diagnoses included Dementia, depression and anxiety disorder. A review of the quarterly MDS with an ARD of 03/08/24 found a BIMS of 00 which indicated a severe loss of cognition. The MDS noted there had been no behaviors noted from the last MDS. Resident #20 had no verbal communication.</p> <p>F609 POC</p> <ol style="list-style-type: none"> 1. Resident to resident incident reported to OHFLAC, Ombudsman, and APS by the facility on Monday, April 1, 2024 at 1500 3:00 PM. 2. No other residents were directly affected by this practice. 3. Department Managers were educated by the Regional Clinical Consultant, RN on Non-Consensual Sexual contact, Abuse, Neglect, Exploitation Policy. Education includes the identification of sexual abuse, stopping and reporting abuse, and the expectations the resident is to remain under direct staff observation until determined to no longer be a risk to other residents. Nursing Home Administrator, Regional Clinical Consultant and Department Heads will immediately begin education of employees until all current employees have received education. Any employees on LOA or not available to be reached by 4/3/24 will be educated prior to working their next scheduled shift. The NHA will ensure that education has been provided to them prior to beginning their shift. 4. The NHA, DON, or designee will administer quizzes daily until all employee validate understanding of education provided. Findings will be reported by the NHA or DON at the monthly Quality Assurance Performance Improvement (QAPI) Meeting for a period of 3 months to monitor progress towards improvement and recommendations. 		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153</p> <p>Based on record review, observations and staff interviews, the facility failed to ensure a resident maintained a continuous oxygen supply. Resident #50 failed to receive oxygen therapy from a portable tank and oxygen concentrator for approximately 20 minutes. This failed practice had the potential to affect all residents receiving oxygen therapy. Resident identifier: #50. Facility census: 49.</p> <p>Findings included:</p> <p>a) Resident #50</p> <p>Resident #50 was admitted on [DATE]. Diagnoses included Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Lung Disease, Hypertension, End Stage Renal Disease, Stage 4, and Respiratory failure. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/23 had a Brief Interview of Mental Status (BIMS) score of 13. This represents the resident is cognitively intact. An addition quarterly MDS with an ARD of 01/19/24 had a BIMS score of 10 which indicated a decline in cognition.</p> <p>Resident #50 is currently in an acute care hospital and returned to the facility on [DATE]. Random observations of Resident #50 on found Resident #50 asleep in her room. Resident #50 had no signs of respiratory distress.</p> <p>Unannounced complaint investigations (#31427 and 31733) were conducted concurrently on 04/02/24 through 04/04/24 and 04/08/24 through 04/10/24. A resident's family member reported that Resident #50 called on 02/18/24 and stated that she was having trouble breathing and the family member called the facility and 911 as well as Resident #50 calling 911.</p> <p>Resident #50 was admitted on [DATE]. Diagnoses included Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Lung Disease, Hypertension, End Stage Renal Disease, Stage 4, and Respiratory failure. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/23 had a Brief Interview of Mental Status (BIMS) score of 13. This represents the resident is cognitively intact. An addition quarterly MDS with an ARD of 01/19/24 had a BIMS score of 10 which indicated a decline in cognition.</p> <p>On 02/18/24 Resident #50 was returned to her room by Activities (NA #40) because of an incontinent episode and oxygen tank switched because of running empty. This resident was taken back to Activities but they were ending. NA #40 returned Resident #50 to her room and connected to the oxygen concentrator removed from a portable oxygen tank around 4:00 PM and placed on an oxygen. Resident #50 expressed no distress during dinner.</p> <p>Staff delivered dinner tray to Resident #50 between 5:00 PM-5:15 PM and picked up dinner tray between 5:45 PM-6:00 PM the resident expressed no concerns at this time.</p> <p>At 6:45 PM MPOA received phone calls from the resident stating that she couldn't breathe. MPOA called the facility and reported that the resident needed help. The MPOA called 911 to report Resident #50 couldn't breathe.