STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515163	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Dawnview LLC	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45173 Based on observation, record review and staff interview, the facility failed to provide a safe, clean, homelike environment regarding the storage of unclean wheelchairs. This was a random opportunity for discovery. Resident Identifiers: #17, #35, #56, #47, #37, #57 and #2. Facility Census: 59. Findings Include: a) Storage of wheelchairs On 11/04/24 at 10:30 AM, a foul odor was noticed by the Surveyors at the end of the 100-hall next to the conference room. Upon further examination, the foul odor was lingering around the wheelchairs and wheelchair cushions were noted with debris and a dried substance. The wheelchairs without cushions were noted with a foul odor and debris on the seats. Most of the wheelchairs observed had the residents' names located on the handles of the wheelchairs. On 11/05/24 at 10:15 AM, the wheel chairs were observed at the end of 100 hall next to conference room. The foul odor and debris were again observed by the Surveyors. On 11/05/24 at 10:25 AM, the Director of Nursing (DON) was asked to come to the end of the 100 halls where the wheelchairs were located. The DON was asked, do you smell a foul odor and see the debris on the wheelchair cushions and the seats of the wheelchairs? The DON agreed there was a foul odor and debris were on the wheelchair cushions and seats of the wheelchairs. The DON stated, there is a schedule for the staff on midnights to clean the wheel chairs. The DON returned with a blank schedule with room numbers and days of the week each wheelchair should be cleaned. The DON then had a staff member bring disinfectant wipes to clean the wheelchairs. The following residents had wheelchairs located in this area: --Resident #17 --Resident #35 --Resident #56 --Resident #47 (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

