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	04/15/2026

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.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and staff interview the facility failed to ensure the the most recent state inspection results were easily accessible to residents and others without having to ask. This was a random opportunity for discovery and had the potential to affect more than a limited amount of residents. Facility census: 61.Findings included:During a facility entry on 04/13/2026 at 12:47 PM, observation revealed that the most recent state inspection results were stored in a wall-mounted box but were obscured by a folder labeled concerns. Consequently, the results were not clearly visible to residents or visitors without inquiry. In a follow-up interview on 04/14/2026 at 12:25 PM, the Director of Nursing acknowledged that the survey results box lacked a proper label and that the state inspection results could not be located without assistance. She stated that the facility would correct this issue.

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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and staff interview, the facility failed to ensure Level 1 pre-screening of a new residents for serious Mental Illness/Intellectual Disability (MD/ID) or a related condition prior to admission to the facility. This failed practice was true for four (4) out of 22 residents reviewed in the Long-Term Care Survey Process. Resident Identifiers: #1, #7, #30 and #45. Facility Census: 61. Findings included: a) Resident #7 During a record review on 04/13/26 at 3:25 PM, it was discovered that a Major Depressive Disorder diagnosis had not been captured on Resident #7's PASARR. There were no other PASARRs on file for this resident. The Director of Social Services, on 04/14/2026 at 3:00 PM, verified the resident's initial PASARR failed to capture the Major Depressive Disorder diagnosis and that a new PASARR had not been completed. b) Resident #1 During a record review on 04/13/26 at 3:36 PM, it was discovered that a Bipolar II diagnosis had not been captured on Resident #1's initial Pre-admission Screening and Record Review (PASARR). There were no other PASARRs on file for this resident. The Director of Social Services, on 04/15/26 at 9:25 AM, verified the resident's initial PASARR failed to capture the Bipolar II diagnosis and that a new PASARR had not been completed. c) Resident #30: During a record review on 04/13/26 at 3:00 PM, it was discovered that a Major Depressive Disorder diagnosis had not been captured on Resident #30's Pre-admission Screening and Record Review (PASARR). There were no other PASARRs on file for this resident. The Director of Social Services, on 04/14/2026 at 3:36 PM, verified the resident's initial PASARR failed to capture the Major Depressive Disorder diagnosis and that a new PASARR had not been completed. c) Resident #45: During a record review on 04/14/26 at 1:50 PM, it was discovered that a Post Traumatic Stress Disorder(PTSD) had not been captured on Resident #45s initial PASARR. There were no other PASARRs on file for this resident. The Director of Social Services, on 04/15/26 at 9:25 AM, verified the resident's initial PASARR failed to capture the PTSD diagnosis and that a new PASARR had not been completed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observations and staff interviews, the facility failed to maintain a safe and accident hazard free environment for the residents. Multiple residents had items/clutter both around and underneath their beds, making both normal movement and resident care dangerous. This was discovered during the normal Long Term Survey Process and has the ability to affect more than a limited number of residents. Resident identifiers #33, #52, #36, #38, #45 and #3. Census: 61.Findings include:During a facility walk through on 4/13/26 the following were accident hazards that were observed in residents rooms:a) Resident #33Books, papers, and boxes on the floor around the bed created a trip and fall hazard for both Resident #33 and staff while providing care.b) Resident #52Multiple personal items created a tight path for movement in the room. This is a trip/accident hazard for the resident and anyone providing care.c) Resident # 36Boxes under the bed made it impossible to lower it fully for safe exit and transfer.d) Resident # 38Boxes under bed and around the sides created a small walking path for resident and caregivers. These are trip and fall hazards and are difficult to clean.e) Resident # 45Boxes and items stored under the bed prevented Resident #45 from safely lowering the bed to proper height for transitioning in and out.f) Resident # 3Boxes surrounded the bed and lined the wall in front of the heating / cooling unit creating a trip and fall hazard and blocking the air/heating control.Interview with Director of Nursing (DON) on 04/13/2026 at approximately 12:20 PM confirmed items on the floor (boxes, papers and other personal items around the resident's bed). They are care-planned for hoarding behaviors, but I agree their things should be on this floor.Secondary followup on [DATE] 3:49ˆPM with the DON, they went around to each room, removed all items from under and around the beds and placed them in more appropriate storage areas. I agree the items under the beds were an issue.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, record review, and staff interview the facility failed to provide dietary staff with proper food handlers certification. This deficient practice involved [NAME] #20. Facility census: 61.Findings include:On 4/15/26 at 10:36 AM, during a telephone interview the Mineral County Health Department confirmed that dietary staff in a long-term care facility must have a valid food handler's certification. Health Department staff stated, It is like a driver's license, once it expires, it is expired.After reviewing staff certifications, the surveyor found that [NAME] #20 did not have a valid food handlers certification. The food handler's certification expired on March 6, 2026. [NAME] #20 did not renew her food handler's certification until April 14, 2026. Healthcare Services Group, INC. job descriptions state that employees must maintain a current food handler's certification as required by state/county law.Cook #20 was on the work schedule on the following dates:3/8, 3/10, 3/11, 3/12, 3/15, 3/17, 3/18, 3/19, 3/21, 3/22, 3/24, 3/25, 3/26, 3/29, 3/31, 4/1, 4/2, 4/5, 4/7, 4/8, and 4/12On 4/15/26 at 10:45 AM an interview with the Administrator verified that [NAME] #20 did not hold a valid food handler's certification. [NAME] #20 also did not have a ServSafe certification.