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Concurrently, NA #13 was walking past Resident #50's room and overheard the Resident say calling 911. NA#13 immediately entered the room to see what was happening. She saw the resident was having trouble breathing and ran up the hall to get the Nurse. NA#40 went into the room and saw the oxygen concentrator was off and could not get it turned back on. NA #40 removed the tubing from the oxygen concentrator and plugged into the portable tank and found it was empty. NA #13 came back to the room with the pulse oximeter and turned the concentrator on and had no issue. NA#13 plugged the oxygen tubing back into the concentrator. Resident #50 began to take deep breaths and her oxygen levels returned to baseline. Oxygen levels were in the 90's by 7:03 PM when the ambulance arrived. Resident #50 refused to go to the hospital with the ambulance.</p> <p>The MPOA reported the situation to the NHA on 02/19/24. The resident was interviewed and she stated she didn't know what happened, she was just sitting in her room and suddenly couldn't breathe. She denied touching her oxygen concentrator. Maintenance ran a safety check of the concentrator and found it operating at 96% flow and all safety alarms functioning. Resident #50 was also assessed by the Nurse Fractionate.</p> <p>The NP made the following assessment:</p> <p>On 02/18/24 at 8:07 PM Nursing observations, evaluation, and recommendations are: Resident family called facility and reported to another nurse that her mother was in her room and was having trouble breathing. They also called 911 and had them come and evaluate her. I was not informed at that time of what was going on, aide came down the hall after me, her O2 stat was reading in the 60's at that time. Oxygen was on and functioning properly at that time. Her oxygen was either not hooked up properly to the concentrator/or the tank was empty, her wheelchair was pushed back against the concentrator and her back was up against her oxygen tubing, possibly cutting off her oxygen supply. She was instructed to take several deep breaths. Her oxygen was up to 96% on 4 liters when the ambulance arrived at facility. A close living family member also came to facility.</p> <p>Resident #50 is currently in an acute care hospital and returned to the facility on [DATE]. Random observations of Resident #50 found Resident #50 asleep in her room. Resident #50 had no signs of respiratory distress.</p> <p>Review of pulse oxygen levels on 04/06/24 at 10:01 AM found the following:</p> <p>04/06/24 at 2:28 AM 97% on room air</p> <p>04/06/24 at 6:15 AM 97% on room air</p> <p>04/06/24 at 6:16 AM 97% oxygen via nasal cannula</p> <p>04/06/24 at 3:12 PM 100% on room air</p> <p>04/07/24 at 2:57 AM 97% oxygen via nasal cannula</p> <p>04/07/24 at 9:30 AM 100% oxygen via nasal cannula</p> <p>04/07/24 at 9:48 AM 100% room air</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>04/08/24 at 4:41 AM 100% oxygen via mask</p> <p>04/08/24 at 10:53 AM 96% room air</p> <p>04/08/24 at 9:031 PM 92% oxygen via nasal cannula</p> <p>04/09/24 at 3:26 AM 93% on room air</p> <p>04/09/24 at 12:00 PM 97% oxygen via nasal cannula</p> <p>04/09/24 at 12:51 PM 98% oxygen via nasal cannula</p> <p>04/09/24 at 5:00 PM 93% oxygen via nasal cannula</p> <p>04/09/24 at 6:36 PM 93% oxygen via nasal cannula</p> <p>04/09/24 at 11:07 PM 95% oxygen via nasal cannula</p> <p>04/10/24 at 5:01 PM 94% oxygen via nasal cannula</p> <p>04/10/24 at 5:26 PM 96% oxygen via nasal cannula</p> <p>Physician ordered oxygen at 3L/m via nasal cannula continuously on 0408/24.</p> <p>The following residents were on oxygen therapy with no issues found of respiratory distress or oxygen therapy issues:</p> <p>Resident #1</p> <p>Oxygen order:4L/minute. Checked on 04/03/24 at 2:24 PM MACHINE TO BE CHECKED ON 6/24. Observed set at 4.0/L. Resident has a trach. This resident discharged on [DATE].</p> <p>Resident #48</p> <p>04/03/24 at 2:19 PM 3L/trach mask 02 94%. Observed on 04/04/24 at 9:54 AM. Had trach collar on with O2 via portable tank.</p> <p>Resident #37 On 4/3/24 at 2:24 PM ordered 2L and on 2 liters 2:30 PM. Resident #37 stated that the oxygen was to be on 2L/m and I get to go home.</p> <p>Resident #50 on 04/03/24 at 3:05 PM entered room was not able to determine when the concentrator was serviced. No date that was readable on concentrator. This resident in hospital Returned on 04/06/24 and ordered oxygen at 3L/m continuously.</p> <p>Resident #7 receiving oxygen concentrator via nasal cannula on 04/03/24 at 3:00 PM. The resident is currently asleep.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Dawnview LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Diane Drive Fort Ashby, WV 26719	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This complaint was substantiated as the facility failed to ensure oxygen was available as ordered and was cited at F695.