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 11/06/2024
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Resident #37 --Resident #57 --Resident #2 There were additional wheelchairs located in this area without names located on the handles. No further information was provided during the survey process.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49467 Based on record review and staff interview, the facility failed to thoroughly investigate allegations of abuse and neglect, by failing to have witness statements signed by witnesses an alleged incident involving Resident #11, and failing to complete witness statements, and notify the police regarding an allegation of misappropriation of funds for Resident #38. This was true for two (2) of four (4) residents reviewed for abuse and neglect during the survey process. Resident identifiers: 11, 38. Facility census: 59 Findings include: A) Resident #11 At approximately 3:30 PM on 11/05/2024, a review was conducted of a facility reported incident concerning Resident #11 on 10/07/2024. During the review, it was noted the administrator of the facility had conducted interviews with four (4) employees regarding the incident. These interviews were typed and signed only by the administrator, with no indication of employee acknowledgement. At approximately 1:00 PM on 11/06/2024 an interview was conducted with the administrator. During the interview, the administrator stated these interviews were conducted over the phone this was the standard way she conducts interviews, and does not usually have the employees interviewed, sign the statements. 50551 b) Resident #38 -Resident Interview: On 11/04/24 at 4:07 PM an interview was conducted with Resident #38 who reported that he had $100 missing from his lock box in his room. He reported that he wears the key around his neck and the only time he takes it off is when he is in the shower. He stated that he reported this incident to staff on 09/05/24. -Review of records: On 11/05/24 at 3:00 PM, a review of the initial reportable, investigation and five-day-follow-up dated for 09/05/24 revealed the following: Resident #38 reported on 09/05/24 to the Social Worker that he had $100 in his lockbox. He reported that the money was in a brown envelope. He does not recall the last time he saw the money. The resident's sister was interviewed by the Social Worker and reported that Resident #38 had money in his lock box. She stated a few months ago she gave him $100 that was wrapped in a piece of white notebook paper and placed in his lockbox. She was uncertain of the last time she saw the money in the lockbox. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were 15 (fifteen) staff interviews/questionnaires on pre-typed forms that were filled in with handwritten answers, 13 (thirteen) of these had no name documented as to the person conducting interview/nor signature of said person. There was 1 (one) form with no date/time of interview. All 15 (fifteen) forms were not signed by the people who had been interviewed. The five-day follow-up revealed that the incident was reported to Adult Protective Services and the Ombudsman. The facility did not verify the incident due to the following: There is no evidence to show any staff member stole his money. He keeps it locked in a lock box with the key around his neck. He has not noticed his lock box out of place or tampered with. Staff who work with resident have not seen or heard of any suspicious activity in his room. Resident and his sister reminded that cash should not be kept in the room. Resident account could be established where he would have access to money as needed. -Staff Interview: On 11/06/24 at 1:25 PM, during an interview the facility administrator revealed she completed the investigation of the incident that occurred on 09/05/24. She stated she only interviewed staff that had recently worked on the resident's hall despite not knowing exactly when the money first came up missing. She acknowledged that these statement interviews were handwritten by her, she had interviewed some via telephone and some face to face, they did not contain her name listed as the Person conducting interview, were not signed by her or by the staff who were interviewed and she stated that she did not know why. She acknowledged that it was unclear as to exactly when Resident #38's money came up missing. She acknowledged that the resident's sister had reported she had given the resident $100 some time ago. Staff interviewed could not recall a time when the resident had it outside of his safe or had spent it. The administrator reported that she assisted the resident in looking through his belongings and did not find the missing money. She could not recall if she had contacted the police but after looking at the five-day-follow-up, she reported that she had not contacted the police in regards to this allegation. She also stated that the money was not replaced by the facility because they did not determine that the facility was at fault. -Review of facility's policy for Abuse, Neglect, Exploitation reveals the following: The facility will report allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property immediately to the administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. Compliance Guidelines: 5. Investigation: a. The facility will investigate all allegations and types of incidents as listed above in accordance with facility procedure for reporting/response as described below. b. The facility will perform an investigation that focuses on whether abuse or neglect occurred and to what extent. Clinical evaluation for any signs of injury, causative factors, and interventions to prevent further injury. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure for response and reporting allegations of Abuse/Neglect/Exploitation: When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: 2. The Administrator or designee will: a. Notify the appropriate agencies as soon as possible but no later than 24 hours after discovery of the incident. b. Initiate and conduct a thorough investigation. Obtain statements related to the incident from victims, individual reporting incident, alleged perpetrator, and any witnesses. d. Notify local law enforcement, Licensing Boards and Registries, and any other agencies as required.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 51553 Based on record review and staff interview, the facility failed upon admission to identify a mental diagnosis for Resident #36 and related diagnoses of dementia and PTSD for Resident #42 on the PASARR. This was true for two (2) of three (3) resident's reviewed under the area of PASARR. Resident identifiers: #42 and #36. Facility Census: 59 Findings included: a) Resident #42 Findings were confirmed by the Social Worker and the Admission's Director on 11/06/24 12:55 PM for Resident #42 included: 1) Diagnoses for PTSD and Dementia were not indicated on the initial PASARR. Diagnosis of dementia from the hospital H&P dated 5/11/22 listed PMH: Dementia 11/2021. 2) The State Surveyor interviewed the Social Worker concerning PASARR for Resident #42 .The Social Worker reported she does not have access to the attached order summary since they had changed companies. The Social Worker stated there was no access to Genesis to attach the diagnosis list. The Social Worker stated, We will have to redo all the summaries. The Social Worker stated, I don't redo them when they get there. (from the hospital) on every resident initially. The Admission's Director stated, Now we know and we will do better. No further information was provided. 3) Record Review indicated a diagnosis of dementia from the hospital H&P dated 5/11/22 listed PMH: Dementia 11/2021. The resident's Physician Determination of Capacity was signed and dated 5/17/22- The patient lacks capacity with a diagnosis of Alzheimer's Disease. 45173 b) Resident #36 On 11/04/24 at 12:54 PM, a record review was completed for Resident #36. The review found the original Preadmission Screening and Resident Review (PASARR) dated 03/04/22 had only dementia listed. The review, also, found the resident had a diagnosis of paranoid schizophrenia. On 11/05/24 at 2:34 PM, the Admissions Director #97 stated, We are trying to get the most recent PASARR from his recent hospitalization in July, 2024. On 11/06/24 at 3:37 PM, the Admissions Director #97 stated, I have called the hospital multiple times and I haven't received the pages that list the diagnoses .I have the signature page from when the physician signed it on 07/22/24 .that's all they have sent. On 11/06/24 at 4:00 PM, the Admissions Director #97 confirmed the initial PASARR dated 03/04/22 did not list the diagnosis of paranoid schizophrenia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was obtained during the survey process.

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

45173

Based on record review and staff interview, the facility failed to revise the care plan regarding a diagnosis of anemia, actual multiple falls with injuries, indicate the diagnosis of dehydration and the administration of intravenous fluids (IVFs), and the discontinuation of an anticoagulant for Resident #28 and Resident #18's transfer to hospice services. This was true for two (2) of 21 residents reviewed during the survey process. Resident Identifiers: #28 and #18. Facility Census: 59.

Findings included:

a) Resident #28

On 11/05/24 at 8:45 AM, a record review was completed for Resident #28. The review found the resident had multiple falls with actual injuries noted, laboratory results indicating elevated liver functions indicating dehydration as well as low hemocrit and hemoglobin, and the discontinuation of an anticoagulant due to the resident having multiple falls.