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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. Based on observation and staff interviews, the facility failed to ensure food was distributed and served accordance with professionalstandards for food safety. This was a random opportunity for discovery and had the potential to affect a limited number of residents.Resident Identifiers: #31 and #34. Facility Census 61. Findings included Dining Room Observations:a) Serving Tray Sanitization between residents:On 04/13/26 at 12:25PM, It was observed that serving trays were being used to serve the residents.Trash was being put on the trays, dumped in the trash and then re-used without sanitizing before serving the next resident.b) Hand Hygiene During dining room Observation on 04/13/2026 12:15PM, Resident Aide(RA), #93 was observed serving and assisting resident # 31 and #39 at the same table, she removed and was spreading butter on corn bread and removing the brownies from the baggie with her bare hands for Residents #31 and #39. Staff Interviews:RA Interview:During an Interview with RA Employee #93 on 04/13/26 at 12:20PM, she acknowledged she should not have handled the residents food without wearing gloves. Assistant Director Of Nursing(ADON) Interview:During an interview with the ADON on 04/13/26 at 12:35PM, she acknowledged the trays had not been sanitized between each resident and that Employee #93 had not been wearing gloves while handling the resident's food and stated she should have known better .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to provide a clean, comfortable, and homelike environment for residents in Rooms #100, #102, and #205.This was a random opportunity for discovery that had the potential to affect a limited number of residents. Facility census: 61. Findings included:a) Resident room [ROOM NUMBER]:Upon survey entrance on 04/13/25 at 11:30AM, it was observed the following issues in Room and bathroom:- The left wall inside the resident room had black scuff marks approximately 3 feet long near the bathroom door.- The right side wall had unfinished drywall patching around the light switch.- The left side of the bathroom wall had rough, painted-over, unfinished drywall patching.-back wall above the sink peeling paint above the sink and loose caulking around the sink and counter- Stained tile on the floor around the wall and under the sink. b) Resident room [ROOM NUMBER]: Upon survey entrance on 04/13/26 at 11:35AM, it was observed the following issues in the bathroom:- Unfinished drywall under the light on the back wall above the sink. - Loose caulking around the sink and counter.- stains on the floor under the sink and down the right side wall - cracked bathroom caulking around the sink- loose and hanging Baseboard trim on the back wall under the windowc) Resident room [ROOM NUMBER]: During a Resident interview in room [ROOM NUMBER] on 04/14/26 at 11:30AM, it was observed the following issues in the room and bathroom:- Long black scuff marks on the left side wall near the bathroom door.- Unfinished drywall marks on the wall to the right of the bathroom door.- Cracked and loose caulking around the sink.- Loose and hanging baseboard trim on the back wall under the window.During a walkthrough with the Administrator and the Environmental Manager, on 04/15/26 at 9:35 AM, the manager acknowledged the observed issues in resident room numbers #100, #102, and #205 and stated she would send a list to maintenance for repairs.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, record review, and staff interview the facility failed to report verbal grievances from resident Council meetings. This affected Residents #68, #3, #13, and #54. Facility census: 61.Findings included:Review of the facility policy titled Resident and Family Grievances policy, dated 4/5/23 revealed: Grievances may be voiced in the following forums: a) Verbal complaint to a staff member or Grievance Official.After interviews with Residents #68, #3, #13, and #54 it was revealed that the issue of Resident #8's loud television disrupting other residents had been raised in Resident Council meetings. A record review found no reported grievances regarding this matter.Review of Resident Council meeting minutes dated October 22, 2025 and November 19, 2025, confirmed the discussion about Resident #8's loud television.An interview with the Administrator on 4/15/26 at 9:58 AM verified that the concerns were discussed in Resident Council but were not advanced to the formal grievance process.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and staff interview, the facility failed to ensure MDS Discharge assessments were completed and submitted in a timely fashion. This was a random opportunity for discovery. Resident Identifier: #46. Facility Census: 61. Findings included: a) Resident #46Review of the electronic medical record revealed that Resident #46 had been discharged from the facility on 08/21/24. The electronic record did not reflect that a Minimum Data Set (MDS) Discharge assessment had been completed and submitted. During an interview on 04/14/26 at 2:07 PM, the MDS Coordinator confirmed the MDS Discharge assessment had not been completed and submitted for Resident #46. The MDS Coordinator stated she would immediately address that oversight.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and staff interviews the facility failed to ensure the nurse staffing post form, with the required census information listed, was easily accessible to residents. This was a random opportunity for discovery and could affect a number of residents. Facility Census: 61. Findings included: Upon facility entrance on 04/13/2026 at 11:00 AM, we observed the post staffing form located between the outer entrance door and the lobby door. This placement made it inaccessible to residents and the form lacked the required census information and nursing staff hours worked. During an interview with the Director of Nursing (DON) on 04/15/2026 at 12:48 PM she acknowledged that the post did not list the required census information and was not easily accessible to residents. She also stated that another form was located in the hall but it did not list the required census information.