The care plan was reviewed regarding the noted change of conditions which were found the resident record. The care did not have an indication of actual falls with injuries, abnormal laboratory results indicating dehydration or anemia, receiving IVFs and the discontinuation of an anticoagulant (Eliquis).

On 11/05/24 at 10:15 AM, the DON was notified the care plan did not indicate any of the change of conditions. The DON confirmed the care plan should have been updated with the change of conditions for Resident #28.

No further information was obtained during the survey process.

51553

b) Resident #18

Findings confirmed on 11/05/2024 by the Director of Nursing for Resident #18 included:

Hospice services were ordered for Resident #18 on 10/28/2024.

The Director of Nursing acknowledged there was no current care plan for hospice services and stated, that's odd.

Findings were confirmed 11/06/24 10:10 AM by the Director of Nursing for Resident #19 included:

The resident's care plan stated the patient had a long term use of insulin. The resident's insulin was discontinued on 9/18/2024.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The State Surveyor reviewed the care plan with insulin documented and matrix with the Director of Nursing. The Director of Nursing stated, I don't think it's his most recent care plan. On 11/06/24 10:26 AM, the Director of Nursing stated she was looking at the wrong care plan. The Director of Nursing confirmed the care plan stated the resident has long term use of insulin. The Director of Nursing reported she talked with the care plan nurse. The Director of Nursing stated, I changed it to 'history of' on a new care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45173 Based on observation and staff interview, the facility failed to provide an accident and hazard free environment as possible by having a treatment cart which would not lock properly on three occasions. These were random opportunities for discovery. Facility Census: 59. Findings Include: a) Treatment Cart On 11/04/24 at 11:40 AM, a treatment cart was observed unlocked behind the nurses' station which was unsecured and residents are able to ambulate in this area. On 11/04/24 at 11:43 AM, the Director of Nursing (DON) was notified of the treatment cart being unlocked and accessible to the residents. The DON stated, the lock is not working .I'll call Maintanence. At this time, the treatment cart was left in the same area behind the nurses' station. On 11/04/24 at 3:15 PM, the treatment cart was observed unlocked behind the nurses' station. At this time, observations of the unlocked treatment cart continued until 3:30 PM. No staff were observed near the unlocked treatment cart during this time. The Administrator was notified and stated, We have contacted the pharmacy and they are coming to check it. The Administrator advised the DON to move the treatment cart and lock it in the medication room. At this time, an inventory of the items in the unlocked treatment cart was completed. The following items were noted: --Microkill Germicidal Alcohol Wipes (one container) --Sani cloth with bleach (one container) --Antifungal Powder (six bottles) --Zinc Oxide (three tubes) --Ammonium Lactate 12% (two tubes) --Mupirocin 2% ointment (one tube) --Sodium Sulfaceamide 10% (one tube) --Ketoconazole Shampoo (one bottle) --Flucinolone Acetonide Cream 0.01% (one tube) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Pluragel (two tubes) --Therahoney (six small tubes) --Iodosorb Cadexomer Iodine Gel (one tube) --Hydrocortisone (one tube) --Hemorrhoid Ointment (two tubes) --Antiseptic skin cleanser (one bottle) --Hydrogel (two tubes) --Moisturize cream (one jar) --Silicone Cream (one tube) --Antifungal Cream (one tube) --A & D ointment (one tube) --Bisacodyl suppositories (1 box) --Wound cleanser (five bottles) --Providone Iodine wipes (1 box) --Alcohol wipes (1 box) --Fresh Odor Eliminator (one bottle) --Chlorhexidine Gluconate 4% --Sure prep (1 box) --Suture removal trays (four) which includes scissors --Scissors (two) --Disposable razors (four) --Nail clippers (five) --Silver Sulfadiazine cream (one jar) --Triamcinolone acetate cream (one jar) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/04/24 at 3:45 PM, the Administrator was asked for a list of wanderers. The Administrator provided a list of 13 wanderers; and, four (4) residents listed on the wanderers list were noted to be wandering in the hallway near the nurses' station. Two (2) residents approached the Surveyors during the time the inventory was being completed. The two (2) residents were redirected by staff. No further information was obtained during the survey process.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and staff interview, the facility failed to follow the proper procedures to appoint a healthcare surrogate for Resident # 35. This was true for one (1) of four (4) residents reviewed for advance directives during the survey process. Resident Identifier: 35. Facility census: 59. Findings include: A) Resident #35 At approximately 2:30 PM on [DATE], a review of Resident #35's electronic health record was reviewed. During this review, it was noted the resident had a Physician Orders for Scope of Treatment (POST) form on file, signed by someone that was not named as her healthcare surrogate. Resident #35 was admitted to the facility on [DATE] after a hospital stay. During her hospital stay, the hospital determined Resident #35 did not have capacity to make decisions on her own due to an Acute Cerebrovascular Accident, resulting in confusion and disorientation. The duration of incapacity was determined to be long term. Due to Resident #35 demonstrating incapacity to make informed choices, the hospital completed a checklist for healthcare surrogate (HCS) selection. Resident #35's husband was determined to be the best choice and he agreed to become the HCS. This was completed on [DATE]. Resident #35 was admitted to the facility on [DATE] and was deemed incapacitated by the facility's physician, on this day, due to Multiple Infarct Dementia as evidenced by inability to understand or make medical decisions and being disoriented to person, place and time. On [DATE], Resident #35's husband signed a POST form indicating the resident was to be a full code. Resident #35 was to receive CPR, full medical interventions, feeding tubes, and IV fluids for a trial period of no longer than seven (7) days. Resident #35's husband was admitted to the facility on [DATE]. On [DATE], Resident #35's husband signed paperwork to make a family friend his Power of Attorney (POA). That same day, Resident #35, witnessed by the Secretary, the Director of Nursing (DON), and notarized by the Social Service Director (SSD), signed the same paperwork to make the same family friend her POA. At the time of signing this paperwork, Resident #35 was incapacitated and had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. On [DATE], Resident #35's husband was declared incapacitated. On [DATE], the newly appointment POA filled out a new POST form, indicating Resident #35's code status was now Do Not Resuscitate (DNR) with comfort focused treatments and no artificial means of nutrition. Resident #35's husband passed away at the facility on [DATE]. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 12:00 PM on [DATE], an interview was conducted with the DON and Business Office Manager (BOM) regarding the POA paperwork. During the interview, the DON and BOM both acknowledged Resident #35 did not have capacity when she signed the paperwork to appointment the family friend as her power of attorney. At approximately 1:00 PM on [DATE], the Administrator acknowledged Resident #35 did not have capacity when she signed the paperwork to appointment the family friend as her power of attorney. At approximately 1:10 PM on [DATE], an interview was conducted with the Assistant Director of Nursing (ADON), while she was working a medication cart, about Resident #35's code status. The ADON was asked, if Resident #35 was to code at that moment, how would the facility determine her code status. The ADON pulled up her computer and pointed to the Resident's code status on her chart, which was DNR. At approximately 2:30 PM on [DATE], an interview was conducted with the Administrator. During the interview, the Administrator stated after Resident #35's husband was deemed incapacitated, the facility made the decision to appointment the family friend to be Resident #35's POA. However, the paperwork was completed to appointment the family friend on [DATE], while the husband was not deemed incapacitated [DATE]. The Administrator stated the facility should have gone through an HCS selection process to appoint the family friend as the POA rather than having Resident #35 fill out the paperwork while being incapacitated with a BIMS score of 3.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51553 Based on observation, record review and staff interview, the facility failed to store and label food in accordance with professional standards for food service safety. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 59. Findings included: a) A bag of elbow macaroni was found open with no dates. A bag of loose tea bags was opened with no dates. One tea bag was found loose and lying out of the bag. On 11/05/25 the Nutrition Pantry was investigated and the findings confirmed by the CDM at 9:07am included: A can of ground roast coffee with a best by date of 02/29/24 was found. No open date was found on the can. The can was rusty and dirty on the bottom. The CDM reported it was, not stocked from the kitchen. CDM to follow up with the administrator. Findings confirmed by the Certified Dietary Manager (CDM) on 11/04/24 during the kitchen investigation initiated at 10:35 am included.

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 11/06/2024
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45173 Based on record review and staff interview, the facility failed to maintain an accurate and complete record regarding transfer dates for Resident #28 and #36. This was true for two (2) of two (2) residents reviewed under the care area of hospitalization s. Resident identifiers: #28 and #36. Facility census: 59. Findings include: a) Resident #28 On 11/05/24 at 10:10 AM, a record review was completed for Resident #28. The review found the resident had been sent to an acute care facility on 08/11/24. However, the transfer form was dated 06/29/24. On 11/05/24 at 11:30 AM, the Director of Nursing (DON) was notified. The DON confirmed the transfer date was incorrect in the medical record. b) Resident #36 On 11/05/24 at 11:00 AM, a record review was completed for Resident #36. The review found the resident had been sent to an acute care facility on 10/04/24. However, the date on the transfer form was 09/04/24. The review, also, found the resident had been sent to an acute care facility on 10/27/24. However, the date on the transfer form was 10/04/24. On 11/05/24 at 11:30 AM, the Director of Nursing (DON) was notified. The DON confirmed the transfer dates were incorrect in the medical record.